

[H.A.S.C. No. 112-145]

**BACK FROM THE BATTLEFIELD: DOD AND  
VA COLLABORATION TO ASSIST SERVICE  
MEMBERS RETURNING TO CIVILIAN LIFE**

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JOINT HEARING  
BEFORE THE  
COMMITTEE ON ARMED SERVICES  
MEETING JOINTLY WITH  
COMMITTEE ON VETERANS' AFFAIRS  
[Serial No. 112-71]

HOUSE OF REPRESENTATIVES  
ONE HUNDRED TWELFTH CONGRESS  
SECOND SESSION

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JULY 25, 2012



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#### BACK FROM THE BATTLEFIELD: DOD AND VA COLLABORATION TO ASSIST SERVICE MEMBERS RETURNING TO CIVILIAN LIFE

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**BACK FROM THE BATTLEFIELD: DOD AND VA COLLABORATION TO ASSIST SERVICE MEMBERS RETURNING TO CIVILIAN LIFE**

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HOUSE OF REPRESENTATIVES, COMMITTEE ON ARMED SERVICES, MEETING JOINTLY WITH COMMITTEE ON VETERANS' AFFAIRS, *Washington, DC, Wednesday, July 25, 2012.*

The committees met, pursuant to call, at 10:00 a.m., in room 2118, Rayburn House Office Building, Hon. Howard P. "Buck" McKeon (chairman of the Committee on Armed Services) presiding.

**OPENING STATEMENT OF HON. HOWARD P. "BUCK" MCKEON, A REPRESENTATIVE FROM CALIFORNIA, CHAIRMAN, COMMITTEE ON ARMED SERVICES**

The CHAIRMAN. Good morning. The committee will come to order. Good morning, I welcome everyone for this special joint hearing with the Committee on Veterans' Affairs. Our focus is the collaboration between the Department of Defense [DOD] and the Department of Veterans Affairs [VA] to assist service members transitioning to civilian life. We have two of America's leaders with us, Secretary Panetta and Secretary Shinseki, to discuss how we as a Nation can best serve those who have served us in uniform.

I also welcome Chairman Jeff Miller and Ranking Member Bob Filner and of course Ranking Member Adam Smith from our committee. I thank them all for their significant efforts to address a range of transition issues.

It is no secret that I oppose plans to reduce the size of our military, especially when contingency operations are still ongoing in Afghanistan. I find it strange that at a time when we are still at war, the Department of Defense has announced it will actually reduce the size of the Army and Marine Corps. Such cuts put strain on our service members and their families.

Moreover, I have been very vocal regarding the threat sequestration poses to the strength and integrity of our military. Reductions in end strengths represent additional service members that will be asked to leave the military on top of the over 175,000 service members that separate every year. I will continue to voice my staunch opposition to further cuts to the Defense budget which, if they take effect, will not only increase the damage to our national security, but also put significant strains on the transition system that is already working too slowly.

Today's hearing demonstrates our joint longstanding commitment that there be no gap in services and support provided to our service members and their families as they transition from the Department of Defense to the Department of Veterans Affairs.

The transition that service members experience from active service into civilian life must be improved. Veterans of Iraq and Afghanistan know that the hardships don't end when they leave the war zone. We in Congress are painfully aware that at this very moment 26,000 service members are in the midst of the disability evaluation process and are forced to wait over 400 days on average before they can return home to their communities.

To further assist this transition the Congress mandated over a decade ago that the DOD and the VA create a joint integrated Electronic Health Record [iEHR] to facilitate the transfer of service members' personal health information between the DOD and the VA health facilities. Unfortunately, after continuing delays we are now told that it isn't expected to be completed until 2017.

And finally we hear about the veteran unemployment numbers; 23.3 percent of veterans between the ages of 18 and 24 are unemployed. This highlights the difficulty our younger veterans are having to find employment. The idea that our service members can go from the front lines to the unemployment lines is unacceptable. These men and women whom I have called the next greatest generation, and who with their families have sacrificed so much for this country, deserve better than to have to face the uncertainty of leaving the military in these very hard economic times. We must never stop working on their behalf, and there is much work still to be done.

During my meeting with Secretary Shinseki I came away impressed by his commitment to improving the transition. He met multiple times with Secretary Gates where a joint commitment to action was born. That commitment has continued with Secretary Panetta. I would like to hear from both of you today on the progress that you have made and also what you believe to be the critical next steps, and I would like to compliment both of you for working so hard together to make these things happen.

Specifically, I want both of your views on the Transition Assistance Program, TAP, which facilitates the transition from Active Duty. With regard to objectives, do you both agree on TAP's objectives? For example, is TAP designed to prepare service members for entry into the job market or is the purpose to actually get a service member a job? How do you measure whether TAP is achieving its objectives?

Service members transitioning deserve a government-wide approach that includes support from the Departments of Defense, Veterans Affairs, Labor, Education, Small Business Administration, among others. How is TAP providing such an approach?

The unfortunate consequence of over a decade of war is that service members return with serious life-changing injuries. Even as the numbers of service members being deployed to combat zones goes down, projections are that the numbers of service members and veterans needing support will grow substantially for the foreseeable future. What are both Departments doing to help service members transition as quickly as possible while providing this generation of veterans the treatment they need to return to their families and live fulfilling, independent and productive lives?

Given the significant evolution of medical science, service members now survive horrific injuries that would have been fatal even

during the first Gulf War. Many of these wounded veterans will need long-term, comprehensive services and support that can only be provided by the military and by the VA. How are the Departments resourced for this long-term effort? What are the plans to maintain an equitable joint venture in light of the fact the Department of Defense is facing another half trillion dollar reduction due to sequestration? But the Department of Veterans Affairs is exempt.

I now recognize Chairman Jeff Miller for his opening remarks to be followed by Ranking Member Adam Smith and Ranking Member Bob Filner for their opening remarks.

[The prepared statement of Mr. McKeon can be found in the Appendix on page 47.]

**STATEMENT OF HON. JEFF MILLER, A REPRESENTATIVE FROM FLORIDA, CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS**

Mr. MILLER. Thank you very much, Mr. Chairman, and to our ranking members for helping set up this really truly historic meeting today. According to a quick search, it appears that we never had these two Secretaries simultaneously appearing before our two committees. And I would suggest that we don't wait so long before we do it again. And if we are going to ask the VA and DOD to work together, I think our committees should be doing exactly the same. Secretary Panetta, Secretary Shinseki, it is a pleasure to have you both with us here today, and your presence I think underscores the goal that we all share that our separating service members have a seamless transition from their military life to the civilian life.

Our committee, the Veterans' Affairs Committee, and the Subcommittee on Oversight and Investigation have held at least 13 oversight hearings on transaction related issues. These topics include improving the joint disability evaluation system that your Departments administer, ensuring that the highest quality of health care for the severely wounded who can no longer continue on Active Duty and ensuring that our service members leaving the military are equipped successfully to enter today's workforce.

We have also focused on the tools that your Departments must use effectively to deliver these 21st century services such as the electronic health records and other IT [information technology] solutions. The testimony that we have received so far on matters that we talked about has been somewhat mixed. Although we have heard a number of initiative plans and processes and improvements from your testimony today, I see that it echoes much of those improvements, but I think what we all want to see is clear bottom-line results. Several examples would include notwithstanding the resources that Congress has provided over the last several years to improve Iraq and Afghanistan veterans' access to mental health care, many, many concerns remain.

A VA psychologist testified that, "VA clinicians are overrun with veterans in need. Mental health service lines are pushing as many veterans into clinicians' schedules as possible to meet their performance measures but those veterans are not getting effective treatment."

Secondly, 5 years ago Secretary Shalala and Senator Dole called for the establishment of an effective Federal recovery coordinator program for the seriously wounded and their families. But rather than a single point of contact they called for, VA and DOD created two separate programs. The GAO [Government Accountability Office] testified that “proliferation of these programs has resulted not only in inefficiencies but also confusion for those being served. So consequently the intended purpose, which is to better manage and facilitate care and service, may actually have had the opposite effect.”

Five years ago Senator Barack Obama said, “All of us are in agreement that we need to make the DOD disability review process less complex and better coordinated with the VA process.” However, that process remains slow and continues to be complex. GAO has reported that case processing times have increased over time and measures of service member satisfaction have shown shortcomings.

Finally, despite repeated assertions about the need for VA and DOD to share medical and other information electronically, it seems the goalpost continues to move over and over again on when this is finally going to take place. GAO says VA and DOD still don’t fully agree on key planning and operational elements that would ensure future success.

So it is my hope that raising these important issues to both of you here today will serve as a benchmark going forward by which all of us can hold you or your successors accountable. I know that both of you and I sincerely believe that both of you are committed to solving these problems. However, if what we have been doing isn’t working or isn’t showing the measurable results that we need, then let’s work together to get things back on track.

I look forward to your testimony and yield back my time.

[The prepared statement of Mr. Miller can be found in the Appendix on page 49.]

The CHAIRMAN. Thank you. Mr. Smith.

**STATEMENT OF HON. ADAM SMITH, A REPRESENTATIVE FROM WASHINGTON, RANKING MEMBER, COMMITTEE ON ARMED SERVICES**

Mr. SMITH. Thank you, Mr Chairman. I thank both of our chairmen for holding this hearing. The service member transition is one of the most important issues that we face I believe as a country. We are going to have a large number of men and women who have served in the military transitioning out. How we take care of them is going to be I think one of the ultimate measures of how strong a society we are. I want to thank Secretary Panetta and Secretary Shinseki for being here today and also for your leadership. Having met with both of you, I know how committed you are to this issue and I see it with your DOD and Veterans Affairs personnel. They are absolutely committed to tackling the problem and making changes and making it better. And I think progress has been made in terms of health care and in terms of finding jobs we’ve seen a slight down-tick in the unemployment rate of service members. But we all know that much more needs to be done. I won’t repeat everything that the two chairmen said except to say that I agree with

them on the challenges in this area and how much more we need to do and how much better we need to get at coordinating that service.

I think one of the things that really struck me about this issue is how so many people in this country want to help. Certainly it is true with your two Departments, it is true in Congress, but business leaders, community leaders, and we have so many people out there coming up with creative ideas every day for how to help our service members and their families as they transition out of the military. I think one of the great challenges is how do you bring those resources together and come up with the best practices approach? What works best and how can you then use all of that enthusiasm for helping the people who have served in the military make the most out of those resources and best coordinate it. I think that is a challenge you will have. There are folks outside of the government who are anxious to help, we need to work them in as well. But I agree with both of the chairmen and the challenges that they have outlined. I look forward to your testimony and the questions and answers about how we can best step up to this critically important challenge for our Nation. And with that, I yield back.

[The prepared statement of Mr. Smith can be found in the Appendix on page 51.]

The CHAIRMAN. Thank you. Mr. Filner.

**STATEMENT OF HON. BOB FILNER, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, COMMITTEE ON VETERANS' AFFAIRS**

Mr. FILNER. Thank you, Mr. Chairman, and thank you for holding this hearing. I mean the picture of our two Secretaries sitting there together says it all. I will tell you, Mr. Chairman, when I was chairman of the Veterans' Committee I was trying to work with our party to have such a joint session and we never could accomplish it. So thank you for getting it done. We appreciate that. Thank you, Mr. Secretaries. We are going to use the word "transition" a lot here. I just want to thank—can I say Leon here? When I first came to Congress the Secretary was very helpful in me transitioning from local government to the Congress. And I will never forget your kindness in mentoring, so thank you, Leon, for all of your work over the years with so many people. You have a legacy here of course that we will never forget.

The issues that we have, we have been talking as a Congress and with the executive branch for many, many years, decades in fact, and we've got to break down the bureaucratic stuff that keeps us from having a common, for example, health record system. I mean it just, people die because that system is not integrated closely enough. And it seems that this is not beyond our capacity as a people to get those systems integrated.

I want to say one word, we want to thank the President for announcing this reverse boot camp. I think it is a good start, the recognition of that. But I think it is just a start. And I have been talking for at least a decade about a deboot camp. I don't think, Mr. Secretaries, that you ought to build it on the TAP program. If any of you have attended those programs—what shall I say kindly—they are a waste of time for most people. The only people more

bored than the service members actually sitting there—they are just thinking about getting out, they are not taking into account anything at these lectures—the only thing more bored than them is the people giving the lectures. It is not a very exciting time and to expand it to 5 days doesn't seem to get at the heart. I think you've got to seriously look at—and I know there is cost factor and your predecessors would not look at it seriously—a real deboot camp. When we send our young men and women to military, they go through 10, 12 weeks to get the military ethos; you need almost as much time to transition.

And first and foremost, which the President's program I don't think has, is adequate medical evaluation. You know we have thousands, tens of thousands, probably hundreds of thousands of young people leaving the military without adequate diagnosis of either their mental health or their physical health. We know PTSD [post-traumatic stress disorder] and TBI [traumatic brain injury] could be undiagnosed, they are unrecognized, people are in self-denial. And so they will transition and then have enormous problems, as you know, suicide, homelessness, whatever. We can stop that with an adequate diagnosis.

If you did it in a setting where there was a transitional setting on a campus or, I don't know, some base somewhere with their families, with their company of soldiers, they get the support they need, that they lack when they do a sudden transition. Their families are with them, that is important. You can do their medical stuff, you do the job counseling, you do the educational counseling but in a relaxed atmosphere where everybody is paying attention. It would be part of Active Duty, 8, 10, 12 weeks, whatever you think you can afford. But I tell you 5 days is a start, it is not going to do it. As you know, you know better than all of us, the rate of suicides, the homelessness, the convictions for crimes of recent veterans are symptoms of an incredible problem. It is an epidemic and we are not focusing on—we really don't want to know about it, it seems to me.

And yet if you look at a reverse or deboot camp, and take it seriously, and deal with the medical and psychological and economic and educational issues over a period of time, I think you can greatly reduce this blot on our record after these young men and women serve so professionally in Iraq and Afghanistan or wherever they happen to serve and then come home and have domestic violence, and suicide, and homelessness, and joblessness.

We are not doing our country a service. And I think you have the leadership skills, you have the ability, you work well together that we can get this blot off of our country's record and really do something seriously.

So thank you all for being here. We thank you for your personal cooperation, your personal leadership. You can really change the two biggest bureaucracies we have in the Nation. You two can change them and we look forward to working with you to do it. Thank you.

The CHAIRMAN. Thank you. Given the interest in the hearing today and it is a joint and that fact that it is a joint hearing and, after consultation with Mr. Smith, Mr. Miller, and Mr. Filner, I ask unanimous consent that each member shall have not more than 2

minutes to question the panel of witnesses, starting with me. Hearing no objection, so ordered.

In addition, we will follow our committee rules and recognize members who arrived before the gavel in the order of seniority, alternating between Armed Services Committee majority and minority members followed by Veterans' Affairs majority and minority members.

Lastly, I want to give special recognition to one of our committee staff, John Johnson, better known as JJ, who is responsible for artfully configuring this hearing room that normally holds 64 members, but today had been expanded to comfortably seat 82. You have my personal thanks, JJ.

Now, Mr. Secretary, Secretary Panetta, if you would please begin.

**STATEMENT OF HON. LEON E. PANETTA, SECRETARY OF  
DEFENSE, U.S. DEPARTMENT OF DEFENSE**

Secretary PANETTA. Thank you, Mr. Chairman. I would ask that my full statement be made part of the record, and I will try to summarize it if I could.

The CHAIRMAN. Both of your statements will be fully entered into the record. Hearing no objection, so ordered.

Secretary PANETTA. Thank you very much, Chairman McKeon, Chairman Miller, Ranking Member Smith, and Ranking Member Filner, dear former colleagues of mine, and I appreciate the opportunity to be here, and I also want to pay my respects to the members of both committees. This is a unique event, it is an important event. And first and foremost I want to thank all of the members of both the Armed Services and Veterans' Committee for the support that you provide the Department of Defense, our men and women in uniform and our veterans. We could simply not do the work that needs to be done in protecting this country and in serving those that are warriors and their families. We just could not do it without the partnership that we have with all of you. And for that reason let me just express my personal appreciation to all of you for your dedication and for your commitment to those areas.

I also want to thank you for the opportunity to appear this morning alongside Secretary Shinseki. He is a great friend, a great public servant, a great military leader and a great friend to me and to our Nation's veterans. I appreciate the opportunity to appear alongside of him.

I am pleased to have this chance to discuss the ways that the Department of Defense and the Department of Veterans Affairs are working together to try to meet the needs of our service members, our veterans, and their families. This hearing comes at a very important time for our Nation and for collaboration between our two Departments. DOD and VA are in the process of building an integrated military and veterans support system. It is something that should have been done a long time ago, but we are in the process of trying to make that happen, and develop a support system that is fundamentally different and a lot more robust than it has been in the past.

Today, after a decade of war, a new generation of service members, of veterans is coming home, our Nation has made a lifetime

commitment to them for their service and for their sacrifice, for their willingness to put their lives on the line for this country. These men and women have shouldered a very heavy burden. They have been deployed, as you know, time and time and time again. They fought battles in Iraq; they fought battles in Afghanistan; they have been targeted by terrorists and by IEDs [improvised explosive devices]; they have been deployed from Kuwait to South Korea, from the Pacific to the Middle East. Many are dealing with serious wounds, as well as with complex and difficult problems, both seen and unseen. They have fought and many have died to protect this country and we need to fight to protect them. We owe it to those returning service members and to the veterans to provide them with a seamless support system so that they can put their lives back together, so that they can pursue their goals, so that they can not only go back to their communities but be able to give back to their communities and to help strengthen our Nation in many ways.

None of this, none of this is easy. It takes tremendous commitment on the part of all Americans, those in government, those in the military, it takes tremendous commitment on the part of those in the private sector, our business leaders and, frankly, all citizens across our country.

There is no doubt that DOD and VA are working more closely together than we have before, but frankly we have much more to do to try to reach a level of cooperation to better meet the needs of those who have served our Nation in uniform, especially our Wounded Warriors.

Since I became Secretary a little over a year ago, Secretary Shinseki and I have met on a regular basis in order to personally guide efforts to share resources and expand cooperation between our Departments. Partnership between our Departments extends to all levels led by a joint committee cochaired by the Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary of Veterans Affairs. Senior military leaders have been deeply committed to this effort. This is about the care of their troops, but it is also about recruiting and retaining the very best military force in the world. When it comes down to it, caring for those who have served and their families is not only a moral imperative, it is a national security imperative as well.

For those who have fought for their Nation we need to protect their care and their benefits, but we also need to protect their integrity and their honor. It is for that reason that before I discuss the specifics about DOD and VA collaboration I want to announce an important step that my Department is taking in order to help maintain the integrity of the awards and honors that are earned by our service members and their veterans. You are all aware of the Supreme Court decision that determined that free speech allows someone to lie about military awards and honors. Free speech is one thing, but dishonoring those who have been honored on the battlefield is something else. For that reason, today we are posting a new page on the Defense Department's Web site that will list those service members and veterans who have earned our Nation's highest military awards for valor. Initially the Web site will list the names of those who have earned the Medal of Honor since 9/11.

But in the near term it will include the recipients of the services Crosses and the Silver Star since 9/11. We will look at expanding that information available on the Web site over time. This effort will help raise public awareness about our Nation's heroes and help deter those who might falsely claim military honors, which I know has been a source of great concern for many veterans and members of these committees and Members of the Congress. I want to thank you for your concerns and for your leadership on this issue, and our hope is that this will help protect the honor of those who serve the United States in battle.

Now let me discuss the five priority areas that DOD and VA are trying to work on to enhance collaboration. The first is this transition program, Transition GPS program. At the Department of Defense our goal is to provide a comprehensive Transition Assistance Program that prepares those who are leaving the service for the next step, whether that is pursuing additional education, whether it is trying to find a job in the public sector or the private sector, or whether it is starting their own business.

On Monday the President announced the new Transition GPS program that will extend transition preparation through the entire span of each service member's military career. The program will ensure that every service member develops their own individual transition plan, meets new career readiness standards, and is prepared to apply their valuable military experience however and wherever they choose.

Second area that we focused on is trying to integrate the disability evaluation system. We have overhauled the legacy disability evaluation system and trying to make improvements with regards to developing a new system. In the past, as you know, service members with medical conditions preventing them from doing their military jobs had to navigate separate disability evaluation systems at both DOD and VA. We have replaced that legacy system with a single Integrated Disability Evaluation System [IDES] that enables our Departments to work in tandem. Under the new system currently in use, service members and veterans have to deal with fewer layers of bureaucracy, and they are able to receive VA disability compensation sooner after separating from the military.

But let's understand as we try to do this, this is a tough challenge to try to make this work in a way that can respond to our veterans effectively. After all, veterans have rights, they have the right to ensure that their claims are carefully adjudicated, but at the same time we need to expedite the process and to ensure that as we do that we protect their benefits, and that is what we are trying to do with this system.

The third area is to try to integrate, as was pointed out, a new electronic health record system. We are working on a major initiative to try to do that. For too long efforts to achieve a seamless transition between our health care systems have been hamstrung by separate legacy health record systems. In response to challenge that was issued by the President and frankly Presidents in the past who have tried to address this issue, DOD and VA is finally working steadily to build an integrated Electronic Health Record system. When operational that system will be the single source for service members and veterans to access their medical history and

for clinicians to use that history at any DOD and VA facility. Again, this is not easy, and so the way we are approaching it is to try to see if we can complete this process at two places, San Antonio and Hampton Roads, and then try to expand it to every other hospital. It is tough, but if we can achieve this, it would be a very significant achievement that I think could be a model not only for the hospitals that we run, but for hospitals in the private sector as well.

Fourthly, we need greater collaboration on mental and behavioral health. Beyond these specific initiatives that I mentioned, we are trying to focus on enhancing collaboration in areas that involve some of the toughest challenges we face now related to mental and behavioral health. Post-traumatic stress has emerged as a signature unseen wound of this last decade of war. Its impact will be felt for decades to come and both the DOD and VA must therefore improve our ability to identify and treat this condition, as well as all mental and behavioral health conditions, and to better equip our system to deal with the unique challenges these conditions can present. For example, I have been very concerned about reports of problems with modifying diagnosis for post-traumatic stress in the military disability evaluation system. Many of these issues were brought to my attention by Members of Congress, and I appreciate their doing that, particularly the Senate Veterans' Affairs Committee chairman, Patty Murray, who addressed this issue because it happened in her own State in a particular way. To address these concerns I have directed a review across all of the uniformed services. This review led by the Under Secretary of Defense for Personnel and Readiness Erin Conaton will help ensure that we are delivering on our commitment to care for our service members. The review will be analytically sound, it will be action oriented, and it will provide hopefully the least disruptive impact to behavioral health services for service members. The effort here is to determine where those diagnoses take place, why they were downgraded downward, what took place so that we know exactly what has happened. I hope that the entire review will be completed within approximately 18 months.

The last area is an area that has really concerned me, which is the area of trying to prevent military suicides. We have strongly focused on doing what we can to try to deal with this issue, which I have said is one of the most frustrating problems that I have come across as Secretary of Defense. Despite increased efforts and attention by both DOD and VA, the suicide trends among service members and veterans continues to move in a very troubling and tragic direction. And part of it is reflected in larger society. The fact is numbers are increasing now within the military. In close cooperation with the VA, DOD is taking aggressive steps to try to address this issue, including promoting a culture to try to get people to seek help, seek the kind of help that they need to improve access to mental and behavioral health care, to emphasize mental fitness and to work to better understand the issue of suicide with the help of other agencies, including the VA. One of the things I am trying to stress is that we have got to improve the ability of leadership within the military to see these issues, to see them coming and to do something to try to prevent it from happening.

Our efforts to deliver the best possible services depend on the dedication of our DOD and VA professionals who work extremely hard every day on behalf of those who have served in uniform, and I extend my thanks to all who help support our men and women in uniform today, to our veterans and to our families.

Let me just say we are one family, we have to be one family at the Department of Defense and the Department of Veterans Affairs, a family that supports one another and all those who have answered the call to defend our country. Together we will do everything possible to ensure that the bond between our two Departments and between our country and those who have defended it only grows stronger in the future.

Let me also say this. As a former Congressman, now as Secretary of Defense and someone who has spent over 40 years involved in government in some capacity or another, I am well aware that too often the very best intentions, very best intentions for caring for our veterans can get trapped in bureaucratic infighting, it gets trapped by conflicting rules and regulations, it gets trapped by frustrating levels of responsibility. This cannot be an excuse for not dealing with these issues. It should be a challenge for both the VA and DOD, for the Congress and for the administration to try to meet that challenge together. Our warriors are trained not to fail on the battlefield. We must be committed not to fail them on the home front. I realize that there have been a lot of good words and a lot of good will and a lot of good intentions, but I can assure you that my interest is in results, not words. I am grateful for the support of the Congress, particularly these two committees, and I thank you and look forward to your questions.

[The prepared statement of Secretary Panetta can be found in the Appendix on page 56.]

