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SEAMLESS TRANSITION: REVIEW OF THE INTEGRATED DISABILITY EVALUATION SYSTEM

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

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SEAMLESS TRANSITION: REVIEW OF THE INTEGRATED DISABILITY EVALUATION SYSTEM

WEDNESDAY, MAY 23, 2012

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:05 a.m., in room SD–562, Dirksen Senate Office Building, Hon. Patty Murray, Chairman of the Committee, presiding.

Present: Senators Murray, Tester, Burr, Johanns, and Boozman.

STATEMENT OF HON. PATTY MURRAY, CHAIRMAN, U.S. SENATOR FROM WASHINGTON

Chairman MURRAY. Good morning and welcome to today's hearing to examine the ongoing efforts of the Department of Defense and the Department of Veterans Affairs to provide a truly seamless transition for our servicemembers and our veterans.

Almost a year ago today, this Committee held a hearing on VA and DOD efforts to improve transition. We explored a number of issues, including the Integrated Disability Evaluation System. At the hearing, we had an opportunity to hear from both Departments about the state of the joint program. The Departments' testimony that day spoke to how the Departments had created a more transparent, consistent, and expeditious disability evaluation process. Their testimony also states IDES is a fairer, faster process.

Well, now that the joint system has been implemented nationwide, I have to say that I am far from convinced that the Departments have implemented a disability evaluation process that is truly transparent, consistent, or expeditious.

There are now over 27,000 servicemembers involved in the disability evaluation system. As more and more men and women return from Afghanistan and as the military downsizes, we are going to see an even larger group of servicemembers transition from the military through the disability evaluation process.

This process impacts every aspect of a servicemember's life while they transition out of the military, but it does not stop there. If the system does not work right, it can also negatively affect the servicemember and their family well after they have left active duty. Getting this right is a big challenge, but it is one that we have no choice but to step up to meet.

I have seen the impacts of a broken system, whether it is from a wrong diagnosis, an improper decision, or never-ending wait

times, and when the system does not work and servicemembers cannot get a proper mental health evaluation or diagnosis, it means they are not getting the care that they need. Without the proper care, these men and women may find themselves struggling to readjust to family or civilian life, and they often struggle to find work.

Worse yet, we have heard stories of soldiers overdosing on drugs, and in far too many cases, taking their own lives. These are real tragedies affecting real servicemembers, and they are happening despite a system intended to provide greater support to our wounded, ill, and injured. I have seen first hand the impact an improper decision can have on a soldier and his family.

Earlier this year, I met Sergeant First Class Stephen Davis and his wife, Kim, at Joint Base Lewis-McChord in my homestate of Washington. Sergeant Davis led his men in combat in both Iraq and Afghanistan. He was exposed to multiple IED explosions during his service, and after being treated by the Army for years for PTSD and other mental health disorders, he was told, during the disability evaluation process, that he was making up his ailments.

From speaking with him, I can tell you that Sergeant Davis and the hundreds of other men and women at Joint Base Lewis-McChord are far from satisfied with the transparency and consistency of the disability evaluation process. All of these men and women had been diagnosed with, and in many cases, were receiving treatment for PTSD during service.

But then during the disability evaluation process, they were told they were exaggerating their symptoms, they were labeled as malingerers, and their behavioral health diagnoses were changed. Since then, the Army has launched investigations and hundreds of soldiers are now being reevaluated in an effort to make this right. In fact, the most recent update from the Army shows that out of the 196 cases that have been reevaluated, 108 have resulted in a diagnosis of PTSD. That is more than half of these men and women.

Still more have received other significant behavioral health diagnoses. Other referrals and reevaluations are still occurring. I am still hearing from those who have completed their reevaluations only to find themselves stuck back in the same Disability Evaluation System that failed them.

Despite all these men and women have been through, they continue to have their behavioral health injuries minimized and feel like their chain of command does not understand what they are going through. Clearly more needs to be done to build uniformity and accountability into the process of identifying those who are struggling with PTSD and other behavioral health problems.

In recent weeks, the Army has taken a number of steps in the right direction. Their recent policy on the diagnosis and treatment of PTSD addresses a number of the concerns that I have raised. It standardizes the Army mental health care through the use of proven treatments and assessments, it recognizes how extraordinarily rare it is for servicemembers to fake symptoms of PTSD, and this acknowledgment is critical, as we saw all too often that accusation at Madigan Army Medical Center.

Additionally, just last week, the Army took another critically important step forward in addressing the concerns I have been raising by announcing a comprehensive Army-wide review of behavioral health evaluations and diagnosis in support of the Disability Evaluation System. I want to applaud the Army leadership for taking some significant steps toward addressing these issues. This is going to take continued engagement from the Army leadership.

Now, I know some may argue that this is just a Joint Base Lewis-McChord problem or an Army problem, but it is not. This is a systemwide problem. We will continue to see issues similar to those at Madigan until the DOD and VA ensure policies and actions, like those we have seen from the Army in recent weeks, are adopted across the services and throughout the joint system.

Ensuring servicemembers receive a proper diagnosis in the care and benefits they earned is an obligation we have as a Nation. We owe it to these men and women to get this right.

These are not the only challenges confronting the Integrated Disability Evaluation System. We are going to hear today from GAO about other challenges facing the Departments, challenges which I must say sound all too familiar. Everyone on this Committee knows of VA's struggles to address the claims' backlog.

I am troubled because numbers from the Integrated Disability Evaluation System paint a similar picture. Enrollment continues to climb, the number of servicemembers' cases meeting the Departments' timeliness goals is unacceptably low, and the amount of time it takes to separate and provide benefits to a servicemember through this system has risen each year since its inception.

This continued rise in the amount of time it takes to provide a servicemember with a decision has to be addressed. The goal the Departments have set for completing IDES is 295 days for active duty and 305 days for reservists. Last year, on average, it took active duty servicemembers 394 days and reservists 420 days. That is around 100 days longer than your goal, and it is simply unacceptable.

Dr. Rooney, Mr. Gingrich, right now the Departments are failing these servicemembers. The only thing this Committee is interested in are the solutions to this problem and the dedication of your leadership in making things better. We cannot allow the same problems that plague the larger disability claim system to negatively impact the transition of thousands of servicemembers in the next few years. The consequences are too severe.

Clearly, a lot of work remains to be done. But we have seen the Army moving in the right direction. Now DOD and VA need to take these lessons learned and apply them across the entire system. Not only will this require quick action, but most importantly, this effort is going to require the total engagement, cooperation, and support of all senior leaders at both Departments to get this done right.

While DOD and VA are at a critical juncture, I am confident that by working harder and smarter and faster, the Departments can improve the system for thousands of men and women who will be transitioning in the next couple of years. With that, I will turn to Senator Boozman.

Ranking Member Burr was in another meeting and just joined us, so we will first turn to Senator Boozman for his statement.

STATEMENT OF HON. JOHN BOOZMAN,
U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Chairman Murray, and thank you and Senator Burr for holding this hearing to discuss the Integrated Disability Evaluation System, including how well it is working and what is being done to improve it. Also thank you to our witnesses for joining us today.

As we will hear today, it is clear that the Integrated Disability Evaluation System, or IDES, is still facing real and significant challenges. Overall, it is taking more than 1 year for servicemembers to go through this process, about one third longer than the VA and the Department of Defense intended. At some military bases, it is still taking much longer than that. In fact, only 18 percent of active duty servicemembers are transitioning to civilian life within the agency's 295-day goal.

During this time, wounded, ill, and injured servicemembers are waiting to find out whether they can continue serving in the military or have to build new lives as civilians. For those who are ready and able to move on with their lives, this must seem like an eternity.

I think the number of servicemembers in this process who are administratively discharged or court martialed or died from unnatural causes, including suicides and overdoses, raises serious questions about what the impact these delays may be having on the personal well-being of our Nation's wounded warriors. Also, I think we need to consider whether the IDES is truly setting them up to succeed after leaving the military.

As the Committee has been told by many servicemembers going through this process, the uncertainty about when and where they might leave the military can actually prevent them from getting their civilian lives in order, such as buying a house, finding a school, or taking a job.

On top of that, it appears that this system is not as straightforward or user-friendly as it was intended. Listen to what the Wounded Warrior Project said about the IDES process earlier this year: "Our wounded warriors still encounter great difficulty in navigating a system they find to be highly complicated, difficult to understand, unnecessarily contentious, and often ponderously slow." Other words that have been used to describe IDES include adversarial, long, and disjointed.

There is another hidden liability here that I think is important to note and that is the potential impact that the backlog may have on our military readiness, particularly in a time when some in Washington are talking about drawing down our force strength. Right now there are about 19,000 soldiers, as in just in the Army, who are in this process. I am under the impression that these servicemembers are still considered as being in the military, so that comes out of the bottom line for Army's in-strength and cannot be replaced until they have completed the IDES process.

Based on these and other issues we will hear about today, it is clear that we are still a long way from actually having created a seamless transition for many wounded, ill, and injured military personnel. So I hope the Committee will have a good discussion about what can be done to simplify this disability system, speed up

the process for those who are ready to move on with their civilian lives. And with that, I yield back my time.

Chairman MURRAY. Thank you very much. Senator Burr?

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Madam Chairman, I just ask unanimous consent to put my statement in the record. Thank you.

[The prepared statement of Senator Burr follows:]

PREPARED STATEMENT OF HON. RICHARD BURR, RANKING MEMBER

Good morning, Chairman Murray. Welcome to you and to our witnesses. Thank you for calling this hearing to discuss the Integrated Disability Evaluation System—or IDES.

This joint VA and Department of Defense process was meant to help ease the transition to civilian life for injured or ill servicemembers, by allowing them to find out before they leave the military what benefits they will receive from both agencies. But, as we'll hear today, there have been consistent performance challenges with this new system.

In fact, at Committee hearings last May, we heard about inadequate IT solutions, staffing shortages, and other problems that were leading to delays and frustrations for many servicemembers. At that time, it was taking about 400 days to go through the process—100 days longer than the target set by the agencies. Also, serious concerns were raised about the personal toll those delays may be having on many servicemembers and about the quality of their lives during this process.

We heard then about a number of efforts that were underway to improve IDES. But—one year later—we'll hear about some of those same problems, and it's still taking nearly 400 days for injured and ill servicemembers to transition to civilian life. For members of the Guard and Reserves, it can take even longer—as much as 650 days. That's a long time for servicemembers to be held in limbo—not knowing whether their military careers are over and, if so, what benefits and services they would receive.

Also, we continue to hear from servicemembers who are frustrated that they cannot plan for civilian life—like accepting a job or enrolling in school—because they don't know when they will leave the military. What's worse is the number of servicemembers going through this process who have taken their own lives, succumb to drugs, or suffered other unfortunate outcomes.

Given all of this, it's understandable that stakeholders have called this process convoluted, contentious, and slow. Even the Army's Deputy Chief of Staff recently said this about it (quote):

> The biggest area that we need help is the Disability Evaluation System. It's fundamentally flawed. It causes an adversarial relationship with our medical professionals * * *. It's long. It's disjointed * * *.

The bottom line is that many servicemembers and their families are not being well served by this process. So, we need to look at what should be done in the short term to bring relief to the 27,000 military personnel going through IDES now. But, we also need to seriously look at whether this system—as currently structured—will ever provide servicemembers with the high level of service they deserve.

Madam Chairman, we should not be content with a cumbersome process that leaves injured and ill servicemembers in a state of uncertainty for more than a year, when they want and need to move on with their lives. The men and women who have been harmed while serving our Nation deserve better. So, I hope we can work collectively to find solutions that will cut through the bureaucracy and, more importantly, will truly help ease their transition to civilian life.

I again thank the witnesses for being here, and I thank the Chair.

Chairman MURRAY. Thank you very much. At this time, I want to—oh, Senator Tester, I did not see you come in.

Senator TESTER. Thanks.

Chairman MURRAY. You are welcome.

STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. I would just like to say thank you, Dr. Rooney, for being here, and Mr. Gingrich, and Mr. Bertoni. I would just say that since I have been on this Committee, which has been five-and-a-half years now, we have been talking about this issue. Obviously it is not an easy issue or it would be done already.

By the same token, maybe we ought to get the Committee on Military Affairs in here, but you are here, Dr. Rooney, but to put pressure on the DOD to make sure they are doing their job as we put pressure on the VA to make sure they are doing their job. Let me just give you a real quick statistic.

Secretary Shinseki mentioned that his goal for the disability compensation and pension claims is 125 days, 98 percent accuracy. Right now, according to the report Mr. Bertoni put out, it is 394 days and it is 79 percent accurate. We have got an issue here, and the reason I know we have got an issue here is because I have got veterans calling me all the time. It is too complicated, they do not know how to get through it, and quite frankly, the folks who serve this country deserve better.

We have got to figure out how to get this right, and I do not think IDES is doing it right now, but I could be corrected on that and I look forward to that if you do correct me, because the bottom line is, what this Committee does is important, but what is even more important is the services we give to our vets and the folks that need help and have earned that help need to get it and need to get it now. Thank you, Madam Chair.

Chairman MURRAY. OK. Thank you very much. Now, at this time, I would like to introduce and welcome today's witnesses. Representing the Department of Defense is the Acting Under Secretary of Defense for Personnel and Readiness, Dr. Jo Ann Rooney. Dr. Rooney, we had the chance to talk about several of these issues at the field hearing I held in Tacoma a few months ago, and I really appreciate your willingness to testify before this Committee again, and I am pleased you are continuing to focus on this issue.

Joining us from the Department of Veterans Affairs is VA's Chief of Staff, Mr. John Gingrich. From the Government Accountability Office, we have Mr. Daniel Bertoni, the Director of Education, Workforce, and Income Security Issues. I want to thank each one of you for joining us this morning and we look forward to hearing your testimony. Your prepared remarks will, of course, appear in the record. Dr. Rooney, we will begin with you.

STATEMENT OF JO ANN ROONEY, ACTING UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

Ms. ROONEY. Thank you. Good morning, Chairman Murray, Ranking Member Burr, and Members of the Committee. It is my pleasure to be here today to testify on current efforts focused on reviewing and improving the Integrated Disability Evaluation System, or IDES. I am pleased to be appearing with one of my partners from the Department of Veterans Affairs.

As Departments, we are working closely together to provide an integrated, seamless process for wounded, ill, or injured service-

members as they transition to veteran status. Taking care of our servicemembers is the absolute highest priority of the Department of Defense. Part of taking care of our servicemembers includes ensuring their honorable service is recognized and they are compensated in both DOD and VA systems for injuries and illnesses incurred during that service.

The Department has undertaken many initiatives to accomplish this, but we acknowledge there is much more work to be done. Over the past 5 years, the Departments of Defense and Veterans Affairs have worked together with assistance and guidance from Congress to reform the cumbersome and often confusing bureaucratic processes which provide care and benefits to our wounded, ill, and injured servicemembers when and where they need them.

Working closely, deliberately, and collaboratively, our Departments have established governance at the highest levels to facilitate continuous improvements. The Joint Executive Council, or JEC, co-chaired by the VA Deputy Secretary Gould and me, devotes part of each bimonthly meeting to reviewing the progress and understanding the ongoing actions toward achieving our goal of seamless transition from servicemembers to veterans.

Similarly, the quarterly meeting conducted jointly by the Secretary of Defense and the Secretary of Veterans Affairs, with their senior leaders, to oversee and drive progress toward the stated goals. One of these efforts is IDES. IDES delivers a more servicemember-centric design, a simpler process, more consistent evaluations, and compensation, easier transition to veteran status, case management advocacy, and an established relationship between the servicemember and VA prior to separation.

It also provides increased transparency through better information flow to servicemembers and their families as well as a reduced gap between separation, or retirement from service, and receipt of VA benefits.

The IDEA streamlines the Disability Evaluation System with servicemembers receiving a single set of physical disability examinations conducted according to VA examination protocols, proposed disability ratings prepared by VA that both Departments can use, and dual processing to ensure the earliest possible delivery of disability benefits.

Currently the IDES is in use at 139 locations across all services. Since November 2007, 19,518 servicemembers have completed the IDES process. The IDES has also reduced that post-separation benefits gap between DOD and VA from an average of 240 days in 2007 to 50 days currently, which means disabled veterans receive their VA benefits 79 percent faster under the current IDES than before.

Even with the marked improvements in performance the IDES has brought to the disability evaluation process, we have much work remaining. Both Departments are committed to constant evaluation of each step throughout the process and will continue to seek long-term innovative solutions focused on improving the experience of our wounded warriors. We must do that.

We also much carefully review the critical steps in IDES to reach the 295-day completion goal for at least 60 percent of those entering the process by the end of this calendar year. The military serv-

ices are each in the process of implementing actions to improve efficiency and effectiveness. Since October 2011, this fall, the Army has added 513 medical evaluation board and physical evaluation board personnel and enhanced accountability by establishing performance metrics to measure the productivity of board staff.

The Army has also completed a senior leader assessment of the execution of the IDES at installations across the Army. This assessment identified specific actions required to enhance and standardize performance across the Army. The Navy and Marine Corps have added ten doctors and 37 case managers to their medical evaluation board staff last year and anticipate the addition of 23 more doctors next year.

Physical evaluation board staffs have increased in both Navy and Marine Corps by 47 percent, allowing them to process 75 percent of the Navy and 69 percent of the Marine cases through this particular phase in less than the 120-day phase goal. The Air Force has also leaned forward and started to utilize Air Force National Guard personnel to support the evaluation process and established a pre-IDES eligibility screening process, again to increase efficiency.

The Office of the Secretary of Defense has also removed policy impediments, implemented procedural improvements, and enhanced oversight and assistance to the services. Examples of these include reducing minimum informal physical evaluation board staffing requirements from three members to two members, authorizing doctoral level psychologists to sign medical evaluation boards. Prior they were not able to.

Allowing military departments to process initial trainees through the Legacy system. Additionally, DOD is working with our VA partners to improve IDES execution by improving training and case management software, implementing a common paperless standard for electronic transfer of files by this summer, and developing other integrated electronic record file sharing methods which will enhance the efficiency of the IDES.

The Departments anticipate these improvements when implemented this summer of 2012 will reduce IDES time, on average, by 20 to 30 days. The Departments are committed to ensuring that disability evaluation and compensation of injured, ill, and wounded servicemembers is thorough, fair, and accurate.

We are continually reviewing the process and the requirements to adequately staff, and when necessary, surge the IDES so it remains responsive to the needs of recovering servicemembers in the services as they draw down and reset their forces. Yet we understand there is room for improvement in all parts of our processes and are committed to working toward that end.

After two decades of war with an all-volunteer force that has seen marked improvements in survival of previously unsurvivable combat injuries, the expectations of what happens after a servicemember becomes ill or injured are fundamentally different. The Department is now focused on taking advantage of all the advances in medical care, restorative therapies, and rehabilitation to allow a servicemember to achieve his or her greatest potential.

This includes retention in military service whenever possible. This concept of being made whole reflects a commitment to the ser-

vicemembers to restore the highest level of function possible physically, mentally, spiritually, and financially and providing all the benefits that are justified.

The target of 295 days to complete the IDES process was originally identified to address the concerns and frustrations of servicemembers who did not believe they were being properly cared for and felt they were languishing in an uncoordinated, insensitive system. Since these issues surfaced, many resources have been brought to bear to improve the coordination and care and the adjudication of benefits.

The complexity of injuries, sophisticated treatment strategies, coordination of care, and change in the philosophical approach to the goals of patient-centric versus military department-centric has redefined the timeliness for completion of the system. In fact, it has become more of a system centered on improving and defining ability rather than singularly focused on transition of a servicemember to veteran status and is often individualized in its application to achieve this goal.

The Department reaffirms its commitment to care for and honor those who have protected our Nation by serving in uniform. In order to meet our sacred responsibilities to this next greatest generation, we must fully leverage the capabilities and strategies and strengths of both the Department of Defense and Veterans Affairs. We must break down the barriers that prevent us from delivering the highest quality care to those who need it and deserve it.

Thank you again for the opportunity to be with you today, Madam Chairman, and I look forward to the Committee's questions.

[The prepared statement of Ms. Rooney follows:]

PREPARED STATEMENT OF DR. JO ANN ROONEY, ACTING UNDER SECRETARY OF DEFENSE, PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE

Chairman Murray, Ranking Member Burr, and Members of the Committee: Thank you for inviting me to testify before you on the current status of the Integrated Disability Evaluation System (IDES) and current efforts to improve it.