The CHAIRMAN. Thank you, Mr. Secretary. You know there have been comments made about how unique this is to have this joint hearing between these two committees. It resulted from Chairman Miller coming to me with the idea and I want to thank him for that, and I think it also happened because we have two such outstanding Secretaries, both of whom are veterans, both of whom have devoted their life to service of this country. Secretary Panetta, many years in Congress, was here when I first came here and a couple of others of us that are still here, Mr. Barton and Mr. Filner. We are the old, old people on this committee now. But you were taken from our midst over to serve the President as Director of OMB [Office of Management and Budget] and then as his Chief of Staff, and then later was Director of Central Intelligence Agency and now as Secretary of Defense. I think that is a lifetime to be commended.

And Secretary Shinseki, starting with entrance into the United States Military Academy, lifetime of service in the Army, culminating as Chief of Staff of the Army. No one could have a better career, leading troops in battle and leading the entire Army in the start of this war against terrorism. Thank you both for your service.

Mr. Secretary.

**STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY OF VETERANS AFFAIRS, U.S. DEPARTMENT OF VETERANS AFFAIRS**

Secretary SHINSEKI. Thank you, Mr. Chairman. Chairman McKeon, Chairman Miller, Ranking Member Smith, Ranking Member Filner, other distinguished members of both committees, the House Armed Services and House Veterans' Affairs Committees, thank you for your steadfast support of service members and veterans and for this opportunity to testify before you.

I am honored to be here with my friend as well, Secretary Leon Panetta. His leadership and close partnership on behalf of those who wear and have worn the uniforms of our Nation has been monumental.

I would also like to acknowledge I believe we have here and other places veterans service organizations [VSOs] and veterans who are here today. I acknowledge them because with the VSOs, their insights have been helpful in developing, resourcing, and improving the programs that we oversee in the Department of Veterans Affairs.

I have said it often enough and I will say it one more time, little of what we do in VA originates in VA. Much of what we work on originates in DOD. And so what this means is that we in VA must be aware, must be agile and then must be fully capable of caring for those who have, in Lincoln's words, borne the battle. As a footnote, we still today in VA care for two children of Civil War veterans. The promises of President Abraham Lincoln are being delivered today by President Barack Obama, this Congress, and the VA. And 100 years from now we will still be fulfilling our commitment to the current generation of veterans, their families, and our survivors.

History also shows, and this is VA's piece of history, also shows that our requirements in VA continue to grow for about a decade and maybe sometimes a little more after the last combatant comes back from operation. And so in this case about a decade or more after the last combatant leaves Afghanistan, VA's requirements will continue to grow; the operation will be over and budget will begin to reflect that, but at VA our requirements will still be growing.

So for us it is important that we spend the time now to better anticipate their needs for care, for benefits and for a successful transition to civilian life for this current generation, without losing sight of the needs of previous generations that we also care for.

Collaboration and cooperation between VA and DOD have never been more important and I think for the next two decades it will be entirely important because this will be in large measure the work of the Nation and focusing on how we care for the less than 1 percent of Americans who serve in uniform today and provide for us this way of life.

Most significantly, we are looking initially here at four areas. Three of those areas will match up with what Secretary Panetta just provided. That doesn't mean that in his five and my four we are disconnected, but we describe them just a little bit differently.

The integrated Electronic Health Record, the iEHR, which you have remarked has been in the process of discussion for 10 years

now, I think both Secretary Panetta and I have agreed on what that will be and we are moving towards a solution.

The second point, more comprehensive sharing of data through a virtual lifetime electronic record, of which integrated Electronic Health Record is a key component.

The third area of focus, the Integrated Disability Evaluation System, which is primarily a DOD enterprise with significant VA support to ensure an efficient process.

And the fourth of our VA's areas of focus, the President's initiative to redesign the transition process and the implementation of the VOW [Veterans Opportunity to Work] to Hire Heroes Act.

My testimony submitted to the committee expands on each of these areas in some detail, and I thank the chairman for accepting that written testimony into the record and I won't go into them in detail at this time.

Well, let me briefly emphasize that it is especially important that we assure the greatest collaboration between VA and DOD in that critical phase before service members leave the military. We simply must transition them better. And I speak as one who has watched that process from a different vantage point over time. We do this best with warm handoffs between the Departments. That is key to assuring the success of transitioning service members back to their communities in productive ways. But it is also key in preventing the downward spiral that some face in being challenged. Transitioning doesn't work quite as well for them and in some cases homelessness and sometimes suicide are what we have to deal with.

So I echo Secretary Panetta's comments. While we are pleased with the progress made to date on critical issues common to both VA and DOD, we know we have a responsibility to better harmonize our two large Departments in ways to better serve service members, families, veterans, and our survivors. Their well-being is the strongest justification of why we should be working together more closely and more collaboratively and we are today. There is more important work to be done, and I am proud to move forward with Secretary Panetta to make the most progress possible in our time on behalf of those who wear and have worn the uniforms of our Nation.

And with that, Mr. Chairman, thank you and to the members of this committee for your unwavering support of our efforts, and I look forward to your questions.

[The prepared statement of Secretary Shinseki can be found in the Appendix on page 64.]

The CHAIRMAN. Thank you very much. I ask unanimous consent to include the record of all member statements into the record. Without objection, so ordered. We have already agreed that we will have about 2-minute questions, so I would encourage members to make their questions short so that we can have the answers complete, and we will start with me.

As I have already said, we know that there is high unemployment among our veterans, our young veterans. And we know with the \$487.0 billion cut in defense we will have 100,000 leaving the military. We will have another 100,000 if the sequestration takes effect.

What plans do we have to ensure that these service members will not go from the front lines to the unemployment lines? And how do you see potential reduction in the defense workforce resulting from the sequestration? What effect will that have on what will you be able to do to try to move them into some meaningful employment, Mr. Secretary?

Secretary PANETTA. Well, I sure as hell hope that sequestration doesn't happen.

The CHAIRMAN. I am with you.

Secretary PANETTA. It would be, as I have said time and time again, a disaster in terms of the Defense Department as far as our budget is concerned and as far as our ability to respond to the threats that are out there and it would have a huge impact. It doubles the cuts in the military. It would obviously add another 100,000 that would have to be reduced, and the impact of that on top of the reductions that are currently going to take place would place a huge burden on the systems to be able to respond to that. I think it would be near impossible to try to do the kind of work that we are trying to do and make it work effectively.

I think we can handle what we have proposed in our budget and the drawdown numbers that are coming now. We have tried to do this pursuant to a rational strategy over these next 5 years. And I think the systems we are working on and what we are trying to put in place I am confident can respond to that. But if sequester should happen and if an additional burden is suddenly put on top of it, I think it could really strain the system.

The CHAIRMAN. Mr. Secretary, could you please give us that input for the record?

Secretary PANETTA. Absolutely.

[The information referred to can be found in the Appendix on page 84.]

The CHAIRMAN. In keeping with it. My time has expired. Mr. Miller.

Mr. MILLER. Both Secretaries, in 1961 John F. Kennedy said we would put a man on the Moon, 8 years later America was there. We are talking about an integrated Electronic Health Record by 2017. Why could we put a man on the Moon in 8 years and we are not starting from ground zero with electronic health record. Why is it taking so long? Because it so vital especially, Secretary Shinseki, to solving the backlog issue that exists out there today in regards to disability claims.

Secretary SHINSEKI. Mr. Chairman, I can't account for the previous 10 years. I do know there is a history here. But let me just suggest that two large Departments, each having their own electronic health record, which happened to be two very good, maybe the two best, electronic health records in the country, and trying to bring that culture together to say we are going to have one, and it is entirely possible. And I agree with you it is not technology, it is leadership here. And between Secretary Panetta and I, we have in the last year met four times. We are going to meet again in September. We are here today testifying together. I think this is a great signal to both of our Departments. Prior to that I recall meeting with Secretary Gates four or five times. So in 17 months, with two Secretaries of these two large Departments have sat side by

side in direct communication on issues like this, with the integrated Electronic Health Record being the primary topic of discussion. It has taken us 17 months to get to an agreement that both Secretary Panetta and I signed that describes the way forward. And the way forward for us is a single joint common integrated Electronic Health Record. Each of those words means something. But key here is an agreement that it will be open in architecture, nonproprietary in design. That is a significant change from previous discussions which were wrapped around which proprietary contractor were we going to be interested in in establishing an arrangement with. I believe that was part of the challenge. The fact that we have agreed on a concept I think is groundbreaking here, and both Secretary Panetta and I have agreed to move forward on this.

The CHAIRMAN. Thank you very much. The gentleman's time has expired. Again if you could complete the record on those questions that would be good.

Mr. Smith.

[The information referred to can be found in the Appendix on page 83.]

Mr. SMITH. Thank you, Mr Chairman. I have a question about the TAP program, following up on some of the comments Mr. Filner made. Exit interviews are notoriously difficult to get people interested in and I think the problem is service members are out, they are moving on. I met with some of your folks from both your offices that showed me how they had refined the program; they used to have a book this big, now they have a book this big.

The bottom line is what are your thoughts on what you can do to get the service members to pay attention to the two or three most important things in that transition. It strikes me like we are overwhelming them with information, eyes just glaze over. If you had to explain it to them in 15 minutes, what are the critical pieces of information that you want to give them? How can we make that work better?

Secretary PANETTA. I will yield to Secretary Shinseki as well on this. You know, I remember when I got out of the service I couldn't wait to get the hell out of there and I didn't really want to spend a lot of time having people tell me what I was or was not going to do. In this instance I think the best way to try to bring these opportunities to attention of members is the counselors. We are assigning individual counselors as part of the transition program. They are going to sit down individually with them. I think that is the best way to get their attention and try to get them moving with regards to the potential benefits that are available to them.

Secretary SHINSEKI. Just very quickly, I would echo Secretary Panetta here. I know that when I got ready to get out of the military I couldn't wait to get the hell out of there either. I would just say if we look at this as a transition assistance program, and the focus is on assistance, I think we come at it with a different attitude. If we look at this as an education responsibility of preparing folks for at least the next phase of their lives to make the right decisions, whether it is education, whether it is a work choice and certainly from the VA's point of view we are entirely interested in getting as many departing service members enrolled with us.

Whether or not they have a requirement for health care today, having them enrolled 5 or 10 years down the road when issues crop up we have the evidence necessary to be able to deal with it. So we need to look at this as more than just assistance, but this is really preparing them, making them career-ready for the next phase of their lives.

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

The CHAIRMAN. Thank you.

Mr. Filner.

Mr. FILNER. You know, in a democracy where you need obviously the support and vote of people to go to war, the cost of war is a pretty important item to understand. And treating our veterans is obviously a part of the cost of war or should be considered that. I have tried on several occasions to add an amendment to any war appropriations, I don't know 15 to 20 percent surcharge, because that is the difference in your budgets for veterans. And of course since we have been borrowing money for war and nobody wants to borrow the money for veterans. So it is not looked on kindly.

But part of the cost of war, you know, we have the statistics, so about 6,000 killed in action—I am sorry, 5,000 killed in action since 9/11, and almost 50,000 wounded. And yet, those who have showed up at the VA for help, and I know there are different definitions and different circumstances, I think it is close to, or could be over a million. Why is there such a disparity between—and it is important for the public to understand, what is the cost of war? How do you account for 1 million veterans seeking help for problems in war, and only 50,000 considered casualties?

Mr. Panetta, I will go to you first. Since you know how to manipulate the 2 minutes, you are looking to him, I know, so you don't have to answer.

Secretary PANETTA. No. I mean, it clearly is the impact of war over the last 10 years and how it has affected those who have served. And when they do return, when they come back, the reality is that, you know, that not all of them, not all of them are getting the kind of care and benefits that they should get. And it is our responsibility to try to respond to those needs as they return.

Look, this system is going to be overwhelmed. I mean, you know, let's not kid anybody. We are looking at a system that is already overwhelmed. The likelihood is as we draw down further troops and, you know, over these next 5 years, assuming sequester doesn't happen, we are still going to—you know, we are going to be adding another 100,000 per year. And the ability to be able to respond to that in a way that effectively deals with the health care issues, with the benefits issues, with all of the other challenges, that is not going to be an easy challenge. And you talk about the cost of war, this is inherently part of the cost of war. It is not just dealing with the fighting, it is also dealing with the veterans who return. And that is going to be a big ticket item if we are going to do this right.

Mr. FILNER. I just hope you look at that boot camp idea as a way to really get at that issue.

The CHAIRMAN. Thank you. Mr. Bartlett.

Mr. BARTLETT. Thank you. By almost every account, we are failing our veterans. More of them are killing themselves than are killed by the enemy in Afghanistan, and the suicide rate is increas-

ing. Homelessness is approaching the percentage of Vietnam veterans, and that is increasing. Unemployment is more than twice the unemployment percentage of the general population. The in-service disability evaluation delays are unacceptable. And after they are out, it may take more than a year. They are unemployable because of a disability, it may take more than a year for them to get that disability.

Secretary Panetta, you mentioned that you hope that an 18-month review could be completed on time. I would suggest, sir, that that does not reflect the sense of urgency that this challenge requires. What do we need to do in the Congress to address this problem?

Secretary PANETTA. You know, I think that the one thing I have seen is that all of us share the same concern with regards to our ability to respond to these issues. The challenge is that as we try to make these systems work, there is a lot of built in resistance to adapting and changing the way we do things. And to the extent that we can work together, to try to make sure that we push for these changes to take place, and do it in a way that effectively responds to the challenges, that is something I think both the Congress as well as the administration have to push.

We cannot accept the old way of doing things. Things are going to have to change. Things are going to have to be modified. People are going to have to respond differently. If we expect the same old responses to the problems we are having, then we are going to have the same old problems. We have got to change the way people respond to these issues.

The CHAIRMAN. Thank you. Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman. And thank you, Secretaries, for being here. First of all, I wanted to thank both of you because you have put your personal leadership in areas that have never been done before. The issue of women have been very important to both of you in the military, both in terms of sexual harassment and attacks and those kinds of things.

Secretary Panetta, you have been a stalwart there. And Secretary Shinseki, your leadership in prioritizing homelessness among veterans, especially among women veterans, is very much appreciated. I can tell you because veterans very much appreciate those priorities and your personal leadership in that. So I know both of you face immense challenges. But reflecting on what Chairman Miller said, I hope we continue to do these kinds of joint hearings because this truly is an important—I think one of the most important things that both of these committees can focus on. Just echoing what my chairman, Chairman Bartlett said, can each of you comment briefly on where we can be most helpful in terms as a Congress, especially from these two committees?

Secretary SHINSEKI. I can speak on the VA piece of this. Actually, the Congress has already provided some significant assistance to VA. I would recall in 2008 and 2009, our budgets were enhanced by Congress. Since then, you have provided us advanced appropriations. Now, not all agree that it was a good move, but for VA, it provided us an opportunity to have a 2-year look at our budgets. And what it assured is that for the health care piece of our budget, every year on 1 October, whether or not there is a continuing reso-

lution, we are able to fund our health care requirements so that veterans—there isn't a gap in care for veterans. In those ways, meaningful support has been provided.

I would also say that we are dealing with issues that grow over time, and some of them very quickly, mental health, PTSD. The budgeting process is based on knowing requirements well out, and methodically reacting to growth in trend. When you have large growth in a short period of time, the budget process is not quite as agile, and it is a bit reactive. And so our efforts to try to harmonize, the reason that we are here is so that VA has some good ideas on what to expect and be able to put that into our budgeting process.

The CHAIRMAN. Thank you. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. Thank you, Secretary Panetta and Secretary Shinseki. You both mentioned in your testimony the prevalence of PTSD and TBI. And I believe we certainly need more research to establish better diagnostic tools and treatments. Through what channels are the DOD, VA, and the private sector sharing the research findings and collaborating on the direction of future research?

Secretary SHINSEKI. I would just offer in 2009, the DOD and VA held its first mental health summit, a joint effort to bring our mental health programs to the same table and have a discussion. Twenty-eight strategic findings that came out of that, those findings we continue to execute today. While it was a broad look, inside that discussion were issues on PTSD, TBI. We spent about \$30 million in the VA budget on research for PTSD. We learned a lot from DOD because they have extensive experience in this area in terms of diagnosis and dealing with PTSD, with formations, with people in formations, in combat, going back to combat.

So there is much that we learn from our collaboration with DOD, through our research. More to be done, to be sure.

Secretary PANETTA. Let me add, what we try to do is to do mental health assessments both before and after deployments, so that we can identify and try to treat somebody who might have a problem, specifically with a PTSD. We have done about 600,000 of these assessments. Our greatest limitation, our greatest limitation is the number of care providers is simply not sufficient for the demand. And we are competing with VA and with private health care systems to hire these people. But that is a real—that is an area of tremendous need in order to address the amount of problems we are facing.

The CHAIRMAN. Thank you. Mr. Michaud.

Mr. MICHAUD. Thank you very much. I want to thank you both for your service and for your both being here this morning. A quick question, and I want to read from a veterans service organization letter that they actually sent to Senator Webb just last week, and just part of it that says: "The only branch of the military to show a marked improvement decreasing the number of persons taking their own lives is the United States Marines. They should also be praised for their active leadership from the very top in addressing the problem and implementing the solutions. The remaining services have yet to be motivated to take any substantive action."

Secretary Panetta, I have been to Iraq and Afghanistan several times, and I looked the generals in the eye and I asked them what are they doing personally to help destigmatize TBI, PTSD. And the second question is do they need any help? I get the same answer over there as I do here in DC, everything is okay. We have all the resources we need, we don't need any help. But the interesting thing is someone of much lesser rank came up to me after I asked the general that question outside and said we need a lot more help. And he suggested I talk to the clergy to find out what they are seeing happening.

And I did, that trip, and every trip since then. And I am finding that our service members are not getting the help that they need. And my questions, particularly after looking at this letter that was sent to Senator Webb, it appears the Marines are doing a good job. So why is it so different between the Marines, the Army, and other branches? And can you address that?

Secretary PANETTA. You know, obviously there is no silver bullet here, I wish there were, to try to deal with suicide prevention. We have a new Suicide Prevention Office that is trying to look at programs to try to address this terrible epidemic. I mean, we are looking just—if you look at the numbers, recent totals are, we have got about 104 confirmed, and 102 pending investigations in 2012. The total is as high as 206, almost one a day that we are seeing. That is an epidemic. Something is wrong.

I think one of the areas—I mean, look, part of this is people are inhibited because they don't want to get the care that they probably need. So that is part of the problem is trying to get the help that is necessary. Two, to give them access to the kind of care that they need. But three, and again, I stress this because I see this in a number of other areas dealing with good discipline and good order and trying to make sure that our troops are responding to the challenges, it is the leadership in the field, it is the platoon commander, it is the platoon sergeant, it is the company commander, it is the company sergeant. The ability to look at their people to see these problems, to get ahead of it, and to be able to ensure that when you spot the problems, you are moving that individual to the kind of assistance that they need in order to prevent it. The Marines stay in close touch with their people. That is probably one of the reasons that, you know, the Marines are doing a good job. But what we are stressing in the other services is to try to develop that training of the command so that they, too, are able to respond to these kinds of challenges.

The CHAIRMAN. Thank you. Mr. Thornberry.

Mr. THORNBERRY. Secretary Panetta, there was a cover story on military suicides in Time Magazine within the past couple weeks. And some statistics really jumped out at me. One fact they said is that 33 percent of military suicides had never deployed overseas at all, and 43 percent had been deployed once. That is 76 percent, if you add it together. I am wondering, number one, are those statistics accurate? And number two, what does that tell us about the problem if a third of all the suicides—we are focused so much on the PTSD and so forth, if they have never deployed at all and a third of the suicides, maybe we are not looking at all the factors.

Secretary PANETTA. Those numbers are accurate as far as we know. And I think what you are seeing is that it reflects the larger problem in the society. Because the fact is that suicides are on the increase in the rest of society as well. So, problems with drinking, problems with finances, problems within the family, problems, you know, of trying to deal with conflicts that they are confronting, problems of dealing with just the general pressures that we are seeing in a society that is dealing, obviously, with economic pressures, at the same time is dealing with social pressures.

All of that is impacting on families. And that is true in the military as well. And that is why we are seeing this occur not just from those that are deployed to the battlefield, but we are seeing it with regards to families that are here.

Mr. THORNBERRY. It just seems to me that puts a little different perspective on the scope of the issues that both you gentlemen have to deal with if it is not just combat, but the entire gamut of those problems. Thank you, I yield back.

The CHAIRMAN. Thank you. Mr. Secretary, do you know if there is any correlation between this age group in the military committing suicide and those not in the military, but of the same age group committing suicide?

Secretary SHINSEKI. Mr. Chairman, an important question. The CDC [Centers for Disease Control] publishes every year the top 10 leading causes of death amongst Americans. And as I recall, the last report—and it is a continuous track in the age group 15 to 24, suicides is the third leading cause of death in the top 10 of Americans. In the age group 25 to 34, it is the second leading cause of death.

So suicides, it is a national discussion here. And when you recruit out of that population and put youngsters through the stresses we all are familiar with in combat, very small percentage serve in uniform, yes, suicides become a matter of great focus, interest, and importance to both Secretaries. I guess the follow-on question is how do we try to decide who are best suited to serve in the recruiting effort? But I no longer have those responsibilities. I used to at one time.

The CHAIRMAN. Thank you. Ms. Sanchez.

Ms. LORETTA SANCHEZ. Thank you, Mr. Chairman. And thank you, gentlemen, again, for being before us today. In preparing for this hearing, I asked my staff back in Orange County to go through the casework we have with respect to veterans in transition. And although we have a great relationship with our VA Hospital in Long Beach, and we have two clinics, one in Santa Ana and one in Anaheim in our district, the reality is that the most troublesome area with respect to these cases involve the quality and the lack of health care for our service members who are transitioning from active, or having been called up and are now out into the veterans world, if you will. And in fact, I have a lot of veterans who come to my office and they express real concern about not receiving treatment or having a long time to wait for a specialty doctor, for example.

In Long Beach, it would be oncology, where we must be short-staffed or something of the sort. And the other really big concern for them is the issue of being prepped up for a surgery and then

somebody on the surgery team doesn't show up out of whatever, and the surgery is then postponed. And it isn't until these people come to my office and we call in directly that we are able to get that rescheduled.

So my question is, how are you addressing these types of concerns with respect to health care? And why, if a surgery is scheduled, why aren't people showing up to be on that surgery team? And more importantly, why does it take a congressional office to call to ask that it be rescheduled?

Secretary SHINSEKI. All fair questions, Congresswoman. If you would give me the details, I am more than happy to research both your frustration and mine. We owe veterans better. And I agree with you.

Ms. LORETTA SANCHEZ. My second question is with respect to homelessness. We have a lot of great organizations helping us with that, but they are low on funds. Is there any grant program coming up for something like that for local 501(c)(3)s to help?

Secretary SHINSEKI. We have provided grants for the past 2 years. Two years ago, about \$60 million worth of grants were provided under the Supportive Services to Veterans' Families Fund. Just recently announced this year's investment of \$100 million. And in the 2013 budget we have a request for an increase to that investment as well.

Ms. LORETTA SANCHEZ. Thank you so much, Mr. Secretary.

Mr. THORNBERRY [presiding]. Mr. Stutzman.

Mr. STUTZMAN. Thank you, Mr. Chairman. Thank you to both you gentlemen for being here today. The President has announced a new model of the TAP program. As we understand it, everyone will be required to attend a 1-day DOD pre-separation class, followed by a 3-day employment workshop, and a 1-day VA benefits briefing.

Other training in non-job seeking, such as determining readiness for postsecondary education and entrepreneurship, will be offered as voluntary, and not subject to the mandatory provisions of law. This is hardly a tailored approach that would meet the needs of those whose post-discharge intentions are to attend school or to start a business. Offering nonemployment-related instruction as voluntary ignores the fact that it is difficult enough to get supervisors to allow service members to attend the current 3½-day course, much less 7 or 8 days away from the unit, especially if that unit is preparing to deploy. Will you make all 8 days of TAP, including the voluntary nonemployment, mandatory?

Secretary PANETTA. I think we have got to move in that direction. You know, we are doing nine pilots that are basically going to test this out. And we are hoping to complete those pilots by November and learn, you know, just exactly what we have to require, how do we have to mandate it, how do we have to revise it. But, you know, my sense is the only way it works is if you make it mandatory.

Mr. STUTZMAN. The model that the Marine Corps is using in giving the options to those who are about to discharge, is that a model that is worth looking at as well?

Secretary PANETTA. I would think so.

Mr. STUTZMAN. It seems like that would give a lot of flexibility, because not every service member is going to be coming out planning on just going into the workforce.

Secretary PANETTA. That is right. Some will want to stay.

Mr. STUTZMAN. Absolutely. Yes. Thank you. I yield back.

Mr. THORNBERRY. Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman. I would like to thank both chairmen and the ranking members for making this happen. I have talked seamless transition for most of my adult life, and it appears like it is happening. So I thank you. And to both of you, you have my deepest gratitude, and the people of the First District, for the defense of this Nation and the care of our veterans. I have got kind of a tough one here, it is a troubling one, I know it troubles both of you. The issue that came out in the GAO report of the 26,000 soldiers discharged under personality disorders. My question is, and it is brought to the fact by the Vietnam Veterans Commission to study at Yale Law School about what are we doing about that? And my question to you, probably to you, Secretary Panetta, is what are we doing to review and correct the records of those veterans who may have been improperly discharged with a personality disorder diagnosis?

Secretary PANETTA. We are conducting a complete review of those areas. We have responded to the situation that took place up in Washington. That was the focus of the GAO report. And that is what concerned us a great deal. And as a result of that, we are not only running a review there, we are running a review elsewhere to make sure that the same kind of problems have not occurred elsewhere. You know, it is important that we determine why someone would get this diagnosis and then it would be downgraded. I mean, there may be some legitimate reasons for it. But in this instance, it happened to too many people. And that raised tremendous concerns.

Mr. WALZ. I appreciate that sentiment. Because my concern, I am sure like yours and now Secretary Shinseki's, is that one of the biggest problems here is it is not benefits compensation, it is the inability to get care for existing, and that could have been whether it was existing or exacerbated by their combat experiences, their time in the military, they are not getting that care through our wonderful folks at the VA, and how do we fix that? I would add, too, that as these have decreased, personality order discharges, adjustment disorder have increased. And so I thank you both for paying close attention to this. I yield back.

Mr. MILLER [presiding]. Mr. Jones.

Mr. JONES. Thank you, Mr. Chairman. Mr. Secretary Panetta, 2 years ago in the NDAA [National Defense Authorization Act] bill, the House had a provision that said if you have served this country at war and you come back home and you are in the process of a medical review of your condition, but in that period of time, you self-medicate and get yourself in trouble, so therefore you have been given less than an honorable discharge before the Medical Review Board finalized their decision, the House position basically said to that individual, if you are given less than an honorable discharge, you can go back to the Department of Defense and ask the

Department of Defense to review your medical records and maybe change your discharge.

And I would like to know how you all are handling this issue, how you are contacting those who maybe were given less than an honorable discharge?

Secretary PANETTA. Congressman, let me respond to you directly through the Department. Because this is the first time I am familiar with the issues you just presented. And I want to give you an accurate answer. And let me give you that answer through the Department, if I could.

[The information referred to was not available at the time of printing.]

Mr. JONES. Thank you, Mr. Secretary. That would be very satisfactory. And thank you very much. I yield back.

Mr. MILLER. Ms. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman. And thank you both for your really unparalleled leadership in trying to work and coordinate these programs. I wanted to ask you about coordination, about resolving the misalignment between the two care coordination programs between the DOD and the VA. You talked about traps and trying to get over those. What is it that is causing these problems? I know one of my colleagues mentioned earlier that it seems to be creating more confusion than anything else.

Secretary PANETTA. You know, the biggest problem here is these things have developed on separate tracks. And as a result, you know, you got two bureaucracies that basically developed their own approach to dealing with these systems. And they get familiar with them, that is what they use, they resist change, they resist coordination, they resist trying to work together. And that is the fundamental problem we have.

Mrs. DAVIS. Have we tried to switch off occasionally? I think one of the other issues I really wanted to ask about was counseling, because the coordination programs as well as the Transition GPS program that the President has proposed and we are moving forward on, call for counselors. And we know the problems in mental health, but how are we planning for the kind of counselors that are going to be needed for this? Because clearly, they are going to have to be cross-trained in many ways, understanding both systems as well as small business, et cetera. How are we planning for the immersion of these kinds of folks who are really going to be critical to this, yet we really don't have them in any great number?

Secretary PANETTA. That, I think, is the fundamental key to making this transition work, is to have counselors that are familiar both with veterans and defense areas. What are the benefits? What are the opportunities that are available? And be able to present that. So it is going to take some training of the people that are going to be part of this effort so that they provide good counseling to those that are involved.

Mrs. DAVIS. Is there a cost factor involved in that as well that we need to address?

Secretary PANETTA. There is going to be a cost factor involved here. And, you know, we will have to discuss it.

Mrs. DAVIS. May I just suggest as well that there may be some great models around the country? We think we have one in San

Diego. And if we could look at some of those models, that would be helpful. Thank you. Thank you, both.

Mr. MILLER. Mr. Flores.

Mr. FLORES. Thank you, Mr. Chairman. Thank you, Secretary Panetta and Secretary Shinseki for being here today. Also Secretary Panetta, thank you for protecting valor for those that have earned it. My question is a little bit more theoretical. And what prompts this is the claims processing time at the Waco Claims Regional Center in Texas, which is the worst in the country when it comes to adjudicating disability claims. What can we do if the IDES doesn't work? I mean, what are you thinking about in terms of a new paradigm to fix this issue? And both of you can answer, either one of you. It seems to me like we have got cultural issues that cannot be fixed by having new systems. So how do you make—I mean, you are doing your best to get the systems right, but what are we doing to fix the culture so that we do what we promised our military men and women, our veterans that we would do in terms of providing benefits to them for their service?

It just seems to me like, you know, we have spent all our time on systems, we are not spending any time on culture. So can you help me with that? And let me interrupt before you answer. One other thing. Are you thinking about a pilot program so that if IDES doesn't work, what are you going to do? Where is the clean sheet of paper? Where is the whiteboard that has the big ideas to fix this?

Secretary SHINSEKI. Congressman, I just want to be sure I am answering the right question here. Waco and claims would sound to me like disability claims that we normally handle. IDES is a joint program that DOD and VA. So it is the IDES question that you have here. We have piloted IDES. We started off with 27 sites. These are a DOD initiative with VA in support. We are at 139 sites now, fully operational across the Nation. And I think we both have put in place controls that will drive this to the target, which is 295 days for processing. Now, that sounds like a lot of time. On the one hand, when we did our systems independently, sequentially, DOD first and then VA, it was like 540 days. Right now, with an Integrated Disability Evaluation System, that is down below 400 days, and we are targeted on 295.

When we get to 295, which is going to be a bit of work, and it sounds like a long time, but involved in the 295 days is care and surgical procedures that veterans who have been injured are still going through. And there is leave associated with that. Whenever a surgery occurs, an individual is provided X amount of days for recuperation leave, so to speak. All of that is factored into this 295. So when the 295, while it sounds large, it is a treatment and transition program. I think we have a right model here. What is incumbent on us is to get to the targets we have described. In the 295, VA's piece of that is about 100 days. Right now we are at 145 days. We have been as low as 103, and then we get a surge from our friends in DOD and we adjust. But we know we can get to 100 days. And we are proceeding.

Mr. MILLER. Mr. Forbes.

Mr. FORBES. Thank you, Mr. Chairman. Secretary Shinseki, we know right now that VA topped out in May at about 904,000

claims. And as you just mentioned, we have got about 65 percent of them are over 125 days, and 1.25 million is projected for 2013. My question is, can the current system handle the expected reductions in end strength projected in the President's budget and under sequestration? And if you could give me a yes or no answer on that, and then elaborate any way you want to to clarify it?

Secretary SHINSEKI. Your number is a little higher than mine, but I will accept it. It is a big number, nearly 900,000 by my count. Let me explain why the inventory, that is the total number of claims in processing, and the backlog portion of that, 65 percent or so, 550,000 of those are backlogged, why these numbers result. In the last 3 years, the VA has made three significant decisions. We awarded Agent Orange service connection for Vietnam veterans, three new diseases; we awarded Gulf War illness, nine new diseases for veterans who had been waiting in the case of Gulf War veterans 20 years since the conclusion of that conflict; for Vietnam veterans, 50 years.

We also granted, the third decision was combat verifiable PTSD service connection for anyone who served in combat and has been diagnosed with verifiable PTSD.

Mr. FORBES. Mr. Secretary, my time is running out. How will sequestration and these end strength reductions impact these claims going forward?

Secretary SHINSEKI. Well, I would say that in the case of VA, we have been informed that VA is exempt from sequestration except for administrative costs. I don't have a definition of administrative costs right now. But what I would, Congressman, say, that I am with Secretary Panetta, the reason you have the two of us here, whatever impacts him is going to have some effect here, even though I have been exempted. And it has my attention.

Mr. FORBES. Thank you, Mr. Chairman.

Mr. MILLER. Mr. Secretary, you just said that possibly administrative costs would be affected by sequestration. The President the other day at the VFW [Veterans of Foreign Wars] said no veteran issues would be touched by sequestration. Could you explain to this committee? Because there is still some conflicting information that is out there from the acting OMB [Office of Budget and Management] director letter that I got back in June. How much is VA going to be affected by sequestration?

Secretary SHINSEKI. I will go back to I believe what you received in that letter, is that VA is exempt from sequestration. And I don't have the letter in front of me, Mr. Chairman. I think administrative costs were listed in that.

Mr. MILLER. So it is your understanding no benefit, function, program, account would be subject to, only administrative costs? And again, if you would like to take it for the record because of time.

Secretary SHINSEKI. I think this would be one that I best provide to you a response for the record.

[The information referred to was not available at the time of printing.]

Mr. MILLER. Thank you, Mr. Secretary. Ms. Bordallo.

Ms. BORDALLO. Thank you, Mr. Chairman. Secretary Panetta and Secretary Shinseki, thank you very much for being with us this morning.

Secretary Shinseki, we talked about suicides quite a bit. But can you provide us with an update on your efforts to end veterans' homelessness? Can you give an estimated number? Is it as serious as suicides? And what programs do you have in place?

Secretary SHINSEKI. Congresswoman, I think you may be familiar with the fact that we in the Department of Veterans Affairs have established 2015 as the point in time where we intend to end veterans' homelessness. And when I say end veterans' homelessness, there are two pieces to veterans' homelessness: One is the rescue. That is getting everyone on the street off the street, into housing, into programs that get them treatment for substance abuse or depression, training for employment, and moving on with their lives.

What won't end in 2015 is prevention. Prevention will be ongoing. What do I mean by "prevention"? Right now we have about 900,000 veterans in the GI Bill programs. And that is colleges, universities, community colleges, tech trade schools. Any youngster who fails out of that program right now in this economy is at high risk of homelessness. And so our prevention effort here is to make sure youngsters get into school, stay in a school, graduate, and have an opportunity to go on and work.

Our housing mortgage program, last year about 90,000 veteran mortgage holders who had defaulted on their home loans, we were able to defer roughly 75 percent of them from being evicted from their homes. And that is with VA's financial counselors getting in there, helping them get control of their finances, lowering the monthly payments, extending the payment period. The return to us is that we are able to then share stability. We will deal with these veterans as homeless veterans otherwise. And our records indicate that a homeless veteran's health care costs is about 3½ times what the health care costs are for veterans who are not homeless. So there is a—it is an important aspect of this. And while I say we were able to save 75 percent, there is still 25 percent we did not save. And we have got to just do better at it.

Ms. BORDALLO. Thank you. Thank you, Mr. Secretary.

Mr. MILLER. Mr. Johnson.

Mr. JOHNSON OF OHIO. Thank you, Mr. Chairman. And both of you, General Shinseki and Secretary Panetta, I have come to respect greatly both of your commitments and your heart for our veterans. I will tell you, though, that I am not convinced that all the members of your organizations, your Departments share that commitment and will follow through with the commitments that you two are making. I understand that you can't account for the last 10 years, Mr. Secretary. And I understand that you've got two bureaucracies that don't necessarily like to be told what to do and get along all the time. But I will submit to you that another 5 years is unacceptable. It is unacceptable to me, and gentlemen, it ought to be unacceptable to you. This is not a matter of can do or should do. This is a matter of want to and will do. This is 2012. And one of the underlying issues, Mr. Secretary, quite honestly, is the VA's lack of an overall information technology architecture.

You and I have talked about this before. And it still doesn't exist today, as far as I know. I have pointed that out. My committee has pointed that out. Organizations outside that have looked at the

VA's IT department have pointed that out. You know, I am just not convinced that 5 years from now, given that I don't know where you two will be, but my fear is that we are going to be sitting right here talking about this same issue again because we are not going about it with the discipline that is needed.

I come from an information technology career of over 30 years. I worked at U.S. Special Operations Command as the director of the CIO [Chief Information Officer] staff. I know what it takes to get this stuff done. And 5 years, gentlemen, is totally unacceptable. And I don't really have a question for you. I just want you to fix this, for crying out loud.

Secretary SHINSEKI. May I respond? Congressman, you and I, but more primarily Roger Baker and you have had this discussion. I will work with you. And we believe we have a good mark on an architecture. Obviously, we haven't satisfied you. We will come back and work it again.

Mr. MILLER. Mr. Turner.

Mr. TURNER OF OHIO. Thank you, Mr. Chairman. To both of our Secretaries, thank you for being here. I appreciate your leadership. And Secretary Panetta, I want to particularly thank you also for your work on sexual assault, which I know that you are working on in coordination with the Secretary of the VA, and your efforts to try to change the culture throughout DOD to both prevent sexual assault and to assist the victims. And thank you for your leadership there.

Many of the questions that you have received from members have been about service members and their families transitioning out of the military. Secretary Panetta, one of the most important things for the service members in transitioning with their family is obviously to keep their family together. And that raises the issue of custody. I want to thank Chairman Miller, Chairman McKeon, Subcommittee Chairman Wilson, and also I want to acknowledge Chairman Skelton, former Chairman Skelton, and of course, Erin Conaton and her work on the issue of custody in this committee.

The House, as you are aware, has passed eight times legislation that would protect the custody rights of service members, the VA Committee twice, HASC six times. Secretary Gates had endorsed the provisions that the committee had passed. You had sent a letter suggesting a compromise that Senator Boozman is going to be drafting in the Senate. I just want to ask for your support for that, and also, to tell you that we are going to need your additional assistance.

The Uniform Laws Commission just brought out a draft uniform bill that would change the State laws, actually reversing all the progress that we have made actually in favor of taking service members' custody rights away. We hope to have your support for Senator Boozman's legislation. Secretary.

Secretary PANETTA. I appreciate that. As I indicated to you in my letter, I support the efforts that you have made. You have provided tremendous leadership on this issue. And I will do the same with regards to the amendments on the Senate side.

Mr. MILLER. Ms. Tsongas.

Ms. TSONGAS. Thank you, Mr. Chairman. And thank you both for being here today. Like others before me, Congressman Turner, I

want to thank you, Secretary Panetta. I appreciate very much your efforts that you have made over the last several months to improve the treatment of survivors of military sexual assault. And Secretary Shinseki, I was so heartened to learn of your recent interest in the documentary film, "The Invisible War." As you say, that which starts during military service ends up in the VA. And that movie so painfully highlights the multiple bureaucratic hurdles survivors of such assaults, which are all too frequent across all the services, must endure to prove that their physical or their psychiatric symptoms are connected to an incident of military sexual trauma.

And it shows that too often, victims are unsuccessful in pursuing their claims for assistance. To address one aspect of this problem, the fiscal year 2012 Defense Authorization Act included language that required the Secretary of Defense, in consultation with the Secretary of Veterans Affairs, to develop a comprehensive policy for the Department of Defense on the retention of and access to evidence and records relating to sexual assaults involving members of the armed services.

This policy is to be in place by October 1, 2012. Can you both comment on the status of this policy? I would also welcome any further thoughts you may have on how these claims can be processed faster and more accurately.

Secretary PANETTA. Well, it is a very important issue for me. I am not going to wait for the legislation in trying to put that policy in place, because I think it ought to take place in providing that kind of guidance and assistance to those that have been the victims of sexual assault so that they get the kind of support that they need in order to not only get the care they need, but if they want to continue in their career, to get the support system that would allow them to continue their career. And I think it is fair to say that Secretary Shinseki and I are going to work together on this issue to make sure that we can deal with this on both sides, not only the Defense side, but on the Veterans side for those that ultimately move in that direction.

Ms. TSONGAS. Thank you both. I look forward to seeing that policy in effect. Thanks.

Mr. MILLER. Mr. Denham.

Mr. DENHAM. Thank you, Mr. Chair. Mr. Panetta, Mr. Shinseki, great to see you both here. Mr. Panetta, I have been working on these veterans issues for quite some time with you in our area of central California. By the way, thank you for support on the Veterans Skills to Jobs Act that was signed this week into law. A good bipartisan effort that Mr. Walz and I worked on after our Afghanistan trip. Another issue that came up during that same trip was working with our veterans on Active Duty that were transitioning back that had disabilities. And further conversations with General Bostick afterwards. You know, he had said that this is the number one issue, the evaluation process of those disabled before they get discharged, making sure that not a day goes by that they are having to wait for disability, or the issue of 20,000 nondeployable men and women that are disabled on Active Duty.

So he said it was the number one issue dealing with—legislative issue that needs to be fixed back from 1940. The question I would

have for you, is what can we get done? What would be your recommendation? What is the legislative fix that you need us to pass that would help with this overall disability evaluation system?

Secretary PANETTA. My view is that one of the most important things we can do is address the needs of our Wounded Warriors and the ability of those individuals. If they want to stay in the service, we ought to do everything we can to help them stay in the service. If they want to move on, then it becomes something where we have got—we and the VA have to work together to make sure that that transition is as smooth as possible. We have a tremendous amount of focus on this. I guess probably the one key is, again, helping us in terms of funding to make sure that we have the funds necessary to complete these evaluations and give them the assistance they are going to need once they move on. That is a key area for me.

Mr. DENHAM. Outside of funding, is there a legislative fix that you are looking for?

Secretary PANETTA. At this point, I have to tell you, I mean, I think we have the pieces we need. I mean, we have got large numbers that we have to deal with. But the programs are in place. The assistance is in place. We have just got to make sure that we provide the resources necessary so that we can do what we have to do to help them. That is the key.

Mr. DENHAM. Thank you.

Mr. MILLER. Mr. Wittman.

Mr. WITTMAN. Thank you, Mr. Chairman. Secretary Panetta, Secretary Shinseki, thank you so much for joining us. Secretary Panetta, I want to ask you about how we can better align military to civilian jobs in transition, especially as it relates to licenses and certifications. Give you a great example. You take a highly trained combat medic, comes back home, wants to go into the civilian side, wants to become an emergency medical technician. Unfortunately, as you know, certifications there prevent him or her from doing that. Has to go through lengthy schooling, take on lots of debt. Many times, they could probably be teaching the class. How can we better align the skills that are obtained in the military to parallel what they could be pursuing in jobs on the civilian side? That is one of many categories that I know that you are aware of. And it is really a matter of taking that military job description and figuring out how do we align that, or how do we get some paralleling with what they are doing in the military versus outside?

Secretary PANETTA. Well, it is a great point. It is something actually the First Lady has dedicated a lot of time to. We have got to push States to try to develop some common standards here with regards to accreditation in these various jobs. These guys come out and they have got great skills, they have worked in these areas, they have done tremendous work in their particular skill area. And to come out and then have to drag them through a whole process in order to be able to take those skills and make them applicable, that is something that—there are a number of States that are willing to basically take these individuals and take the accreditation that we provide and incorporate that at the State level. We have got to get all of the States to recognize that kind of credentialing.

Mr. WITTMAN. Mr. Secretary, is it something we could do within DOD so as these individuals come out, if they become a trained medic, they would also, at the same time, that they get that certification would get something within the military to say by the way, now you have a credential that is an EMT [emergency medical technician] within that particular State, say where they are based or they have some kind of way that there is an equivalency there? Because they are obtaining the same skills there as they would outside.

Secretary PANETTA. I think that is a good point. One of the things I am looking at is can we develop some kind of certification within the military that would then be transferable in terms of their getting a job within the State.

Mr. WITTMAN. It seems like if you just align things that align with outside, there could be some reciprocity.

Secretary PANETTA. That is right. Good point.

Mr. WITTMAN. Thank you. Thank you, Mr. Chairman. I yield back.

Mr. MILLER. Mr. Courtney.

Mr. COURTNEY. Thank you, Mr. Chairman, and thank both witnesses for your attendance here today. Secretary Shinseki, you know, I am wondering if you could talk for a minute about an initiative that I think falls under today's hearing, which I think is a very exciting example of the work the VA has been doing with health IT, which is the Blue Button program, which, again, is something that again, I think you have surpassed even the private sector in terms of really trying to give patients control over their own medical situation, as well as make a smarter system in our health care delivery.

Secretary SHINSEKI. I will just say it is one of several IT initiatives, but Blue Button is the one that has received a lot of attention. And there are civilian health care systems now that are adopting the concept. And that is with a single stroke of a mouse on the Internet, you are able to access your data, personal data regarding health care. And you can download your records, you can take those records and use them as you would with your own private physician. It has tremendously grown in size, into the millions. And we think this is also helpful for the private sector in having that kind of concept capability.

Mr. COURTNEY. And the nice thing about it is it gives the patient control in terms of being able to move, go from one provider to another. And again, just congratulations to you and your team for really leading the way for the whole health care sector really in terms of that initiative. And I know comments have come up, and I am running out of time, the issue of regionalizing claims is emerging as an issue in Connecticut as well. And again, I look forward to working with your Department in terms of trying to solve that problem.

Secretary SHINSEKI. We will do that.

Mr. MILLER. Ms. Buerkle.

Ms. BUERKLE. Thank you, Mr. Chairman. And thank you both for being here this morning and for your service to our Nation. It is an honor to have you both here. My question has to do with, and you have heard some references to it, the Dole-Shalala Commis-

sion, and the fact that now 5 years later, after they issued this urgent call to streamline, to make sure we have a single point of reference for the care and the services and the benefits of our military, we have two very distinct entities. We have had multiple hearings trying to get assurance from DOD and from the VA as to how you are going to get this together so that we can make sure our veterans get the services without being overwhelmed by an extremely complex system.

So I would ask both of you today, please, how specifically, what are the goals, what is the plan to get these two entities under one roof so that you are complying with the Dole-Shalala Commission and their recommendations for our veterans? I thank you both.

Secretary SHINSEKI. The program, the Federal Recovery Coordination Program, in existence since 2007. And I think as Secretary Panetta indicated earlier, two good Departments launched and essentially developed good programs that don't quite harmonize. We have a task force with the specific direction to study and bring harmony to these programs. Where are we being—duplicating one another? Where are we not doing things that we should be doing? So it is going to get a good look here, and I say in the next couple of months. And I would be happy, and I think Secretary Panetta would be as well, to make our people available to provide the results of that.

Secretary PANETTA. You know, look, Secretary Shinseki and I share the same frustration. I mean, we have been working on this, and, frankly, we have been pushing to try to say why can't we get faster results? Why can't we get this done on a faster track? And, you know, bottom line is, frankly, we just have got to kick ass and try to make it happen. And that is what we are going to do.

Ms. BUERKLE. I would suggest in your opening statement, Mr. Panetta, you mentioned commitment, and that we look to our military as an example, their commitment to our country. We should be that committed to them to make sure we get this job done. I thank you both very much.

Mr. MILLER. Dr. Heck.

Dr. HECK. Thank you, Mr. Chairman, and thank both of you for being here today. Likewise for your long and distinguished service to our country. Secretary Panetta, I am happy to hear about your initiative on the Stolen Valor Web site, realizing that any Web site will probably have limitations. As you may know, myself and Senator Brown have introduced legislation to reinstitute the Stolen Valor that will meet constitutional scrutiny. So hopefully, we will be able to gain your support on that. We have heard a lot about the Integrated Disability Evaluation System, something that after spending over 20 years in the Army Medical Department I think was far too long in coming. And I am encouraged by the pilot results. In fact, I have two down-trace units that are getting set to mobilize in October to support those efforts, CONUS [continental United States]. But we have seen over time the processing times start to creep back up.

And even though there has been—customer service has increased over the legacy system, that was really a low bar to overcome. And we are hearing a lot of the fact that the program is somewhat complicated and convoluted. Other than volume driving the creep in

processing times going back up, what other issues are there that are causing that processing time to increase, and what can we do to help you decrease those times?

Secretary SHINSEKI. Well, I think I indicated earlier that we have a target of 295 days. Within, I would say, the DOD's portion of that is the medical care of seriously wounded and injured individuals who still have their care to be completed, and also recuperation leave as part of that. So it is a little bit—individuals have some control here. And also, I think Secretary Panetta alluded to this, these youngsters know the military health care system. They know it very well. They are very comfortable with it. It is world class. They know VA's health care system less. And there is a point in time where a decision has to be made to make that psychological commitment you are going to leave the military.

We in VA can do a lot to help educate folks to make them comfortable about being able to let go of—you know, like wing walking, one hand hold before taking the next one. And I think that will help streamline the process. But as I say, we have both agreed to this 295-day target, and we are moving to that point.

Mr. MILLER. Mr. Johnson.

Mr. JOHNSON OF GEORGIA. Thank you, Mr. Chairman. Thank you, gentlemen, for being here. Secretary Panetta knows how much I appreciate his service to the Nation over the years. And I certainly thank you again, sir, in public. And General Shinseki, I have not had the opportunity to spread my love for you publicly, but you are a true gentleman.

You served admirably in the United States Army, became a four-star general, became the Secretary of the Army—or chairman of the Army. Army Chief of Staff. That is what it was. And in that capacity, you put in place strategies, very innovative, that have held us in good stead up to this point.

You are a forward-thinking leader. And you are also a courageous and honest leader. I would be remiss not to point out the fact that during the run-up to the war in Iraq, you took a public bashing from high-level members of the previous administration for your assessment as to the number of troops we would need to effectively occupy Iraq in the aftermath of the war going in. And you paid the price for that in being it said that you were perhaps forced to resign early. But nevertheless, the underdog is now on top.

And you bring the same innovative, strategic thinking to your new post that you had in the old post. And it is definitely needed. And I think it is going to pay off. And I am glad that your Department and the Department of Defense have both become more integrated in how we address the needs of our service men and women as they make the transition from military force—has my time expired already? Okay. I keep hearing a—you want me to move on from what I am saying, or what?