The 2007 revelations regarding suboptimum conditions for wounded warriors at Walter Reed Army Medical Center made for a stark wakeup call. In the nearly five years since, the Department of Defense (DOD) has worked in tandem with our Department of Veterans Affairs (VA) colleagues to improve policies, procedures, and conditions that impact care of our wounded warriors. Today, we meet at a time of historic cooperation between the Departments of Defense and Veterans Affairs. Thanks to President Obama's commitment to Veterans and delivering the care they have earned, we have established a program of support between our Departments that is more responsive and comprehensive in scope than ever before. More so than at any time in our Nation's history, those who separate from military service are greeted by more comprehensive mental and physical care; by greater opportunity for education and jobs, and by a deeper societal commitment to ensuring their welfare. When you compare the experience of our troops today to the generation of heroes who returned from Vietnam, the progress made toward a single system of lifetime care is significant, yet we must continue to make improvements.

BACKGROUND

After the Career Compensation Act of 1949 created the basic structure of the Department's Disability Evaluation System (DES), it remained relatively unchanged until November 2007. In response to public and Congressional concern after reports of inadequate conditions for wounded warriors at Walter Reed, the joint DOD and VA Senior Oversight Committee (SOC) chartered a pilot designed to create a more Servicemember-centric, seamless, and transparent disability program. The DES Pilot implemented many of the changes recommended by groups like the Veterans'

Disability Benefits Commission and the President's Commission on Care for America's Returning Wounded Warriors to the degree allowed within law.

The pilot was launched at three major military medical treatment facilities in the National Capital Region on November 21, 2007—Walter Reed Army Medical Center, National Naval Medical Center, Bethesda, and Malcolm Grow Air Force Medical Center. It successfully created an integrated process that delivers Departments of Defense and Veterans Affairs benefits as soon as possible following release from active duty and significantly reduced the gap in benefits that existed in the previous system. DOD found the DES Pilot to be faster, more equitable, and more efficient than previous approaches. In a representative survey of over 1,000 Servicemembers, those in the DES Pilot were more satisfied with their experience than those in the legacy process. As a result, in July 2010, the Deputy Secretaries of Defense and Veterans Affairs directed worldwide implementation to begin in October 2010, and to be completed by September 2011. On December 31, 2010, the DES Pilot officially ended and the first Integrated Disability Evaluation System (IDES) site became fully operational.

The IDES, similar to the DES Pilot, streamlines the disability process so Servicemembers receive a single set of physical disability examinations conducted according to VA examination protocols and disability ratings prepared by VA. The Departments of Defense and Veterans Affairs share the examination results and ratings to relieve Servicemembers of the burden of redundant examination requirements and divergent ratings for the same disability. Under Title 10 authority, the Department determines fitness for duty and compensates for unfitting conditions incurred in the line of duty, while under Title 38 authority VA compensates for all disabilities resulting from disease or injury incurred or aggravated in line of duty during active military, naval, or air service for which a disability rating of 10 percent or higher is awarded. It also determines eligibility for other VA benefits and services. The IDES permits both Departments to provide disability benefits at the earliest point allowed under their respective U.S.C. Titles. In March 2012, the post-separation wait for VA disability benefits was 79% shorter than in 2007 under the separate DOD/VA processes.

The National Defense Authorization Act (NDAA) for FY 2008, Public Law 110–181, required DOD to utilize the VA Schedule for Rating Disabilities (VASRD). The Departments of Defense and Veterans Affairs are currently developing a memorandum of understanding that will allow DOD to become a member of the working groups updating the VASRD and give DOD the opportunity to make recommendations prior to the publication of proposed changes in the *Federal Register*. The Department's ability to provide this input is critical given the direct connection between VASRD ratings and the decision to place Servicemembers on the medical retirement list with annuities, benefits, and healthcare. This issue is being evaluated by the Benefits Executive Council, which is a joint DOD/VA forum, and anticipates completion over the next several months.

In summary, IDES delivers a more Servicemember-centric design, a simpler process, more consistent evaluations and compensation, easier transition to Veteran status, case management advocacy, and an established relationship between the Servicemember and VA prior to separation. It also provides increased transparency through better information flow to Servicemembers and their families and a reduced gap between separation or retirement from service to receipt of VA benefits.

CASELOAD

The Department evaluated 18,393 Servicemembers for disability during 2011, 22% more than in 2001. More than 50% of the Servicemembers evaluated for disability in 2011 completed the legacy DES process. Today, fewer than 2,000 Servicemembers remain in that legacy process. The Department is rapidly completing the evaluation of these legacy cases and will be complete with a small number of exceptions by September 2012.

As the number of Servicemembers in the independent legacy process has declined, the number of Servicemembers in IDES has grown. Since November 2007, 49,478 Servicemembers have entered and 19,518 have completed the IDES, 2,589 members did not complete the IDES process due to a host of reasons including death, disenrollment, or return to active duty. As of early this month, 27,371 Servicemembers were in the IDES (67 percent Army, 12 percent Marines, 9 percent Navy, and 12 percent Air Force). Two decades of war has contributed to the Department's disability case load and many of these ill and injured suffer from complex conditions which take time to properly diagnose and evaluate. We anticipate the number of Servicemembers in the IDES will continue to grow as members return from Afghanistan and the Services reduce their end strength.

We are concerned about the IDES performance, both in terms of the quality of service provided and time it takes to complete the process, the Department is mindful that disability evaluation has a dual purpose. The first purpose is to ensure our Nation maintains a fit fighting force. The second is to compensate disabled Servicemembers and recognize their honorable service. The Department also understands that before we evaluate a Servicemember for possible separation from service, we must also ensure we provide them the best medical treatment and consider them for other duties that allow continued service to their country. Both of these factors affect the time required to complete the IDES process to ensure we provide due diligence and process to every Servicemember. It is the Department's strong conviction that we must not simply expedite the process at the expense of eroding these basic tenets. However, we must ensure the process is as efficient as possible. The Department is committed to ensuring the disability evaluation and compensation of injured, ill, and wounded Servicemembers is thorough, fair, and accurate. We are continually reviewing the process and the requirements to adequately staff, and when necessary, surge the IDES so it remains responsive to the needs of recovering Servicemembers and the Services as they draw-down and reset their forces.

CURRENT PERFORMANCE

Prior to the IDES, the Departments of Defense and Veterans Affairs used separate disability evaluation processes which resulted in long wait times within each department. In addition, in 2007, the Departments of Defense and Veterans Affairs estimated disabled Veterans faced a 240-day gap between exiting military service and receiving full VA benefits. By March 2012, the IDES enabled the Departments of Defense and Veterans Affairs reduce the post-separation benefits gap from an average of 240 days in 2007 to 50 days, which means disabled Veterans received their VA benefits 79% faster under the IDES than before.

Active component Servicemembers averaged 395 days in the IDES in March 2012. Approximately 80 days of this time consisted of Servicemembers in transition—clearing their installation and taking voluntary earned leave prior to separating from military service. Voluntary leave and clearing the barracks are distinct efforts from disability processing and vary significantly by individual. Therefore, the Department is evaluating whether this transition time should be excluded as part of the IDES time measurement metric. The Department is committed to constant evaluation of all our processes and will continue to seek long-term innovative solutions focused on improving the experience of our wounded warriors. Although the Department is not currently meeting the IDES processing time goal, we are focusing on the following action areas to close the 100-day gap.

Staffing. The Services are applying surge manpower where needed. The Army has hired 1,218 out of 1,400 additional civilians (87% complete) to staff the IDES in anticipation of current caseload and future spikes in the IDES utilization. The Department of the Navy added staff at Camp Lejeune and reduced cases experiencing time delays by 21% in one month. The Department of the Navy also increased its Informal Physical Evaluation Board (IPEB) staffing by 47%, which reduced IPEB processing time from 50 days in January to 11 days in March 2012, well within the goal of 15 days. The Department of the Air Force is currently reviewing staffing requirements for their physical evaluation board.

Leadership. The Services and VA leaders meet regularly (both inter-agency and intra-agency) to ensure they oversee and drive progress within their organizations. There are several examples of this coordination. The first is the bi-monthly Joint Executive Council (JEC) chaired by the Deputy Secretary of Veterans Affairs and Under Secretary of Defense for Personnel & Readiness. The second includes monthly reports of the IDES performance provided to the Secretaries of Defense and Veterans Affairs and reviewed at each JEC. The third is the ability of the Services to provide examinations of each installation including the performance of individual cohorts and identify under-performing situations. The fourth is the focus Deputy of Defense Management Action Group (DMAG) meeting, attended by senior military and civilian leaders from across DOD. The DMAG agenda for the summer of 2012 includes a detailed review of the IDES program. The Department is in the beginning stages of exploring strategic reforms to the process. The Department appreciates the Committee's support, and looks forward to working with the Congress as we continue to improve IDES.

A LOOK TOWARDS THE FUTURE

In past wars, particularly with a conscripted force, it was expected that seriously injured or ill Servicemembers would transition to veteran status and receive long-

term care through VA. This concept was generally accepted by all stake holders including lawmakers, military leadership, Servicemembers, and society.

After two decades of war with an all-volunteer force that has seen marked improvements in survival of previously un-survivable combat injuries, the expectations of what happens after a Servicemember becomes ill or injured are fundamentally different. The Department is now focused on taking advantage of all the advances in medical care, restorative therapies, and rehabilitation to allow a Servicemember to achieve his or her greatest potential. This includes retention in military service when possible. This concept of being made "whole" reflects a commitment to the Servicemember to restore the highest level of function possible—physically, mentally, spiritually, and financially—and providing all benefits that are justified. We now have many Servicemembers, some of whom are blind, have spinal cord injuries, or have lost limbs serving proudly on active duty.

This strong commitment to rehabilitation and continued productive service in the military by ill and injured Servicemembers, many with more complex visible and invisible wounds then previously seen, has lengthened treatment and rehabilitation strategies and the time retained on active duty while recovering. It has also created a new mind-set for the injured Servicemember. Today there is a focus on attaining maximum functional ability before a decision is made to remain in or separate from active duty. Lawmakers and senior military leaders have endorsed this philosophy and Servicemembers embrace this change, driven by the desire to remain in active service because it is their chosen career.

The target of 295 days to complete the IDES process was originally identified to address the concerns and frustrations of Servicemembers who did not believe they were being cared for properly and felt they were languishing in an uncoordinated, insensitive system. Since these issues surfaced, many resources have been brought to bear to improve the coordination of care and the adjudication of benefits. Specifically, Wounded Warrior Regiments and Wounded Warrior Battalions have been established along with other efforts to group, coordinate and focus optimized care and recovery for the Servicemembers and provide for families. In addition, much attention and unprecedented resources have focused on addressing the invisible wounds of war—PTSD, TBI and Behavioral Health issues—largely ignored in previous conflicts; illnesses which often complicate recovery from other injuries. The complexity of injuries, sophisticated treatment strategies, coordination of care and change in the philosophical approach to the goals of patient centric vs. military department centric care has redefined the timelines for completion of the disability evaluation system. In fact, it has become more of a "system" centered on improving and defining "ability" rather than singularly focused on transition of the Servicemember to veteran status and is often individualized in its application to achieve this goal. The current philosophical commitment to make the Servicemember "whole" and give them opportunities to remain in service is now coming in conflict with rigid timelines and legacy policies and procedures. As we look to long-term strategic reform being satisfied that we have achieved maximum efficiencies in the current IDES, it may be appropriate to focus on developing metrics which consider the number of days along with desired outcomes that measure how the system serves the overall needs of wounded warriors and the contemporary military.

CONCLUSION

While the Department supports the level of effort and progress made, we fully acknowledge there is much more to do. The Department has positioned itself to implement improvements and continue progress in providing support to our Servicemembers, veterans, and their families while supporting recovery, rehabilitation, and re-integration. Our dedicated Servicemembers, veterans, and their families deserve the very best. We pledge to give our best efforts to supporting their recovery, rehabilitation, and return to their communities.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO DOD, OFFICE OF WOUNDED WARRIOR CARE AND TRANSITION POLICY AND VA, OFFICE OF POLICY AND PLANNING, INTEGRATED DISABILITY EVALUATION SYSTEM

(a) The number of servicemembers expected to enter the IDES process per year at each site.

DOD Response. See attached spreadsheet, WWCTP SVAC Response Data, column header, "Expected Referrals per year (a)."

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Branch		Expected Referrals per Year (a)	Average Time Pending (d)	# Cases Pending > 285 Days (e)	# Cases Pending > 540 Days (f)	# Cases Completed VA Benefits (g)	# PDRL Cases (h)	# TDRL Cases (i)	# Separated with Severance (j)	# Separated without Severance	# Cases RTD (o)	# Cases RTD After Exam (o1)	# Cases RTD After Not for VA Benefits (o2)	# Cases with Exams Used by DoD But	# Removed from IDES (k)	# Court Martial (l)	# Admin Removed excluding Court Martial (m)	# SM Deceased (n)
	DoD	34844	207	6933	840	15874	4577	5431	5624	242	4215	3927	3462	1955	134	795	119
A	Army	27658	206	4673	583	10310	3514	3296	3434	66	1745	1577	1275	1075	82	485	76
AF	Air Force	1887	171	471	26	1016	312	363	294	47	657	631	568	197	11	21	10
N	Navy	5299	223	701	84	1644	350	676	576	42	1014	973	914	253	8	93	20
MC	Marine Corps	--	238	1088	147	2904	401	1096	1320	87	793	745	704	430	32	197	13
A	Ft. Belvoir, VA	--	325	172	71	261	105	91	62	3	112	109	76	8	2	1	3
A	Ft. Benning, GA	1630	170	71	5	400	213	132	53	2	40	37	28	37	1	14	2
A	Ft. Bliss, TX	1174	136	6	0	5	1	1	3	0	11	7	7	13	0	6	3
A	Ft. Buchanan, PR	132	82	0	0	0	0	0	0	0	0	0	0	0	0	0	0
A	Ft. Bragg, NC	1248	198	344	25	611	240	109	262	0	59	55	49	49	2	35	2
A	Ft. Campbell, KY	1188	130	95	0	74	24	9	41	0	9	9	9	21	1	7	2
A	Ft. Carson, CO	1347	242	399	102	1515	288	632	583	12	207	200	178	138	14	86	11
A	Ft. Drum, NY	880	208	231	27	810	209	328	265	8	50	47	42	59	5	24	3
A	Eustis JB, VA	569	184	73	0	38	9	15	13	1	15	14	13	15	1	8	1
A	Ft. Gordon, GA	2658	183	215	0	29	15	6	7	1	63	52	40	12	2	2	1
A	Ft. Hood, TX	3206	240	763	55	1207	305	539	359	4	233	196	183	164	9	75	13
A	Ft. Huachuca, AZ	207	92	0	0	7	3	0	3	1	1	1	1	0	0	0	0
A	Ft. Irwin, CA	126	100	0	0	0	0	0	0	0	1	1	1	6	0	4	1
A	Ft. Jackson, SC	375	181	21	0	13	5	2	6	0	7	7	4	1	0	0	1
A	Ft. Knox, KY	581	79	0	0	0	0	0	0	0	6	6	2	1	0	1	0
A	Ft. Leavenworth, KS	90	140	1	0	0	0	0	0	0	2	0	0	1	0	0	0
A	Ft. Lee, VA	196	181	24	0	16	7	2	7	0	1	1	1	4	0	2	0
A	Ft. Leonard Wood, MO	772	168	19	0	7	1	0	5	1	7	6	6	6	0	4	0
A	Lewis JB, WA	1903	238	518	78	613	165	116	328	4	87	79	59	57	3	24	10
A	Ft. Meade, MD	--	303	146	38	320	124	131	61	4	77	66	39	19	1	6	0
A	Ft. Polk, LA	996	216	124	6	804	405	63	328	8	110	103	86	73	11	35	3
A	Redstone Arsenal, AL	115	103	0	0	0	0	0	0	0	3	3	2	0	0	0	0
A	Richardson JB, AK	496	222	44	4	157	36	67	53	1	18	17	15	36	0	9	1
A	Ft. Riley, KS	1482	254	561	14	262	70	88	101	3	86	70	66	100	9	34	3

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A	Ft. Rucker, AL		79	196	11	0	7	1	2	4	0	1	1	0	2	0	0	0
A	San Antonio JB (Sam Houston), TX		1523	243	228	64	956	357	321	276	2	179	171	123	62	9	26	6
A	Ft. Sill, OK		1166	153	5	0	7	2	4	1	0	4	4	4	3	1	0	0
A	Ft. Stewart, GA		1527	194	322	53	1227	489	330	406	2	155	150	118	75	8	42	5
A	Tripler AMC, HI		911	176	133	0	115	40	21	54	0	21	19	17	12	1	6	0
A	Ft. Wainwright, AK		--	171	31	2	196	41	64	90	1	19	18	18	14	0	8	0
A	West Point, NY		282	106	0	0	1	1	0	0	0	2	2	2	6	0	0	0
A	Walter Reed NMMC (Army), MD		799	314	114	38	552	358	223	63	8	157	125	86	81	2	26	5
AF	Altus AFB, OK		22	203	0	0	1	0	0	1	0	7	6	6	1	0	0	0
AF	Andrews JB, MD		136	249	56	9	290	99	109	67	15	155	146	116	35	4	3	4
AF	Aviano AB, Italy		0	107	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AF	Barksdale AFB, LA		17	149	1	0	0	0	0	0	0	4	4	4	0	0	0	0
AF	Beale AFB, CA		36	186	7	0	12	4	3	5	0	3	2	2	3	0	0	1
AF	Bolling JB, DC		0	100	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AF	Buckley AFB, CO		7	127	0	0	0	0	0	0	0	1	1	1	0	0	0	0
AF	Cannon AFB, NM		17	179	9	0	0	0	0	0	0	4	4	4	0	0	0	0
AF	Charleston JB (AF), SC		32	189	8	0	10	2	2	3	3	2	2	2	2	0	0	0
AF	Columbus AFB, MS		4	139	0	0	0	0	0	0	0	4	4	4	2	0	0	0
AF	Davis-Monthan AFB, AZ		38	136	6	0	17	9	3	5	0	8	8	8	1	0	0	0
AF	Dover AFB, DE		1	99	0	0	0	0	0	0	0	1	1	1	3	0	1	0
AF	Dyess AFB, TX		38	170	6	0	5	2	1	2	0	9	8	8	1	0	0	0
AF	Edwards AFB, CA		26	183	8	0	2	0	1	1	0	6	4	4	6	0	0	0
AF	Eglin AFB, FL		4	129	0	0	0	0	0	0	0	2	0	0	5	0	0	0
AF	Elelson AFB, AK		23	230	11	0	4	2	0	2	0	4	4	4	0	0	0	0
AF	Ellsworth AFB, SD		16	195	0	0	2	0	1	1	0	1	1	1	1	0	1	0
AF	Elmendorf JB, AK		73	234	25	6	74	20	28	24	2	18	18	15	10	1	1	0
AF	F. E. Warren AFB, WY		27	159	6	0	7	3	0	3	1	5	5	5	1	0	0	0
AF	Fairchild AFB, WA		33	182	6	0	7	2	3	2	0	6	5	5	3	0	0	0
AF	Goodfellow AFB, TX		17	193	3	0	2	0	0	2	0	0	0	0	0	0	0	0

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AF	Grand Forks AFB, ND	5	132	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AF	Hanscom AFB, MA	8	141	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0
AF	Hickam JB, HI	39	185	20	0	8	3	4	1	0	5	4	3	6	0	1	0	0
AF	Hill AFB, UT	36	170	12	0	9	2	2	4	1	6	6	5	5	0	1	0	0
AF	Holloman AFB, NM	0	67	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AF	Hurlburt Field, FL	8	139	0	0	0	0	0	0	0	3	3	3	0	0	0	0	0
AF	Incirlik AB, Turkey	0	109	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0
AF	Kadena AB, Japan	0	68	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
AF	Keesler AFB, MS	6	146	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0
AF	Kirtland AFB, NM	9	150	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AF	Kunsan AB, Korea	0	53	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0
AF	San Antonio JB (Lackland), TX	50	113	3	1	16	0	8	7	1	2	2	2	2	0	0	0	0
AF	Lajes Field, Portugal	0	52	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AF	Langley JB, VA	129	262	38	0	27	11	9	7	0	34	34	34	12	0	2	1	0
AF	Laughlin AFB, TX	3	167	2	0	0	0	0	0	0	1	1	1	1	0	0	0	0
AF	Little Rock AFB, AR	23	147	1	0	0	0	0	0	0	2	2	2	0	0	0	0	0
AF	Los Angeles AFB, CA	11	261	6	0	1	0	1	0	0	2	2	2	1	0	0	0	0
AF	Luke AFB, AZ	20	183	3	0	2	0	0	2	0	6	5	5	2	0	1	0	0
AF	MacDill AFB, FL	53	249	20	4	70	32	21	15	2	39	38	32	16	1	1	1	0
AF	Malmstrom AFB, MT	28	219	8	0	7	2	1	2	2	5	5	5	2	0	0	0	0
AF	Maxwell AFB, AL	16	134	4	0	6	4	2	0	0	3	3	3	5	0	0	0	0
AF	McChord JB, WA	11	113	3	0	1	1	0	0	0	3	2	1	1	0	0	0	0
AF	McConnell AFB, KS	1	103	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AF	McGuire JB, NJ	12	143	1	0	0	0	0	0	0	4	4	4	1	0	0	0	0
AF	Minot AFB, ND	24	149	2	0	3	0	1	2	0	0	0	0	0	0	0	0	0
AF	Misawa AB, Japan	0	88	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AF	Moody AFB, GA	0	151	6	0	0	0	0	0	0	5	5	5	2	0	1	0	0
AF	Mountain Home AFB, ID	25	142	2	0	15	3	2	9	1	1	1	1	0	0	0	0	0
AF	Nellis AFB, NV	146	209	28	2	164	52	60	45	7	52	52	51	11	4	1	0	0

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AF	Offutt AFB, NE	12	127	1	0	0	0	0	0	0	6	6	6	0	0	0	0
AF	Osan AB, Korea	0	128	0	0	0	0	0	0	0	1	1	1	0	0	0	0
AF	Patrick AFB, FL	24	209	10	0	4	2	1	0	1	5	4	4	1	0	0	0
AF	Peterson AFB, CO	47	182	7	0	4	0	2	1	1	19	19	18	4	0	0	0
AF	Pope AFB, NC	11	223	6	0	1	1	0	0	0	2	2	2	0	0	0	0
AF	San Antonio JB (Randolph), TX	24	245	3	0	2	0	2	0	0	8	8	8	2	0	0	0
AF	RAF Lakenheath, UK	0	71	0	0	0	0	0	0	0	0	0	0	1	0	0	0
AF	Ramstein AB, Germany	0	106	0	0	0	0	0	0	0	2	2	2	2	0	0	0
AF	Robins AFB, GA	100	223	34	0	16	10	3	3	0	30	30	23	5	0	0	2
AF	Scott AFB, IL	17	139	1	0	7	2	5	0	0	3	3	3	1	0	0	0
AF	Seymour-Johnson AFB, NC	87	258	35	0	18	3	5	10	0	24	23	22	1	0	0	0
AF	Shaw AFB, SC	59	171	7	0	15	4	5	6	0	18	18	17	4	0	0	0
AF	Sheppard AFB, TX	52	191	11	0	16	3	3	10	0	20	20	20	0	0	0	0
AF	Spangdahlem AB, Germany	0	83	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AF	Tinker AFB, OK	10	108	0	0	0	0	0	0	0	5	5	5	3	0	0	0
AF	Travis AFB, CA	143	202	32	4	144	25	70	45	4	64	61	55	20	1	6	1
AF	Tyndall AFB, FL	3	136	0	0	0	0	0	0	0	3	3	2	0	0	0	0
AF	USAF Academy, CO	6	149	1	0	1	1	0	0	0	2	2	2	0	0	0	0
AF	Vance AFB, OK	7	176	3	0	15	4	4	6	1	9	9	9	3	0	1	0
AF	Vandenberg AFB, CA	24	162	3	0	9	2	1	1	5	9	9	8	1	0	0	0
AF	Whiteman AFB, MO	10	146	0	0	2	2	0	0	0	5	5	5	0	0	0	0
AF	Wright-Patterson AFB, OH	8	98	0	0	0	0	0	0	0	5	5	3	1	0	0	0
AF	Yokota AB, Japan	0	118	0	0	0	0	0	0	0	0	0	0	0	0	0	0
N	29 Palms NH , CA	115	171	1	0	0	0	0	0	0	4	4	4	0	0	0	0
N	Annapolis NHC, MD	33	136	0	0	0	0	0	0	0	0	0	0	1	0	0	0
N	Beaufort NH, SC	139	276	1	0	0	0	0	0	0	2	2	2	1	0	1	0
N	Bremerton NH, WA	127	195	17	3	157	29	53	71	4	32	31	29	15	2	4	1
N	Charleston NH, SC	45	185	14	0	10	0	6	3	1	4	4	4	4	0	1	0
N	Cherry Point NH, NC	163	302	2	0	0	0	0	0	0	7	7	7	1	0	1	0

WWCTP SVAC Response - May 11, 2012

Branch		Expected Referrals per Year (a)	Average Time Pending (d)	# Cases Pending > 365 Days (e)	# Cases Pending > 540 Days (f)	# Cases Completed VA Benefits (g)	# PDRL Cases (h)	# TDRL Cases (i)	# Separated with Severance (j)	# Separated without Severance	# Cases RTD (o)	# Cases RTD After Exam (r1)	# Cases with Exams Used by DoD But Not for VA Benefits (r2)	# Removed from IDES (k)	# Court Martial (l)	# Admin Removed excluding Court Martial (m)	# SM Deceased (n)
N	Corpus Christi NHC, TX	19	207	4	0	1	0	1	0	0	4	4	4	0	0	0	0
N	Ft. Worth BHC, TX	24	162	2	0	0	0	0	0	0	3	2	2	0	0	0	0
N	Great Lakes FHCC, IL	99	158	2	0	4	0	1	2	1	21	21	16	6	0	2	0
N	Hawaii NHC, HI	239	189	27	0	28	2	17	8	1	35	35	35	10	0	4	0
N	Jacksonville NH, FL	268	216	63	0	19	2	11	5	1	46	45	40	11	0	4	1
N	Camp Lejeune NH, NC	1062	244	13	4	57	11	30	16	0	55	52	51	13	0	6	1
N	Lemoore NH, CA	48	206	10	0	6	2	2	1	1	7	7	6	2	0	0	0
N	New England NHC, CT	53	120	1	0	1	0	1	0	0	14	14	9	1	0	0	0
N	Oak Harbor NH, WA	57	194	9	0	13	1	6	5	1	12	12	12	1	0	1	0
N	Patuxent River NHC, MD	20	159	3	0	0	0	0	0	0	4	4	4	0	0	0	0
N	Pensacola NH, FL	73	140	0	0	0	0	0	0	0	15	12	11	2	0	0	1
N	Camp Pendleton NH, CA	369	323	20	6	85	13	35	36	1	24	22	18	5	1	0	0
N	Portsmouth NMC, VA	667	242	225	34	316	57	138	112	9	214	203	198	56	1	24	6
N	Quantico NHC, VA	157	85	0	0	0	0	0	0	0	2	1	1	1	0	0	0
N	San Diego NMC, CA	1259	245	246	31	725	178	263	266	18	331	320	304	99	1	43	6
N	Walter Reed NMMC (Navy/Marine Corps), MD	261	232	38	6	222	55	112	51	4	174	168	154	22	3	1	4
MC	29 Palms NH , CA	--	179	17	0	17	2	3	11	1	15	15	15	19	0	6	0
MC	Annapolis NHC, MD	--	155	1	0	0	0	0	0	0	0	0	0	0	0	0	0
MC	Beaufort NH, SC	--	185	21	0	47	0	19	27	1	16	14	14	3	0	2	0
MC	Bremerton NH, WA	--	191	1	1	15	3	4	8	0	2	1	1	1	0	0	0
MC	Charleston NH, SC	--	213	4	0	0	0	0	0	0	0	0	0	0	0	0	0
MC	Cherry Point NH, NC	--	217	44	0	26	1	7	18	0	27	25	25	23	0	11	0
MC	Corpus Christi NHC, TX	--	237	7	0	0	0	0	0	0	4	4	3	0	0	0	0
MC	Ft. Worth BHC, TX	--	184	1	0	0	0	0	0	0	1	1	1	3	0	2	0
MC	Great Lakes FHCC, IL	--	117	2	0	1	0	0	1	0	5	4	3	2	0	1	0
MC	Hawaii NHC, HI	--	196	22	0	23	0	13	9	1	16	16	16	5	0	2	0
MC	Jacksonville NH, FL	--	222	31	1	11	2	2	6	1	14	14	13	1	0	1	0
MC	Camp Lejeune NH, NC	--	242	353	46	1286	146	529	583	28	310	290	283	190	17	100	5
MC	Lemoore NH, CA	--	165	0	0	1	0	0	1	0	2	1	0	0	0	0	0

WWCTP SVAC Response - May 11, 2012

Branch		Expected Referrals per year (a)	Average Time Pending (d)	# Cases Pending > 295 Days (e)	# Cases Pending > 540 days (f)	# Cases Completed VA Benefits (g)	# PDRL Cases (h)	# TDRL Cases (i)	# Separated with Severance (j)	# Separated without Severance	# Cases RTD (o)	# Cases RTD After Exam (p1)	# Cases RTD After Exam (p2)	# Cases with Exams Used by DoD But Not for VA Benefits	# Removed from IDES (k)	# Court Martial (l)	# Admin Removed excluding Court Martial (m)	# SM Deceased (n)
MC	New England NHC, CT	--	137	1	0	1	0	0	1	0	0	5	5	2	0	0	0	0
MC	Oak Harbor NH, WA	--	61	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MC	Patuxent River NHC, MD	--	167	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MC	Pensacola NH, FL	--	153	1	0	0	0	0	0	0	0	3	2	1	0	0	0	0
MC	Camp Pendleton NH, CA	--	304	218	59	390	42	107	224	17	106	102	102	92	61	5	30	2
MC	Portsmouth NMC, VA	--	254	24	3	40	6	16	16	2	8	5	5	5	8	1	3	1
MC	Quantico NHC, VA	--	239	64	0	8	1	2	5	0	11	10	10	10	13	3	0	0
MC	San Diego NMC, CA	--	246	226	26	672	122	214	310	26	163	158	158	155	70	5	26	4
MC	Walter Reed NMMC (Navy/Marine Corps), MD	--	245	47	9	365	76	179	100	10	83	76	76	64	25	1	11	1

Note: a "--" indicates that the value was provided rolled up into another figure

Notes:

(1) Expected referrals per year based on medical evaluation boards the Military Departments reported in fiscal year 2011.

(2) Department of the Navy data represents combined referrals for Navy and Marine Corps servicemembers.

(3) Referral data for Walter Reed National Military Medical Center includes referrals from Ft. Belvoir and Ft. Meade.

(b) For each site, the total current staffing level for Physical Evaluation Board Liaison Officers (PEBLOs) and the ratio of PEBLOs to servicemembers.

DOD Response. See attached PEBLO ratio spreadsheet for ratio of PEBLOs to servicemembers.

Army PEBLO Ratios for CONUS and OCONUS

As of April 2012, reported quarterly to WWCTP

Military Treatment Facility	April 2012 PEBLO Ratio	April 2012 PEBLO FTEs	April 2012 Contact Rep FTEs	April 2012 Total FTE Staff	Comments
Brooke Army Medical Center	1:16	25	27	52	
Ft. Belvoir	1:9	11	2	13	
Ft. Benning	1:23	16	16	32	
Ft. Bliss	1:12	33	23	56	
Ft. Bragg	1:29	23	28	51	
Ft. Buchanan	1:57	2	4	6	
Ft. Campbell	1:19	17	14	31	
Ft. Carson	1:12	34	14	48	
Ft. Drum	1:16	13	8	21	
Ft. Eustis	1:12	10	6	16	
Ft. Gordon	1:45	22	22	44	
Ft. Hood	1:19	48	68	116	
Ft. Huachuca	1:19	3	0	3	
Ft. Irwin	1:13	3	3	6	
Ft. Jackson	1:14	5	5	10	
Ft. Knox	1:18	22	14	36	
Ft. Leavenworth	1:10	3	3	6	
Ft. Lee	1:20	1	3	4	
Ft. Leonard Wood	1:23	12	13	25	
Ft. Meade	1:9	8	7	15	
Ft. Polk	1:17	10	13	23	
Ft. Richardson	1:2	4	4	8	
Ft. Riley	1:9	32	26	58	
Ft. Rucker	1:16	1	1	2	
Ft. Sill	1:15	13	14	27	
Ft. Stewart	1:20	25	26	51	
Ft. Wainwright	1:46	3	3	6	
Lewis JB	1:29	20	16	36	
Redstone Arsenal	1:16	2	2	4	
Tripler AMC	1:9	16	15	31	
Walter Reed NMMC	1:7	8	3	11	
West Point USMA	1:7	12	4	16	

Comment Summary

Note: PEBLO Case ratio is defined as the number of trained PEBLO FTE staff divided by 100/365 (.27) multiplied by the total number of new cases (to be defined by the Military Department) at the location per year.

(# of PEBLOs) ÷ [(.27) × (# of MEBs per year)] = Current PEBLO Ratio

Navy PEBLO Ratios and staffing for CONUS

As of April 2012 reported quarterly to WWCTP

Military Treatment Facility	April 2012 PEBLO Ratio	April 2012 PEBLO FTEs	April 2012 Admin Support FTEs	FY 12 PEBLO Hiring Actions Ongoing	Comments
29 Palms, CA	1:30	1	1	1	29 Palms has requested and been funded for 1 additional PEBLO FTE hiring actions pending. Will supplement as needed IAW Contngency plan
Annapolis, MD	1:10	2	0	0	Site currently meets 1:20 ratio; recruiting a new PEBLO who will be onboard on April 23rd
Beaufort, SC	1:28	1	1	1	One vacancy for FY12. Hiring Action pending.
Bethesda, MD	1:10	6	1	0	Site currently meets 1:20 ratio.
Bremerton, WA	1:13	2	0	0	Site currently meets 1:20 ratio.
Camp Lejeune, NC	1:20	13	8	0	Site currently meets 1:20 ratio.
Camp Pendleton,CA	1:16	5	1	0	Site currently meets 1:20 ratio.
Charleston, SC	1:20	2	0	0	Site currently meets 1:20 ratio.
Cherry Point, NC	1:12	2	1	0	Site currently meets 1:20 ratio.
Corpus Christi, TX	1:24	3	1	0	Will supplement as needed IAW Contingency Plan
Great Lakes, IL	1:22	2	0	0	Great Lakes hiring actions completed as of Jul 2011. Will supplement as needed IAW Contngency plan
Groton, CT	1:17	0	0	0	Site currently meets 1:20 ratio
Jacksonville, FL	1:20	5	1	0	Site currently meets 1:20 ratio
Lemoore, CA	1:13	0	2	0	Site currently meets 1:20 ratio
Newport, RI	1:20	1	0	0	Site currently meets 1:20 ratio
Oak Harbor, WA	1:14	0	1	0	Site currently meets 1:20 ratio
Patuxent River, MD	1:21	1	0	0	Will supplement as needed IAW Contngency plan
Pearl Harbor, HI	1:12	3	1	0	Site currently meets 1:20 ratio
Pensacola, FL	1:22	4	0	0	PH Pensacola placed a PEBLO within AF MDG Gulfport MS. Will supplement IAW Contingency Plan
Portsmouth, VA	1:20	9	0	0	Site currently meets 1:20 ratio
Quantico, VA	1:18	2	1	0	Hiring actions of 3 PEBLO's complete. Site meets 1:20 ratio
San Diego, CA	1:22	14	4	0	Will supplement as needed IAW Contngency plan

Navy Medicine Funding for additional PEBLOs is being provided via Wounded, Ill, and Injured program management at the Bureau of Medicine and Surgery (BUMED). Navy Medicine's staffing model focuses on the moving average of cases being processed through the Integrated Disability Evaluation System as the basis for establishing the 1:20 PEBLO minimum staffing requirements at each MTF. Additional staffing needs may be identified by the MTF based upon operational requirements and local needs. Currently we have 110 PEBLO's

OCONUS Locations: For OCONUS, the PEBLO's that are stationed there (Navy ADSM) will continueto perform their duties as assigned in PAD Department. There will be front end administrative requirements for OCONUS

Navy Medicine Funding for additional PEBLOs is being provided via Wounded, Ill, and Injured program management at the Bureau of Medicine and Surgery (BUMED). Navy Medicine's staffing model focuses on the moving average of cases being processed through the Integrated Disability Evaluation System as the basis for establishing the 1:20 PEBLO minimum staffing requirements at each MTF. Additional staffing needs are identified by the MTF based upon operational requirements and local needs. Currently we have 56 PEBLO's we are looking to hire 44 additional PEBLO's across the enterprise to include the phase III sites in FY 12.

OCONUS Locations: For OCONUS, the PEBLO's that are stationed there (Navy ADSM) will continueto perform their duties as assigned in PAD Department. There will be front end administrative requirements for OCONUS PEBLOS that will not change. We will not be standing up any IDES Sites OCONUS.

Note: PEBLO Case ratio is defined as the number of trained PEBLO FTE staff divided by 100/365(.27) multiplied by the total number of new cases (to be defined by the Military Department) at the location per year.

Air Force PEBLO Ratios for CONUS and OCONUS

As of April 2012, reported quarterly to WWCTP

Military Treatment Facility	April 2012 PEBLO Ratio	April 2012 PEBLO FTEs	Comments
Altus AFB	1:13	1	
Andersen AFB	1:11	1	
Andrews AFB	1:16	6	
Aviano AB	1:10	1	
Barksdale AFB	1:26	1	
Beale AFB	1:24	1	
Bolling AFB	1:7	1	
Buckley AFB	1:7	2	
Cannon AFB	1:11	1	
Charleston AFB	1:7	2	
Columbus AFB	1:4	1	
Davis-Monthan AFB	1:8	4	
Dover AFB	1:10	2	
Dyess AFB	1:17	2	
Edwards AFB	1:5	2	
Eglin AFB	1:18	2	
Eielson AFB	1:8	1	
Ellsworth AFB	1:27	1	
Elmendorf AFB	1:15	2	
F.E. Warren AFB	1:25	1	
Fairchild AFB	1:7	2	
Goodfellow AFB	1:8	1	
Grand Forks AFB	1:6	1	
Hanscom AFB	1:14	2	
Hickam AFB	1:14	2	
Hill AFB	1:12	2	
Holloman AFB	1:43	1	
Hurlburt AFB	1:7	3	
Incirlik AB	1:4	1	
Kadena AB	1:11	2	
Keesler AFB	1:12	4	
Kirtland AFB	1:7	2	
Kunsan AB	1:7	1	
Lackland AFB	1:26	12	
Lajes Field	1:2	1	
Lakenheath	1:11	2	
Langley AFB	1:17	4	
Laughlin AFB	1:2	1	
Little Rock AFB	1:15	2	
Los Angeles AFB	1:2	1	
Luke AFB	1:5	3	
MacDill AFB	1:12	4	
Malmstrom AFB	1:12	2	
Maxwell AFB	1:13	1	
McChord AFB	1:9	2	
McConnell AFB	1:4	2	
McGuire AFB	1:10	2	
Minot AFB	1:34	1	

Military Treatment Facility	April 2012 PEBLO Ratio	April 2012 PEBLO FTEs	Comments
Misawa AB	1:6	1	
Moody AFB	1:3	3	
Mountain Home AFB	1:9	2	
Nellis AFB	1:27	4	
Offutt AFB	1:10	3	
Osan AB	1:5	1	
Patrick AFB	1:4	2	
Peterson AFB	1:27	2	
Pope AFB	1:5	1	
Ramstein AB	1:14	2	
Randolph AFB	1:9	3	
Robins AFB	1:9	4	
Scott AFB	1:9	3	
Seymour Johnson AFB	1:35	1	
Shaw AFB	1:12	2	
Sheppard AFB	1:9	3	
Spangdahlem AB	1:9	1	
Tinker AFB	1:20	2	
Travis AFB	1:12	10	
Tyndall AFB	1:9	1	
US Air Force Academy	1:20	2	
Vance AFB	1:6	1	
Vandenberg AFB	1:32	1	
Whiteman AFB	1:16	1	
Wright-Patterson AFB	1:36	6	
Yokota AB	1:11	1	

Comment Summary

Note: PEBLO Case ratio is defined as the number of trained PEBLO FTE staff divided by 100/365 (.27) multiplied by the total number of new cases (to be defined by the Military Department) at the location per year.

(# of PEBLOs) ÷ [(.27) × (# of MEBs per year)] = Current PEBLO Ratio

The Services reported staffing for each location based upon the following:

PEBLO Case ratio is defined as the number of trained PEBLO full-time-equivalent (FTE) staff divided by 100/365 (.27) multiplied by the total number of new cases (to be defined by the Military Department) at the location per year.

(# of PEBLOs) ÷ [(.27) × (# of MEBs per year)] = Current PEBLO Ratio

(c) For each site, the total current staffing level for Military Service Coordinators (MSCs) and the ratio of MSCs to servicemembers.

DOD/VA Response. The attached spreadsheet, "IDES Sites VA MSC-VSR Staff Levels," is the list of IDES Sites and respective military services coordinator caseloads. Monthly volumes at IDES sites range from less than 1 per month to a high of nearly 150 cases. VBA supports low-volume sites with part-time staffing.