Mr. MILLER. Your time has expired, Mr. Johnson.

Mr. JOHNSON OF GEORGIA. Has my time already expired?

Mr. MILLER. A minute ago.

Mr. JOHNSON OF GEORGIA. Oh, 2 minutes. I am sorry. All right. But thank you, sir, for your service. And I yield back.

Secretary SHINSEKI. Mr. Chairman, may I just a small point here. I thank the Congressman for his compliments. I would just

say there are more than this one individual who held that opinion. And I was not forced to resign. I served a full and complete tour as the Army Chief, and I was very proud to do that. Thank you.

Mr. JOHNSON OF GEORGIA. Thank you. I stand corrected.

Mr. MILLER. Mr. Johnson, I am trying to save you from yourself because the next person up is Mr. Runyan.

Mr. JOHNSON OF GEORGIA. Oh, I don't think I need to be saved from myself.

Mr. MILLER. You haven't seen Mr. Runyan.

Mr. RUNYAN. Thank you, Mr. Chairman, and, gentlemen, thank you for being here. I want to touch on the IDES process. I know in Secretary Panetta's opening statement the last sentence of that particular paragraph or the end of the IDES statement says you are going to have a senior level working group in coordination with the VA and provide recommendations on how to move forward. I know Secretary Shinseki knows that I happen to chair the DAMA [Disability Assistance and Memorial Affairs] Subcommittee in the House VA Committee. We just had a hearing on this back in March, and I asked the DOD to acknowledge the specific roles the VA has in the process and distinguish the roles that the VA and DOD carry out. And I have also been briefed by the GAO that they have great concern of the overlapping responsibilities in the two.

There is a couple of issues and time running out that I just want to bring to both of your attention you can have here, specifically dealing too with the medical evaluation narrative summaries, is that clear, and they lack clear and complete diagnosis of the service member which a lot of times renders an unfair decision. And the arbitrary time date of 7 days to challenge that, refuting that decision. I sometimes think to get the complete medical evaluation you need I don't think that is possible. Dealing with the PEBLOs [Physical Evaluation Board Liaison Officers] and their ability or lack of—I don't know—I know quality control has been used a couple of times by some VSOs [veteran service organizations] but not so much they are not reaching out to the veteran. And I know some of the VSOs brought up instances where JAGs [Judge Advocate Generals] have been involved and the process went a lot smoother because they understand the process a lot better. There are some points I wanted to bring to both of your attention that I hope would come up in those discussions and I yield back.

Mr. MILLER. Mr. Scott.

Mr. SCOTT. Thank you. Thank you, Mr. Chairman. Secretary Panetta, you mentioned earlier one the problems was the limitation of the number of health care providers. I have got some information I would like to share with you. I represent Georgia, which has a tremendous number of veterans, a proud military history. And one of the medical providers gave me this list and it is actually a list of reimbursements versus Medicare reimbursements. And I will just give you a couple of examples. For the exact same code, Medicare reimburses about \$2,000 and TRICARE reimbursement is somewhere in the \$630 range. That is one of the reasons that many of the private sector providers out there are having to limit the number of our veterans that they are seeing; they are covered under TRICARE. So I will just share this with you, and it is not that they don't want to see them, it is that if they are the only per-

son that is signed up in that area, then it becomes a huge portion of their practice. And quite honestly the practices have to be revenue positive. But I will leave this for you and we will go from there.

Mr. Shinseki, if I had a second copy I would give it to you and I can get copy for you as well. We kind of beat around this a little bit. I trust both of you as great leaders. We beat around this issue of having two bureaucracies that resist change. And so my question, open-ended to either one of you that wants to take it, is would the men and women that are serving this country be better served if the health care benefits were handled under either one of the agencies instead of both of the agencies in having to make that transition?

Secretary PANETTA. Well, you know, I thought about that a lot. But I think the reality is we have got these systems in place. The veterans are very tied to their health care system and, you know, the benefits that they receive there, and obviously DOD is very tied to our system. But the key—I don't think that ought to inhibit our ability to bring these two systems together, let me put it that way. I don't think we have to create another monster. I think all we have to do is be able to get both of these two systems to work together and get it done.

Secretary SHINSEKI. Mr. Chairman, might I add a little bit here. Two huge Departments, we are already collaborating, both bringing together in a number of locations joint and integrated activities; North Chicago, a Federal health care center, the director is a VA person, the second in command is a Navy captain. And we are learning a lot from that and we look for other areas where we can do this and there are several other examples of that. We look at bundling acquisition, large acquisition decisions. We are working on right now trying to see whether there is a benefit to bringing our pharmacy programs together.

So I think there is great opportunity from efficiencies and a business standpoint. I would be cautious about saying we are going to create one system here. He has a to-go-to-war requirement and the go-to-war requirement has with it a whole list of preparations that you have to have competent leadership who have been trained how to do this in combat from the top of the organization all the way down to the youngest medic in that formation. That is an enormous responsibility, and that is a culture we don't want to change. We have the best go-to-war medical capability anywhere, and that has got to be a primary function here.

Mr. MILLER. Ms. Hanabusa.

Ms. HANABUSA. Thank you, Mr. Chairman. Thank you both for being here. A special aloha to General Shinseki. My questions are for you, General. On page 7 of your testimony you talked about of course the VOW to Hire Heroes Act of 2011 which Congress and the President signed into law. Do you have any statistics or any report you can give us as to how that is coming along? And in that same light also on page 7 you talked about removing the impediments to credentialing with of course the DOD and I would like to know where we are in that as well. Thank you.

Secretary SHINSEKI. On the VOW to Hire Heroes Act implementation, there are various pieces of that. I would say one piece,

VRAP [Veterans Retraining Assistance Program], is up and running. We have veterans who are signing—this is between veterans between the age of 35 and 60 who have exhausted their unemployment benefits, have a capability for 1 year of training in a high priority work area. That is up and running, in the tens of thousands people have signed up. In the transition arena both Secretary Panetta and I are working this very hard. We think we have a good plan being put together, but in our case we are still looking at the details of that.

I am not sure I have addressed all of your questions, Congresswoman, but—was there something I missed.

Ms. HANABUSA. No, I will follow up with any specific questions that I may have for the record. Thank you very much. I yield back.

Mr. MILLER. Dr. Roe.

Mr. ROE. Thank both of you all for being here today and your service to our Nation. Yesterday we had a hearing, just a briefing with Dr. David Rudd on the suicide problem and I would like to share with you, both of you all, I won't do it today because of time, with his data which was very impressive about multiple deployments and how that affected soldiers.

Number two, I know I have been to Great Lakes twice and it is clear when you are a freshman Congressman as I was two terms ago when your CODEL [congressional delegation] is to Great Lakes in January when it was 4 below zero. So I have been there and the question is how is that interconnect interactivity between DOD and VA doing now, General Shinseki? Is that working better? I was there about a year ago. I know it is up and running but how is that working?

Secretary SHINSEKI. It just gets better over time, Congressman. New concept, bringing two good teams together, integrating them. I would say that the area of challenge is the single electronic health record. And for the most part there are great workarounds but when you get to some places like pharmacy, because of the sensitivity to the safety aspects of that there are a lot of checks and rechecks. I don't think we have solved all of those issues and won't until we get this integrated Electronic Health Record. So one team, veteran or an active service family member walks in a front door, they go wherever. So in terms of the provision of care and access to care I think it is first rate. It is the business aspects of this that still require more work and the integrated Electronic Health Record will go a long way to solving that.

Mr. ROE. Mr. Chairman, I had a Wounded Warrior in my office yesterday lost a leg above the knee, and I personally cannot do enough for these Wounded Warriors. I know that you all feel exactly the same way, and I certainly appreciate your service. Mr. Secretary, I will ask you any further questions at the Harris Teeter. I see you there shopping from time to time.

Mr. MILLER. Mr. Coffman.

Mr. COFFMAN. Thank you, both of you, for your long and distinguished service to our country. Secretary Panetta, I just want to commend you and the Secretary and the Department of Defense for your work in dealing with combat stress. I have served in the Marine Corps in the first Gulf War, in the Iraq War. I remember the out-briefings I received in 1991 before I left the theater and they

were excellent, 2006 they were excellent as well. I tracked the improvements in the Department of Defense in terms of on the Active Duty side in working with our military personnel and those new programs and I think we are doing the best we can.

And you see, the Department of Defense sees post-traumatic stress disorder as a wound. However, Secretary Shinseki, the VA sees it as a disability. And the signature wound of this war is post-traumatic stress disorder and it seems that we have a disability-centric approach and not a treatment-centric approach in the Veterans Administration. And wouldn't it be wise if we invested dollars in treatment and reform the current system that was both compassionate, more compassionate I think to those who served our country and fair to the taxpayers and saving money in the long run by again investing in treatment in the short run and being able to allow veterans to see mental health practitioners within their private ones, within their own communities and not be relying upon the VA. And I would love it if you could respond to me now but also respond to me on the record because of our limited time.

Secretary SHINSEKI. I would be happy to provide a more detailed response for the record.

[The information referred to was not available at the time of printing.]

Secretary SHINSEKI. Congressman, let me just say I am not sure when the decision to treat this as a wound occurred, but I think we have all used PTSD disorder as the descriptor for many, many years. We are closely linked with DOD on all things, we will go back and look at this. So on the one hand I don't disagree with what you are suggesting, but I would offer that we treat PTSD, we screen every veteran who comes to VA for PTSD, TBI, substance abuse, sexual assaults. And so we have a pretty comprehensive record of who to treat and then we set about treating them.

Mr. COFFMAN. There is no requirement for treatment once that disability determination is made and I think we need to really rethink that and take a look at that again. All the mental health professionals that I talk to feel that it is treatable down to a level to where it is no longer debilitating. And so we need to rethink and potentially reform this again to be more compassionate for those who have served our country in repairing their lives, and also I think in the long run certainly being fair to the taxpayers of this country.

Secretary SHINSEKI. I don't disagree. But I do say we treat, it is not just a disability.

Mr. COFFMAN. Thank you, Mr. Chairman. I yield back.

Mr. MILLER. Ms. Speier.

Ms. SPEIER. Thank you, Mr. Chairman. To each of you, we are in awe of the extraordinary contributions you have made to this country. Thank you for being here today.

I am going to try to cram three questions into my two minutes so I am going to move fairly quickly. On Schedule II drugs there is an addiction that often occurs while members are still in the military that also continues once they are in the VA system. What are we doing to try and deal with this addiction problem?

The for-profit colleges that many of our GIs are accessing, there are some bad actors. I want to know if you are sharing the bad actors with each other, both from the Department of Defense and the VA.

And finally, I want to tell you about a 24-year-old Iraqi veteran who started community college, is starting community college next month, he wants to go to law school. His present worry is that his foot operation will make it difficult for him to get to class in this hilly community college campus. He and other injured veterans in my district all would like more time to complete their studies under the post-9/11 GI bill. I would argue that a 1-year extension would be in order for veterans with service-connected disabilities.

I would like your opinions, both of your opinions on that.

Secretary SHINSEKI. Let me just very quick try to take all three of them on. On addiction, I myself have asked our people whether or not we have medication policies that lead to addiction, and we are looking at it; I know that both DOD and VA look at this. I was speaking publicly at one point and I asked the question are we courageous enough to ask the question of whether or not our medication policies create other problems. It got a response out of the audience and so I think there is something here and we are looking at it.

On the for-profits, we do share that information. In our case we found three bad actors and we have cut them off, and we will continue to look at that. But I would just say there are bad actors. It is just not for-profits, there are others that we need to be sensitive to.

More time for individuals who are severely injured, you indicated. VA has a program for rehabilitating seriously injured folks that is a little more liberal and very capable. And I would like to ensure that the individuals you are talking to are aware of the voc rehab, we call it, vocational rehabilitation.

Ms. SPEIER. I think you misunderstood my question, Mr. Secretary. Whether or not we can extend the GI bill for severely disabled veterans so that it does not elapse in the 4 or 5 years that it is presently the time limit in which they have to access those benefits.

Secretary SHINSEKI. I would say on the voc rehab—let me come back to you on the record to see the amount of time on voc rehab is enough. For the GI bill, it is stipulated in law how much time is available.

[The information referred to was not available at the time of printing.]

Secretary PANETTA. I think it should be modified because it would give us that additional time in the event that they are dealing with the kind of serious wounds that your veteran is dealing with.

Ms. SPEIER. Thank you.

Mr. MILLER. Mr. Gibson.

Mr. GIBSON. Thanks, Mr. Chairman. I thank the gentlemen for being here, for their distinguished careers and their leadership. And what they are doing is so important right now in terms of bringing us better transition.

I would like to make a couple comments here just based on my experience initially as a private in the New York Army National Guard and over the course of 24 years rising to the rank of colonel, including brigade command where I had troopers that made the transition from Active Duty back home and now in the vantage point of serving in these responsibilities, that I think over time the Department of Defense has really done incredible work before service men and women, before they separate in terms of education and training, understanding what is out there. And now all these efforts to integrate the DOD and the VA, but what I think is missing is that back home, just when we think we are making a difference we learn of a new case, somebody in a village or a town that I was not even aware was struggling and they are spiraling down and we are looking to make a difference and get them into a community of caring, including the VA, VFW, American Legion.

So Peter Welch and I, my colleague from Vermont, we have been working on a program that is actually doing very well for the National Guard, the Yellow Ribbon Program, and seeing if are there ways we can learn from that that we can provide better situational awareness to State officials that are actually working this issue. In New York, for example, we have it to the county level. And many times they just don't have the information knowing a veteran is coming home. Sometimes they get it a year of that after they get home but they don't have it before they get home; that is to say, the service man or woman is coming home and then when they get home. So we are very enthused about what you are doing. We don't want to duplicate what you are doing. What we are looking to do is to sort of evaluate it and see if there aren't ways that we can have in the framework, DOD, VA, and then the transition in the framework to the State apparatus. So I wanted to mention that and just make you aware. I know we have been working with your offices and they are doing great work on this.

And then finally thank you for your work on Agent Orange. I will tell you we are not done, we still have Navy veterans from Vietnam that don't have the presumed coverage and we are working on that effort as well.

Thank you, gentlemen.

Mr. MILLER. Mr. Larsen.

Mr. LARSEN. Thank you, Mr. Chairman. General, continue to support HUD-VASH [Department of Housing and Urban Development Veterans Affairs Supportive Housing]. HUD-VASH program is well used in Washington State, especially in my district, the housing authorities are partnering very well with others to make that happen.

Second, we started a program in my office to assist some of our community and technical colleges to translate the skills and abilities that veterans bring into the private sector language of what they need, especially as it applies to aerospace manufacturing and aerospace skills needed. What we found is that some of our community and technical colleges did not even know there actually was a translator available online. It is sad enough we have to translate that language from military to private sector, but we do. So there is a fellow in my office we hired who is a 30-year chief, retired after 30 years out of the Navy as a command master chief. And so his

job now is doing some outreach to community colleges all over the State because they come to this one research or aerospace training center and let them know how this works. You might want to use that with the DOL [Department of Labor] and the Department of Education.

But finally, where does this one kid fit? He comes home, he is discharged from the military, he goes home to a rural town, he is not enrolled in VA, has trouble adjusting, commits suicide, an actual story in my district. So he doesn't fit the military, he doesn't fit the VA. I am not asking you to solve that problem from 3 years ago, but I am asking you what is being done to reduce the likelihood of that kind of thing happening again?

Secretary SHINSEKI. This is part of the reason you have two Secretaries sitting here, and our efforts are to create a warm handoff by and large across the board anyone departing the military, but especially for those that have indicated while they are serving in uniform that they have some mental health challenges. We need not to discover that the hard way. This handoff would give us the opportunity to bring to bear VA's significant mental health treatment capability so that there is a smooth transition for this.

Secretary PANETTA. I would agree with that. In these situations you have got to ring the bell, you have got to say there is a problem here, and the key right now is to be able to pick up that there are those problems, to make sure that that individual gets into the health care system and then to alert the VA so that they pick it up when we try to make this handoff, but that is one the keys we are focusing on.

Secretary SHINSEKI. Mr. Chairman, just for one second, the translator that you were talking about, Congressman, we in VA have created one called VA for Vets. I am pretty sure your master chief is familiar with it, but there are about five others that touch on various aspects of translating skills.

Mr. MILLER. Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman, and let me compliment you for bringing these two committees together. I think this is fabulous. I have served on the Veterans Committee for 24 years, so I think this is a first and I just think it is a very good idea.

Mr. Panetta and Mr. Shinseki, welcome. I am going to ask you sort of a basic question that the GAO has reported that basically it takes 200 days with a 68 percent accuracy to address the current backlog. And we are hoping that—I mean think the timeline is in 2015 to get to 100 days with 98 percent accuracy. But the question would become how could you do this if roughly almost 700,000 new service members are coming in? I mean, come on now. How are you going to do this with 700,000 new members, new veterans coming in? How are you going to cut the backlog in half and increase the accuracy by almost 30, 40 percent?

I will start with you Mr. Veteran Secretary.

Secretary SHINSEKI. We are in the process of piloting now, you are familiar with VBMS, it is Veterans Benefit Management System, first automation tool we have had in VA. We are still paperbound today all these many years later.

Mr. STEARNS. I just don't want to interrupt you but Steve Buyer was chairman of the committee, he had a bill that was going to

solve that problem, and this is many moons ago. So when you indicate you had this for the first time—I am just saying I thought that was implemented some time ago, but you are saying it wasn't.

Secretary SHINSEKI. I would have to go back and refresh myself on what Chairman Buyer's initiative was. But clearly in the testimony I presented before the committee there was no automation tool ever discussed in the last 3½ years. In fact, the testimony was that we were building this and it was going to require close collaboration with DOD. We get paper from DOD, we are a paperbound process. And so in order to go paperless in VA, it is going to take coordination between both Departments and we are piloting that automation tool today and we intend to have 16 regional offices automation on VBMS by the end of this year. And by the end of 2013, VBMS on all of our 56 regional offices, 14 and 15 to take down the backlog.

Now Mr. Stearns, we created the backlog in large measure. We made an Agent Orange decision that added a quarter of a million claims to the existing inventory. We made a decision on combat PTSD that added half a million claims to that inventory. Some would say, why would you do that. It was the right decision to do for veterans had been waiting for many, many years. We are going to work the backlog now. Automation is the key piece here we are after.

Secretary PANETTA. Congressman, what you pointed out is a hell of a challenge. I mean, we are not kidding anybody. What you pointed out is exactly the concern because we are going to be adding more and more to that list. I think the key for us is if we can develop the systems to deal with what we are dealing with now and make those work, it is going to make it much easier as additional individuals come on board. If we don't get through this, if we don't deal with it and make it more efficient now, then it will become an even worse problem in the future.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. MILLER. Our final questioner today will be Dr. Benishek. You are recognized for 2 minutes.

Mr. BENISHEK. Thank you, Mr. Chairman. I have a question as to the nature of the collaboration between the Department of Defense and the VA on reducing the backlog. Can you tell me more about that? How much—are you working together for this or can you just comment on that?

Secretary PANETTA. That is one of the fundamental challenges that we have taken on in both Departments is to address that backlog and try to make sure that both of us are trying to work in a way that reduces those numbers. I think the Secretary has done a great job at the Veterans side to try to reduce the number of days there. We are working to try to reduce the number of days on our side and to be able to try to provide this kind of seamless relationship so that overall we can deal with this huge backlog. It is a problem, we have recognized it as a problem, and I can tell you we are doing everything possible to try to see if we can confront it.

Mr. BENISHEK. Are your staff talking every day then?

Secretary SHINSEKI. Yes, they are. They are. When we say backlog here, there are about two or three transition programs from

DOD to VA. We have IDES that most of us are familiar with, which is primarily a transitioning of seriously wounded and injured folks out of uniform and then to veteran status with us. That is only about 7 percent of the people leaving the military. We have two other programs called Benefits Delivery at Discharge and Quick Start, again transitioning individuals out of the military to us. Together those two programs account for maybe 6 percent of the number of folks leaving the military. So the vast majority is this large discussion of backlog that I was responding to Mr. Stearns on. And part of that backlog is created by decisions we have made and that we have testified to. Agent Orange, combat PTSD, Gulf War illness, all the right decisions. But understand that that creates a volume of claims. We are going to be better able to deal with it as we get automation in place. So that is an important step. We need to get that program funded and hold onto IT funding dollars that we have testified to.

The second piece of this is this collaboration of DOD and VA sitting side by side making sure we have warm handoffs. It is one thing to know that there are 100,000 people coming out next year, but if they all come out on 1 October that is a different problem than this being scheduled out over 12 months or if they all come out at one location that is different than being spread across the country. We will match up, VA will match up with whatever the plan is in DOD and that is why this collaboration is important.

Mr. BENISHEK. Thank you, gentlemen. I see my time is up.

Mr. MILLER. Thank you very much, gentlemen. Thank you for being here today, spending 2½ hours with our two committees. We appreciate you being so generous with your time to answer some very important questions. I would ask unanimous consent that all members would have 5 legislative days to revise and extend their remarks. Without objection, so ordered.

With that, the committee is adjourned.

[Whereupon, at 12:35 p.m., the committees were adjourned.]



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**A P P E N D I X**

JULY 25, 2012

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**PREPARED STATEMENTS SUBMITTED FOR THE RECORD**

JULY 25, 2012

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**Statement of Chairman Howard P. “Buck” McKeon,  
Committee on Armed Services**

**“Back from the Battlefield: DOD and VA Collaboration to Assist Service Members  
Returning to Civilian Life”**

**July 25, 2012**

Good morning. I welcome everyone today to this special joint hearing with the Committee on Veterans Affairs. Our focus is the collaboration between the Department of Defense and Department of Veterans Affairs to assist service members transitioning to civilian life.

We have two of America’s leaders on this issue with us, Secretary Panetta and Secretary Shinseki, to discuss how we as a nation can best serve those who have served us in uniform. I also welcome Chairman Jeff Miller and Ranking Member Bob Filner and thank them for their significant efforts to address a range of transition issues.

It’s no secret that I oppose plans to reduce the size of our military, especially when contingency operations are still ongoing in Afghanistan. I find it strange that, at a time when we are still at war, the Department of Defense has announced it will actually reduce the size of the Army and Marine Corps. Such cuts put strain on our service members and their families. Moreover, I have been very vocal regarding the threat sequestration poses to the strength and integrity of our military. Reductions in end strengths represent additional service members that will be asked to leave the military on top of the over 175,000 service members that separate every year. I will continue to voice my staunch opposition to further cuts to the defense budget – which, if they take effect, will not only increase the damage to our national security, but also put significant strains on the transition system that is already working too slowly.

Today’s hearing demonstrates our joint, long-standing commitment that there be no gap in services and support provided to our service members and their families as they transition from the Department of Defense to the Department of Veterans Affairs.

The transition that service members experience from active service into civilian life must be improved. Veterans of Iraq and Afghanistan know that the hardships don’t end when they leave the war zone. We in Congress are painfully aware that at this very moment, 26,000 service members are in the midst of the disability evaluation process, and are forced to wait over 400 days on average before they can return home to their communities.

To further assist this transition, the Congress mandated over a decade ago that the DOD and VA create a joint integrated electronic health record to facilitate the transfer of service members’ personal health information between DOD and VA health facilities. Unfortunately, after continuing delays, we are now told that it isn’t expected to be completed until 2017.

And finally, we hear about the veteran unemployment numbers: 23.3 percent of veterans between the ages of 18 and 24 are unemployed. This highlights the difficulty our younger veterans are having to find employment.

The idea that our service members could go from the front lines to the unemployment lines is unacceptable. These men and women - whom I have called the “next greatest generation” and who, with their families, have sacrificed so much for this country – deserve better than to have to face the uncertainty of leaving the military in these very hard economic times. We must never stop working on their behalf and there is much work still to be done.

During my meeting with Secretary Shinseki I came away impressed by his commitment to improving the transition. He met multiple times with Secretary Gates where a joint commitment to action was born. That commitment has continued with Secretary Panetta. I would like to hear from both of you today on the progress that you have made and also what you believe to be the critical next steps.

Specifically, I want both of your views on the transition assistance program, TAP, which facilitates the transition from active duty. With regard to objectives, do you both agree on TAP’s objectives? For example, is TAP designed to prepare service members for entry into the job market, or is the purpose to actually get a service member a job? How do you measure whether the program is achieving its objectives? Service members transitioning deserve a government-wide approach that includes support from the Departments of Defense, Veterans Affairs, Labor, Education, Small Business Administration, among others. How is TAP providing such an approach?

The unfortunate consequence of over a decade of war is that service members return with serious, life-changing injuries. Even as the numbers of service members being deployed to combat zones goes down, projections are that the numbers of service members and veterans needing support will grow substantially for the foreseeable future. What are both Departments doing to help service members transition as quickly as possible while providing this generation of veterans the treatment they need to return to their families and live fulfilling, independent, and productive lives?

Given the significant evolution of medical science, service members now survive horrific injuries that would have been fatal even during the first Gulf War. Many of these wounded veterans will need long-term, comprehensive services and support that can only be provided by the military and by the VA. How are the departments resourced for this long-term effort? What are the plans to maintain an equitable joint venture in light of the fact that the Department of Defense is facing another half trillion dollar reduction due to sequestration, but the Department of Veterans Affairs is exempt?