IDES Sites VA MSC-VSR Staff Levels as of April 30, 2012

MTF Location	FY12 New Cases	Service	# Full Time MSCs	Averages Cases Per Month	Avg Case Load for FY2012 to date
Ft. Hood, TX	1025	Army	6	146.4	24
Ft. Gordon, GA	922	Army	5	131.7	26
Ft. Stewart, GA	826	Army	3	118.0	39
Lewis JB, WA	780	USAF/Army	4	117.7	29
Ft. Campbell, KY	772	Army	5	110.3	22
Ft. Bragg, NC	771	Army	5	110.1	22
San Diego NMC, CA	713	Navy	5	101.9	20
Ft. Bliss, TX	681	Army	6	104.6	17
Ft. Carson, CO	624	Army	5	89.1	18
Ft. Benning, GA	615	Army	3	87.9	29
Camp Lejeune NH, NC	554	Navy	4	79.1	20
Ft. Drum, NY	499	Army	3	71.3	24
Ft. Riley, KS	453	Army	4	64.7	16
Tripler AMC, HI	414	Army	1	59.1	59
San Antonio JB (Sam Houston), TX	401	Army	7	57.3	8
Portsmouth NMC, VA	371	Navy	3	53.0	18
Ft. Polk, LA	268	Army	2	38.3	19
Eustis JB, VA	222	Army	2	36.4	18
Ft. Sill, OK	209	Army	1	29.9	30
Camp Pendleton NH, CA	187	Navy	3	26.7	9
Ft. Leonard Wood, MO	176	Army	3	25.1	8
Jacksonville NH, FL	163	Navy	1	23.3	23
Walter Reed NMMC (Navy/Marine Corps), MD	154	Navy	2	22.0	11
Ft. Irwin, CA	151	Army	1	21.6	22
Ft. Knox, KY	147	Army	3	21.0	7
Ft. Belvoir, VA	136	Army	4	19.4	5
Ft. Wainwright, AK	134	Army	1	21.6	29
Ft. Meade, MD	129	Army	2	18.4	9
Hawaii NHC, HI	127	Navy	1	18.1	18
Tinker AFB, OK	118	USAF	Part Time	16.9	17
West Point, NY	106	Army	1	15.1	15
Great Lakes FHCC, IL	102	Navy	3	14.6	5
Richardson JB, AK	96	Army	2	32.9	19
Cherry Point NH, NC	95	Navy	1	13.6	14
Walter Reed NMMC (Army), MD	94	Army	2	13.4	7
San Antonio JB (Lackland), TX	94	USAF	2	13.4	7
Travis AFB, CA	94	Air Force	2	22.3	11
Ft. Lee, VA	86	Army	1	12.3	12
Andrews JB, MD	85	Air Force	2	22.6	11
Quantico NHC, VA	82	Navy	1	11.7	12
Ft. Jackson, SC	81	Army	Part Time	11.6	12
Ft. Huachuca, AZ	79	Army	1	11.3	11
Beaufort NH, SC	76	Navy	Part Time	10.9	11
29 Palms NH , CA	75	Navy	1	10.7	11
Bremerton NH, WA	75	Navy	1	10.7	21
New England NHC, CT	74	Navy	Part Time	10.6	11
Dyess AFB, TX	74	USAF	Part Time	10.6	11
Nellis AFB, NV	66	Air Force	1	9.4	9
Shaw AFB, SC	63	USAF	Part Time	9.0	9
Minot AFB, ND	63	USAF	Part Time	9.0	9
Robins AFB, GA	62	Air Force	Part Time	8.9	9
Hurlburt Field, FL	61	USAF	1	8.7	9
Pensacola NH, FL	58	Navy	1	10.6	11
Little Rock AFB, AR	54	USAF	1	7.7	8
Wright-Patterson AFB, OH	53	USAF	1	7.6	8
Holloman AFB, NM	51	Air Force	Part Time	7.3	7
Elmendorf JB, AK	50	Air Force	1	7.1	7
Hickam JB, HI	49	USAF	1	7.0	7
Ft. Leavenworth, KS	48	Army	1	6.9	7
Offutt AFB, NE	47	USAF	1	6.7	7
Eglin AFB, FL	45	USAF	1	6.4	6
Kirtland AFB, NM	45	USAF	1	6.4	6

MTF Location	FY12 New Cases	Service	# Full Time MSCs	Averages Cases Per Month	Avg Case Load for FY2012 to date
Barksdale AFB, LA	43	USAF	Part Time	6.1	6
Scott AFB, IL	43	USAF	1	6.1	6
McGuire JB, NJ	41	USAF	Part Time	5.9	6
Hill AFB, UT	41	USAF	1	5.9	6
Davis-Monthan AFB, AZ	41	USAF	1	5.9	6
Seymour-Johnson AFB, NC	40	USAF	Part Time	5.7	6
MacDill AFB, FL	40	Air Force	1	5.7	6
Charleston NH, SC	39	Navy	Part Time	5.6	6
Sheppard AFB, TX	39	USAF	Part Time	5.6	6
Peterson AFB, CO	39	USAF	Part Time	5.6	6
Keesler AFB, MS	38	USAF	1	5.4	5
Redstone Arsenal, AL	36	Army	Part Time	5.1	5
Dover AFB, DE	35	USAF	Part Time	5.0	5
Charleston JB (AF) SC	31	USAF	Part Time	4.4	4
Whiteman AFB, MO	31	USAF	2	4.4	2
Lemoore NH, CA	31	Navy	Part Time	4.4	4
Maxwell AFB, AL	31	Air Force	1	4.4	4
Moody AFB, GA	31	Air Force	Part Time	4.4	4
F. E. Warren AFB, WY	30	USAF	1	4.3	4
Hanscom AFB, MA	28	USAF	Part Time	4.0	4
Ft. Rucker, AL	28	Army	Part Time	4.0	4
Cannon AFB, NM	28	USAF	1	4.0	4
Langley JB, VA	28	Air Force	1	4.0	4
Fairchild AFB, WA	27	USAF	1	3.9	4
Oak Harbor NH, WA	27	Navy	1	3.9	8
Ft. Buchanan, PR	26	Army	1	3.7	4
Grand Forks AFB, ND	24	USAF	Part Time	3.4	3
Altus AFB, OK	23	USAF	Part Time	3.3	3
Luke AFB, AZ	23	USAF	1	3.3	3
Ft. Worth BHC, TX	22	Navy	Part Time	3.1	3
McConnell AFB, KS	21	USAF	Part Time	3.0	3
Beale AFB, CA	21	USAF	Part Time	3.0	3
Vandenberg AFB, CA	20	USAF	Part Time	2.9	3
Patrick AFB, FL	19	Air Force	Part Time	2.7	3
Edwards AFB, CA	19	USAF	Part Time	2.7	3
Columbus AFB, MS	17	USAF	Part Time	2.4	2
Buckley AFB, CO	17	USAF	Part Time	2.4	2
Eielson AFB, AK	17	Air Force	Part Time	2.4	2
Patuxent River NHC, MD	16	Navy	1	2.3	2
USAF Academy, CO	16	USAF	Part Time	2.3	2
Ellsworth AFB, SD	15	USAF	Part Time	2.1	2
Malmstrom AFB, MT	15	USAF	Part Time	2.1	2
Mountain Home AFB, ID	14	USAF	Part Time	2.0	2
Goodfellow AFB, TX	13	USAF	Part Time	1.9	2
Annapolis NHC, MD	10	Navy	1	4.1	4
Pope AFB, NC	10	USAF	Part Time	1.4	1
Tyndall AFB, FL	10	USAF	1	1.4	1
San Antonio JB (Randolph), TX	9	USAF	Part Time	1.3	1
Vance AFB, OK	9	Air Force	Part Time	1.3	1
Corpus Christi NHC, TX	8	Navy	1	1.1	1
Laughlin AFB, TX	7	USAF	Part Time	1.0	1
Los Angeles AFB, CA	7	USAF	Part Time	1.0	1
Bolling JB, DC	3	USAF	Part Time	0.4	1
Total			**127**	**2208.0**	**17**
			# Full Time MSCs or VSRs	**Total Avg Cases Per Month**	**Overall Avg Case Load for FY2012 to date**

(d) The length of time, on average, servicemembers have been pending in the IDES process at each site.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "Average Time Pending (d)."

(e) The number of individuals who have been pending in the IDES process for longer than 295 days at each site.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# Cases Pending > 295 Days (e)."

(f) The number of individuals who have been pending in the IDES process for longer than 540 days at each site.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# Cases Pending > 540 days (f)."

(g) The total number of individuals who have completed the IDES process at each site.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# Cases Completed VA Benefits (g)."

(h) The number of individuals from each site who completed the IDES process and were placed on the permanent disability retirement list.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# PDRL Cases (h)."

(i) The number of individuals from each site who completed the process and were placed on the temporary disability retirement list.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# TDRL Cases (i)."

(j) The number of individuals from each site who completed the process and were separated with severance pay.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# Separated with Severance (j)."

(k) The total number of individuals from each site who have been removed from the IDES process.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# Cases Removed from IDES (k)."

(l) The number of individuals from each site who were removed from the IDES process and received an Administrative Discharge after court martial.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# Court Martial (l)."

(m) The number of individuals from each site who were removed from the IDES process and received an Administrative Discharge (excluding court martial).

DOD Response. See WWCTP SVAC Response Data (response to question (a)), "# Admin Removed excluding Court Martial (m)."

(n) The number of individuals from each site who have died during the IDES process and the causes of their deaths.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# Deceased (n)." For detailed information about causes of death, see the following chart from Office of Wounded Warrior Care Transition Policy.

Office of Wounded Warrior Care Transition Policy

IDES - VTA Disenrollment Subcategory, Service Member Passed Away, Updated May 15, 2012

using April 2, 2012 data in VTA. Cause of Death provided by Services, cumulative since Nov 2007

Army

Case Count	CASE ID	SERVICE	MEB LOCATION	CAUSE OF DEATH	Last Date Entered in VTA	Last IDES Phase at time of death
1	1422	A	Ft. Stewart, GA	Cancer	8/28/2009	PEB
2	2445	A	Walter Reed AMC, DC	Asphyxia due to hanging	12/24/2009	MEB
3	2491	A	Ft. Stewart, GA	DX. Combined ethanol, cocaine, oxycodone, and hydrocone toxicity.	10/26/2009	PEB
4	3028	A	Walter Reed AMC, DC	Death from carcinoma	10/6/2009	PEB
5	3437	A	Walter Reed AMC, DC	Suicide	8/14/2009	MEB
6	4419	A	Ft. Carson, CO	Natural causes	7/28/2011	Transition
7	4540	A	Ft. Carson, CO	Natural causes	9/29/2009	MEB
8	5033	A	Ft. Carson, CO	Homocide (spouse killed soldier, then shot self)	6/11/2010	MEB
9	5655	A	Ft. Carson, CO	Self inflicted gun shot	10/29/2010	PEB
10	6832	A	Ft. Polk, LA	Multiple prescription drugs toxicity	2/11/2010	MEB
11	7203	A	Ft. Carson, CO	Suicide	5/29/2011	Transition
12	7819	A	Ft. Hood, TX	Suicide	4/26/2010	MEB
13	8408	A	San Antonio JB (Sam Houston), TX	colitis; acute lymphocytic leukemia status post bone marrow transplant	4/15/2010	MEB
14	8657	A	San Antonio JB (Sam Houston), TX	Complication of mixed drugs (Date of Death: 4 Oct 2010)	7/15/2010	MEB
15	8748	A	San Antonio JB (Sam Houston), TX	Synovial cell carcinoma left leg (SP below the knee amputation) with metastases to the lungs	1/19/2011	PEB
16	9121	A	Ft. Hood, TX	Drive by shooting victim	11/15/2010	PEB
17	9347	A	Ft. Hood, TX	Bacterial Sepsis	12/13/2010	PEB
18	9538	A	Ft. Polk, LA	Natural causes	5/13/2010	MEB
19	9735	A	Ft. Carson, CO	Natural causes	5/18/2010	MEB
20	10206	A	Ft. Hood, TX	Overdose - "huffing"	10/4/2010	PEB
21	10591	A	Ft. Hood, TX	Drug overdose	8/10/2010	MEB
22	10647	A	Ft. Hood, TX	Self inflicted gun shot	6/15/2010	MEB
23	10870	A	Ft. Benning, GA	Died after completing IDES processing and separating from the Army	12/28/2010	VA Benefits
24	11261	A	Ft. Belvoir, VA	Cancer	4/7/2011	Transition
25	11763	A	Ft. Stewart, GA	Cardiac Arrest	9/12/2011	PEB
26	11873*	A	Ft. Bragg, NC	Suicide		
27	12165	A	Ft. Carson, CO	Murder	8/26/2011	VA Benefits
28	12334	A	Ft. Drum, NY	Self inflicted gun shot	12/15/2010	MEB
29	13018	A	Richardson JB, AK	Multiple gun shot wounds to head and trunk	8/12/2010	MEB
30	13388	A	Ft. Carson, CO	Natural causes	12/2/2011	VA Benefits
31	13684	A	Walter Reed AMC, DC	Multiple Injuries	6/6/2011	PEB
32	13776	A	Lewis JB, WA	Acute intoxication by the combining effects of amitripyline and ethanol	3/1/2011	MEB
33	14408	A	Ft. Drum, NY	Malignant Brain Tumor	12/15/2010	MEB
34	14944	A	Lewis JB, WA	Motorcycle accident	10/18/2010	MEB
35	15967	A	Ft. Carson, CO	Pulmonary embolism	1/31/2011	MEB
36	16258	A	Ft. Riley, KS	Metastasized Esophageal Melanoma	6/14/2011	Transition
37	16323	A	Ft. Hood, TX	Complications of Mixed Drug Toxicity	10/26/2011	PEB
38	16798	A	Ft. Carson, CO	Cancer	9/27/2011	MEB
39	17417	A	Lewis JB, WA	Auto Accident	3/29/2011	MEB
40	17446	A	San Antonio JB (Sam Houston), TX	Complications of pulmonary foreign body granulomatosis	8/24/2011	PEB
41	17901	A	Ft. Bragg, NC	Malignant Melanoma	8/27/2011	Transition
42	19588	A	Ft. Stewart, GA	Seizure	6/16/2011	MEB
43	19600	A	Ft. Bragg, NC	Suicide	2/10/2012	VA Benefits
44	20381	A	Ft. Drum, NY	Natural causes		
45	21469	A	Ft. Belvoir, VA	Lung Cancer	12/9/2011	PEB
46	21774	A	Ft. Carson, CO	Accidental Over Dose	3/9/2012	VA Benefits
47	21791	A	Ft. Hood, TX	Multidrug Intoxication	4/15/2011	Referral
48	21804	A	Ft. Stewart, GA	Suicide	4/21/2011	MEB
49	21919	A	Ft. Jackson, SC	Congestive Heart Failure	11/9/2011	PEB
50	23386	A	Ft. Riley, KS	Acute Bronchopneumonia	11/3/2011	MEB
51	24760	A	Ft. Drum, NY	Motor Vehicle Accident	12/22/2011	VA Benefits
52	24769	A	Lewis JB, WA	Suicide	7/26/2011	MEB
53	25706	A	Ft. Belvoir, VA	Cancer	8/16/2011	MEB
54	26155	A	Ft. Polk, LA	Natural causes	7/14/2011	MEB
55	26365	A	San Antonio JB (Sam Houston), TX	Cardiac Dysrhythmia; Metastic Cancer	9/1/2011	MEB
56	26407	A	Ft. Hood, TX	Cardiac Arrest due to motorcycle accident	8/16/2011	MEB
57	27776	A	Lewis JB, WA	Colon Cancer	2/28/2012	PEB
58	27807	A	Ft. Hood, TX	Complications of Methadon Intoxication	9/29/2011	MEB
59	28914	A	Ft. Bliss, TX	Suicide	12/16/2011	Transition
60	30348	A	Ft. Campbell, KY	Natural causes	8/25/2011	MEB
61	30365	A	San Antonio JB (Sam Houston), TX	Renal Cancer	2/26/2012	Transition
62	31804	A	Ft. Bliss, TX	Motorcycle Accident	11/7/2011	MEB
63	32347	A	Ft. Hood, TX	Hepatic Encephalopathy, Hepatocellular Carcinoma with Mets to lungs	12/5/2011	PEB
64	33363	A	Ft. Benning, GA	Motor Vehicle Accident	3/13/2012	MEB
65	34434	A	Lewis JB, WA	Suicide	11/5/2011	MEB
66	34846	A	Lewis JB, WA	Liver Cancer	12/27/2011	PEB

Services must provide the cause of death since this is not captured in the VTA database.

* Date of Death missing in VTA **cases added since last report are highlighted YELLOW**

Office of Wounded Warrior Care Transition Policy
IDES - VTA Disenrollment Subcategory, Service Member Passed Away, Updated May 15, 2012
using April 2, 2012 data in VTA. Cause of Death provided by Services, cumulative since Nov 2007

Case Count	CASE ID	SERVICE	MEB LOCATION	CAUSE OF DEATH	Last Date Entered in VTA	Last IDES Phase at time of death
67	36422	A	Walter Reed NMMC (Army), MD	Cancer	11/18/2011	MEB
68	36428	A	Lewis JB, WA	Suicide	11/18/2011	MEB
69	39899	A	Ft. Bliss, TX	Suicide	1/18/2012	MEB
70	41041	A	Ft. Irwin, CA	Suicide	1/26/2012	MEB
71	42734	A	Lewis JB, WA	Lung Cancer	2/14/2012	MEB

Air Force

Case Count	CASE ID	SERVICE	MEB LOCATION	CAUSE OF DEATH	Last Date Entered in VTA	Last IDES Phase at time of death
70	976	F	Andrews JB, MD	Motor Veh Accident w multiple traumatic injuries	12/30/2008	MEB
71	1450	F	Andrews JB, MD	cancer	4/9/2009	MEB
72	12436	F	MacDill AFB, FL	suicide	2/17/2011	PEB
73	14815	F	Travis AFB, CA	cancer	10/27/2010	MEB
74	18928	F	Robins AFB, GA	cancer	3/17/2011	MEB
75	19081	F	Langley JB, VA	cancer	4/7/2011	MEB
76	20207	F	Robins AFB, GA	suicide	6/24/2011	MEB
77	25710	F	Beale AFB, CA	Esophageal Cancer	9/20/2011	Transition
78	28079	F	Andrews JB, MD	Stage IV Breast Cancer	10/19/2011	MEB
79	36660	F	Andrews JB, MD	Member expired on 15FEB12 of a cardiac arrest.	2/1/2012	PEB

Marine Corps

Case Count	CASE ID	SERVICE	MEB LOCATION	CAUSE OF DEATH	Last Date Entered in VTA	Last IDES Phase at time of death
80	1388	M	Bethesda NNMC, MD	Suicide	2/25/2009	MEB
81	2901	M	Camp Lejeune NH, NC	Multidrug Toxicity	12/14/2009	PEB
82	5534	M	Camp Lejeune NH, NC	Lymphoma	8/10/2010	Transition
83	6595	M	Camp Lejeune NH, NC	Gunshot wound to the Head April 2010	7/2/2010	MEB
84	7104	M	San Diego NMC, CA	Synovial Sarcoma	3/19/2010	MEB
85	9282	M	Camp Lejeune NH, NC	Gunshot wound to the Head May 2010	4/30/2010	MEB
86	9598	M	Camp Pendleton NH, CA	CASE STILL PENDING DETERMINATION by Armed Forces Institute of Pathology (AFIP)	5/26/2010	MEB
87	11027	M	San Diego NMC, CA	Metastatic Neoplasim Rectum and Liver	12/22/2010	Transition
88	9969	M	Portsmouth NMC, VA	suicide	7/19/2010	MEB
89	12579	M	San Diego NMC, CA	pending investigation HQMC	3/21/2011	PEB
90	26684	M	Camp Pendleton NH, CA	Death occurred after separation. Cause of death not provided to MTF at this time. Date of daeth 1/15/2012	11/0/2011	MEB
91	32604	M	San Diego NMC, CA	Gunshot Wound	11/9/2011	MEB

Navy

Case Count	CASE ID	SERVICE	MEB LOCATION	CAUSE OF DEATH	Last Date Entered in VTA	Last IDES Phase at time of death
92	9	N	Walter Reed AMC, DC	Cancer	12/5/2007	MEB
93	1140	N	Bethesda NNMC, MD	Renal failure	10/26/2009	PEB
94	1355	N	Bethesda NNMC, MD	Cancer	9/1/2009	PEB
95	2057	N	San Diego NMC, CA	Anoxic Encephalopathy	4/29/2010	VA Benefits
96	2811	N	Camp Lejeune, NC	tapentadose toxicity	8/17/2010	PEB
97	3676	N	San Diego NMC, CA	Heart Failure	12/9/2009	PEB
98	7239	N	San Diego NMC, CA	Melanoma of the R. Thigh	2/22/2010	MEB
99	10625	N	San Diego NMC, CA	Meta. Ewings Sarcoma	5/27/2010	MEB
100	10694	N	San Diego NMC, CA	Metastatic Nasopharyngeal Cancer	12/13/2010	PEB
101	13561	N	Portsmouth NMC, VA	result of medical condition	2/14/2011	MEB
102	14260	N	Portsmouth NMC, VA	suicide	10/7/2010	MEB
103	15700	A	Portsmouth NMC, VA	Cancer	6/16/2011	Transition
104	16645	N	Bethesda NNMC, MD	Cancer	12/10/2010	MEB
105	16943	N	San Diego NMC, CA	Cancer	7/12/2011	PEB
106	22722	N	Portsmouth NMC, VA	Cancer	10/3/2011	PEB
107	28416	N	Pensacola NH, FL	Stroke	7/29/2011	MEB
108	31679	N	Bremerton NH, WA	Alcoholic hepatitis/alcoholic cirrhosis	11/30/2011	PEB
109	32398	A	Jacksonville NH, FL	Cardiac arrest as a result of a Malignant Neoplasm of the Spinal Cord	12/22/2011	PEB
110	34375	N	Portsmouth NMC, VA	Aneurysm	11/18/2011	MEB

Services must provide the cause of death since this is not captured in the VTA database. cases added since last report

* Date of Death missing in VTA

O:\IES-TPCC-VA\TPCC\Transition Policy\DES\3. IDES Pilot Working\3.1 Data Collection\Service member deaths while in IDES

Services must provide the cause of death since this is not captured in the VTA database.
* Date of Death missing in VTA **cases added since last report are highlighted YELLOW**

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(o) The number of individuals in the IDES process at each site who were returned to duty.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# Cases RTD (o)."