I now recognize Chairman Jeff Miller for his opening remarks, to be followed by Ranking Member Adam Smith and Ranking Member Bob Filner for their opening remarks.

Statement of Hon. Jeff Miller, Chairman, Committee on Veterans' Affairs

"Back from the Battlefield: DOD and VA Collaboration to Assist Service Members Returning to Civilian Life"

July 25, 2012

Thank you Chairman McKeon, and Ranking Members Smith and Filner, for working with me to assemble what is truly an historic hearing. According to a quick search of our records, this is the first time our full committees have jointly met for a hearing.

And never have we had the privilege of receiving testimony from two Cabinet Secretaries.

Mr. Chairman, I would suggest that we don't wait so long before our next joint hearing. If we're going to be asking VA and DOD to work hand-in-glove on these issues, our committees ought to be seen as doing the same.

Secretaries Panetta and Shinseki, welcome to you both. Your presence underscores the goal we all share that separating servicemembers have a "seamless transition" from military service to civilian life.

Let me quickly say that I only wish the Office of Management and Budget would improve its "seamless transition" in getting your testimony cleared and here to Congress on time...but that's just an aside. I'm thrilled you both are here this morning.

This Congress, the Veterans' Affairs Committee, or its Subcommittees, have held 13 oversight hearings on transition-related topics. These topics include improving the joint disability evaluation system your departments administer; ensuring the highest quality of health care for the severely wounded who can no longer continue on active duty; and ensuring service members leaving the military are equipped to successfully enter the civilian labor force.

We have also focused on the tools your departments must use to effectively deliver these services in the 21st Century, such as electronic health records and other IT solutions.

The testimony we've received so far on these matters has been mixed. Although we've heard a number of initiatives, plans, and processes for improvement, and your testimony today echoes much of that, what we've not seen are clear, bottom-line results. Here are several examples:

First, notwithstanding the resources Congress has provided over the last several years to improve Iraq and Afghanistan veterans' access to effective mental health care, concerns remain. A VA psychologist testified that (quote) ".....VA clinicians are overrun with veterans in need. Mental Health Service Lines are pushing as many veterans into clinician schedules as possible to meet their performance measures, but those veterans are not getting effective treatment...." (end quote)

Second, five years ago Secretary Shalala and Senator Dole called for the establishment of an effective Federal Recovery Coordinator program for the seriously wounded and their families. But rather than the single point of contact they called for, VA and DOD created two separate programs. The Government Accountability Office (GAO) testified that (quote) "...the proliferation of these programs...has resulted not only in inefficiencies, but also confusion for those being served. Consequently, the intended purpose [which is] to better manage and facilitate care and services may actually have the opposite effect...." (end quote).

Third, five years ago, then-Senator Barack Obama said (quote) "all of us are in agreement that we need to make the DoD [disability review] process less complex and better coordinated with the VA process," (end quote)...However, that process remains slow and complex. GAO reported that (quote) "Case processing times...have increased over time, and measures of servicemember satisfaction have shortcomings." (end quote). A witness from the Wounded Warrior Project stated that (quote) "[o]ur Wounded Warriors still encounter great difficulty in navigating a system they find to be highly complicated, difficult to understand, unnecessarily contentious, and often ponderously slow." (end quote).

Finally, despite repeated assertions about the need for VA and DoD to share medical and other information electronically, it seems the goalposts continue to move on when this will finally happen. GAO says VA and DoD still don't fully agree on key planning and operational elements that would ensure future success.

My hope is that raising these important issues to both of you will serve as a benchmark going forward by which all of us can hold you or your successors accountable. I know you both are committed to solving these problems. However, if what we've been doing isn't working, or isn't showing the measurable results we need, then let's work together to get on track.

Again, thank you for being here. I look forward to your testimony.

**Statement of**  
**Representative Adam Smith, Ranking Member**  
**House Committee on Armed Services**  
**Back from the Battlefield: DOD and VA Collaboration to Assist Service**  
**Members Returning to Civilian Life**  
**July 25, 2012**

Thank you, Mr. Chairman. I also want to welcome Secretary Panetta and Secretary Shinseki. Thank you for coming, I know both of you have been personally engaged on the transition of service members and we appreciate your participation in today's hearing.

Each year, thousands of service members transition out of uniform and back into their civilian communities. In fiscal year 2011, over one hundred and eighty-six thousand men and women in uniform left active duty, and in this fiscal year, nearly one hundred and twenty-five thousand service members are expected to transition out of the services. The numbers of those transitioning in the near future are only expected to increase as the force structure of the military draws down over the next several years.

Transition has been a challenge for our service members moving on to new careers and opportunities. While the economy across the country is slowly improving, service members currently leaving active duty are often faced with a competitive and difficult employment climate. Many find that their skills and experiences while in uniform do not easily translate into civilian positions. Although efforts to improve these challenges have been undertaken, more can be done to assist our service members and their families as they make their transition.

Such assistance and support is particularly important for wounded warriors and their families as they transition from the Department of Defense to the Department of Veterans' Affairs. Several thousand wounded warriors are now going through the Integrated Disability System (IDES) that recently started out as a pilot program, and last year was expanded across the country. While the program's intent is to reduce the time and uncertainty warriors and their families face while going through the disability evaluation systems for the Department of Defense and the Department of Veterans' Affairs, many still question whether the new system has improved the process. For example, while the single disability exam by the Department of Veterans' Affairs has reduce duplication by eliminating a similar exam by the Department of Defense. Some service members

are still confused by the two disability rating determinations by each of the Departments—because the Department of Defense only takes into account service disqualifying conditions, and Veterans' Affairs undertakes a more holistic review of long-term employability of an individual. Another issue is unintended consequences the Department of Veterans' Affairs requirements are having on the Department of Defense. For example, Veterans' Affairs requires a mental health review every 6 months for those with Post Traumatic Stress Disorder, the Department of Defense implementation of this requirement has had a significant impact on the availability of mental health resources available within the Department of Defense, which has had an impact on new patients seeking care.

Access to mental health services are vitally important and play an essential role in efforts to reduce suicide among service members and veterans. Transition can be a stressful experience for anyone making a significant change in their lives, but for those who have mental health issues, such a change can be problematic. The successful transition between the two Departments to provided continued support to service members is extremely important and I am interested in what efforts both Departments have taken to address this issue.

Another vital component in the transition of service members, and specifically for the wounded, ill and injured, is the ability to transition their medical records in a complete and timely manner. For the last several decades, both the Department of Defense and the Department of Veterans' Affairs have spent millions of dollars and countless hours working toward an interoperable electronic health record. Both Departments have testified before Congress on their efforts in moving forward, yet more challenges than accomplishments have been noted by both committees over the years. The recent announcement that the Department of Defense and Veterans' Affairs was moving toward a "single" electronic health record is notable and highly encouraged, but concerns remain whether this new goal is really achievable in the current resource constrained environment.

On Monday, the President announced a redesign of the Transition Assistance Program to address the concerns that we have heard from our service members and families. I look forward to hearing more specifics on how the programs will be improved, including what will be part of the 5-day core curriculum, and what services and programs will be available as part of the pre-separation assessment and individual counseling.

Secretary Panetta and Secretary Shinseki, again, welcome, I look forward to your testimony and learning hearing more on what efforts are being taken to improve the transition assistance to our service members and their families. I look forward to a frank and open discussion.

**Statement for the Record of the Honorable Ann Marie Buerkle, Chairwoman  
House Committee on Veterans' Affairs, Subcommittee on Health**

***"Back From the Battlefield: DOD and VA Collaboration to Assist Servicemembers Returning  
to Civilian Life"***

**July 25, 2012**

Thank you, Mr. Chairman.

I am pleased to join my colleagues from the Armed Services and Veterans' Affairs Committees and the Secretaries of the Departments of Defense (DOD) and Veterans Affairs (VA) this morning to continue a conversation of critical importance to our servicemembers, veterans, and their families.

Following reports on deficiencies in the quality of care and living conditions at Walter Reed Army Medical Center in 2007, President George W. Bush established the Commission on Care for America's Returning Wounded Warriors. The Commission, chaired by former Senator Bob Dole and former Secretary of the Department of Health and Human Services, Donna Shalala, was tasked with evaluating the challenges faced by DOD and VA in creating a seamless transition for wounded warriors from injury to active-duty or veteran status.

The Commission found that the complex systems of care, benefits, and services presented difficulties and bureaucratic obstacles for wounded warriors whose recovery, rehabilitation, and transition needs crossed the jurisdictional boundaries of VA and DOD.

The Dole-Shalala Commission report called for "fundamental changes in care management and the disability system." However, despite the urgent call to simplify the complicated systems that are in place to support and serve our warriors and their families, the transition from active duty to veteran status remains anything but seamless today.

Five years later, we continue to see servicemembers, veterans and their families struggling to navigate the immense bureaucracies of DOD and VA as they attempt to access the care and benefits they need.

Further, we continue to see the Departments, hindered by organizational and cultural reluctance to change, operating separate disability systems; duplicative and overlapping care coordination programs; and most critically disparate and outdated electronic medical records systems. The interoperable, bidirectional electronic medical record we know is essential to providing a smooth transition for our separating service members, may be light years away.

The written statements provided by the Secretaries this morning speak of progress and change but very little specifics. They could have been written any time in the last decade.

Last week, I met with a group of wounded warriors and caregivers and spent an hour listening to them recount their personal experiences of transition, recovery, and the aftermath of war.

Effectively and efficiently meeting their unique needs will require the focused attention and dedicated partnership of all of us – DOD, VA, Congress, and community and faith-based groups across our great country – right now.

When our nation needed defending, our servicemembers and veterans did not hesitate to answer the call of duty. I urge us all not to let another five years pass without doing the same for them in return.

Thank you again and I yield back.

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**SECRETARY OF DEFENSE LEON E. PANETTA  
STATEMENT ON DOD AND VA COLLABORATION  
JOINT HOUSE ARMED SERVICES COMMITTEE AND HOUSE  
COMMITTEE ON VETERAN'S AFFAIRS  
WEDNESDAY, JULY 25, 2012**

Chairman McKeon, Chairman Miller, Ranking Member Smith, Ranking Member Filner, and members of the committees: thank you for the opportunity to appear here this morning alongside Secretary Shinseki, who is a great public servant and a great friend to me and to our nation's veterans.

I am pleased to be able to have this chance to discuss the ways the Department of Defense (DoD) and the Department of Veterans Affairs (VA) are working together to meet the needs of service members, veterans, and their families.

This hearing comes at an important time for our nation, and for collaboration between our Departments. DoD and VA are in the process of building an integrated military and veteran support system that is fundamentally different – and far more robust – than it has been in the past. We have not forgotten when the Vietnam generation – my generation and Secretary Shinseki's generation – came home from war and were largely left to fend for themselves, without the kind of support system that they deserved.

Today, after a decade of war, a new generation of service members and veterans is coming home, and our nation has made a lifetime commitment to them for their service and sacrifice – for their willingness to put their lives on the line for our country. These men and women have shouldered a heavy burden, and many are dealing with complex and difficult problems.

We owe it to these returning service members and veterans to provide them a seamless support system so they can pursue their goals, give back to their communities, and strengthen our nation in new ways.

But this will not be easy. It will take a tremendous commitment on the part of all of us in government and in the military, and on the part of business leaders and citizens across the country. Even in a tough fiscal environment, we have a solemn obligation to continue to invest our time, effort, and money in helping those who have fought for us.

Every service member and every veteran has a unique story and experience – and because of that, providing each service member with the quality services they need is a complex challenge. But it is a challenge our nation and our departments must meet.

To fulfill the sacred responsibility of caring for those who have fought for our country, close and effective collaboration between DoD and VA is essential. While there is no doubt that DoD and VA are working more closely together than ever before, it is also clear that we need to reach an even deeper level of cooperation to better meet the needs of those who have served our nation in uniform, especially our wounded warriors.

Secretary Shinseki and I meet regularly in order to personally guide efforts to share resources and expand cooperation between our departments. But the partnership between our departments extends to all levels, led by a joint committee co-chaired by the Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary of

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Veterans Affairs. Both departments have offices solely focused on DoD-VA issues, and joint strategic plans that we have put in place guide our collaboration on benefits and services, health care, and operational efficiency.

Our efforts have been boosted by strong leadership at the top of the executive and legislative branches. I'd like to applaud President Obama and the First Lady for their strong leadership on behalf of military families, and I am grateful for the support of Congress, particularly these two committees, as well. The senior military leadership has also taken a strong interest in this issue, recognizing that meeting commitments to veterans is essential to recruiting and retaining the best military force in the world. When it comes down to it, caring for those who have served is not only a moral imperative – it is a national security imperative as well.

Working together, our Departments have already made a number of important changes to our system of care for wounded warriors, service members, veterans, and their families. But clearly, there is considerably more work to be done, particularly to meet the needs of the post-9/11 generation of warriors. It is critically important that we overcome the bureaucratic processes of the past – and therefore we are working to implement major changes in several areas that together will dramatically improve the quality of the services DoD and VA are able to provide.

Among these changes, let me discuss five priority areas where we are enhancing collaboration between our departments, including specific initiatives in transition assistance, disability evaluation, and electronic health records, as well as broader cooperation efforts in mental and behavioral health, and suicide prevention.

#### Transition Assistance

First, at the Department of Defense, our goal is to ensure that those who are leaving the service are prepared for their next step – whether that is pursuing additional education, finding a job in the public or private sector, or starting their own business. In this economic climate in particular, all of us are concerned about the number of unemployed veterans. Finding ways to help veterans contribute to our economic recovery is a priority for President Obama, for Secretary Shinseki and for me.

One thing we've learned is that we cannot wait until the end of a service member's military career to help him or her succeed after separation. We have to start from the first day of training and give our people the tools they need to develop, set goals, and reach milestones throughout their careers.

The cornerstone of the Department's transition efforts is the Transition Assistance Program, known as TAP. Currently, TAP is a voluntary program that provides counseling and guidance near the end of a service member's career.

Under the leadership of President Obama, and with the strong support of Congress, we are fundamentally redesigning TAP. Earlier this week, President Obama announced a new "Transition GPS program" that will establish new career readiness standards, extend the transition preparation through the entire span of a service member's career, and provide one-on-one counseling to facilitate the development of an individual

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transition plan. Our goal is to fully equip service members so they can apply their valuable military experience however and wherever they choose.

Many of the features of the redesigned TAP were laid out in the Veterans Opportunity to Work (VOW) to Hire Heroes Act of 2011, and we are on track to have implemented TAP-related provisions of the VOW Act by November of this year. The new TAP program will be mandatory for nearly all service members, including the Reserve and National Guard. The new TAP's "5-Day Core Curriculum" will include standardized training objectives that are aligned with service members' personal goals. It will also include a VA benefits briefing, as required by the VOW to Hire Heroes Act.

To implement the new TAP curriculum, we are conducting a pilot program from this month until the end of August at seven training locations. The pilot program will enable DoD and each of the military services to refine the curriculum and optimize the experience for their transitioning service members.

Closely related to these efforts, DoD is leading a new Credentialing and Licensing Task Force that was directed by President Obama this May in order to address gaps between military occupational specialties and civilian licensing requirements.

The task force will:

- Identify military specialties that readily transfer to high-demand jobs, such as aircraft maintenance, automotive mechanics, health care specialists, truck drivers, information technology professionals, and logisticians;
- Engage civilian, state, and local credentialing and licensing entities to close gaps between military training programs and credentialing and licensing requirements; and
- Seek ways to partner with VA to help certain groups of veterans develop new skills in order to better compete in the private sector. For example, some infantry veterans – who have expertise that may not transfer readily to the business world – are acquiring information technology skills through a digital tutoring program developed by the Defense Advanced Research Projects Agency.

Our goal is to help private sector employers appreciate veterans' valuable skills and experiences, and to simplify the process for earning private sector credentials. For our communities, there is an enormous return on our investment in these veterans. We began this effort with a focus on the manufacturing sector, and partnered with leading manufacturing credentialing agencies to enable up to 126,000 service members to gain industry-recognized certifications for high-demand manufacturing jobs.

We are also working closely with VA and the Small Business Administration on entrepreneurship initiatives for separating service members who are interested in starting their own businesses. The goal is to provide intensive levels of training in entrepreneurship, including the development of a business plan. Veterans are extremely well-equipped to lead in the business community and their entrepreneurial success will strengthen our nation's economic future, which is a key source of our military strength.

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Integrated Disability Evaluation System (IDES)

The second area where we have made progress, but have more work ahead, is in evaluating those service members who have medical conditions that prevent them from working in any military occupation and who must, as a result, enter a disability evaluation process. In the past, these service members had to navigate separate disability evaluation systems at DoD and VA – meaning they also had to deal with additional layers of bureaucracy and unacceptable delays following a military discharge until receiving VA disability compensation.

DoD and VA embarked on a complete overhaul of the legacy system and have put in place a single Integrated Disability Evaluation System (IDES).

Over the past two years, we have extended this system to virtually all disabled service members. As a result, our Departments have decreased the time it takes after military discharge until receipt of VA disability compensation by over 70 percent, from 240 to the current 63 days. The overall time it takes to receive disability compensation has been reduced from 540 days under the separate DoD and VA legacy system to the current 396 days in IDES, a 26 percent improvement. We have been able to meet these goals despite a rapid increase in the number of exam requests.

Even as we focus on reducing unneeded bureaucratic delays in the disability evaluation system, we also recognize that our main measure of effectiveness must be our ability to meet the individual needs of wounded, ill and injured service members.

This is an especially important consideration when determining the retention status of ill or injured service members who desire to continue serving in uniform. Many of these men and women are dealing with complex visible and invisible wounds that require lengthy treatment and rehabilitation times. Even as DoD focuses on achieving timely processing of disability cases, we recognize our additional obligation to help service members attain maximum functional capability before deciding whether they should remain in military service. In the coming months, a senior level working group, in coordination with VA, will provide recommendations for how to better tailor the process based on the different needs and desired outcomes of service members going through the system.

Integrated Electronic Health Record

A third DoD-VA collaboration initiative is in the area of electronic health records. For too long, efforts to achieve seamless transition between our health care systems have been hamstrung by separate legacy health record systems.

In response to a challenge issued by President Obama three years ago, DoD and VA have been working steadily to build an integrated Electronic Health Record system (iEHR). The iEHR is a key component for the President's Virtual Lifetime Electronic Record initiative – a ground breaking vision for the future of electronic data sharing among federal agencies and the private sector.

This system, when implemented, will be used by a service member from the first day of a military career throughout the life of that individual. It will help ensure the seamless transition of care between DoD and VA treatment facilities – and eventually the

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private sector as it increasingly adopts electronic health records. Medical providers will be able to view consistent and comprehensive patient data, and that means they will be able to deliver better care. Researchers will also be able to securely and privately study trends across the large population in the system, which could lead to new medical breakthroughs that would benefit the entire population.

This is an ambitious effort, to be sure. But we have set interim milestones on the road toward the fully capable system. Beginning in 2014, we will demonstrate this system at sites in San Antonio, Texas and Hampton Roads, Virginia. We are starting to test and execute critical infrastructure components of this system this year, and we will steadily add capabilities toward the 2014 milestone. We are already testing a new user interface at two medical facilities that enables medical providers to review health records from both DoD and VA systems on a single screen. Implementing this new system as it is being developed will ensure we are doing it right and allow us to make adjustments based on experience in the field.

When operational, the integrated Electronic Health Record will be the single source for service members and veterans to access their medical history at any DoD and VA medical facility. It will help ensure they get the best care possible. It will also be the world's largest health record system, and that could mean that other federal and commercial health care providers may adopt our protocols, which will expand the capabilities of the system still further.

#### Mental and Behavioral Health

Beyond these specific initiatives, DoD and VA are focusing on enhancing collaboration in the broader area of serving the mental and behavioral health needs of service members, their families and veterans. Post-traumatic stress disorder (PTSD) has emerged as a signature unseen wound of a decade at war. Its legacy will be felt for decades to come, and both DoD and VA must therefore improve our ability to identify and treat this condition, as well as all mental and behavioral health conditions, and to better equip our system to deal with the unique challenges these conditions can present.

For example, I have been very concerned about reports of problems with modifying diagnoses for post-traumatic stress in the military disability evaluation system. Many of these issues were brought to my attention by members of Congress, and I thank you – and particularly Senate Veterans Affairs Committee Chairman Patty Murray – for their vigilance on this subject.

To address these concerns, I have directed a review across all of the uniformed services. This review, led by Under Secretary of Defense for Personnel and Readiness, Erin Conaton, will help ensure we are delivering on our commitment to care for our service members. We've got to do everything we can to make sure the system itself is working to help service members, not to hide this issue, not to make the wrong judgments about this issue, but to face facts and deal with the problems upfront, and make sure that we provide the right diagnosis and that we follow up on that kind of diagnosis.

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This review will be analytically sound, action-oriented, and the least disruptive to behavioral health services for service members. I anticipate the entire review will take approximately 18 months.

The Department will continue to be an innovative leader in research and treatment of traumatic brain injury and PTSD. In partnership with organizations like the Intrepid Foundation, we are transforming how we treat these conditions.

The Intrepid Fallen Heroes Fund and DoD are collaborating on nine National Intrepid Center of Excellence satellites to supplement the existing flagship facility at Walter Reed National Medical Center in Bethesda, Maryland. We just broke ground on the first two of these satellites, at Fort Belvoir and Camp Lejeune. These new facilities will provide programs for active duty service members that incorporate multidisciplinary evaluation, diagnosis, and care. We are developing a single concept of care, expanding our capacity and capability to care for patients with traumatic brain injury and psychological health conditions.

The advances from research in these areas are ground-breaking not just for wounded warriors, but for all who are dealing with similar injuries across our country and the world.

#### Suicide Prevention

Improving access to and the quality of mental and behavioral health care services will also help us in our efforts to prevent military suicides – which I have said is one of the most frustrating problems I have come across as Secretary of Defense.

Suicide prevention is another priority area for enhanced DoD-VA collaboration. Despite increased efforts and attention by both DoD and VA, the suicide trend among service members and veterans continues to move in a troubling and tragic direction.

In close cooperation with the VA, DoD is taking aggressive steps to address this issue – ones that I outlined at a joint DoD-VA suicide prevention conference held last month in Washington:

- First, I have directed leaders to promote a culture that encourages individuals to seek behavioral health treatment, if needed.
- Second, as I mentioned earlier, we are improving the quality and access to health care.
- Third, the Department is placing the same emphasis on mental fitness as it does on physical fitness and reducing the stigma associated with seeking help.
- Fourth, we are continuing to partner with other governmental agencies, the private sector, and researchers from academia to improve our understanding of suicide and other issues such as traumatic brain injury and PTSD.

We are also directly partnering with VA on a number of specific suicide prevention efforts, including a joint Suicide Data Repository, a military crisis line, and a host of cutting-edge research initiatives.

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Conclusion

The Department is partnering with VA closer than ever before to meet the needs of those who serve our country. In the coming years, as we continue to implement these new changes across the DoD-VA system, we will be able to better support service members and veterans throughout their careers and the rest of their lives.

The joint capabilities of DoD and VA not only support service members and veterans, but they also have the potential to transform care outside the military. That is especially true in health care, with the introduction of a standard for exchanging electronic health records, ground-breaking work on prosthetics and brain injury, and other important innovations.

As DoD and VA seek to integrate our services even further, we must strengthen accountability, promote a culture of teamwork, reduce administrative burdens, and consolidate duplicative programs and services. And we will need your help and support in Congress as we continue to deliver on these promises, even in these tight fiscal times.

Ultimately, our efforts to deliver the best possible services depend on the dedication of our DoD and VA professionals, who work hard every day on behalf of those who have served in uniform. I extend my thanks to all who help support our men and women in uniform today, to veterans, and to all of their families.

We truly are one family at the Department of Defense and Department of Veterans Affairs – a family that supports one another, and all those who have answered the call to defend our country. Together, we will do everything possible to ensure that the bond between our Departments, and between our country and those who have defended it, only grows stronger in the years ahead.

Thank you and I look forward to your questions.

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**Leon E. Panetta**  
**Secretary of Defense**



Leon Edward Panetta was sworn in as the 23<sup>rd</sup> Secretary of Defense on July 1, 2011.

Before joining the Department of Defense, Mr. Panetta served as the Director of the Central Intelligence Agency from February 2009 to June 2011. Mr. Panetta led the agency and managed human intelligence and open source collection programs on behalf of the intelligence community.

Secretary Panetta has dedicated much of his life to public service. Before joining CIA, he spent 10 years co-directing with his wife, Sylvia, the Leon & Sylvia Panetta Institute for Public Policy, based at California State University, Monterey Bay. The Institute is a nonpartisan, not-for-profit center that seeks to instill in young men and women the virtues and values of public service. In March 2006, he was chosen as a member of the Iraq Study Group, a bipartisan committee established at the urging of Congress to conduct an independent assessment of the war in Iraq.



From July 1994 to January 1997, Mr. Panetta served as Chief of Staff to President William Clinton. Prior to that, he was Director of the Office of Management and Budget, a position that built on his years of work on the House Budget Committee. Mr. Panetta represented California's 16<sup>th</sup> (now 17<sup>th</sup>) Congressional District from 1977 to 1993, rising to House Budget Committee chairman during his final four years in Congress.

Early in his career, Mr. Panetta served as a legislative assistant to Senator Thomas H. Kuchel of California; special assistant to the Secretary of Health, Education and Welfare; director of the U.S. Office for Civil Rights; and executive assistant to Mayor John Lindsay of New York. He also spent five years in private law practice.

He served as an Army intelligence officer from 1964 to 1966 and received the Army Commendation Medal.

Secretary Panetta holds a Bachelor of Arts degree in political science and a law degree, both from Santa Clara University. He was born on June 28, 1938 in Monterey, where his Italian immigrant parents operated a restaurant. Later, they purchased a farm in Carmel Valley, a place Secretary and Mrs. Panetta continue to call home. The Panettas have three grown sons and six grandchildren.

**STATEMENT OF THE HONORABLE ERIC K. SHINSEKI**

**SECRETARY OF VETERANS AFFAIRS  
DEPARTMENT OF VETERANS AFFAIRS (VA)  
BEFORE THE  
HOUSE COMMITTEE ON VETERANS' AFFAIRS  
AND  
THE HOUSE COMMITTEE ON ARMED SERVICES  
U.S. HOUSE OF REPRESENTATIVES**

**JULY 25, 2012**

Chairman McKeon, Chairman Miller, Ranking Member Smith, Ranking Member Filner,  
and Members of the Armed Services and Veterans Affairs Committees:

I am honored to be here to testify with Secretary of Defense Leon Panetta. Since July 2011, we have worked closely together on priority issues common to both the Department of Defense (DoD) and the Department of Veterans Affairs (VA), meeting five times over the past ten months to resolve issues and advance priorities that are critical to our Nation's Servicemembers and Veterans. Our most recent meeting in May involved a joint visit to the James A. Lovell Federal Health Care Center (JALFHCC) in North Chicago. We plan to meet again on 10 September. Secretary Panetta's leadership and close partnership on behalf of those who wear and have worn the uniforms of our Nation have been monumental. As a result, we have brought our Departments closer together than ever before.

Because our Servicemembers and Veterans represent the continuity between our Departments, DoD and VA must be collaborative, attentive, and cooperative. Little of what we do in VA originates in VA; much of what we do originates in DoD. This means

that we, in VA, must be aware, agile, and fully capable of caring for those “who have borne the battle” and their families and survivors, long after the guns have fallen silent. Today, we still care for two children of Civil War Veterans, over a hundred spouses and children from the Spanish-American War, about 5,000 from World War I, and the numbers increase with each succeeding generation. The promises of President Abraham Lincoln are being delivered today by President Barack Obama, and a century from now, the same will be true as VA continues to fulfill the promises of Presidents and the obligations of the American People.

Our history suggests that VA’s requirements will continue growing for a decade or more after the operational missions in Iraq and Afghanistan are ended. Over the next five years, there is the potential for one million serving men and women to either leave military service or demobilize from active duty. The newest of our Nation’s Veterans are relying on VA at unprecedented levels. Most recent data indicate that, of the approximately 1.4 million Veterans who returned from deployments to Iraq and Afghanistan, roughly 67 percent are using some VA benefit or service.

As these newest Veterans return, we must provide the care and benefits they have earned and that they will need to successfully transition home, just as we must for Veterans of previous conflicts. We deliver much needed, high quality benefits and services – and we must do this faster and with greater efficiency. The Veterans Benefits Administration is pursuing a transformation plan that integrates people, process, and technology, a set of initiatives to eliminate the claims backlog in 2015.

The standard is to process all claims within 125 days at a 98 percent accuracy rate in 2015. This transformation is driven by a new era, emerging technologies, demographic changes in the Veteran population, and our renewed commitment to do what's right by today's Servicemembers, Veterans, family members, and survivors.

We have placed a priority on improving mental health care for both Veterans and Servicemembers. Our efforts reflect an unprecedented level of collaboration between VA and DoD on mental health issues and care, beginning with our joint Mental Health Summit in 2009. That summit led to the development of a joint Integrated Mental Health Strategy (IMHS), approved by our departments in October 2010, to address growing mental health needs. Twenty-eight joint actions are fully underway to address issues that are common to the two Departments, organized into 4 strategic goals:

- Expanding access to behavioral health care in DoD and VA (e.g., integration of mental health into primary care);
- Ensuring quality and continuity of care across DoD and VA (e.g., coordinated, joint training in evidence-based psychotherapies for PTSD);
- Education and outreach efforts to increase provider skills and overcome the stigma associated with mental health treatment (e.g., military culture training for clinicians and use of innovative web-based and smartphone technologies);
- Promoting resilience and expanding nonclinical services to promote mental health (e.g., expanding the role of chaplains in mental health and joint suicide prevention efforts).

The IMHS employs a coordinated public health model to better serve Active and Reserve Component Servicemembers, Veterans, and families.

VA's Suicide Prevention Program elements have been shared with DoD, and we hold a joint Suicide Prevention Conference annually to review, update, and refocus all elements of our strategy to combat suicide. This collaboration helped us to transition the Veterans Crisis Line, established in 2007 and expanded to include a Veterans' Chat Service in 2009, into a joint program for both VA and DoD. Conducted in partnership with the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Suicide Prevention Lifeline, the program now takes calls from Veterans, Servicemembers, family members, and friends. In 2012, we expanded the program to include a texting service. This program is now referred to as the Military Crisis Line in DoD, and the Veterans' Crisis Line in VA—but it is a joint, collaborative effort run out of Canandaigua, New York. Since 2007, the mental health staff have received over 625,000 calls:

- Initiated over 22,500 rescues;
- Referred over 95,803 Veterans to local Suicide Prevention Coordinators for same day or next day services;
- Answered calls from over 8,000 Active Duty Servicemembers;
- Responded to over 57,000 chats.

The call center is responsible for an average of 300 admissions a month into VA health care facilities and an average of 200 new enrollments a month for VA health care.

Three priority programs, on which both Departments have focused, are: the integrated Electronic Health Record (iEHR); the Integrated Disability Evaluation System (IDES); and ongoing efforts to energize the transition process for Servicemembers as they become Veterans.

Our two Departments have historically had two independent health care systems with two independent healthcare record systems. In the past, Servicemembers had to hand-carry paper copies of their DoD health care records to VA. With the introduction of electronic health records, much of the information can now be transmitted electronically, but the departments still have separate electronic systems. A shared, integrated electronic health record will improve decision support by providing a full and complete view of the patient record. This will reduce redundancy in tests and procedures, thereby reducing costs, will provide access to an expanded community of subject matter experts, and will provide an IT platform that serves potentially as a National model that is highly responsive to future enhancements.

Today, DoD and VA share more electronic health information than any two organizations in the Nation. Over the past three years, DoD and VA have increased the number of Servicemembers and Veterans whose electronic data is shared between the two Departments by 1.1 million. That 1.1 million increase means the increased sharing of:

- 23 million more laboratory results;
- 3.6 million more radiology reports; and
- 24 million more pharmacy records.

This information sharing helps improve the continuity of care for our Servicemembers and Veterans, helps ensure that physicians have the most accurate medical information for a patient, and significantly improves patient safety. For instance, the two Departments now share medication allergy information for 1.2 million patients, up from 27,000 just three years ago. These records are used to care for not only transitioning wounded, ill, and injured, but also for all Servicemembers and Veterans in our two health care systems.

The progress we have made in records sharing has been substantial, but we must do more to ensure a seamless transition. To accomplish that goal, Secretary Panetta and I have committed to developing a single, common, joint electronic health record, known as iEHR. This effort began on January 21, 2009, when then-Secretary Gates and I agreed to develop that vision. Our commitment was reinforced by the President in April of that year in a directive to both Departments to create a Virtual Lifetime Electronic Record (VLER), within which the electronic health record would be a key platform. Last year, after two years of hard work by teams from both Departments, then-Secretary Gates and I met on 5 February, 17 March, 2 May, and 23 June. Thereafter, Secretary Panetta and I met on five additional occasions to provide continuing guidance and energy for the implementation of the iEHR. It will unify the two Departments' electronic health record systems into a common system to ensure that all DoD and VA health

facilities have Servicemembers' and Veterans' health information available throughout their lifetimes.

iEHR will enable the free flow of essential medical information among DoD, VA, and other community care providers who treat Veterans and Servicemembers. Benefits adjudicators, family members, care coordinators, and other caregivers, at the discretion of the Veteran, may also be granted iEHR access. Potentially a national model for capturing, storing, and sharing electronic health information, iEHR is being developed utilizing an Open Source Electronic Health Record Agent (OSEHRA). OSEHRA is a non-profit enterprise that VA established in the fall of 2011, in close collaboration with DoD. It serves as our "open source custodian," a place where companies, individual innovators, and the government come together to develop electronic health record software. So far, over 1,000 people representing 100 companies have signed on to OSEHRA, including former-VA Secretary and former-Army Surgeon General James Peake, who serves as its chairman. Northrop Grumman and other leading health care companies have contributed their code, and one of our existing vendors – Hawaii Resource Group, who designed and built our graphical user interface (GUI) – recently put its proprietary application into our open source custodian to make it available to all our hospitals and clinics. The Palo Alto VA Medical Center has since installed the GUI in one of its clinics, and others will soon follow suit. This augers well for both iEHR's success and for open architecture, standards based, and modular solutions to our most challenging IT problems – at VA, DoD, and across the federal government.

Equally important is our continued commitment to preserving the privacy of our Veterans' and Servicemembers' personal and health record information. We will work jointly with DoD to ensure that iEHR systems are secure and meet the ardent standards by which we evaluate and maintain our information technology and clinical investments.

A critical component of the iEHR is the GUI, which allows all validated system users and health providers to be able to see health records fully. A working GUI was created in May 2011 through collaboration between Tripler Army Medical Center and the co-located Spark M. Matsunaga VA Medical Center in Honolulu, Hawaii. It has since been introduced in the JALFHCC in North Chicago where both Secretary Panetta and I watched demonstrations of it this past May. It is impressive, and it represents a major step forward for the iEHR. We are now decisively committed to a single, common, joint platform for an electronic health record. Secretary Panetta and I have reaffirmed our commitment to a fully operational iEHR, no later than 2017, with clinical capabilities deployed in Hampton Roads and San Antonio in 2014 — a significant challenge, but one that is critical to achieve for our Nation's Veterans and Servicemembers.

iEHR is the major health record component of the larger Presidential initiative known as the Virtual Lifetime Electronic Record (VLER). With appropriate controls to ensure privacy and security, VLER aims to share health, benefits, and administrative information, including personnel records and military history records, among DoD, VA, Social Security Administration, private health care providers, and other Federal, state, and local governmental partners. The Department of Health and Human Services

(HHS) also plays a vital role in creating this essential backbone for health information data exchange: the Nationwide Health Information Network (NwHIN). The NwHIN is a set of standards, services, and policies that enable secure health information exchange over the Internet. The network will provide a foundation for the exchange of health information across diverse entities, within communities and across the country, helping to achieve the goals of the HITECH Act. This critical part of the national health IT agenda will enable health information to follow the consumer, be available for clinical decision making, and support appropriate use of healthcare information beyond direct patient care so as to improve population health. Efforts like NwHIN will help enable clinicians to “pull” records from other sources (CONNECT), allows clinicians and health data providers to “push” data (DIRECT), and empowers patients to access their personal health information (BLUE BUTTON).

Key components of the VLER initiative are providing Veterans access to their benefits information through online tools such as Blue Button and eBenefits. The Blue Button is a joint program between HHS, DoD, and VA that provides Veterans on-demand access to personal health information at the click of a button, delivered in a format that is easy to read and accessible without any special software. It was announced by President Obama in the summer of 2010 and officially launched that October. Today, about 20 months later, just under 1 million Servicemembers, beneficiaries, and Veterans have downloaded electronic copies of their personal health records. Perhaps more importantly, the private sector is embracing Blue Button as “the brand” that means

access to health information. United Health recently joined Aetna in enabling Blue Button on their patient portal. We expect more providers will follow suit.

eBenefits is a VA/DoD initiative that consolidates information regarding benefits and services and includes a suite of online, self-service capabilities for enrollment, application, and utilization of benefits and services. Thanks to DoD leadership, Servicemembers now automatically sign up for eBenefits when they enter service.

eBenefits enrollment now exceeds 1.6 million users, and VA expects enrollment to exceed 2.5 million by the end of 2013. Users can check the status of a claim or appeal, review the history of VA payments, request and download military personnel records, generate letters to verify their eligibility for Veterans' hiring preferences, secure a certificate of eligibility for a VA home loan, view their scheduled VA medical appointments, and complete numerous other benefit actions. As enrollments continue to expand, capabilities available through the eBenefits portal will also continue to grow.

This year, eBenefits enhancements will allow Veterans to file benefits claims online in a "Turbo Claim-like" approach and upload supporting claims information that feeds our paperless claims processing system, the Veterans Benefits Management System (VBMS). In fiscal year 2013, Servicemembers will be able to complete their Servicemembers' Group Life Insurance applications and other transactions through eBenefits.

Since the problems at DoD's Walter Reed Army Medical Center in 2007, VA has supported DoD and the military services in improving DoD's legacy disability evaluation system (DES) and creating a new integrated VA/DoD approach. Under DES, the total number of days a Servicemember could wait from referral through military discharge, followed by receipt of a VA disability rating, to receipt of the first VA disability payment averaged 540 days. In November 2007, VA and DoD launched a new, integrated process to eliminate the duplicative, time consuming, and often confusing elements of two separate disability processes. The goals of the integrated DES process were to: (1) increase transparency for the Servicemember; (2) reduce processing time; (3) improve consistency in ratings of those being medically separated; and (4) reduce the benefits gap between separation from the military and receipt of VA disability compensation. Congress authorized the integrated DES Pilot in the National Defense Authorization Act for Fiscal Year (FY) 2008.

The integrated pilot was launched at three sites in the National Capital Region (NCR): Walter Reed Army Medical Center, Bethesda National Naval Medical Center, and Malcolm Grow Medical Center on Andrews Air Force Base. By April 2010, the integrated DES Pilot had expanded to 27 sites and covered 47 percent of the required outprocessing population. In July 2010, the DoD/VA Senior Oversight Committee (SOC) expanded the integrated DES Pilot to include more departing Servicemembers and the process was formally renamed the Integrated Disability Evaluation System (IDES). This decision was approved by the senior leadership of both Departments.

Full implementation of IDES was completed by September 30, 2011, at 139 IDES operational sites worldwide.

VA and DoD have made considerable progress towards achieving an integrated process. We have improved transparency and consistency of outcomes, while reducing processing times. As of June 30<sup>th</sup>, we have reduced the processing time under the separate DoD and VA legacy processes from about 540 to 396 days. Our goal is 295 days. VA's portion of this goal is 100 days, and we have been as low as 105 days before responding to surges in military departures. As of June 2012, we are at 145 days.

DoD/VA cooperation on IDES has eliminated many of the sequential and duplicative processes found in the legacy system. Servicemembers no longer undergo two separate examination and rating processes. VA conducts exams and provides a tentative rating for use by both Departments' processes, resulting in more consistent evaluations, faster decisions, and timely benefits delivery for those medically retired or separated. VA is approaching its goal of delivering benefits in the shortest period of time allowed by law following discharge, thus reducing the "benefits gap" that previously existed under legacy DES between Servicemembers' disability separation from DoD and receipt of their first VA disability payment. This lag time used to be 6 to 9 months; it now varies between 31 and 60 days.

At our quarterly meetings, Secretary Panetta and I personally review the status of our efforts, and we remain determined to improve our processing time, while still allowing Servicemembers to exercise leave options and other personal choices throughout the healing process.

Finally, we have devoted considerable effort to improving the transition of all Servicemembers back into civilian life. In August 2011, the President announced a comprehensive plan to address transition issues to ensure that all of America's Servicemembers have the support they need and deserve as they leave the military, look for a job, and join the civilian workforce. A key part of the President's plan was his call for a "career-ready military." Specifically, he directed DoD and VA to work closely with other agencies and the President's economic and domestic policy teams and to lead a task force that would develop a new training and services delivery model to help strengthen the transition of our Servicemembers as they become Veterans.

Congress passed, and the President signed into law, the "VOW to Hire Heroes Act of 2011" (VOW Act) in November 2011, which included steps to improve the existing Transition Assistance Program (TAP) for Servicemembers. Among other things, the VOW Act made participation in several components of TAP mandatory for all Servicemembers.

The redesigned transition program was developed to ensure transition standards for all Servicemembers. Implementing uniform standards will transform the transition process

into a detailed, mandatory, integrated sequence of events that enables Servicemembers to make fully informed career decisions and equips them with tools they will need to be successful. This redesigned program complements many of the transition-related provisions of the VOW Act to offer a tailored curriculum that provides Servicemembers useful, quality instruction, while connecting them with the benefits and resources available to Veterans. The transition program focuses on the "end-game" of Servicemember readiness to move from the military to a civilian profession. In order to meet VOW Act compliance, VA and the Military Services began pilot programs to test portions of the redesigned transition program in July 2012, which included participation by inter-agency partners. The pilot programs are evaluating the curriculum, which we will adjust as necessary, to scale delivery to all transitioning Servicemembers beginning in November, 2012.

In addition, VA and DoD are working closely to remove impediments to credentialing for separating Servicemembers, which will enable Veterans to more easily gain civilian employment.

VA and DoD continue to work together to resolve transition issues while aggressively implementing improvements and expanding existing programs. While we are pleased with the quality of effort and progress to date, we fully understand that our two Departments are responsible to drive these efforts to successful completion, in spite of differing titles of the U.S. Code complicating our abilities to design new business processes. As a result, we are challenged to develop efficient funding mechanisms. As

an example, for the JALFHCC, special legislation was required to establish a joint Treasury fund to enable joint operations. In VA's FY 2013 budget submission, we requested that Congress change the existing statute in a number of areas to better assist our collaborations with DoD, such as to allow for additional flexibility in the transfer and/or receipt of funds between another Federal agency for use in planning, design, and construction of shared medical facilities, as well as similar authorities in leasing space for shared medical facilities.

VA and DoD are committed to our collaborations, and we continue to look for ways to improve our decision-making, achieve greater efficiencies, and accelerate the transition process for Servicemembers and Veterans. Thank you again for your support to our Servicemembers, Veterans, and their families and your interest in the ongoing collaboration and cooperation between our Departments.



### The Honorable Eric K. Shinseki

### Department of Veterans Affairs

Washington, D.C.

Retired U.S. Army General Eric K. Shinseki was nominated by President Barack Obama on Dec. 7, 2008 to serve as Secretary for the United States Department of Veterans Affairs. His nomination was confirmed by the Senate January 20, 2009, and he was sworn in as the seventh Secretary of Veterans Affairs on January 21, 2009.

General Shinseki served as Chief of Staff, United States Army, from 1999 until June 11, 2003, and retired from active duty on August 1, 2003. During his tenure, he initiated the Army Transformation Campaign to address both the emerging strategic challenges of the early 21st century and the need for cultural and technological change in the United States Army.

Following the Sept. 11, 2001 terrorist attacks, he led the Army during Operations Enduring Freedom and Iraqi Freedom and integrated the pursuit of the Global War on Terrorism with Army Transformation, enabling the Army to continue to transform while at war.

Prior to becoming the Army's Chief of Staff, General Shinseki served as the Vice Chief of Staff from 1998 to 1999, after serving simultaneously as Commanding General, United States Army, Europe and Seventh Army; Commanding General, NATO Land Forces, Central Europe, both headquartered in Heidelberg, Germany; and Commander of the NATO-led Stabilization Force, Bosnia-Herzegovina, headquartered in Sarajevo.

He was commissioned a second lieutenant of Artillery upon graduation from the United States Military Academy in June 1965, and was attached to Company A, 1st Battalion, 14th Infantry Regiment, 25th Infantry Division as a forward observer from December 1965 to September 1966, when he was wounded in combat in the Republic of Vietnam. He was returned to Tripler Army Medical Center, Honolulu, Hawaii to recuperate, following which he was assigned as Assistant Secretary, then Secretary to the General Staff, U.S. Army, Hawaii, Schofield Barracks, from 1967-1968. He transferred to Armor Branch and attended the Armor Officer Advanced Course at Fort Knox, Ky, before returning to Vietnam a second time in 1969. While serving as Commander, Troop A, 3d Squadron, 5th Cavalry Regiment, he was wounded in action a second time in 1970.

Other assignments include Commander, 3rd Squadron, 7th Cavalry, 3rd Infantry Division; Commander, 2nd Brigade, 3rd Infantry Division; Deputy Chief of Staff, Support for Allied Land Forces Southern Europe; Assistant Division Commander-Maneuver, 3rd Infantry Division; Commander, 1st Cavalry Division, as well as G-3, 3rd Infantry Division, 1984-1985; G-3, VII US Corps, 1989-1990; and Deputy Chief of Staff for Operations and Plans, Headquarters, Department of the Army, 1996-1997.

Shinseki holds a Bachelor of Science degree from the U.S. Military Academy at West Point; a Master of Arts degree from Duke University, and is a graduate of the National War College. General Shinseki has been awarded the Defense Distinguished Service Medal, Distinguished Service Medal, Legion of Merit (with Oak Leaf Clusters), Bronze Star Medal with "V" Device (with 2 Oak Leaf Clusters), Purple Heart (with Oak Leaf Cluster), Defense Meritorious Service Medal, Meritorious Service Medal (with 2 Oak Leaf Clusters), Air Medal, Parachutist Badge, Ranger Tab, Joint Chiefs of Staff Identification Badge, and the Army Staff Identification Badge.

January 2009



**Secretary  
of Veterans Affairs**



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**WITNESS RESPONSES TO QUESTIONS ASKED DURING  
THE HEARING**

JULY 25, 2012

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**RESPONSE TO QUESTION SUBMITTED BY MR. MCKEON AND  
MR. MILLER**

Secretary PANETTA. DOD and VA currently share more clinical data than any other two healthcare organizations in the world. However, healthcare operations between the Departments are not integrated. The DOD and VA have multiple healthcare legacy systems and data stores, developed over decades, that must be modernized to enable the sustainability, flexibility and interoperability required to improve continuity of care. The integrated Electronic Health Record (iEHR) will employ a joint platform and service-oriented architecture that is standards-based; this will give the Departments the ability to integrate healthcare capabilities for streamlined care and benefits delivery and an architecture that supports rapid delivery and enhancement of new capabilities as needed. The agreements between the Departments associated with iEHR have been widely publicized. The Departments must balance the need to conduct proper planning for the overall effort with a strong desire to field new systems and applications as rapidly as possible.

Effective governance has been established and put in place to assist the DOD/VA Interagency Program Office (IPO) in navigating Department-specific processes for acquiring IT solutions to ensure iEHR does not incur unnecessary delays. Given the need to merge two acquisition life cycles, the Departments have acknowledged the need to optimally align their processes to ensure agile and cost efficient delivery of capabilities to the clinical community. The iEHR is subject to the programmatic requirements of both the DOD Business Capability Lifecycle (BCL) and the VA Program Management Accountability System (PMAS). The IPO, DOD, and VA identified areas where process differences may exist, and are collaboratively engaging in efforts to ensure that any impediment that may arise is resolved in an efficient manner. The IPO leveraged BCL and PMAS to create a Capability Development Life Cycle Framework which captures the required documentation and milestone decisions for each phase, to include funding and investment decisions.

The IPO has appropriately placed its initial focus on putting critical iEHR infrastructure and services in place. The iEHR requires significant work to create a technical framework in which clinical capabilities can be incrementally incorporated. Key steps have been taken toward achieving the infrastructure upon which the iEHR will be built and a master schedule is in place to guide iEHR progress: A Service Oriented Architecture (SOA) and Enterprise Service Bus (ESB) contract that has been let and those programs are meeting their milestones. Use of SOA reduces dependence on proprietary technologies and enables the Departments to avoid being "locked-in" to a specific vendor for a long term, which would hamper ongoing competition and stifle innovation.

Ultimately, the iEHR will unify the two Departments' EHR systems into a common system that will ensure that DOD and VA health facilities have Service members' and Veterans' health information available throughout their lifetime. We anticipate joint use of the iEHR will help contain healthcare costs and provide higher value based healthcare delivery systems. By implementing a single, common health record for DOD and VA medical facilities, the iEHR will ensure that information about injuries and illnesses incurred during military service remain available for health and benefits purposes throughout a person's lifetime, supporting patient safety and continuity of care and facilitating access to and delivery of benefits. Seamless information sharing is expected to support the expeditious processing of disability claims in the future. Further, the iEHR will support the objectives of the HIPAA Privacy and Security Rules to ensure that when protected health information (PHI) is collected, maintained, used, disclosed or transmitted, reasonable and appropriate administrative, physical and technical safeguards have been implemented to ensure integrity, availability and confidentiality.

The initial iEHR capabilities, laboratory and immunizations, will be delivered to two sites (San Antonio, Texas and Hampton Roads, Virginia) by the end of 2014. The capabilities of the iEHR will be increased incrementally through the end of 2017. [See page 15.]