(p) Of the individuals who were returned to duty at each site, the number who underwent medical examinations provided by the Department of Veterans Affairs (or its contractors) prior to being returned to duty and the total number of examinations that were provided for those individuals.

DOD Response. See WWCTP SVAC Response Data (response to question (a)), column header, "# Cases RTD after Exam (p1)."

Note: This column contains the number of cases that were returned to duty after receiving IDES exams. DOD was not able to subtract the number of cases in which DOD performed the exam and also notes that DOD used these exams in their process to determine fitness for duty.

WWCTP SVAC Response Data, column header, "# Cases with Exams Used by DOD But Not for VA Benefits (p2)" contains the number of cases with exams that were used by DOD but not usable to determine eligibility for VA benefits.

DOD suggests the SVAC staff query VA to determine the total number of compensation and pension exams provided by the Department of Veterans Affairs (or its contractors) prior to Servicemembers being returned to duty.

VA Response. The cumulative enrollment of Servicemembers in IDES since November 2007 is 50,021. The total number returned to duty (RTD) who also had examinations is 3,270. *The average number of examinations provided by VA for Servicemember returned to duty is four (3,270 x 4 = 13,080) (*sentence added by WWCTP).

The overall percentage of Servicemembers returned to duty who also had examinations is 6.5 percent. The attached spreadsheet, "VA Analysis of Servicemembers Returned-to-Duty After VA Medical Exams since IOC," provides the RTD requested information by site.

VA Analysis of Service Members Returned-to-Duty After VA Medical Exams since IOC as of May 6, 2012

MTF Location	Total # Cases	# of Cases Returned to Duty	# of Cases RTD After Medical Exam	Percent of RTD Cases that Completed ME	Percent RTD of Total # of Cases
Ft. Hood, TX	3889	184	161	88%	5%
San Diego NMC, CA	3427	415	402	97%	12%
Ft. Carson, CO	3051	182	158	87%	6%
Camp Lejeune NH, NC	3014	265	238	90%	9%
Ft. Stewart, GA	2768	135	118	87%	5%
Lewis JB, WA	2317	80	72	90%	3%
Ft. Bragg, NC	2061	56	53	95%	3%
San Antonio JB (Sam Houston), TX	1945	166	156	94%	9%
Ft. Drum, NY	1827	43	40	93%	2%
Ft. Riley, KS	1621	73	53	73%	5%
Ft. Gordon, GA	1564	47	37	79%	3%
Ft. Polk, LA	1528	91	88	97%	6%
Portsmouth NMC, VA	1363	204	191	94%	15%
Walter Reed NMMC (Army), MD	1288	126	120	95%	10%
Ft. Benning, GA	1255	37	33	89%	3%
Camp Pendleton NH, CA	1168	92	86	93%	8%
Walter Reed NMMC (Navy/Marine Corps), MD	1148	213	204	96%	19%
Ft. Campbell, KY	1106	8	8	100%	1%
Ft. Bliss, TX	901	8	5	63%	1%
Tripler AMC, HI	787	15	14	93%	2%
Ft. Meade, MD	727	62	49	79%	9%
Andrews JB, MD	639	150	139	93%	23%
Ft. Belvoir, VA	579	87	81	93%	15%
Eustis JB, VA	441	8	8	100%	2%
Ft. Wainwright, AK	422	19	17	89%	5%
Richardson JB, AK	405	16	13	81%	4%
Travis AFB, CA	370	63	60	95%	17%
Jacksonville NH, FL	359	54	53	98%	15%
Nellis AFB, NV	350	42	41	98%	12%
Bremerton NH, WA	336	33	31	94%	10%
Hawaii NHC, HI	316	48	45	94%	15%
Ft. Leonard Wood, MO	314	8	6	75%	3%
Ft. Sill, OK	312	6	6	100%	2%
Cherry Point NH, NC	231	22	21	95%	10%
Quantico NHC, VA	214	9	7	78%	4%
MacDill AFB, FL	207	40	37	93%	19%
Elmendorf JB, AK	197	16	16	100%	8%
Beaufort NH, SC	191	16	16	100%	8%
Robins AFB, GA	161	27	27	100%	17%
Ft. Lee, VA	161	1	1	100%	1%
Langley JB, VA	154	30	29	97%	19%
Ft. Irwin, CA	153	1	1	100%	1%
Ft. Knox, KY	152	6	6	100%	4%
29 Palms NH , CA	151	17	16	94%	11%
Great Lakes FHCC, IL	147	21	21	100%	14%
Ft. Jackson, SC	145	7	7	100%	5%
San Antonio JB (Lackland), TX	134	2	2	100%	1%
Tinker AFB, OK	131	4	4	100%	3%
Seymour-Johnson AFB, NC	127	13	13	100%	10%
Shaw AFB, SC	120	17	16	94%	14%
Dyess AFB, TX	112	8	8	100%	7%
West Point, NY	106	1	1	100%	1%
New England NHC, CT	96	18	17	94%	19%
Sheppard AFB, TX	93	14	14	100%	15%
Ft. Huachuca, AZ	92	0	0	0%	0%
Hickam JB, HI	91	3	3	100%	3%
Minot AFB, ND	88	0	0	0%	0%
Pensacola NH, FL	85	9	9	100%	11%
Peterson AFB, CO	84	17	17	100%	20%
Davis-Monthan AFB, AZ	81	8	8	100%	10%
Charleston NH, SC	80	4	4	100%	5%
Hill AFB, UT	76	6	6	100%	8%
Little Rock AFB, AR	76	2	2	100%	3%

MTF Location	Total # Cases	# of Cases Returned to Duty	# of Cases RTD After Medical Exam	Percent of RTD Cases that Completed ME	Percent RTD of Total # of Cases
Oak Harbor NH, WA	71	12	12	100%	17%
Hurlburt Field, FL	70	3	3	100%	4%
Ft. Rucker, AL	67	1	1	100%	1%
Lemoore NH, CA	64	7	7	100%	11%
Ft. Leavenworth, KS	64	1	0	0%	2%
Scott AFB, IL	62	2	2	100%	3%
Wright-Patterson AFB, OH	61	4	4	100%	7%
Barksdale AFB, LA	61	4	3	75%	7%
Offutt AFB, NE	60	10	10	100%	17%
Fairchild AFB, WA	59	5	5	100%	8%
Charleston JB (AF), SC	58	2	2	100%	3%
McChord JB, WA	58	2	1	50%	3%
San Antonio JB (Randolph), TX	57	10	10	100%	18%
Beale AFB, CA	57	2	2	100%	4%
F. E. Warren AFB, WY	56	4	4	100%	7%
Keesler AFB, MS	56	1	1	100%	2%
Holloman AFB, NM	55	0	0	0%	0%
McGuire JB, NJ	53	4	4	100%	8%
Kirtland AFB, NM	53	0	0	0%	0%
Eglin AFB, FL	52	0	0	0%	0%
Cannon AFB, NM	51	3	3	100%	6%
Maxwell AFB, AL	48	4	4	100%	8%
Altus AFB, OK	46	5	4	80%	11%
Moody AFB, GA	44	5	5	100%	11%
Redstone Arsenal, AL	44	3	3	100%	7%
Vandenberg AFB, CA	43	6	6	100%	14%
Malmstrom AFB, MT	43	5	5	100%	12%
Whiteman AFB, MO	43	4	4	100%	9%
Luke AFB, AZ	43	3	3	100%	7%
Edwards AFB, CA	42	2	2	100%	5%
Patrick AFB, FL	41	4	4	100%	10%
Eielson AFB, AK	40	3	3	100%	8%
Vance AFB, OK	39	6	6	100%	15%
Mountain Home AFB, ID	39	1	1	100%	3%
Ft. Worth BHC, TX	38	4	3	75%	11%
Misawa AB, Japan	37	2	1	50%	5%
Hanscom AFB, MA	37	0	0	0%	0%
Dover AFB, DE	36	1	1	100%	3%
MCDONALD ACH-FT. EUSTIS	35	2	2	100%	6%
Goodfellow AFB, TX	35	0	0	0%	0%
Patuxent River NHC, MD	32	3	3	100%	9%
Ellsworth AFB, SD	32	0	0	0%	0%
Grand Forks AFB, ND	30	0	0	0%	0%
Ft. Buchanan, PR	26	0	0	0%	0%
RAF Lakenheath, UK	26	0	0	0%	0%
Buckley AFB, CO	24	1	1	100%	4%
Ramstein AB, Germany	23	2	2	100%	9%
McConnell AFB, KS	23	0	0	0%	0%
USAF Academy, CO	22	2	2	100%	9%
Columbus AFB, MS	20	4	4	100%	20%
Pope AFB, NC	19	1	1	100%	5%
Los Angeles AFB, CA	18	1	1	100%	6%
Kadena AB, Japan	18	0	0	0%	0%
BMC LAKEHURST	14	0	0	0%	0%
Tyndall AFB, FL	13	3	3	100%	23%
Corpus Christi NHC, TX	12	2	2	100%	17%
Aviano AB, Italy	12	0	0	0%	0%
Yokota AB, Japan	12	0	0	0%	0%
NAVAL AMBULATORY CARE CENTER, WEST BANK NEW ORLEANS (LA)	11	1	1	100%	9%
Annapolis NHC, MD	11	0	0	0%	0%
BMC COLTS NECK EARLE	11	0	0	0%	0%
Laughlin AFB, TX	10	1	1	100%	10%
Incirlik AB, Turkey	9	0	0	0%	0%
BMC GULFPORT	8	0	0	0%	0%
NAVAL AMBULATORY CARE CENTER, NSA JRB BELLE CHASSE (LA)	7	0	0	0%	0%
Andersen AFB, Guam	5	0	0	0%	0%
Spangdahlem AB, Germany	5	0	0	0%	0%
BMC MERIDIAN	4	1	1	100%	25%
Osan AB, Korea	3	1	1	100%	33%
Bolling JB, DC	3	0	0	0%	0%
Kunsan AB, Korea	2	1	1	100%	50%
Lajes Field, Portugal	2			0%	0%
Landstuhl AMC, Germany	1	0	0	0%	0%
Heidelberg MEDDAC, Germany	1	0	0	0%	0%
(blank)		0	0	0%	0%
TOTAL	50021	3536	3270	92%	7%
	Total # Cases	**# of Cases Returned to Duty**	**# of Cases RTD After Medical Exam**	**Percent of RTD Cases that Completed ME**	**Percent RTD of Total # of Cases**

data as of 05/06/2012

The average number of examinations provided by VA for Servicemember returned to duty is four (3,270 x 4 = 13,080). (comment added by WWCTP)

(q) The funding level for the IDES process for each site, including funds that will be provided from any source.

DOD Response. DOD will provide the requested budget execution information as soon as possible. DOD is not able to provide the information at this time because the Department does not fund disability costs from a single program and collecting the information requires an extensive data call to the Military Departments. In the interim, the attached funding data was submitted as part of the FY 2013 President's Budget request. In addition, the attached spreadsheet includes the Services estimated FY 2013 funding requirements that were requested within the Overseas Contingency Operations budget request. The Department is developing a future budget exhibit to provide this information annually.

NOTE: The DOD answer is pending final review by OSD Comptroller office.

VA Response. In FY 2012, VA will spend approximately $70.8 million in support of the IDES process. This figure is comprised of $18.2 million for IDES exams through the Veterans Health Administration, $38.6 million for General Operating Expenditures which includes payroll (salary and benefits), travel, equipment and supplies, etc., and $14 million on contract exams through VBA.

IDES Funding for Services

	IDES Baseline					
Baseline	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY13-17**
Army	$ 45,598	$ 45,707	$ 45,787	$ 45,837	$ 46,010	$ 228,939
Navy	$ 10,356	$ 10,720	$ 11,095	$ 11,483	$ 11,885	$ 55,539
Air Force	$ 6,746	$ 7,015	$ 7,294	$ 7,490	$ 7,796	$ 36,341
TOTAL	**$ 62,700**	**$ 63,442**	**$ 64,176**	**$ 64,810**	**$ 65,691**	**$ 320,819**

	IDES Enhanced Requirement					
Enhanced Requirement	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY13-17**
Army	$ 81,737	$ 77,162	$ 71,718	$ 56,854	$ 49,106	$ 336,575
Navy	$ 5,700	$ 5,755	$ 5,667	$ 5,180	$ 5,206	$ 27,506
Air Force	$ 7,200	$ 7,164	$ 7,068	$ 6,804	$ 6,756	$ 34,992
Total	**$ 94,637**	**$ 90,080**	**$ 84,452**	**$ 68,837**	**$ 61,067**	**$ 399,073**

	Total IDES Requirement					
	FY13	**FY14**	**FY15**	**FY16**	**FY17**	**FY13-17**
Army	$ 127,335	$ 122,869	$ 117,505	$ 102,691	$ 95,116	$ 565,514
Navy	$ 16,056	$ 16,475	$ 16,762	$ 16,663	$ 17,091	$ 83,045
Air Force	$ 13,946	$ 14,179	$ 14,362	$ 14,294	$ 14,552	$ 71,333
Total	**$ 157,337**	**$ 153,522**	**$ 148,628**	**$ 133,647**	**$ 126,758**	**$ 719,892**

	IDES Base Funding					
O&M	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY13-17**
Army	$ 45,598	$ 45,707	$ 45,787	$ 45,837	$ 46,010	$ 228,939
Navy	$ 10,356	$ 10,720	$ 11,095	$ 11,483	$ 11,885	$ 55,539
Air Force	$ 6,746	$ 7,015	$ 7,294	$ 7,490	$ 7,796	$ 36,341
TOTAL	**$ 62,700**	**$ 63,442**	**$ 64,176**	**$ 64,810**	**$ 65,691**	**$ 320,819**

	IDES DHP / OCO Funding					
DHP	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY13-17**
Army	$ 24,167	$ 22,470	$ 24,702	$ 30,947	$ 27,037	$ 129,323
Navy	$ 3,990	$ 4,130	$ 4,270	$ 4,410	$ 4,550	$ 21,350
Air Force	$ 6,480	$ 6,480	$ 6,480	$ 6,480	$ 6,480	$ 32,400
Sub Total	**$ 34,637**	**$ 33,080**	**$ 35,452**	**$ 41,837**	**$ 38,067**	**$ 183,073**
OCO (1 yr appropriated)						
OCO Army	$ 57,570	$ -	$ -	$ -	$ -	$ 57,570
OCO Navy	$ 1,710	$ -	$ -	$ -	$ -	$ 1,710
OCO Air Force	$ 720	$ -	$ -	$ -	$ -	$ 720
Sub Total OCO	**$ 60,000**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 60,000**

	TOTAL Funding					
O&M, DHP & OCO	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY13-17**
Army	$ 127,335	$ 68,177	$ 70,489	$ 76,784	$ 73,047	$ 415,832
Navy	$ 16,056	$ 14,850	$ 15,365	$ 15,893	$ 16,435	$ 78,599
Air Force	$ 13,946	$ 13,495	$ 13,774	$ 13,970	$ 14,276	$ 69,461
TOTAL	**$ 157,337**	**$ 96,522**	**$ 99,628**	**$ 106,647**	**$ 103,758**	**$ 563,892**

OCO Requirements	**Future Supplemental Requests (Requirements)**					
OCO Army Requirements*	$ -	$ 54,692	$ 47,016	$ 25,907	$ 22,069	$ 149,682
OCO Navy Requirements*	$ -	$ 1,625	$ 1,397	$ 770	$ 656	$ 4,446
OCO Air Force Requirements*	$ -	$ 684	$ 588	$ 324	$ 276	$ 1,872
Sub Total OCO Requirements*	**$ -**	**$ 57,000**	**$ 49,000**	**$ 27,000**	**$ 23,000**	**$ 156,000**

* Identified future supplemental requests

NOTE:

$397 is the required enhancement to baseline $321 to fully resource IDES

$563 is the current funding towards resourcing IDES. DHP enhancement to baseline + OCO enhancement in FY13

$156 is the future supplemental requests

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO JO ANN ROONEY, ACTING UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE AND JOHN R. GINGRICH, CHIEF OF STAFF, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. In 2010, GAO identified the issue of diagnostic disagreement within the Integrated Disability Evaluation System (IDES) in their report GA0–11–69, Military and Veterans Disability System. Recommendation 2 of GA0–11–69 recommended that the Secretaries of the Departments of Defense (DOD) and Veterans Affairs (VA) "establish a mechanism to continuously monitor disagreements about diagnoses between military physicians and VA examiners and between PEBs and VA rating offices." In response to this finding:

a. Has DOD and VA modified the VA's Veterans Tracking Application (VTA) to continuously monitor diagnostic disagreements?

VA Response. VTA has now been modified to include a Quality Review Tab. The Physical Evaluation Board (PEB) can use this tab to identify a diagnostic variance.

DOD Response. Yes, VA provides IDES IT support and recently modified VT A to incorporate a diagnostic difference monitoring capability.

b. When will this modification be available to all VTA users?

VA Response. This modification was made available to all VTA users on June 11, 2012.

DOD Response. VA made this VTA modification available to all IDES users on June 9, 2012.

c. How will VTA users be instructed to utilize this capability to capture data on diagnostic disagreements?

VA Response. VTA users have been instructed via monthly VTA live meeting training to utilize this capability to identify data in cases that have diagnostic disagreements. VTA reporting capability to track and monitor diagnostic disagreements has not been developed at this time.

DOD Response. The Military Departments received familiarization with the VTA 2.0 enhanced capabilities during pre-release user acceptance testing. We and our VA partners continue to conduct monthly training for PEBLO's to address basic and advanced/detailed capabilities, such as Quality Review, which includes Diagnostic Disagreement. We continue to improve our training materials through the VT A web site and recurrent training teleconferences.

Question 2. Provide DOD, VA and any individual Service policy guidance that addresses the handling of diagnostic disagreements between DOD and VA.

VA Response. The process of addressing the issue of diagnostic differences needs to include a definitive determination that there is in fact an issue with significant impact to the disability process. The Government Accountability Office (GAO) in 2010 noted that the occurrence and prevalence of diagnostic disagreements and their impact on IDES case processing time are unknown because DOD and VA have no way to track such disagreements. Following a period of discussion, DOD engaged the contractor LMI to study claims of diagnostic disagreements (aka diagnostic difference); LMI issued a report in October 2011.

a. LMI confirmed that diagnostic disagreements are not tracked by any DOD or VA system or reporting process. Because they are not tracked, they were unable to quantify the prevalence of diagnostic disagreements and their effect on timeliness within IDES.

b. LMI concluded that generally (1) the issue of diagnostic disagreements is almost completely confined to behavioral and mental health conditions and (2) improved coordination between the VA and DOD has significantly reduced the number of disagreements.