**RESPONSE TO QUESTION SUBMITTED BY MR. MCKEON**

Secretary PANETTA. The President's budget makes the necessary budget constrictions to avoid devastating the Department through sequestration. If sequestration becomes an inevitability, the Department will evaluate all options available to comply with the law. [See page 14.]

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**QUESTIONS SUBMITTED BY MEMBERS POST HEARING**

JULY 25, 2012

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### QUESTIONS SUBMITTED BY MR. LANGEVIN

Mr. LANGEVIN. Both DOD and the VA receive funding for spinal cord injury treatment, research, and education—the VA through the Office of Research and Development, and the DOD specifically through the Congressionally Directed Medical Research Program.

While the programs share a common goal, there are important differences. To what extent are spinal cord injury research efforts coordinated and shared across Departments?

Secretary PANETTA. Spinal cord injury (SCI) research efforts are coordinated and shared across the Departments of Defense and Veterans Affairs at several levels. First, DOD and VA jointly sponsor research portfolio reviews and analyses (R&A) of major research efforts in Traumatic Brain Injury and Psychological Health; Clinical, Rehabilitative, and Regenerative Medicine; Combat Casualty Care; Military Operational Medicine; Military Infectious Diseases; and Health Information Technology and Medical Training. SCI research is covered in the Traumatic Brain Injury and Psychological Health, and Clinical, Rehabilitative, and Regenerative Medicine R&As. Through this review, research gaps are identified for future research investment and collaborative DOD/VA research opportunities.

Second, VA participates in the CDMRP research planning efforts. Specifically, VA has co-chaired the SCI Research Program Integration Panel for the past two years. Other Panel members are from the VA the military Services (Army, Navy, and Air Force), the National Institutes of Health (NIH), and academic institutions, the Department of Education's National Institute on Disability and Rehabilitation Research, and consumer advocacy organizations (Paralyzed Veterans Association, United Spinal Association). The SCI panel provides strategic direction, screens pre-proposals, recommends proposals for funding, identifies research gaps and sets the vision for the coming year.

Mr. LANGEVIN. Secretary Panetta, in today's tepid economy, the DOD cannot downsize our forces without ensuring we provide mechanisms and programs for the service members to utilize before, during and after their transition from the military. In your words, what is the single most important role the DOD can play to assist these warriors in transition?

Secretary PANETTA. The Department's most important role is to prepare our Service members to become successful civilian citizens in their communities. We do this through a re-designed transition assistance program that focuses on providing all Service members with the appropriate tools needed to succeed. These tools include a crosswalk between military service and civilian experience; financial planning seminar; information about Department of Veterans Affairs (VA) benefits, and the Department of Labor employment workshop. The transition assistance program provides a transitioning Service member with a tangible product such as a budget, resume, listing of civilian careers that match military service experience and the practical application of how to apply for education benefits, home loans, disability (benefits, as appropriate) and experience in interviewing and searching for jobs. Using these tools along with the support from our interagency partners will result in the smooth transition from Service member to civilian.

Mr. LANGEVIN. Both DOD and the VA receive funding for spinal cord injury treatment, research, and education—the VA through the Office of Research and Development, and the DOD specifically through the Congressionally Directed Medical Research Program.

While the programs share a common goal, there are important differences. To what extent are spinal cord injury research efforts coordinated and shared across Departments?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. LANGEVIN. The suicide rate for both service members and veterans is rising at an alarming rate, what is the VA doing to address this tragic rise today and what are your plans to address this trend in the future?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

**QUESTIONS SUBMITTED BY MR. COOPER**

Mr. COOPER. Has VA measured how effective the VA National PTSD Center's numerous webinars and training sessions are for promoting among providers safer drug treatments for veterans experience PTSD? How many providers use those webinars and training sessions? Is this a number of providers that is satisfactory to VA and DOD? Has VA and DOD seen a change yet in PTSD treatment plans following these webinars and trainings? Are DOD and VA prepared to measure how effective the sessions are?

Secretary PANETTA. The Under Secretary for Health of the Department of Veterans Affairs and the Assistant Secretary of Defense for Health Affairs signed a formal Memorandum of Understanding (MOU) in March 2012 to facilitate collaboration, coordination, and evaluation of training courses and programs in both Departments. DOD encourages providers to utilize all government resources when meeting continuing education requirements for medical professionals.

Although DOD has not specified a target number of providers to participate in VA webinars, the new MOU can be used to further develop methods to increase DOD and VA webinar participation as well as efforts to develop a formalized method to assess the impact on provider practice.

DOD has also partnered with VA via the Integrated Mental Health Strategy (IMHS) to improve collaboration related to provider training and webinars. In addition, DOD has begun to develop processes to measure effectiveness and changes in PH treatment outcomes after best practice implementation across the Military Health System.

Mr. COOPER. A July 13, 2012, IOM study noted that PTSD screening, treatment, and rehabilitation services should be done "in different populations of active-duty personnel and veterans." Does VA and DOD know of PTSD studies performed on active-duty service men and women, and/or military veterans? How numerous and how comprehensive have those studies been? That recent IOM study goes on to recommend that "the DOD and the VA should coordinate, evaluate, and review these [active-duty personnel and veteran study] efforts continually and routinely and should disseminate the findings widely." How is the VA and DOD disseminating treatment findings now? How can they disseminate best practice treatment findings now? Would the EHR or drug formulary be helpful in doing this? Is there any incentive in place for VA and DOD providers to share, consult with, and use best practices found in other VA facilities?

Secretary PANETTA. There have been over 1,500 studies related to Active Duty military with PTSD, and 3,000 studies related to veterans with PTSD, completed since 1980. DOD has allocated significant resources dedicated to fund ongoing comprehensive PTSD research focused on the effectiveness of prevention, screening, treatment, and rehabilitation programs for Service members. PTSD research is also in progress through multiple military research institutions, to include the Armed Forces Health Surveillance Center, the Army Medical and Materiel Research Command, the Walter Reed Army Institute of Medicine, the Deployment Health Clinical Center, the Center for the Study of Traumatic Stress, and the Naval Health Research Center. These entities share their findings through annual reports posted on websites, publications in scientific journals, presentations at professional conferences, and various public forums. The VA/DOD Integrated Mental Health Strategy (IMHS) has specific task groups working to develop processes to rapidly translate research and move innovative programs into practice.

DOD findings are translated into clinical practice via formal and informal PTSD training programs as well as clinical practice guidelines, recommendations, and support tools. For example, the Center for Deployment Psychology (CDP) is a DOD resource that trains mental health providers in evidence-based psychotherapies for PTSD. To date, CDP has trained approximately 6,700 mental health providers to deliver evidence-based psychotherapies for PTSD. There are also provider on-line training courses that are hosted through DOD, such as the Military Health System Learning Portal and the Center for Deployment Psychology. The Army Medical Command's Office of Quality Management provides tools to assist providers to follow the VA DOD Clinical Practice Guideline for Management of Post-traumatic Stress.

DOD's National Center for Telehealth and Technology (T2), a Component Center of the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), has developed products to inform providers, Service members, and their families about evidence-based practices for the treatment of PTSD, to include smart phone applications that assist patients and providers to follow evidence-based practices. T2 also designed innovative, state-of-the-art virtual delivery systems to increase the availability of evidence-based PTSD treatment. Further, DOD has multiple postgraduate education, internship, and fellowship behavioral health training

programs for new accessions that require students to be trained in evidence-based Psychological Health (PH) practices.

The electronic health record (EHR) will continue to be an important dissemination tool for PH treatment best practices, and DOD is positioned to further leverage the EHR to develop and implement standard PH practice guidelines, to include PTSD guidelines. For example, DOD currently uses an application in the EHR to inform primary care providers about medication best practices related to PTSD; the application has been used to treat over 30,000 patients. DOD recognizes that pharmacists in the Military Health System can help further improve psychiatric medication standard of care, and created a policy memorandum from February 22, 2012 entitled "Guidance for Providers Prescribing Atypical Antipsychotic Medication." This memorandum suggests that Military Treatment Commanders work with their Pharmacy and Therapeutics Committee to monitor providers and their compliance with best practices related to use of medication for PTSD treatment.

DOD ensures evidence-based and best practice treatment skills are integrated into care as part of the health care appraisal system, including a peer review process to ensure the highest standard of care is met. In addition, hospitals are motivated to use best practices that decrease care costs and maximize treatment outcomes through various means.

Mr. COOPER. Do DOD and VA plan to create "an evidence base to guide the integration of treatment for comorbidities with treatment for PTSD?" How do you plan to encourage that kind of research?

Secretary PANETTA. DOD has already provided an evidence-based guide that helps providers manage co-occurring conditions, the "Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health." This toolkit, based on scientific evidence, was developed to help primary care providers better assess and manage patients with psychological health and TBI conditions. In formulating these guides, knowledge gaps were identified to inform future research. In addition, DOD has funded over 30 studies related to treatment of PTSD and comorbid diagnoses (TBI, sleep disorders, alcohol and substance use disorders, anxiety, depression, and suicide). The results from these studies will further our knowledge in improving diagnosis and treatment of these conditions.

In addition, DOD partners with other research institutes. For example, STRONG STAR (The South Texas Research Organizational Network Guiding Trauma and Resilience) is a multidisciplinary, multi-institutional research consortium funded by the DOD's Psychological Health and TBI Research Program. Their research includes the investigation of PTSD treatment with co-occurring disorders that include chronic pain, alcohol use, and insomnia.

DOD creates research opportunities annually in the areas of traumatic brain injury and psychological health through the release of Program Announcements that describe the program of interest and the research need, the purpose and objectives, submission information, application review procedures, award administrative information, agency contacts, and time lines for submission and reviews. Program Announcements are posted on grants.gov for open and fair competition and submissions are received electronically.

Mr. COOPER. Have DOD and VA identified PTSD treatment practices that are usually ineffective in active-duty service men and women and veterans?

Secretary PANETTA. DOD and VA published the VA DOD Clinical Practice Guideline for the Management of Post-Traumatic Stress in 2010. This guideline is based on thorough reviews of scientifically published evidence of Posttraumatic Stress Disorder treatments, including psychotherapy, medication, and complementary and alternative medicine interventions. This guideline includes an extensive discussion about treatments that have been found to be effective, found to be ineffective, have yet to be established as either effective or ineffective, or have found to be potentially harmful. A copy of the guideline is available at:

[http://www.healthquality.va.gov/Post\\_Traumatic\\_Stress\\_Disorder\\_PTSD.asp](http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp)

Mr. COOPER. Approximately what percentage of the experts who put together the VA/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress have first-hand experience with treating veterans or active-duty personnel with prescription drugs? How much are those guidelines based on studies done in active-duty personnel and veterans?

Secretary PANETTA. Twenty one of the thirty-two DOD and VHA members of the Working Group for the 2010 revision of the VA/DOD Clinical Practice Guideline for the Management of Post-Traumatic have first-hand experience as prescribers. All of the members have experience treating veterans and active-duty personnel. A full list of members of this working group is found on page 10 of the Guideline (see below footnote for link).

The Guidelines were based on literature and empirical findings specific to—and most relevant to—treatment of active duty Service members and veterans. The Introduction section of the Guideline provides an excellent overview of the criteria and standards used in the review of literature.

Mr. COOPER. A July 13, 2012, Institute of Medicine study recommended that “to study the efficacy of treatment and to move toward measurement-based PTSD care in the DOD and the VA, assessment data should be collected before, during, and after treatment and should be entered into patients’ medical records. This information should be made accessible to researchers with appropriate safeguards to ensure patient confidentiality.” How quickly can the VA and DOD put this recommendation into practice? What are the barriers to beginning to do this and how substantial are those barriers if they exist?

Secretary PANETTA. Assessment data is already collected before, during, and after treatment and entered into patients’ medical records. The administration of standardized and validated PTSD clinical screening tools that are often used in research (e.g., the PTSD Checklist) is endorsed by the DOD for use when a Service member might benefit from further clinical evaluation or in monitoring treatment response. No standardized screening or assessment tool is available that can replace a comprehensive clinical interview that assesses the full spectrum of both PTSD and non-PTSD symptoms within broader social and occupational contexts. The DOD standard of care is that all data, inclusive of clinical assessment measures, becomes a part of the Service member’s healthcare record.

There are no inherent barriers to access of these records for research. Access to the use of TRICARE Management Activity (TMA) owned or managed data is subject to patient protections, privacy safeguards, and other research protocols mandated by law and implemented by institutional review boards and obtained through a formal agreement with TMA for sharing and use of data elements. The TMA Privacy and Civil Liberties Office (TMA Privacy Office) manages the data sharing agreement program and research protection program.

The Department of Defense (DOD), Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) and the TRICARE Management Activity (TMA) support and encourage research, including human subject research. The Department of Defense (DOD) invests in Psychological Health (PH) research and the largest portion of the PH portfolio is directed toward PTSD. Out of the 225 current research projects in the PH portfolio, 162 focus on PTSD including studies specific to examining efficacy of treatment for PTSD and studies that focus on evidence-based long-term recovery protocols to decrease recurrence of PTSD symptoms.

Recently, the Department in collaboration with the VA announced the creation of two research consortia one of which is focused on PTSD. The Consortium to Alleviate PTSD (CAP) Award will consist of a Coordinating Center and multiple Study Sites, and will be supported through this DOD/VA collaborative research effort. The primary purpose of the collaborative DOD/VA Consortium will be to improve the health and well-being of Service Members (Active Duty, National Guard, and Reservist) and Veterans, with the most effective diagnostics, prognostics, novel treatments, and rehabilitative strategies to treat acute PTSD and to prevent chronic PTSD. Key priorities of this Consortium are elucidation of factors that influence the different trajectories (onset/progression/duration) of PTSD and associated chronic mental and physical sequelae (including depression, anger/aggression, and substance use/abuse, etc.) and identification of measures for determining who is likely to go on to develop chronic PTSD. The Consortium will therefore work to improve prognostics, advance treatments, and mitigate negative long-term consequences associated with traumatic exposure.

Mr. COOPER. In general, how does VA and DOD get evidence based medical information out to be used systematically throughout the systems? Is there a good example of a best practice being widely disseminated and used?

Secretary PANETTA. There are many points for wide dissemination of evidence-based medical information. A few are listed below:

- The DOD has central website for wellness resources for the military community at <http://www.afterdeployment.org/>. An adjunct program to this website has just been opened as a centralized information mart for providers at <http://www.afterdeployment.org/providers/home>. It includes continuing education materials, mobile applications, patient educational resources, libraries, briefings and quick links to the DOD/VA Clinical Practice guidelines.
- The DOD/VA Clinical Practice Guidelines are available at <http://www.healthquality.va.gov/index.asp>.
- PDHealth.mil at <http://www.pdhealth.mil/main.asp> provides a gateway to information on deployment health and healthcare for healthcare providers, service members, veterans, and families. It was designed to assist clinicians in the de-

livery of post-deployment healthcare by fostering a partnership between service members, veterans, families, and healthcare providers.

- Up-to-date and current information pertaining to research and best practices is available through the Combat & Operational Stress Research Quarterly published by the Navy ([www.nccosc.navy.mil](http://www.nccosc.navy.mil) or direct link @ <http://bit.ly/wnadBm>) and the Deployment Health Clinical Center newsletter dispatched daily by email.
- The Department of Defense also disseminates evidence based information pertaining to practice, responsibilities, and requirements through the publication of Directives, Instructions and Guidance Memorandums.

The clinical practice guideline titled “Management of Post-Traumatic Stress Disorder and Acute Stress Reaction (2010)” posted on the DOD/VA Clinical Practice Guidelines home page is an excellent example of a best practice that is widely disseminated and used.

Mr. COOPER. Has evidence based psychotherapy been evaluated in active-duty service men and women with PTSD?

Secretary PANETTA. There are many points for wide dissemination of evidence-based medical information. A few are listed below:

- The DOD has central website for wellness resources for the military community at <http://www.afterdeployment.org/>. An adjunct program to this website has just been opened as a centralized information mart for providers at <http://www.afterdeployment.org/providers/home>. It includes continuing education materials, mobile applications, patient educational resources, libraries, briefings and quick links to the DOD/VA Clinical Practice guidelines.
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The clinical practice guideline titled “Management of Post-Traumatic Stress Disorder and Acute Stress Reaction (2010)” posted on the DOD/VA Clinical Practice Guidelines home page is an excellent example of a best practice that is widely disseminated and used.

Mr. COOPER. Has VA measured how effective the VA National PTSD Center’s numerous webinars and training sessions are for promoting safer drug treatments for veterans experience PTSD? How many providers use those webinars and training sessions? Is this a number of providers that is satisfactory to VA and DOD? Has VA and DOD seen yet a change in treatments following these webinars and trainings? Are they prepared to measure how effective the sessions are?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. COOPER. A July 13, 2012, IOM study noted that PTSD screening, treatment, and rehabilitation services should be done “in different populations of active-duty personnel and veterans.” Does VA and DOD know of PTSD studies performed on active-duty service men and women, and/or military veterans? How numerous and how comprehensive have those studies been? That recent IOM study goes on to recommend that “the DOD and the VA should coordinate, evaluate, and review these [active-duty personnel and veteran study] efforts continually and routinely and should disseminate the findings widely.” How is the VA and DOD disseminating treatment findings now? How can they disseminate best practice treatment findings now? Would the EHR or drug formulary be helpful in doing this? Is there any incentive in place for VA and DOD providers to share, consult with, and use best practices found in other VA facilities?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. COOPER. Do DOD and VA plan to create “an evidence base to guide the integration of treatment for comorbidities with treatment for PTSD?” How do you plan to encourage that kind of research?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. COOPER. Have DOD and VA identified PTSD treatment practices that are usually ineffective in active-duty service men and women and veterans?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. COOPER. Approximately what percentage of the experts who put together the VA/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress have first-hand experience with treating veterans or active-duty personnel with prescription drugs? How much are those guidelines based on studies done in active-duty personnel and veterans?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. COOPER. As Secretary Shinseki mentioned, the VA has “a pretty comprehensive record of who to treat [for PTSD, TBI, substance abuse, sexual assaults] and then [the VA] sets about treating them.” If this is the case, is how these veterans are treated for PTSD, tracked at all? Does the VA know for a fact which treatments are given most frequently to veterans with PTSD and in what combination? Do these treatments match up with what evidence there is for the most effective way to treat these veterans? Has either the VA or DOD studied patterns in treatment of PTSD in active-duty personnel and veterans?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. COOPER. A July 13, 2012, Institute of Medicine study recommended that “to study the efficacy of treatment and to move toward measurement-based PTSD care in the DOD and the VA, assessment data should be collected before, during, and after treatment and should be entered into patients’ medical records. This information should be made accessible to researchers with appropriate safeguards to ensure patient confidentiality.” How quickly can the VA and DOD put this recommendation into practice? What are the barriers to beginning to do this and how substantial are those barriers if they exist?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. COOPER. In general, how does VA and DOD get evidence based medical information out to be used systematically throughout the systems? Is there a good example of a best practice being widely disseminated and used?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

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#### QUESTIONS SUBMITTED BY MS. BORDALLO

Ms. BORDALLO. If we are to create a joint medical electronic records system, where all services including the VA will be using it at the same time, what will be different about this system that will prevent the system from running slow during peak hours or crashing in the middle of a heavy patient appointment schedule?

Secretary PANETTA. Systems Engineering and Testing will be conducted throughout the development and deployment of the integrated Electronic Health Record (iEHR) to ensure the system is stable and reliable in production environments. Network capacity planning will be performed and performance measures will be validated. The Development and Test Center/Environment (DTC/DTE), which consists of a set of systems, software, network, and test tools will be utilized throughout the system life cycle for continuous test and evaluation of system performance.

Ms. BORDALLO. Aside from the efficiencies a joint electronic medical record system will create, could you share some of the other benefits this system will produce as a byproduct?

Secretary PANETTA. The ultimate benefit the integrated Electronic Health Record (iEHR) will be improved quality of healthcare for our Service members and Veterans. The iEHR’s close coupling with the VLER Health information exchange initiatives will accelerate the ability for DOD and VA healthcare providers to exchange information with other federal and private industry partners about patients they collectively care for.

- Patient-Centered Care: Patients will have a comprehensive and transportable medical profile that will support seamless transition of care between DOD and VA treatment facilities—as well as private providers. The iEHR will promote and facilitate an empowered patient, healthcare staff, and patient-centric approach, that will support healthcare information technology (HIT) systems that foster the delivery of effective, efficient, safe, and quality patient care.

- Precision of Care: Enhanced Clinical Decision Support (CDS) tools enabled by the iEHR will increase the precision of care delivered/received by providing access to comprehensive patient data and increased information exchange capabilities among providers that would otherwise not be available.
- More Time with Patients: Healthcare providers will be able to spend more time with their patients instead of searching for their data and signing on to multiple systems.
- Personal Health Records: Promoting partnership between healthcare team members and patients through an empowered patient care model for delivery of high quality medical care that engages patients in the healthcare process.
- Improve Quality of Care per Dollar Spent: Improving clinical outcomes while creating cost efficiencies in both workforce and IT life cycle costs.
- Population Health: Access to quality population health data and analytic tools will result in cost efficiencies and improved preventative healthcare. For example, insight into the number of diabetics who have not had their H1Cs done could inform a patient outreach program that have been shown to result in a reduction in amputations.
- Innovation: Promote innovations in technology and product research that support the delivery of quality healthcare and improved patient outcomes.
- Maturity of International HIT Standards: As the largest healthcare network in the world encouraging open solutions, the iEHR will be a driving force in the maturation of HIT standards improving the quality and landscape of HIT solutions available in the market.
- Interagency Collaboration Center of Excellence: The scale and scope of this effort provides the opportunity set the standard and influence policy for large scale interagency collaboration activities moving forward.

Ms. BORDALLO. What efforts are underway to improve the electronic delivery of information from DOD to VA and vice versa to improve benefits and health care delivery to service members and veterans? Additionally, can either witness discuss what is being done to develop a joint electronic medical records system. It's my understanding that each service including the VA currently operates a separate system and there is very little cross service functionality between any of the systems so how will you achieve cross-functionality and how do we improve the slow processing of the systems currently in place?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Ms. BORDALLO. If we are to create a joint medical electronic records system, where all services including the VA will be using it at the same time, what will be different about this system that will prevent the system from running slow during peak hours or crashing in the middle of a heavy patient appointment schedule?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Ms. BORDALLO. Aside from the efficiencies a joint electronic medical record system will create, could you share some of the other benefits this system will produce as a byproduct?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

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#### QUESTIONS SUBMITTED BY MR. FRANKS

Mr. FRANKS. Reports show that suicide rates among veterans, especially combat veterans, have increased over the past several years. Furthermore, studies have shown a correlation between people of faith and lower rates of suicide. Therefore, I'm concerned by reports indicating that the military is censoring religious references and symbols beyond Constitutional requirements. How is religion being incorporated into suicide prevention, and does the military's extra-Constitutional censorship of religion support your departments' suicide prevention efforts?

Secretary PANETTA. Suicide and the prevention thereof is one of the most vexing and important challenges the Department faces and we are committed to using every means available to assist our Service members and their families. Progress on this crucial issue will require a multi-functional and multi-faceted approach and our Chaplains fulfill a vital role in lending assistance to commanders, troops, and families in need. The Chaplaincies of the Military Departments are established to advise and assist commanders, troops, and families in the free exercise of religion in the context of military service as guaranteed by the Constitution. Our Chaplains serve a religiously diverse population and provide comprehensive religious support to all who seek it.

The Department does not censure religious support. Indeed, all of the Military Departments have, over the course of the last several years, placed increased emphasis upon holistic efforts aimed at improving every aspect of fitness. This emphasis with a view toward the total comprehensive fitness of the force recognizes the vital component faith serves in the lives of many of our military families.

Mr. FRANKS. Reports show that suicide rates among veterans, especially combat veterans, have increased over the past several years. Furthermore, studies have shown a correlation between people of faith and lower rates of suicide. Therefore, I'm concerned by reports indicating that the military is censoring religious references and symbols beyond Constitutional requirements. How is religion being incorporated into suicide prevention, and does the military's extra-Constitutional censorship of religion support your departments' suicide prevention efforts?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

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#### QUESTIONS SUBMITTED BY MR. LOEBSACK

Mr. LOEBSACK. What specific steps are the Department of Defense and the Department of Veterans Affairs taking to coordinate transition assistance and benefits for members of the National Guard and Reserve transitioning from Active Duty service back to civilian jobs and civilian life? How are the Departments coordinating to ensure members of the Reserve Component are aware of the DOD and VA benefits available to them?

Secretary PANETTA. In order to coordinate transition assistance and benefits for members of National Guard and Reserve transitioning from active duty to civilian life, DOD has worked with the Department of Veterans Affairs, Department of Homeland Security, Department of Education and Office of Personnel Management over the last year to redesign the Transition Assistance Program (includes eligible National Guard and Reserve Service members).

All eligible National Guard and Reserve Service members will receive transition assistance, which includes Pre-separation Counseling and VA Benefits Briefing. They will also be afforded the opportunity to register for their eBenefits account as well as the opportunity to either sign up for VA benefits to which they may be entitled and/or schedule a one-on-one appointment with a VA representative to submit applications for benefits.

In addition, the VOW to Hire Heroes Act requires all eligible National Guard and Reserve members to participate in the re-designed Department of Labor Employment Workshop (except those with exemptions).