While VA has no written policy guidance regarding diagnostic discrepancies for disability evaluations, VA has no objection to such a policy once it is established what barriers may exist in executing acceptable disability examinations. Meanwhile, opportunities to enhance DOD/VA communications are available. For example, if the examiner is aware that there is treatment history in the service medical record, he/she should request the Military Services Coordination to have it provided to him/her. If the Medical Evaluation Board (MEB) clinician determines that a diagnostic discrepancy exists, then the most efficient way to manage this is for the MEB clinician to phone the VA mental health disability examiner and provide the additional information. This is the same methodology utilized to address a diagnostic discrepancy in the therapeutic arena, clinician-to-clinician follow-up.

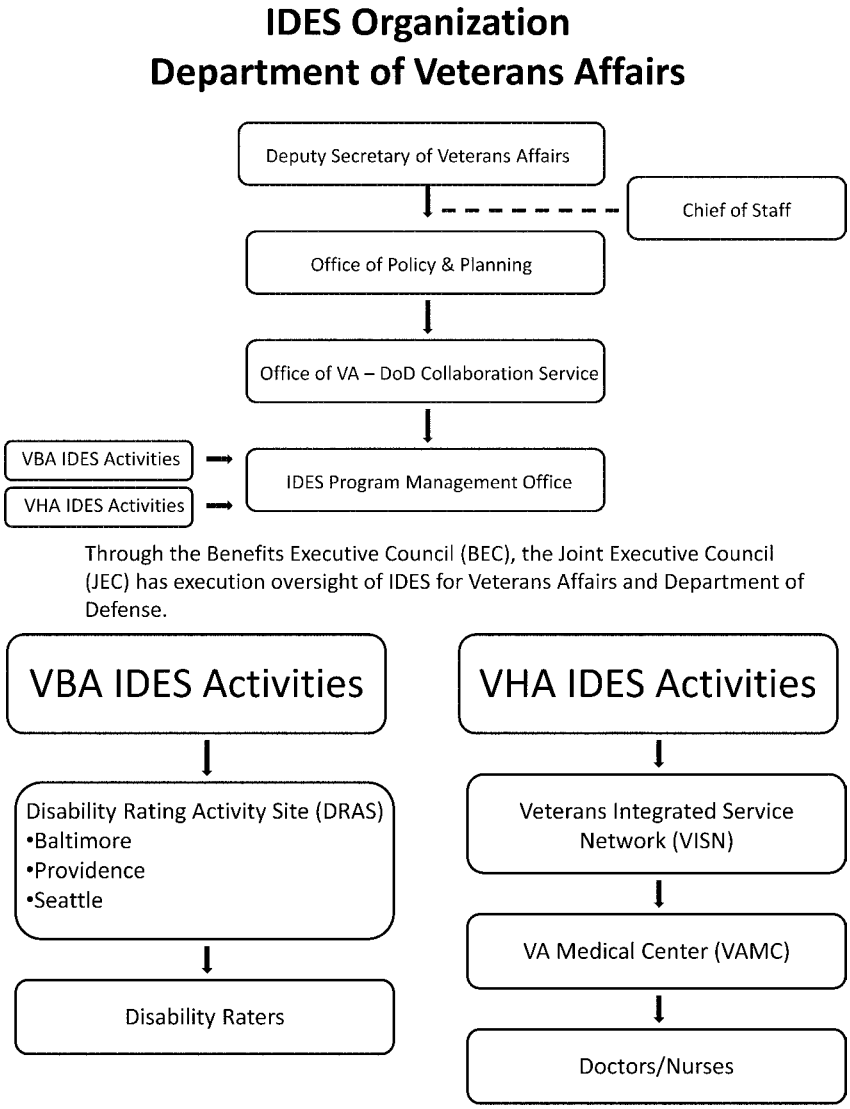
DOD Response. DOD issued policy guidance on handling diagnostic disagreements in December 20 II (http://www.dtic.rniVwhs/directives/corres/pdf/DTM–11–0l5.pdf).

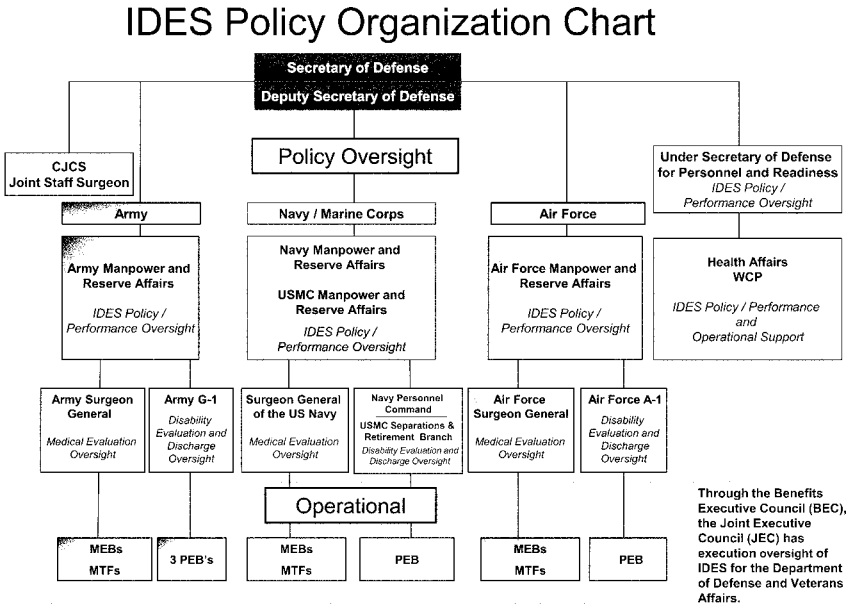
An excerpt of DOD's guidance, which instructs Military Department Physical Evaluation Boards to apply the diagnostic codes VA provides if the diagnoses differ between the Departments, follows:

> "b. Within 15 days of receiving proposed disability ratings from the D-RAS, apply the ratings using the diagnostic code(s) provided by the D-RAS to the Servicemember's unfitting conditions and publish the disposition recommendation. For example, if the PEB identifies a condition to the D-RAS as schizophreniform disorder but the D-RAS rates the condition as psychotic disorder not otherwise specified (VASRD 9210), the PEB will apply the rating as "schizophreniform disorder rated as psychotic disorder not otherwise specified (VASRD 9210)."

Question 3. Please provide an organizational chart for the management of IDES within DOD, VA and within each Service.

VA Response. Note attached Operational Model Diagram.





Question 4. In their March, 2012, briefing to the Committee, the Departments reported, in part: Deputy Chief Management Office (DCMO)—is the single DOD POC for IDES Information Technology (IT); leading efforts to define IT strategy, discover and map IT portfolio and lead collaboration with VA.

VA Executive Director Virtual Lifetime Electronic Record (VLER) EPMO identified as VA POC for IDES Information Technology. Please detail the collaboration between DOD and VA POCs, including:

a. A delineation of the Departments' shared strategic goals, assumptions and planning for IDES IT collaboration;

VA Response. VA's VLER Enterprise Program Management Office (EPMO) works closely with DOD Deputy Chief Management Office (DCMO) and the Under Secretary of Defense for Personnel and Readiness (USD (P&R)) to delineate shared strategic goals, assumptions and planning for IDES IT collaboration as part of ongoing governance activities and documentation created under the Joint Executive Council (JEC), Benefits Executive Council (BEC), VLER Overarching Integrated Project Team (OIPT) and other VA/DOD interagency governance boards. VA VLER EPMO regularly meets with DCMO, USD P&R, and the three Military Departments during the VLER OIPT to review IDES requirements and perform IT planning, design, and execution.

DOD Response. The DOD Deputy Chief Management Office (DCMO) and the Under Secretary of Defense for Personnel and Readiness (USD (P&R)) work closely with the Department of Veteran Affairs (VA) Executive Director (ED) Virtual Lifetime Electronic Record (VLER) to delineate shared strategic goals, assumptions and planning for IDES IT collaboration. DCMO, USD P&R, and three Military Departments regularly meet with VA VLER during the VLER Overarching Integrated Project Team (OIPT) to review IDES requirements and perform IT planning, design, and execution. The Departments share IT goals via the Joint Executive Council (JEC), the Benefits Executive Council, Information Sharing/Information Technology (BEC IS/IT) working group, HEC/IM/IT Information Management Technology Working Group, Interagency Program Office (IPO) and the Virtual Lifetime Electronic Record (VLER) office.

b. A prioritized list of current and planned IDES IT projects, including timeline, critical milestones, and planning documents for the development and implementation of each such project;

VA Response. The VLER EPMO works closely with DCMO and USD (P&R) on several IT projects that will provide benefits to our transitioning Servicemembers and Veterans:

• Automating Disability Benefits Questionnaire (DBQ) Information Collection: A capability to provide a TurboTax®-like, Web-based forms to facilitate the collection of specific disability VA Rating Schedule information from VA and private clinicians who perform disability examinations. The initial capability will be available by the end of Summer 2012, with all Disability Benefits Questionnaire (DBQ) forms available in the automated solution by Fall 2012.

• eBenefits: Secure Web portal that provides a central location for Servicemembers, Veterans, and their families to research, find, access, and manage their benefits and personal information. VA and DOD are committed to improving the online experience for Veterans and Servicemembers. More than 1.4 million Veterans and Servicemembers use eBenefits to access more than 40 capabilities made available via eBenefits.va.gov.

• Electronic Case File Transfer (eCFT): Provides VA case managers, Veterans Health Administration (VHA) Clinicians, and Veterans Benefits Administration (VBA) Rating Adjudicators the ability to receive Service Treatment Records and additional claims information in an electronic format from the DOD, ultimately resulting in more timely and efficient adjudication of disability claims. VA and the DOD will deploy the capability at several pilot sites during August 2012.

• VLER Data Access Services (DAS): The initial capability to implement core data access services for use by producers and consumers of information through the VLER DAS will be available by July 2012.

• Veteran Tracking Application (VTA): Electronic system designed to monitor Servicemembers and Veterans performance of the IDES process. VTA 2.0 was released on June 9, 2012 providing enhanced information sharing between VA and DOD case managers and additional DD–214 data required for claims processing.

DOD Response. DCMO and USD (P&R) ED VLER work closely on several IT projects that will benefit transitioning Servicemembers. Some of these are "bridge" solutions until fielding of Integrated Electronic Health Record (iEHR) and VLER. Projects include:

Automating Disability Benefits Questionnaire (DBQ) Information Collection: VA is developing a capability to provide a TurboTax®-like, Web-based forms to facilitate the collection of specific disability VA Rating Schedule information from VA and private clinicians who perform disability examinations. The initial capability will be available in summer 2012, with all Disability Benefits Questionnaire (DBQ) forms available in the automated solution by fall 2012.

eBenefits: Secure Web portal that provides a central location for Servicemembers, Veterans, and their families to research, find, access, and manage their benefits and personal information. VA and DOD are committed to improving the online experience for Veterans and Servicemembers. More than 1.4 million Veterans and Servicemembers use eBenefits to access more than 40 capabilities made available via eBenefits.va.gov.

Electronic Case File Transfer (eCFT): Will provide DOD and VA the ability to exchange Service Treatment Records and additional claims information in an electronic format, resulting in more timely and efficient adjudication of disability claims. VA and the DOD plan to deploy the capability at several pilot sites in August, 2012.

VLER Data Access Services (DAS): VA and DOD plan to provide an initial capability to implement core data access services for use by producers and consumers of information through the VLER DAS.

Veteran Tracking Application (VTA): Electronic system designed to monitor Servicemembers and Veterans performance of the IDES process. VA released VTA 2.0 on June 9, 2012, providing enhanced information sharing between VA and DOD case managers and provides additional DD–214 data required for claims processing.

c. An end-to-end enterprise-wide IDES IT solution;

VA Response. VA receives over a million claims for benefits each year. IDES is a critical program in support of Servicemember transition to Veteran status. As such, VLER EPMO has worked closely with subject matter experts and senior leaders within the VA—Veterans Benefits Administration (VBA) and VHA—and the Department of Defense USD (P&R), DCMO, Military Departments—in developing and documenting strategies to provide full IT support to the IDES program. Capabilities such as tracking, work flow management, reporting, and case file transfer are developed and delivered on incremental basis.

Under the VLER Initiative, VA delivers enhancements every 6 months to better support the field and increase transparency, accountability, and timeliness within IDES. In an effort to modernize the tools available to IDES care managers and to better serve our Veterans, VLER is transitioning VTA to a new technology platform. This platform, which is shared with the Veterans Relationship Management (VRM)

initiative, will provide VTA users with enhanced functionality and streamline future information sharing efforts between VA and DOD case/care management/coordination and benefits assistance lines of business. The Federal Recovery Coordination Program (FRCP) was the first VTA module to transition to this new platform on June 4, 2012. VA is facilitating the transition of the remaining VTA modules such as IDES. In addition, VA and DOD are piloting strategies to exchange case files electronically between care coordinators in an effort to diminish the time it takes to physically transfer files.

VLER Data Access Services (DAS), referenced above, in conjunction the Veterans Benefit Management Systems (VBMS), represent the latest in technology and business transformation efforts focused on reducing claims backlog for Veterans. Once fully implemented, claims information from DOD will be orchestrated by the VLER DAS to VBMS for streamlined, paperless claims adjudication.

DOD Response. DCMO and the Office of Warrior Care Policy (WCP) have worked closely with VA and the Military Departments to develop and document strategies to provide full IT support to the IDES program. Capabilities such as tracking, work flow management, reporting, and case file transfer are developed and delivered on incremental basis. The DCMO, supporting the Office of Warrior Care Policy (WCP), is providing business process mapping, and business process analysis expertise to identify best practices and system architecture best practices. The Department will use this effort to inform and integrate IDES IT requirements into larger enterprise solutions, including iEHR, VLER, and the VLER Data Access Services (DAS). VLER DAS, in conjunction the Veterans Benefit Management Systems (VBMS), represent the latest in technology and business transformation efforts focused on reducing VA's claims backlog. Once fully implemented, VLER DAS will enable streamlined, paperless claims adjudication from the DOD to VBMS.

d. Any formal policy, directive(s) or other guidance issued by the Department(s) establishing an organizational, leadership and or governance structure for joint IDES IT collaboration; and

VA Response. Business process and requirements validation for VLER Capability Area (VCA) 1 is governed by the Health Executive Council (HEC). Business process and requirements validation for VCAs 2, 3, and 4 is governed by the Benefits Executive Council (BEC). VCA 1 IT execution is overseen by the DOD/VA IPO Advisory Board, which is officially chartered and reports directly to the Secretary of Veterans Affairs and Secretary of Defense. VCA 2, 3, and 4 IT execution is overseen by the VLER Overarching Integrated Project Team (OIPT), which reports to several Executive Steering Committees and Task Forces. The VLER OIPT charter is currently in coordination.

DOD Response. The DOD/VA Joint Executive Council (JEC) provides overall organization IT governance oversight for functional requirements and IDES/VLER Benefits. The Inter-Agency Program Office Advisory Board, which is officially chartered and reports directly to the Secretary of Veterans Affairs and Secretary of Defense, provides organization IT governance oversight for iEHR and VLER Health acquisition, and IT execution. The Health Executive Council governs business process and requirements validation for VLER Capability Area (VCA) 1. The Benefits Executive Council governs business process and requirements validation for VCAs 2, 3, and 4. The VLER Overarching Integrated Project Team (OIPT), which reports to several Executive Steering Committees and Task Forces, oversees IT execution of VCA 2, 3, and 4. The VLER OIPT charter is currently in coordination between DOD and VA.

e. Metrics or criteria utilized by the Departments (e.g., VA's project management accountability system (PMAS)) to evaluate the status of project-specific and enterprise level IDES IT collaboration between the Departments.

VA Response. The VA Office of Information and Technology (OIT) Program Management Accountability System (PMAS) sets strict guidance on metrics and criteria to evaluate project specific and enterprise level IDES IT. PMAS is a performance-based project management discipline that is mandated by the Assistant Secretary for Information & Technology (AS/IT) for all planning, development, and delivery all IT development projects. The intent of PMAS is to improve the rate of success of VA's IT projects. PMAS uses incremental product build techniques for IT projects, with delivery of new functionality (tested and accepted by the customers) in cycles of six months or less. Projects managed under PMAS are tightly monitored and are subject to being halted when significant deviations to plan occur and insufficient remediate plans are presented. PMAS is a rigorous management approach intended to deliver smaller, more frequent releases of new functionality to customers.

All IT projects in support of IDES tracking/reporting are governed by PMAS. Throughout the lifecycle of the project, status against project milestones (e.g. re-

quirements complete, development complete, Production Release) is recorded within the Primavera scheduling tool, and used to track the progress of the project.

A monthly Warrior Support IPT meeting is held on the 3rd Wednesday of every month, and includes representatives from the business and technical communities. VA leadership reviews the status of PMAS projects through regular and consistent reporting against established baselines, such red-flag and milestone reviews.

DOD Response. The VA Office of Information and Technology (OIT) Program Management Accountability System (PMAS) sets strict guidance on metrics and criteria to evaluate project specific and enterprise level IDES IT. PMAS is a performance-based project management discipline that is mandated by the Assistant Secretary for Information & Technology (AS/IT) for all planning, development, and delivery all IT development projects. The intent of PMAS is to improve the rate of success of VA's IT projects. PMAS uses incremental product build techniques for IT projects, with delivery of new functionality (tested and accepted by the customers) in cycles of six months or less. Projects managed under PMAS are tightly monitored and are subject to being halted when significant deviations to plan occur and insufficient remediate plans are presented. PMAS is a rigorous management approach intended to deliver smaller, more frequent releases of new functionality to customers.

All VA IT projects in support of IDES tracking/reporting are governed by PMAS. Throughout the lifecycle of the project, status against project milestones (e.g. requirements complete, development complete, Production Release) is recorded within the Primavera scheduling tool, and used to track the progress of the project. VA hosts a monthly Warrior Support IPT meeting the 3rd Wednesday of every month, which includes representatives from the business and technical communities. VA leadership reviews the status of PMAS projects through regular and consistent reporting against established baselines, such red-flag and milestone reviews.

Question 5. Please describe the steps taken by the Departments to ensure that any IT solution for IDES is capable of being integrated into VLER. As part of this description, please detail how VLER factors into the Departments' development of a shared IDES IT strategy and ongoing collaboration.

VA Response. The Departments have taken deliberate steps to ensure any IT solution for IDES is capable of being integrated into VLER. VLER EPMO oversees IDES IT systems as an integrated component of the broader VLER EPMO portfolio.

To ensure the synchronization of current and future IT solutions with the long-term VLER effort, VLER leverages existing projects, carefully defined architecture, and web services strategies to ensure that interfaces with the VLER Data Access Services can be created. For example, through the Information Sharing Initiative (ISI), VA and DOD share case coordinator information across Federal Case Management Tool (FCMT), VTA, and DOD systems.

DOD Response. The Departments have taken deliberate steps to ensure any IT solution for IDES is capable of being integrated into VLER. VLER oversees IDES IT systems as an integrated component of the broader VLER portfolio. The DOD/VA Benefits Executive Council Information Sharing/Information Technology (BEC IS/IT) group is specifically tasked to coordinate, validate and promote IDES strategic and interagency information sharing to ensure an IDES end-to-end information technology solution within iEHR and VLER. Additionally, the effort to map current DOD, VA and Military Department IT systems (and their funding streams) supporting IDES will help inform the BEC IS/IT of near, mid and long term IT requirements.

To ensure the synchronization of current and future IT solutions with the long-term VLER effort, VLER leverages existing projects, carefully defined architecture, and web services strategies to ensure that interfaces with the VLER Data Access Services can be created. For example, through the Information Sharing Initiative (ISI), VA and DOD share case coordinator information across Federal Case Management Tool (FCMT), VTA, and DOD systems.

Question 6. Committee oversight has discovered that the current medical evaluation process for soldiers with TBI and PTSD is inconsistent. The medical records of reviewed cases reflect these inconsistencies, as some medical records combine and document symptoms of both PTSD and TBI and others do not, leaving each as a separate diagnosis.

a. What is the DOD and VA standard of practice for diagnosing TBI and PTSD?

VA Response. VA clinicians adhere to the standards of practice established by the VA/DOD Clinical Practice Guideline for the Management of Concussion/Mild Traumatic Brain Injury (TBI). VA clinicians also adhere to the standards of practice established by the VA/DOD Clinical Practice Guideline for the Management of Post-Traumatic Stress.

DOD Response. The DOD and VA standards of practice for diagnosing TBI and PTSD are based on published definitions and clinical practice guidelines. Both the Veterans Health Administration (VHA) Directive 2009–028 and the DOD (Health Affairs Memorandum, October 2007) define TBI as a traumatically induced structural injury or physiological disruption of brain function as a result of an external force. The VHA Directive and DOD Memorandum define severity level of TBI using the Glasgow Coma Scale score, length of loss of consciousness, and length of post-traumatic amnesia. In both agencies, the diagnosis of mild TBI (mTBI) is based on the injury event as well as changes in mental status occurring during the injury. The VA/DOD Clinical Practice Guidelines for the Management of Concussion/Mild Traumatic Brain Injury was developed in 2009 and outlines the standard criteria for the diagnosis of mTBI.