Finally, the Transition GPS (Goals, Plans, Success) includes a CORE Curriculum which consists of the following modules and topics: Transition Overview, Considerations for Families, Special Issue, Value of a Mentor, Military Occupational Code (MOC) Crosswalk, and a Financial Management Seminar. The Transition GPS also includes three tracks (Education, Career Technical Training, and Entrepreneurship) which are in addition to the CORE curriculum. The track they select is based on their personal needs and goals.

Furthermore, the DOD's Yellow Ribbon Reintegration Program (YRRP) provides National Guard and Reserve Service members and their families with critical support throughout the entire deployment cycle (pre- during and post-), easing transitions as Service members move between their military and civilian roles. Post-deployment activities are specially focused on reintegration into the family, community and workforce, providing information and resources through local and state agencies, military transition assistance, and other military-related non-profit organizations. On-site assistance with enrollment and other benefits is included in all YRRP activities, with follow-up capabilities offered for those Service members with more long-term needs.

Mr. LOEBSACK. What specific steps are the Department of Defense and the Department of Veterans Affairs taking to identify service members transitioning to civilian life who require Post Traumatic Stress, Traumatic Brain Injury, or mental health care? How are the Departments ensuring that these service members do not fall through the cracks as they transition between the DOD and VA health systems? What steps are being taken to ensure that transitioning service members and their families are aware of the suicide prevention resources available to them?

Secretary PANETTA. For those Service members transitioning to civilian life who require Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), or mental health care for other identified mental health conditions, the DOD ensures proper treatment and successful transition to civilian life through care coordination and transition assistance services through the following policies and practices:

- The Military Departments have engineered clinical case management services and practices for aspects of care within the Military Health System (MHS), particularly as it relates to the care of the wounded, ill or injured (WII) Service members. Directive-Type Memorandum (DTM) 08-033, "Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the Military Health System" was initially published in 2009 and updated in 2012. This guidance delineates the requirements for the implementation of clinical case management in the MHS and established MHS medical and clinical policies and procedures for WII care.
  - In 2011, DOD published policy, "Continuity of Behavioral Health Care for Transferring and Transitioning Service Members," which prescribes guidelines that ensure continuity of care for Service members transferring to a new duty station or transitioning out of the Service. This policy directs the Military Services to develop policies for transfer of behavioral health care from military to civilian providers, including VA providers. When a separating Service member provides consent for sharing information with a follow-on behavioral health provider, DOD shares all relevant clinical information. This includes diagnoses, medications, treatment history including suicide risk, test results, treatment plans and prognosis. Service members' treatment record information is available to VA providers via the Bidirectional Health Information Exchange.
  - DOD's inTransition program provides a telephonic coach for transitioning Service members with behavioral health issues, whether that is in the VA health care system, the Military Health System, TRICARE, or the community. The inTransition program has opened thousands of coaching cases since its inception in February 2010. The acceptance rate for service members referred to the program since inception exceeds 95%.
  - The VA Liaison for Healthcare, a social worker or nurse strategically placed at an MTF with recovering service members returning from Afghanistan, is another asset. 33 Liaisons for Healthcare are stationed at 18 MTFs, helping transition ill and injured Service members from DOD to the VA system of care. Thousands of health care transitions have been coordinated.
- For individuals who have suffered a traumatic brain injury:
- The Defense Veterans Brain Injury Center (DVBIC) Regional Care Coordinator (RCC) program provides a nationwide care coordination network for Service members with TBI. This program facilitates transition from the DOD to VA care by working with VA case management teams.
  - For Service members with more severe brain injuries, a DOD-VA Polytrauma Telehealth Network connects the current DOD treating team with the accepting treating team in the VA. This facilitates transfer planning, affords families an opportunity to meet care teams and ensures that medical records are transferred between facilities.
  - DOD and VA work together on a Congressionally-mandated five year pilot program which assesses the effectiveness of providing assisted living services to Service members and Veterans with TBI who require ongoing care in the community. VA collaborated with the DVBIC on a family caregiver panel to develop a uniform training curriculum for family members in providing care and assistance.

TRICARE Regional Offices have VA Liaisons who serve as intermediaries between VA facilities and the TRICARE regional contractors. VA Liaisons actively assist with authorizations and claims, and TRICARE contractors hold monthly calls with the VA's Medical Sharing Office to review the cases of active duty Service members who are receiving joint VA/DOD care.

At each point of contact in these chain of transition events and post-active duty follow-on (e.g., the periodic health assessments, post-deployment screening, and yellow ribbon events), assessment for the potential for suicide occurs and information regarding suicide prevention and other helping resources are made available. In addition, Service and VA Mental Health and suicide prevention coordinators, suicide hotlines (VA and DOD), we have Military OneSource are available resources.

The DOD-VA Integrated Mental Health Strategy includes actions specifically focused on transition and continuity of behavioral health care. DOD will continue to work with VA in implementation of our policies regarding transition and continuity of behavioral health and TBI care. We will ensure our providers address transition of behavioral health care for wounded warriors to VA and other civilian providers, and will continue to manage the important issues of suicide risk, occupational impairment, and PTSD.

Mr. LOEBSACK. I have held multiple veterans forums across my District and have heard time and again from Iowa veterans that they are deeply frustrated by the time it takes to process their disability claims. The Integrated Disability System

was meant to integrate the DOD and VA disability evaluation processes. What steps are being taken to improve IDES? Do additional steps need to be taken to standardize and streamline the disability evaluation process and improve DOD and VA collaboration?

Secretary PANETTA. The Departments collaborate closely on efforts to jointly refine and improve the IDES. In FY 2012, major efforts in this area included:

- The Military Departments significantly increased IDES staff levels in FY2012. DOD added authorizations for over 1,500 case managers, administrative assistants, and lawyers over the next four fiscal years to improve case processing timeliness and customer service. Additionally, each of the Services is increasing efforts to hire and retain physicians, particularly behavioral or mental health professionals. We expect to see process improvements during FY2013.
- In April 2012, the Secretary of Defense and Secretary of Veterans Affairs directed their Departments to implement a paperless, searchable claims file for the Integrated Disability Evaluation System (IDES). The Departments created an electronic case file transfer capability for IDES cases as an interim step towards that objective. The Departments initiated a pilot test of that capability at 11 locations in September 2012. The Departments will decide whether to field the electronic case file transfer capability in January 2013.
- In June 2012, VA released version 2.0 of the Veterans Tracking Application (VTA). This version incorporated operational reports that improved IDES case oversight capabilities. Additionally, DOD developed and fielded case tracking tools that enable installation-level visibility of case duration and data errors.
- A DOD IDES Task Force, comprised of senior leaders from the Department, conducted an end-to-end business process review of the IDES and, as of October 2012, is preparing recommendations for additional improvements for the Secretary of Defense.

Mr. LOEBACK. What specific steps are the Department of Defense and the Department of Veterans Affairs taking to coordinate transition assistance and benefits for members of the National Guard and Reserve transitioning from Active Duty service back to civilian jobs and civilian life? How are the Departments coordinating to ensure members of the Reserve Component are aware of the DOD and VA benefits available to them?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. LOEBACK. What specific steps are the Department of Defense and the Department of Veterans Affairs taking to identify service members transitioning to civilian life who require Post Traumatic Stress, Traumatic Brain Injury, or mental health care? How are the Departments ensuring that these service members do not fall through the cracks as they transition between the DOD and VA health systems? What steps are being taken to ensure that transitioning service members and their families are aware of the suicide prevention resources available to them?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. LOEBACK. I have held multiple veterans forums across my District and have heard time and again from Iowa veterans that they are deeply frustrated by the time it takes to process their disability claims. The Integrated Disability System was meant to integrate the DOD and VA disability evaluation processes. What steps are being taken to improve IDES? Do additional steps need to be taken to standardize and streamline the disability evaluation process and improve DOD and VA collaboration?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

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#### QUESTIONS SUBMITTED BY MR. KISSELL

Mr. KISSELL. What is the possibility of getting VA and DOD medical records electronically available for civilian medical venues? How and when might this be implemented?

Secretary PANETTA. One important goal of the integrated electronic health record (iEHR) is to maximize the information exchanged among DOD and VA health providers and private providers via bilateral communications and health information sharing. Specifically, the IPO is continuing to develop the Virtual Lifetime Electronic Record (VLER) Health program that enables the exchange of electronic medical data with the private sector. For example, under VLER Health, a private sector provider or hospital can request electronic health data from the DOD or VA, and the Departments can securely provide that information back to the requesting party.

This exchange is governed by the Data Use and Reciprocal Support Agreement (DURSA) developed by the Office of the National Coordinator (ONC) at Health and Human Services (HHS). ONC is also responsible for the development of the infrastructure that supports this exchange. This infrastructure is called the Nation-wide Health Information Network (NwHIN), and the DOD and VA have been actively engaged in its development. Through the DOD's and VA's participation in the NwHIN, the departments will be able to exchange electronic health data in a secure and trusted way with private healthcare entities.

VLER Health capability has been demonstrated at 4 joint DOD/VA sites, and at 11 other VA sites as part of the VLER Health demonstrations. Recently, the Joint Executive Committee (JEC) has approved the further deployment of VLER Health at sites that meet criteria that ensures its effective implementation: where there are large numbers of beneficiaries using private sector care, where the state Health Information Exchanges (HIEs) are mature, where the private sector has electronic medical records, and where the beneficiaries have "opted-in" to the program. These exchanges will continue to grow over the life of the iEHR.

Mr. KISSELL. What is the possibility of getting VA and DOD medical records electronically available for civilian medical venues? How and when might this be implemented?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

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#### QUESTIONS SUBMITTED BY MR. GARAMENDI

Mr. GARAMENDI. Please advise of the contractor that developed and currently maintain DOD's electronic health records system and the contractor that developed and currently maintain the VA's electronic health records system. Are either of these contractors developing the Joint Electronic Health Record, iEHR? If not, has this attributed to the delay of iEHR? What steps are being taken to ensure a seamless transition between current contractors and new contractor?

Secretary PANETTA. VistA was developed by the VA clinical community, rather than contractors. The Composite Health Care System (CHCS), DOD's predecessor system, was developed using the Veteran Administration's Decentralized Hospital Computer Program (DHCP) as the foundation and modifying modules when possible to meet the requirements established by DOD. Additionally, CHCS has a long history and does not have one specific contractor that can be singled out as responsible for its development.

The current contractor support to iEHR was not involved in the support provided to DOD and VA legacy electronic health record (EHR) systems; however, this has not resulted in a delay. The DOD/VA IPO's government staff has extensive technical knowledge of respective legacy systems and/or reach back to the Departments for expertise as needed.

Mr. GARAMENDI. In your testimony, you stated that the iEHR is expected to be fully operational no later than 2017. Considering the immediate need for this system, will additional funding enable you to provide the system sooner? If not, what steps can be taken to improve your current schedule?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

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#### QUESTIONS SUBMITTED BY MR. SCHILLING

Mr. SCHILLING. From casework, I've heard that veterans who have been treated for PTSD have been overwhelmed by doctors and that they have not made things better, but worse. In fact in one case a patient, who later committed suicide, was over-medicated by multiple doctors who did not check with each other, per his father. Is it common practice to have multiple doctors for one patient with PTSD? Can this be fixed by this new system?

Secretary PANETTA. It is not common practice for one patient to be treated for the sole condition of PTSD at the same time by multiple doctors. However, conditions that lead to or co-occur with PTSD (e.g. poly-trauma) may involve multiple providers and teams of care. The current system implemented by the DOD has many safeguards and risk mitigation strategies in place to prevent this type of incident from occurring—especially in regard to the prescription of pharmaceuticals. For example:

- The Tricare Policy Manual mandates that coordination between various medication providers must be evidenced in the treatment plan.

- Poly-pharmacy in the use of opiate medications has been reduced in Warrior Transition Units, and other clinical settings owing to leadership and case management interventions.
- The Army has implemented the Sole Provider Program to help identify patients who exhibit drug-seeking behavior by conducting periodic reviews of all prescriptions for controlled substances, identifying suspicious drug usage patterns.
- Clinic procedures limit the number of pills dispensed to potentially high-risk patients.
- Warning flags appear in electronic drug dispensing menus which require physician attention.
- Military Treatment Facilities (MTFs) have prescription restriction programs, and real-time monitoring and reconciliation of prescriptions dispensed through MTFs, mail-order, and network pharmacies.
- The Department of Defense (DOD) PharmacoEconomic Center (PEC) provides a single, comprehensive patient drug profile for DOD beneficiaries across the Military Health System, allowing monitoring and surveillance of drug contraindications or usage patterns of concern.
- When a prescription is filled within the U.S. Military Health System, an online system, the Pharmacy Data Transaction System, automatically checks the prescription against the patient's medication history before the drug is dispensed. This process includes retail, mail and military treatment facility pharmacies and has helped avoid more than 171,000 potentially life-threatening drug interactions.
- Pharmacists throughout the Military Health System provide consumers with a medication information sheet on each new and renewed prescription. DOD evaluates for drug-drug interactions on every prescription prescribed by mail order, a retail pharmacy or MTF, ensuring our patients receive medication that is safe and medically indicated.

Mr. SCHILLING. From casework, I've heard that veterans who have been treated for PTSD have been overwhelmed by doctors and that they have not made things better, but worse. In fact in one case a patient, who later committed suicide, was over-medicated by multiple doctors who did not check with each other, per his father. Is it common practice to have multiple doctors for one patient with PTSD? Can this be fixed by this new system?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

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#### QUESTIONS SUBMITTED BY MR. BARBER

Mr. BARBER. Our armed service members are some of the best trained, most disciplined, and most ambitious men and women in our country. How can the Department of Defense work with our other agencies, including the Department of Labor, to better educate employers and departing service members about how military skill sets translate to civilian skill sets? How Congress can be more helpful in conveying the skills and attribute of our veterans?

Secretary PANETTA. The Department very much appreciates Congress' actions to improve the employability of our Veterans. Sections 558 and 551 of the National Defense Authorization Act for Fiscal Year 2012 are assisting us in identifying critical training gaps and in beginning skills training in sufficient time to facilitate a smooth transition to civilian life. Authorities in the recently enacted Veterans Skills to Jobs Act, Public Law 112-147 (H.R. 4155) will help with several aspects of credentialing and licensing of Service members. These recent Congressional initiatives are essential in the transition of our Service members from Active Duty to civilian life.

The Department is working very closely with our federal partners to better educate employers about translating military to civilian skills. In May, we established the DOD Credentialing and Licensing Task Force led by the Deputy Assistant Secretary of Defense for Readiness to oversee all credentialing and licensing initiatives within the Department. Our Federal partners from the Departments of Labor, Veterans Affairs, Education and Transportation are represented on the Task Force and are working with us to address the unique challenges faced by Service members as they transition to civilian life. The Department is also working with the National Council of State Legislators, the American Legion, and several state governments to facilitate civilian recognition of military skills.

Education and outreach by DOD and other Federal agencies are critical to helping employers better understand military skills. Meeting with employers on a regular, ongoing basis to address specific issues, such as promoting the quality and transfer-

ability of military education, training and experience, is important and may include translation of military technical and leadership skills using a nationally recognized badging system. Also, educating employers about Service members unique needs in regard to domicile/residency requirements, recognizing national certifications or other national exams, and deployment experiences and why these are not detriments to hiring Veterans would also be helpful.

Civilian companies can become more involved in the hiring process by being encouraged to participate in job fairs where military members can interview with their resumes and military records in hand.

DOD and other Federal agencies can also help business leaders better understand how well military members perform using recently added title 10 authorities that deal with apprenticeship and transition training opportunities for separating Service members. This may involve pilots with industry to hire military members at mid to senior levels on a trial basis and not merely focusing on the unemployed or sponsoring them at entry levels.

Mr. BARBER. As service members return from deployment and reintegrate, they experience a period of readjustment. Growing up in a military family, I know that their families, too, go through an often difficult transition. What are some of the efforts that DOD is working on to engage military families in the transition process and encourage spouses to take advantage of transition services?

Secretary PANETTA. The Department of Defense provides a number of services that support the transition of Service members and their families throughout the military life cycle. The return of a Service member from deployment is understandably an adjustment for the military family and calls for targeted efforts.

Each Service branch sponsors information and support programs for Service members and their families and begin with pre-deployment preparation, like family care plans, and include deployed family events that take place during the Service member's deployment. Current programs also consist of reintegration briefings sponsored by the installation Family Support, Community Support or Readiness center. These reintegration briefings include family members and cover topics like preparing for a reunion, updating administrative, legal, financial, and employment affairs, and adjustments to be experienced by a Service member, spouse, and children. For Guard and Reserve personnel, Yellow Ribbon Reintegration events and the Joint Family Support Assistance Program are integral to family support.

These centers also provide resources in the form of DVDs, books and activities for children of Service members to assist with dealing with the absence and return of the deployed family member.

The Family Support Centers and Chapels of most military installations also offer Military Family Life Counselors (MFLCs), marriage counseling and communication classes, free childcare and or discounted activities for families.

Of course, the military lifecycle includes the transition into civilian life. The redesigned Transition Assistance Program (TAP), known as Goals, Plans, Success (GPS), prepares separating Service members and their families by building career readiness skills and self-confidence necessary to assist in successful reentry into the civilian work force or student life. Spouses are encouraged to participate in transition planning and curriculum to the maximum extent possible alongside their spouses or attend on their own.

The TAP GPS core curriculum provides information and training on financial management, teaches Service members how to translate their individual military skills into civilian skills, provides a detailed overview of potential veteran's benefits, and employment tools and resources to aid in finding a career. The TAP GPS Career Track modules are provided based on an individual's career choices and needs be those higher education, technical training, or entrepreneurial aspirations. Transition preparation cannot be a one size fits all approach and, just as our military families don't fit one mold, the new TAP GPS can be customized to meet their family needs.

Service members must also create an Individual Transition Plan (ITP), a holistic tool that leads Service members through thoughtful consideration of family issues like impact of the career change upon children, elderly parents, and spouses. The changing financial situation, due to separation from military careers, is specifically highlighted and planned. Social support networks must be considered. The ITP is competed in private during TAP GPS modules so that family members can participate in its development at home and in classes.

Utilization of Transition GPS will improve the Service members' effectiveness and their ability to be "career ready." By creating an ITP that starts early and considers the spouse, children and family needs, the family can also be better prepared.

Mr. BARBER. Post Traumatic Stress Disorder and Traumatic Brain Injury have been called the signature injuries of the current wars abroad, but they can be silent injuries that often go undiagnosed or come with a stigma that cause them to go un-

reported. What steps is the Department of Defense taking to identify these service members and ensure their complete and successful transition into civilian life?

Secretary PANETTA. The Department of Defense (DOD) has pre- and post-deployment screening for symptoms of TBI, mental health issues and substance use and abuse (which can signal unidentified problems). The post-deployment screening occurs immediately following a deployment and is repeated at 3, 6 and 12 month intervals thereafter. All deployment health assessments incorporate both self-report questions for Service members and specific questions that guide healthcare providers in conducting mental health assessments for suicide risk, TBI, PTSD, depression, and alcohol use.

National Guard and Reserve units partner with VA to conduct Yellow Ribbon events 90 days post-deployment, increasing awareness of VA benefits, programs and services. Military Services' demobilization events provide a setting for post-deployment National Guard and Reservist members to meet with VA staff to complete enrollment forms. As well, referral recommendations for VA behavioral health care are generated for National Guard and Reserve members during the 3-month post deployment assessment.

For those who are injured and/or transitioning out of active duty status, the DOD ensures proper treatment and successful transition to civilian life through care coordination and transition assistance services. This continuum of evaluation, assessment, treatment, and coordination and transition services is carried out throughout the lifecycle of a Service member's tenure.

In 2011, DOD published "Continuity of Behavioral Health Care for Transferring and Transitioning Service Members," which prescribes guidelines that ensure continuity of care for Service members transferring to a new duty station or transitioning out of the Service. This policy directs the Military Services to develop policies for transfer of behavioral health care from military to civilian providers, including VA providers. When a separating Service member provides consent for sharing information with a follow-on behavioral health provider, DOD shares all relevant clinical information. This includes diagnoses, medications, treatment history including suicide risk, test results, treatment plans and prognosis. Service members' treatment record information is available to VA providers via the Bidirectional Health Information Exchange. DOD's inTransition program provides a telephonic coach for transitioning Service members with behavioral health issues, whether that is in the VA health care system, a Military Treatment Facility, TRICARE, or the community. The inTransition program has opened thousands of coaching cases since its inception in February 2010. The acceptance rate for service members referred to the program since inception exceeds 95%.

For those who have suffered a traumatic brain injury, The Defense Veterans Brain Injury Center (DVBIC) Regional Care Coordinator (RCC) program provides a nationwide care coordination network to support Service members with TBI. This program facilitates transition from the DOD to VA care by working with VA case management teams. For Service members with more severe brain injuries, a DOD-VA Polytrauma Telehealth Network connects the current treating team with the accepting treating team in the VA. This facilitates transfer planning, affords families an opportunity to meet receiving care teams and ensures that medical records are transferred between facilities. DOD and VA are working together on a Congressionally-mandated five year pilot program which assesses the effectiveness of providing assisted living services to Service members and Veterans with TBI who require ongoing care in the community. VA collaborated with the DVBIC on a family caregiver panel to develop a uniform training curriculum for family members in providing care and assistance.

TRICARE Regional Offices have VA Liaisons who serve as intermediaries between VA facilities and the TRICARE regional contractors. VA Liaisons actively assist with authorizations and claims, and TRICARE contractors hold monthly calls with the VA's Medical Sharing Office to review the cases of active duty Service members who are receiving joint VA/DOD care.

The VA Liaison for Healthcare, a social worker or nurse strategically placed at an MTF with recovering service members returning from Afghanistan, is another asset. 33 Liaisons for Healthcare are stationed at 18 MTFs, helping transition ill and injured Service members from DOD to the VA system of care. Thousands of health care transitions have been coordinated.

The DOD-VA Integrated Mental Health Strategy includes actions specifically focused on transition and continuity of behavioral health care. Data are being shared between the Departments on rates of follow-up in at VA Medical Centers and Vet Centers for Service members referred to VA for a behavioral health issue identified during the PDHRA or the Post Deployment Health Assessment (PDHA). These data show that among Service members whose behavioral health follow-up is rec-

ommended during the PDHRA, 43% have a behavioral health encounter at a VA facility within 90 days.

DOD will continue to work with VA in implementation of our policies regarding transition and continuity of behavioral health and TBI care. We will ensure our providers address transition of behavioral health care for wounded warriors to VA and other civilian providers, and will continue to manage the important issues of suicide risk and occupational impairment and suffering from PTSD.

Mr. BARBER. What is the Department of Defense doing to ensure close access to health care services for service members who are stationed in rural areas? Does DOD contract with exiting, private sector behavioral health professionals and agencies to provide health care services close to where service members are stationed?

Secretary PANETTA. Active duty members, including activated National Guard/Reserve members, who are stationed more than 50 miles or more than one hours drive from a military treatment facility are enrolled in TRICARE Prime Remote (TPR) to ensure most care is provided in their local area. Members may select a primary care manager (PCM) from the TRICARE network, or if one is not available, can select any TRICARE-authorized, non-network provider as their PCM. The PCM refers members to TRICARE network specialists in the local area if available (or TRICARE-authorized, non-network specialists), and coordinates with the regional contractor for authorizations and claims.

Mr. BARBER. My district in Southern Arizona is home to more than 10,000 veterans. I appreciate the attention that VA and DOD are giving to this issue of transition assistance—an issue of critical importance to the service men and women I represent and their families. I hear from service members frequently about the long lag time between the time they file their VA claims at time of discharge, and the time the claim is adjudicated. They frequently wait 6 months or more before they receive compensation from the VA. For a service member transitioning from Active Duty and looking for a job, that VA check could be their only resource for buying food and paying rent. In addition to providing additional transitional assistance to our service members, what more can be done to fast track basic transition services and reduce the wait time?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. BARBER. Unemployment among our veterans has reached historic proportions. Nearly 780,000 veterans are unemployed, and as the numbers of troops in the Middle East are reduced, about 100,000 more vets will be looking for jobs. According to the Bureau of Labor Statistics the average unemployment rate in the U.S. in 2011 was 8.9 percent, but the rate of unemployment among anyone who was a member of the U.S. Armed Services since September 2001 was 12.1 percent. As part of the new Veterans Employment Initiative Task Force, what specifically will be done to eliminate this disparity in current unemployment levels between veterans and the general population? How will the Department of Veterans Affairs work to accomplish that goal?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. BARBER. Post Traumatic Stress Disorder and Traumatic Brain Injury have been called the signature injuries of the current wars abroad, but they can be silent injuries that often go undiagnosed or come with a stigma that cause them to go unreported. What steps is the Department of Veterans Affairs taking to identify these service members and ensure their complete and successful transition into civilian life?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]

Mr. BARBER. What is the Department of Veterans Affairs doing to ensure close access to health care services for veterans who live in rural areas far away from VA centers and clinics? Is the VA authorizing VA centers to contract with exiting, private sector behavioral health professionals and agencies to provide services close to where veterans live?

Secretary SHINSEKI. [The information referred to was not available at the time of printing.]