Policy Guidance for the Management of Concussion/Mild TBI in the Deployed Setting (DTM 09–033) requires mandatory assessment of a Servicemember (SM) involved in potentially concussive events including vehicle associated with a blast event, collision or rollover; any SM within 50 meters of a blast, a direct blow to the head or loss of consciousness. The identified potentially concussive events provide a standardized method for the implementation of screening and diagnosis of acute mTBI in a deployed setting.

In 2010, the DOD and VA jointly published, "The Clinical Practice Guidelines for the Management of Post-traumatic Stress." This guideline supports the Diagnostic and Statistics Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV TR) as the standard for all behavioral health providers who work within Military Treatment Facilities (MTFs) to use for the diagnosis of PTSD, as required by licensing laws and credentialing agencies.

b. How is each standard of practice applied?

VA Response. VA issued VHA Directive 2010–012, "Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom/Operation Iraqi Freedom Veterans," in March 2010. This Directive establishes the policy for the administration of the TBI screening, comprehensive evaluation, and treatment of Operation Enduring Freedom/Operation Iraqi Freedom Veterans receiving medical care within VHA.

VA also developed a computerized Comprehensive TBI Evaluation Template that is used to document the results of every comprehensive evaluation conducted following positive TBI screening findings.

The VA Uniform Mental Health Services Handbook (VHA Handbook 1160.01) addresses a multitude of clinical practice issues, and indicates that treatment and assessment for mental health disorders must be consistent with the appropriate clinical practice guidelines.

DOD Response. VA and DOD application of practice policies and procedures address the deployed and non-deployed DOD settings, as well as the post-separation environment of the VA. MTF credentialed providers make a diagnosis of TBI and PTSD based on appropriate provider education, clinical references, and compliance with licensing laws. These providers combine clinical practice guidelines and clinical judgment to arrive at a diagnosis. They may use various methods of assessment, including interviews, instruments and psychological screening, to evaluate whether or not a given SM meets the criteria for TBI and or PTSD.

DTM 09–033 is an example of a DOD deployed setting policy for mTBI that is a standard applied to practice. DTM 09–033 requires all military personnel involved in potentially concussive events be promptly evaluated through use of a standard tool, the Military Acute Concussion Evaluation (MACE). There are also comprehensive screening programs for TBI that have been implemented to facilitate the detection of mTBI. The Post Deployment Health Assessment has PTSD and TBI screening questions to identify redeployed SMs who may have a history of concussion or have PTSD symptoms. In the non-deployed setting, the standard of practice for both PTSD and TBI care is applied through dissemination and implementation of evidence based guidelines. In addition, numerous clinical support tools have been developed and disseminated to assist the provider in navigating the assessment and treatment of both PTSD and mild TBI when SMs continue to have symptoms.

Additionally, programs such as PTSD Treatment in Primary Care Settings, Re-Engineering Systems of Primary Care Treatment in the Military (RESPECT-Mil), and Behavioral Health Integration enables DOD primary care providers to screen and treat health-seeking patients in primary care clinics for PTSD, suicidal ideation, and depression while integrating behavioral health care providers into routine care.

VA issued the VHA Directive 2010–012, "Screening and evaluation of possible TBI in OEF/OIF Veterans," in March 2010. This Directive establishes the policy for the administration of the TBI screening, comprehensive evaluation, and treatment of

OEF/OIF/OND Veterans receiving medical care within VHA. As part of this evaluation protocol, VHA developed a mandatory computerized Comprehensive TBI Evaluation Template that requires a diagnostic conclusion regarding the occurrence of TBI to be documented.

c. What is the DOD and VA standard of practice for documenting differences between TBI and PTSD in the medical record?

VA Response. VA's Comprehensive TBI Evaluation Template directs the medical provider to make a determination as to whether the Veteran's current symptoms are related to TBI, or to a mental health condition, including Post-Traumatic Stress Disorder (PTSD), or to a combination of TBI and mental health problems. It is not always possible to differentiate between the causes of some symptoms. In those cases, the symptoms are related to both conditions. VA's PTSD and Mental Health Disorders Disability Benefits Questionnaires (DBQs) specifically require the examiner to document whether or not the Veteran has a diagnosed TBI, and if so, to document if it is possible to differentiate what symptom(s) is/are attributable to each diagnosis. The topic of differentiating PTSD symptoms from TBI symptoms is addressed during the Office of Disability and Medical Assessment's online TBI and PTSD Certification trainings.

DOD Response. Although many symptoms of TBI and PTSD overlap, they are two separate clinical conditions with two separate diagnostic criteria. The diagnostic criteria for TBI are established through a history and physical exam at time of injury and are documented through the use of ICD–9 codes as further defined by published definitions and guidelines. Point of injury assessment remains the most accurate approach to early identification of the presence of a TBI through mandatory concussion screening that occurs at various levels to ensure detection and maximize treatment opportunities. If a SM is diagnosed with PTSD and TBI, two separate ICD–9 codes are entered into the electronic health record. VA directs the medical provider to determine if the Veteran's current symptoms are related to TBI, or to a mental health condition (to include PTSD), or to a combination of TBI and mental health problems. It is not always possible to differentiate between the causes of some symptoms. If symptoms are related to both conditions, both diagnoses are made. VA's PTSD and Mental Health Disorders Disability Benefits Questionnaires (DBQs) specifically require the examiner to document whether or not the Veteran has a diagnosed TBI and if so, to document if it is possible to differentiate what symptom(s) is/are attributable to each diagnosis. The topic of differentiating PTSD symptoms from TBI symptoms is addressed during Disability and Medical Assessment online TBI and PTSD Certification trainings.

d. Do all DOD and VA medical facilities adhere to the same standards of practice in diagnosing TBI and PTSD?

VA Response. The policy established by VHA Directive 2010–012 and the Comprehensive TBI Evaluation Template apply across all VA facilities. VHA-wide performance measures allow monitoring of adherence to standards utilizing an External Peer Review Process. This External Peer Review Process would address the standards of practice of diagnosing both TBI and PTSD.

DOD Response. DOD and VA have policies and procedures in place to ensure adherence to standards of practice in TBI and PTSD care by all providers. Some of these VA guidelines have already been discussed. The Services generate policies to which DOD providers are expected to adhere. Examples of Service policies related to these issues include the following:

- OTSG/ MEDCOM Policy Memo 12–035 Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder
- OTSG/ MEDCOM Policy Memo 10–040 Screening Requirements for Post-Traumatic Stress Disorder and Mild Traumatic Brain Injury (mTBI) for Administrative Separations of Soldiers
- NAVMED Policy 11–001 Implementing Required Medical Exam before Administration Separation For Post-Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI).

e. If not, what are the reasons for not adhering to the standard of practice?

VA Response. VA monitors consistent adherence to the TBI and PTSD standards of practice across all medical facilities.

DOD Response. Providers are expected to meet the standard of care for each individual patient. Policies and guidelines cannot anticipate all of the possible reasons a provider may deviate from a standard of practice. Patients may require deviations from standard practice due to individual clinical care needs as determined by their health care provider. Providers are expected to clearly document rationale and clin-

ical decisionmaking whenever they deviate from these standards of practice. In addition, an individual may refuse care.

f. Are there instances in which a provider may deviate from the standard of practice in evaluating TBI or PTSD? If so, please explain these instances.

VA Response. VA has policy and procedures in place to ensure adherence to standards of practice in TBI and PTSD care by all providers. VHA Rehabilitation Services and Mental Health Services are not aware of TBI/PTSD assessments or diagnoses being made outside of the standard of practice and do not sanction providers diagnosing outside of standard clinical guidance. DMA has in place Quality Assurance programs that can identify compliance with standards of practice.

DOD Response. TBI and PTSD patients may require deviations from standard practice due to individual clinical care needs as determined by their health care provider. At times, standards of practice have difficulty keeping pace with the ever-evolving science of diagnostics, treatment and care. As a result, providers must use reasonable clinical judgment and support their diagnostic and care decisions with sound scientific literature and patient care documentation. With respect to TBI care, the clinical algorithms and guidelines are applied to each patient. Provider guidance addresses individual variations in treatment based upon each SM's symptoms and recovery time. Each Veteran who enters the Polytrauma System of Care, at any level of service, requires an Individualized Rehabilitation and Community Reintegration Care Plan (VHA Handbook 1172.04). Differences in treatment approach or the need for consultative service with the other specialty care center would be documented in these treatment plans.

Question 7. During testimony, VA referenced the potential impact that passage and implementation of the "VOW to Hire Heroes Act" may have on IDES.

a. Describe how VA anticipates this law will impact IDES.

VA Response. Section 1631(b) of Pub. L. 110–181, the National Defense Authorization Act of 2008, authorized automatic eligibility to VA's Vocational Rehabilitation and Employment services for severely injured or ill Servicemembers. Section 231 of the VOW to Hire Heroes Act (PL 112–56) extended the sunset date of that authorization from December 31, 2012, to December 31, 2014.

VA implemented Pub. L. 110–181 through a memorandum of understanding (MOU) with DOD. In this MOU, it was agreed that a Servicemember participating in IDES and/or referred to a Physical Evaluation Board (PEB) is automatically eligible. This process allows VA to assist Servicemembers early in their transition to civilian life without waiting for a VA memorandum rating to determine entitlement to vocational rehabilitation and employment services.

We are currently finalizing the details of a plan to implement the portion of the VOW Act related to Transition Assistance Program (TAP).

b. What is the expected increase in the number of disability claims that VA anticipates as a result of implementation of this law?

VA Response. As noted above, we are currently working out the details of a plan to implement the portion of the VOW Act related to TAP, which may impact the number of disability claims that VA anticipates. Until we have the final plan, we are unable to make any estimates. We expect the final plan to be completed in October 2012.

c. If VA anticipates an increase in disability claims receipts, what actions has VA taken to prepare for this anticipated increase?

VA Response. As noted above, we are currently working out the details of a plan to implement the portion of the VOW Act related to TAP, which may impact the number of disability claims that VA anticipates.

Question 8. DOD testimony stated that the Departments "* * * are currently developing a memorandum of understanding that will allow DOD to become a member of the working groups updating the VASRD and give DOD the opportunity to make recommendations prior to the publication of proposed changes in the *Federal Register*."

a. Has DOD participated in the VASRD update project to date and if so in what capacity?

VA Response. DOD has appeared at the public forums on the VASRD update project and offered expertise and assistance at several of its working groups.

DOD Response. DOD's participation in the update project has so far been limited to the public forums.

The Deputy Assistant Secretary of Defense (Health Affairs, Clinical and Program Policy) attended portions of the VASRD Public Forum in New York City from January 17–26, 2012. DOD will continue to participate by sending representatives to these VASRD forums that review updates on ratings for specific body systems when-

ever possible. DOD representatives at these forums may provide input, but will not be voting members on the potential adjustments. The Secretary of the VA retains ultimate authority for managing changes to the VASRD.

b. What impact, if any, will the memorandum of understanding and DOD participation have on VA's timeline for issuance of proposed rules?

VA Response. The memorandum of understanding states that DOD may participate in the working groups and that VA will provide DOD 30 days to comment before publishing its proposed rules. VA does not anticipate any significant impact to the existing project timeline.

DOD Response. The memorandum of understanding (MOU) mentioned above will provide for DOD to have clear methods for requesting any changes to the VASRD. It includes a provision for the DOD to apply to have a representative on the VA Advisory Committee, subject to approval by the Secretary of the VA. It provides DOD with a 30 day period to make comments on any updates to the VASRD prior to publication. Given these opportunities for DOD to participate early in the update process, it is anticipated that there will be minimal impact on the overall timeline for VA issuance of proposed rules and adjustments. This MOU has been coordinated at the deputy assistant secretary level at VA and DOD; it requires a legal review and then approval through the Secretaries.

c. VA has announced that a VASRD Status Summit will be held on June 4–8 and 11–13, 2012 to allow the public to comment on working drafts of proposed regulations for nine body systems. Has or will DOD make recommendations prior to publication of proposed rules on the body systems for which draft proposed regulations have already been developed?

VA Response. As stated above, the MOU gives DOD 30 days to comment before VA publishes the proposed rules.

DOD Response. DOD was invited to send representatives to the conferences referenced, and the invitations and agendas were passed on to the Services, but they were not able to send subject matter experts for the particular body systems discussed. DOD was provided opportunity to comment on the proposed rules prior to the conferences, but did not have any recommended changes or objections. Based on the MOU, in the future DOD will have an opportunity to comment prior to publication of notice for these conferences, and will have longer lead time to ensure that DOD subject matter experts can take advantage of that opportunity for review and comment as needed.

Question 9. The minutes of the VA and DOD Secretaries' February 27 meeting state that the "results of decisions on how redundancy and overlap issues in the VA and DOD care coordination programs will be resolved (to be made at May 2012 JEC)" was set as a deliverable for the next Secretaries' meeting. Please describe that decision, the results, and the plan of action to address those issues.

VA Response. The Joint Executive Council (JEC) formed a VA DOD Warrior Care and Coordination Task Force (VA DOD WC2TF). Task force recommendations will be briefed to the JEC (via the HEC and BEC) in August 2012. Current work of the VA DOD WC2TF includes:

- Establish overarching care coordination policy for severely injured, ill, and wounded warriors in transition
- Crosswalk the DOD Instructions and VA Handbooks addressing care coordination and case management into a single directive ("common doctrine")
- Create a single, Comprehensive Plan for care, services and benefits for better synchronization and integration
- Establish a formal governance structure, informed by a Community of Practice that will serve as an ongoing forum for policy, programming and oversight.

DOD Response. The Secretaries have directed that the two Departments complete the review and resolve the redundancies between the Federal Recovery Coordination and Recovery Coordination Programs by their next meeting in the September timeframe. DOD and VA, along with the military services and the Wounded Care Policy Department, have formed a Task Force which will forward recommendations to the August 10 JEC.

Question 10. The minutes of the VA and DOD Secretaries' February 27 meeting state that for the next Secretaries' meeting the Departments will "i. Determine resource implications of implementing the revised transition program for FY 2012 and FY 2013," as well as "ii. Deliver implementation plan for revised Transition Assistance Program (TAP) and implementation of VOW Act to White House including the 'virtual delivery' of TAP so that interagency partners can plan the requisite support." Please provide the determination of resource implications described in (i), as

well as the implementation plan for revised TAP (including virtual TAP) described in (ii).

VA Response. As noted above, we are currently working out the details of a plan to implement the portion of the VOW Act related to TAP, which may impact the number of disability claims that VA anticipates.

DOD Response.

"i. Determine resource implications of implementing the revised transition program for FY 2012 and FY 2013,"

Members of the DOD/VA Veterans Employment Initiative Joint Task Force are in close dialog with the Office of Budget Management and the agencies and Military Departments have developed the implementation plan with costing. The IP is currently at the White House awaiting approval.

In the meantime, the Department of Defense and our Department of Labor and Veterans Affairs are working hard to implement the mandate of the VOW to Hire Heroes Act. This requires all Servicemembers to attend the DOL Employment Workshop, which essentially nearly doubles the throughput for the DOL workshop. While some members will receive waivers to participate in the workshop, no member will be exempt from receiving Pre-separation Counseling and the VA Benefits briefing.

"ii. Deliver implementation plan for revised Transition Assistance Program (TAP) and implementation of VOW Act to White House including the 'virtual delivery' of TAP so that interagency partners can plan the requisite support."

The response is at the end of the first paragraph:

> The DOD/VA Veterans Employment Initiative Task Force Implementation Plan is under review by the White House staff. This includes the proposal and costing for delivering new curriculums virtually. The Task Force proposes to leverage the Army's extensive work on virtual curriculums to develop and deploy the revised standardized curriculum in a virtual format. It is planned for the pilot to set the stage for expanded virtual delivery of instruction to meet the needs of dispersed military members. This will help Servicemembers access instruction more readily and prepare for transition earlier in the military life cycle.

Additionally, President Obama announced, at the VFW Convention on July 23, the launch of the redesigned Transition Assistance Program (TAP) developed by an interagency task force which includes DOD, the Departments of Veterans Affairs (VA), Labor (DOL), Homeland Security (DHS), Education (ED), Office of Personnel Management (OPM), and the Small Business Administration (SBA). The re-design includes modified curriculum that assists in making transitioning Servicemembers "career ready" upon separation.

The re-designed DOL Employment Workshop and the core modules for transition preparation began being piloted in July and will continue through August 2012. The locations include: Fort Hood, Texas; Ft. Sill, Okla.; Utica Army National Guard Base, N.Y.; Jacksonville Naval Air Station, N.C.; Norfolk NAS, VA; Randolph Air Force Base, Texas and Miramar Marine Corps Air Station, California. Based on results of the pilot, the curriculum will be modified, as appropriate. Using the modified curriculum and standardized learning objectives, the Military Services will expand Department-wide, to deliver service at approximately 250 military installations worldwide preparing Servicemembers to transition confidently from military service to the civilian workforce.

Question 11. Please provide an update on progress made in the merger of the SOC and JEC, including any functions of the SOC which have not yet been fully incorporated into JEC operations. Has the Secretary of Defense appointed the DOD Deputy Secretary to co-chair the SOC, does the Department feel it is necessary or appropriate for the Deputy Secretary to continue overseeing the issues following the merger of these entities?

VA Response. As of January 19, 2012, the JEC assumed all of the Senior Oversight Committee (SOC) functions for oversight of IDES. VA's Deputy Secretary Co-Chairs the JEC. DOD must decide the appropriate level of participation on the JEC.

DOD Response. The merger of the SOC and JEC has been completed as of 20 March 2012 with all the former functions of the SOC incorporated into the JEC process. Due to the inclusion of senior leadership and the initiation of the Secretary of Defense/Secretary of Veterans Affairs meetings, which discuss specific JEC topics, it is not necessary for the Deputy Secretary to oversee JEC issues. Title 38 Section 320 has identified the Under Secretary of Defense for Personnel and Readiness as the DOD chair for the interagency committee. The Under Secretary of Defense for Personnel and Readiness has oversight for all policy issues and has direct access

to the Secretary of Defense. The portfolios of both DOD and VA now line up for oversight of former SOC and current JEC topics.

Question 12. Please describe any recent or planned realignment of components or functions of the Office of Wounded Warrior Care and Transition Policy, including what improvements the Department expects from such realignment, as well as how DOD will oversee and evaluate the efficacy of the realignment.

VA Response. [VA defers to DOD.]

DOD Response. The Office of Wounded Warrior Care and Transition Policy (WWCTP) was moved, effective June 1, 2012, to the Office of the Assistant Secretary of Defense for Health Affairs (ASD HA). Simultaneously, the Transition Assistance Program (TAP) component of WWCTP was moved under the office of the Assistant Secretary of Defense for Readiness and Force Management (ASD R&FM). WWCTP's name has been changed to Warrior Care Policy (WCP).

The realignment of WCP, and its TAP component, within the broader Personnel and Readiness (P&R) portfolio will strengthen WCP's effectiveness in carrying out the Department's commitment to wounded warriors and its ability to effect change. WCP's current activities and support for wounded warriors directly relates to the health and healthcare of these individuals. WCP's programs and initiatives in support of wounded, ill and injured Servicemembers will not change; alignment within HA will provide enhanced support and coordination for these activities. WCP's strategic initiatives are being folded into the HA strategic plan and will be monitored and tracked during quarterly review and analysis meetings with the Service surgeon generals. The Deputy Assistant Secretary for WCP (DASD WCP) reports directly to the ASD HA and provides regular program updates at weekly ASD HA leadership meetings. The DASD WCP also retains responsibility as the principal advisor to the Office of the Under Secretary of Defense for Personnel and Readiness for Wounded Warrior matters.

Likewise, the Transition Assistance Program (TAP), because of its wider applicability to all transitioning Servicemembers, is best aligned with activities and programs of the ASD R&FM. The ASD R&FM has oversight of military personnel policy, education policy and civilian policy, and is in the best position to lead, integrate and enhance the Department's necessary and critical focus on the transition issues for our military personnel. Direct oversight for TAP strategic initiatives and policy is provided by the deputy director of the newly established Transition to Veterans Program Office. The deputy director reports directly the ASD R&FM.

Question 13. Please describe the activities and findings to date of the VA Wounded, Ill, and Injured Task Force, including a timeline for completion of the Task Force's review and implementation of any recommendations it will make.

VA Response. The Wounded, Ill, and Injured Task Force conducted a VA-wide survey of programs providing care coordination, case management and/or benefits advisors. This identified a need to synchronize and integrate services amongst programs within VA and DOD. Current work of the VA DOD WC2TF includes:

- Establish overarching care coordination policy with common mission, language for severely injured, ill, and wounded warriors in transition
- Crosswalk the DOD Instructions and VA Handbooks addressing care coordination and case management into a single directive ("common doctrine")
- Create a single, Comprehensive Plan for care, services and benefits for better synchronization and integration
- Establish a formal governance structure, informed by a Community of Practice that will serve as an ongoing forum for policy, programming and oversight.

Recommendations will be briefed to the JEC (via the HEC and BEC) in August 2012.

DOD Response. DOD defers to VA to provide the activities and findings to date of the VA Wounded, III, and Injured Task Force. However, Secretary Panetta directed that an internal DOD task force review the IDES process, with VA's support, and report to him by the end of September 2012 on improvement recommendations.

Question 14. The Departments have set a goal of having 60 percent of new IDES claims processed within 295 (Active) and 305 (Reserve/Guard) days. Why was the goal set at only 60 percent of new claims? What is the Departments' plan for reaching 100 percent of new claims processed within the Departments established timelines?

VA Response. The Departments strive to process all IDES cases within 295 days for Active Duty and 305 days for RC members. However, because each case has its unique challenges and there are many variables involved 60 percent was established as an initial achievable goal for calendar year 2012. In an ongoing effort to achieve 100 percent of new claims processed within the established timelines, the depart-

ments will continue to streamline and automate as much of the process as possible, and explore and implement other process improvement measures.

DOD Response. The DOD/VA Joint Executive Council established activities and milestones for improving the IDES in Joint Strategic Plan for Fiscal Years 2011–2013, Goal 3, Efficiency of Operations. The improvement metric is the percentage of Servicemembers who complete the IDES process within goal. In the plan, the Departments set a long-term goal that 80% of Servicemembers complete the IDES within goal (295 days for active component or 305 days for reserve component). The Departments set the interim that 60% of Servicemembers complete the IDES within goal in calendar year 2012. The Departments' goals recognize that each Servicemember's case is unique and that some Servicemembers will finish IDES in less than 295 days while others with more complex cases will take longer than 295 days. Although the Departments are striving to accelerate the IDES process for all, the current JSP goals incorporate the reality of variations in case complexity and the current caseload of Servicemembers awaiting disability evaluation.

Question 15. Please detail the current operational status, activities, and resource, space and personnel allocations for each of the Vision, Traumatic Extremity Injuries and Amputation, and Hearing Centers of Excellence.

VA Response. [VA defers to DOD.]

DOD Response.

Hearing Center of Excellence (HCE)

Operational Status	• Achieved Initial Operating Capability (IOC): key staff appointed, plus contracted staff for daily operations, strategic communications, registry planning, research administration, and fitness for duty support. • Full Operating Capability (FOC), defined as an operating hearing data registry, with launch of hearing protection campaign-expected December 2013.
Activities	• Published Concept of Operations to guide IOC/FOC progression. • Selected HCE Leadership-staff is joint DOD/VA (pending formal appointment process); extremely cohesive team and unified alignment of objectives. • Determined overall staffing requirements-pending validation review and approval. • Launched Web site (hearing.health.mil). • Chartered DOD Fitness for Duty working group to determine auditory standards required for specific military occupations. • Cataloged portfolio of DOD/VA hearing-related research activities to orchestrate best use of limited Federal research funding.
Resources	• Sufficient resources to date and into next FYs (FY 2012 = $10.9M).
Space	• Sufficient space allocated within Wilford Hall Ambulatory Surgical Center (8200 sq. ft. (SF) temporary space). Anticipate 3000 SF in permanent space.
Personnel Allocations	• Executive Director appointed; 4 Directorate Chiefs assigned; civil service hiring progressing with expected staff late CY 2013.

Extremity Trauma and Amputation Center of Excellence (EACE)

Operational Status	• Current manning is eight DOD staff, one VA staff, and zero contractors. Key staff hired include the Executive Director, Deputy Director, and Chief of Staff; contract manpower equivalents equal to 2.4 are inbound in July 2012; the VA is hiring four full-time staff and each of the DOD Advanced Rehabilitation Center (ARC) sites are initiating actions for hiring personnel approved in the Concept of Operations (CONOPS). • Planned Initial Operating Capability (IOC) date is 1 October 2012 and is defined as 50% manning at each ARC site, staff Directorate, and Executive Office, with the Manpower Concept Plan submitted. We forecast 17 DOD, three contractors, and one VA FTE on-board by our projected IOC. Research, global outreach, informatics, clinical care, and leadership sections are currently sustained. With future hires we will gain momentum toward greater capability.
Activities	• Published CONOPS and Balanced Scorecard to guide EACE progression. • Army Manpower Concept Plan currently being written to conform to the Center of Excellence Oversight Board approved CONOPS staffing requirements. Selected EACE leadership team including Executive Director, Interim VA Deputy Director, Chief of Staff, and Deputy Director for Research. The four VA staff were approved for hire by VA leadership. • Established Capability Integrated Product Team (DOD/VA) to develop the EACE-specific registry requirements for the planned Federated Registry, led by the Vision Center of Excellence. • Building EACE Web site on health.mil. Expect completion within 30 days.

Extremity Trauma and Amputation Center of Excellence (EACE)—Continued

	• EACE executive leadership, VA Amputation System of Care (ASoC) leadership, and DOD ARC representatives met in January 2012 to establish strong working relationships and gain better understanding of each other's missions. Currently conducting biweekly conference calls with ARC and ASoC leadership to better collaborate and address joint issues. Next EACE, DOD, and VA leadership meeting will be held in San Antonio 31 July to 2 August 2012 during the VA Amputation Skills Conference. • Building portfolio development for DOD/VA EACE-related research activities. Seeking seats on programming boards, i.e. the Medical Research and Materiel Command (MRMC) Joint Program Committee for Clinical Rehabilitative Medicine (JPC–8), identifying research gaps and helping to establish research priorities. • At the request of the European Command (EUCOM), EACE global outreach consultative activity to enhance amputee care capability in the Republic of Georgia Ministry of Defense is ongoing.
Resources	• Sufficient operations and maintenance (O&M) resourcing to date and in the Future Years Defense Program (FYDP). FY 2012 budget: $5.9 million.
Space	• Sufficient space allocated within all ARCs (San Antonio Military Medical Center (180 SF); Walter Reed National Military Medical Center, Bethesda (300 SF); and Naval Medical Center, San Diego) and Executive Office in San Antonio, Texas (330 SF).
Personnel Allocations	• Each ARC is actively hiring civil service employees. The Executive Office and VA are also placing maximum priority on hiring. The process is lengthy but is progressing well.Extremity Trauma and Amputation Center of Excellence (EACE)

Vision Center of Excellence (VCE)

Operational Status	• DOD and VA executive leadership in place; leadership for 4 of 6 Directorates hired. • Currently, 15.6 government staff hired with 8 contractors providing administrative support to two regional locations: National Capital Region and Joint Base Lewis-McChord.
Activities	• Transitioned from TRICARE Management Activity (TMA) to Navy Bureau of Medicine and Surgery (BUMED)—October 2011. • Published and received approval of VCE Strategic Plan and Concept of Operations by the MHS CoE Oversight Board—January 2012. • Developing VCE Program Management Plan. • Developed FY11–12 vision research priorities—April 2011. • Research grantee site visits—in process. • Deployed Defense and Veterans Eye Injury and Vision Registry (Vision Registry) Pilot—March 2012. • Developing VA Eye Injury Data Store to provide VA clinical data to the Vision Registry. • Leading effort to develop functional requirements of a joint VA/DOD electronic eye note for the integrated Electronic Health Record (iEHR). • Partnered with Harvard Medical School/Massachusetts Eye and Ear Infirmary/Schepens Eye Institute and Smith-Kettlewell Research Institute to conduct biannual symposia. • Coordinating monthly Worldwide Ocular Trauma Video Teleconferences—March 2011 (ongoing). • Leading the process to include Fox eye shields in military individual first aid kits. • Developing training initiatives and clinical recommendations for VA and DOD vision care providers. • Coordinating with the Committee for Tactical Combat Casualty Care to include Fox eye shield use in first-responder training programs. • Leading the effort with MHS Office of Strategic Communications for the health.mil Web site re-design. • Presented/participated in national and international vision care educational programs. • Directing gap analysis for assistive technology for the visually impaired. • Published Federal Practitioner (circ.~35,000) update ''Focus on Capabilities Not Disabilities—Sports and Recreation for the Visually Impaired Servicemember and Veteran''—June 2012. • Implementing a pilot vision impairment education center for Servicemembers, Veterans and their families at Walter Reed National Military Medical Center, Bethesda, MD.
Resource Allocation	• Budget FY 2012: DOD $17.911M; VA $2.272M.
Space Allocation	• Headquarters: Bethesda, MD (Walter Reed National Military Medical Center), approx. 1,700 sq. ft.—opened March 2012; Arlington (Crystal City), VA; approx. 14,500 sq. ft.—opened July 2011 • VCE West: Tacoma, WA (Madigan Army Medical Center), approx. 120 sq. ft. under tenancy negotiation—opened October 2010. • VCE South: San Antonio, TX (San Antonio Military Medical Center)—in planning stages.
Personnel Allocation	• Human capital assets as of 6/11/2012: Mil—1, DOD—11, VA—3.6; Total government staff—15.6; Total contract staff—8. • Executive Director (DOD) appointment 2008. • Deputy Director (VA) initial appointee 2008, successor appointment 2010.

Vision Center of Excellence (VCE)—Continued

	• Four of six Mission Area Directors hired (Information & Information Management, Technology, Rehabilitation & Reintegration, and Education and Training). Two Directors remaining to be hired: (Clinical Care Integration, and Research & Development • Human capital, facilities, and resource management administrative support hired. • Vision Services Care Coordinator hired to support DOD and VA clinical care coordination.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO JO ANN ROONEY, ACTING UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE AND JOHN R. GINGRICH, CHIEF OF STAFF, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. In written testimony for the record, Paralyzed Veterans of America said this about the Integrated Disability Evaluation System (IDES):

> "Servicemembers who are participating in the new approach to discharge evaluation are not systematically being encouraged to seek representation from a [veterans' service organization] Service Representative. Most are relying instead on the advisory services of military counsel, yet each service provides access to military legal counsel in different manners and circumstances."

a. What is being done to provide Servicemembers in IDES with access to representatives from veterans' service organizations (VSOs)?

VA Response. [VA defers to DOD.]

DOD Response. DOD policy requires the Military Departments to inform Servicemembers they may seek assistance during the IDES process from Government legal counsel provided by the Military Departments, private counsel retained at their own expense, or from a VA-accredited representative of a service organization recognized by the Secretary of Veterans Affairs, using VA Form 21–22, "Appointment of Veterans Service Organizations as Claimant's Representative," or from a VA-accredited claims agent or attorney using VA Form 21–22a, "Appointment of Individual as Claimant's Representative."

b. Of the 139 sites using the IDES process, how many have representatives from VSOs on site to help Servicemembers with the IDES process?

VA Response. [VA defers to DOD.]

DOD Response. VA indicates all IDES sites can accommodate VSO's that choose to make themselves available to Servicemembers. Some sites are able to provide dedicated space for accredited VSOs, while other sites accommodate VSOs through temporary meeting space.

c. Has the Department of Defense (DOD) provided uniform guidance or requirements about when Servicemembers should have access to counsel during the IDES process? If so, please provide a copy to the Committee.

VA Response. [VA defers to DOD.]

DOD Response. Yes. DOD policy (Directive-Type Memorandum (DTM) 11–015—Integrated Disability Evaluation System (IDES), December, 2011) provided uniform guidance or requirements about when Servicemembers should have access to counsel during the IDES process.

Question 2. In a September 2010 report, VA and DOD identified customer satisfaction as a key indicator of IDES performance.

a. What is currently being done to gauge customer satisfaction with the IDES process?

VA Response. [VA defers to DOD.]

DOD Response. The IDES Customer Satisfaction Survey was suspended as of December 6th, 2011, following funding cuts. Currently the VA and DOD are not involved in any systematic data collection efforts for customer satisfaction data.

b. Does DOD plan to use customer satisfaction surveys in the future?

VA Response. [VA defers to DOD.]

DOD Response. Yes, the DOD plans to resume use of the customer satisfaction surveys by October 2012, subject to availability of funds.

c. If so, when will those surveys begin and what, if any, changes would be made to the surveys that were being used previously?

VA Response. [VA defers to DOD.]

DOD Response. DOD plans to resume IDES Customer Satisfaction surveys beginning in fiscal year 2013. DOD is currently reviewing previous IDES surveys to determine whether they can be improved.

Question 3. The Government Accountability Office (GAO) has previously reported that staffing shortages are part of the reason for delays during the IDES process.

a. Of the 139 sites using IDES, how many have enough staff to meet all of the agencies' staffing goals for each phase of the IDES process?

VA Response. VHA uses a flexible approach to providing staffing options to Veterans Integrated Service Network (VISN) and facility directors. Facilities and VISNs have used Locum Tenens and contract providers to supplement their staffs as surges have impacted their facilities. They have also managed the schedules of their Compensation and Pension (C&P) staff to maximize efforts to meet examination demands. This approach has shown results as VHA has in 9 of the past 10 months exceeded the goals for IDES medical examinations at a time when examination demand has more than doubled. Further, VHA's flexible approach has allowed it to meet or exceed national standards for general C&P examinations as well. This agile approach was proven necessary as the services often are challenged in identifying workload numbers or impact locations in a timeframe allowing for long-term planning/staffing.

VA is staffed to support the estimated steady state of 27,000 IDES claims per year. VA and DOD continue to assess the impact of troop movement and drawdown of forces on the IDES program. We will monitor resource needs as part of our overall evaluation of the program.

DOD Response. All the Services are required to provide quarterly reports of PEBLO staffing ratios at each IDES military treatment facility. Navy indicates that all but two IDES sites are adequately staffed, with positions being filled at Naval Hospital29 Palms and Naval Hospital Beaufort. Army reports indicate adequate staffing at 21 sites with hiring actions at the other 15. Air Force reports adequate staffing at their 74 sites, though 13 use alternate staff to assist as required. Air Force is requesting additional PEBLO assistants for every site.

b. If any sites are not meeting all staffing goals, please provide a timeline for when those sites will have sufficient staff to meet all goals.

VA Response. As stated to the previous question, it is important to note that a flexible staffing approach is necessary given how surges, by definition, ebb and flow. Contractors and Locum Tenens are the best approach to these examination needs.

MSC staffing goals were met at each site as IDES was implemented worldwide, and continue to be met at all sites today.

DOD Response. The Department of the Army projected but did not complete hiring of long-term IDES staff at MTFs in July 2012. Army has filled over 90% of positions for MEB physicians, PEBLOs, and legal assistants. Filling behavioral health positions remains the Army's largest challenge—36% currently filled, expected to rise to 69% once current candidates are on boarded. The Army continues hiring efforts for the remaining positions. In addition, the Army is also establishing 5–7 remote IDES processing locations to handle peak overflow volume. The Air Force projects completing additional PEBLO assistant hiring in FY 2014. Navy's hiring actions are currently open and should be filled before the end of the fiscal year.

c. Do the agencies have plans to use sites other than medical treatment facilities to expand IDES capacity? If so, please explain.

VA Response. The term "medical treatment facilities" is normally associated with health care facilities under the auspices of DOD. VA, however, has no plans to conduct IDES C&P examinations at other than facilities agreed upon during the initial IDES implementation or locations established by our Disability Examination Management (DEM) Contractors located within the vicinity of the military installations.

DOD Response. The Air Force and Navy have no plans to use sites other than MTFs to expand IDES capacity. The Army is pursuing a strategy to establish 5–7 remote IDES processing locations to handle peak overflow volume. The Army anticipates the expansion locations will be located near MTFs to allow sharing of administrative support. The Army's expansion centers will be located in government facilities or leased space adjacent to Army installations.

d. How many of the 139 IDES sites prepare Narrative Summaries at their own locations?

VA Response. VHA does not prepare Narrative Summaries. This question should be redirected to DOD.

DOD Response. Narrative Summaries are prepared within the MTF at all IDES sites.

Question 4. In May 2011, the Secretary of Defense and Secretary of Veterans Affairs committed to revising IDES so that it could be completed in 150 days. They also agreed to explore options so it could be completed in 75 days. For the record, please explain the status of those efforts.

VA Response. The remodeled Integrated Disability System (rIDES) was designed to meet the Secretaries intent of completing the process in less than 295 days. However, the Army had concerns about the effectiveness of rIDES and wanted to focus their energy on improving IDES. At the December 2011 SOC meeting, the decision was made to defer rIDES proof of concept. The SOC directed the workgroup to continue to focus on IDES improvements, harvest best practices from site visits, analyze and test them and continue to move forward.

DOD Response. We continue to focus on IDES improvements which include actions such as:

- IDES site visits by interdisciplinary teams to identify and communicate specific refinements across the Services. Those visits yielded improvements that have been implemented system-wide, such as a locally developed case management tool for tracking medical board cases;
- Working closely with VA to develop and implement in 2012 an IT capability to electronically transfer IDES case files among case workers;
- Establishing the task force Secretary Panetta directed to review the IDES process by the end of September 2012 on improvement recommendations;
- Evaluating ways to improve utilization of our expedited evaluation process for catastrophically ill or injured Servicemembers.

Question 5. As reflected in VA Fast Letter 12–07, IDES examinations for members of the Guard and Reserves are being handled closer to their current locations.

a. How and when are the local facilities notified of how many Guard and Reserve members they should expect to provide with examinations?

VA Response. The local facilities are notified of how many Reserve Component (RC) members they should expect to provide with examinations when the MSC inputs the exam request(s) into the Compensation and Pension Records Interchange (CAPRI) system. This occurs after the MSC conducts the initial interview with the Servicemember. The request is forwarded electronically to the VA facility closest to the RC member's home that has the clinical capability to satisfy the examination requirements. Currently, predictability of the RC workload and the proposed distribution of this workload remains a challenge.

DOD Response. DOD updates VA on anticipated case flow estimates. In addition, DOD and VA require local leaders to communicate anticipated changes in case flow or capability and to develop contingency plans to meet unanticipated changes in case flow.

b. When a local facility receives a request to perform an IDES examination, does that examination take priority over that facility's standard compensation and pension examination workload?

DOD Response. [DOD defers to VA.]

VA Response. IDES examinations enjoy the same priority as the C&P examinations offered to our Veterans. Facilities do attempt however, to get these examinations scheduled and completed as soon as possible to remain within the IDES goals for conducting medical examinations.

As of May 20, 2012, the VHA average for completing IDES medical exams was 38 days plus one day for administration; the IDES Program goal for examination completion is 45 days.

Question 6. According to written testimony for the May 23, 2012, hearing, the Joint Executive Council (JEC) reviews a monthly report regarding the performance of IDES.

a. Please explain what role the JEC plays in terms of trying to improve IDES performance.

VA Response. The JEC replaced the SOC on January 12, 2012. The JEC serves as the primary VA and DOD coordination body for overseeing and supporting joint activities, initiatives and wounded, ill and injured issues. IDES is one of those joint initiatives the JEC provides oversight and guidance to. The JEC recommends to the respective Secretaries the strategic direction for joint coordination and sharing efforts. The JEC then oversees the execution and implementation of those efforts.

b. Who ultimately has responsibility for IDES decisionmaking and fixing any existing problems with IDES?

VA Response. The Secretaries of the VA and DOD are ultimately responsible for decisionmaking and fixing any existing problems with IDES. The Deputy Secretary of VA and Under Secretary of Defense for Personnel and Readiness serves as co-chairs of the Joint Executive Council (JEC) which coordinates and oversees joint VA/DOD initiatives.

c. Please provide an organizational chart showing all offices within VA, DOD, and the military services that are involved in the IDES process and the lines of authority for reporting and accountability.

DOD Response. [DOD defers to VA.]

VA Response. See Operational Model Diagram (which is displayed previously under responses to Senator Murray's Question 3).

Question 7. According to written testimony for the May 23, 2012, hearing, there are currently over 27,000 military personnel going through the IDES process.

a. In total, how many additional military personnel are projected to enter the IDES process in 2012, 2013, and 2014?

VA Response. [VA defers to DOD.]

DOD Response. Army expects their IDES caseload to continue to increase to approximately 30,000 cases by the end of 20 12 and to remain steady through 2014, then to decrease back to pre-deployment levels of around 12,000. Navy projects 1275 additional cases beyond current levels in FY 2012, 541 in FY 2013, and 549 in FY 2014. The Air Force projects 400 Servicemembers beyond current levels will enter the IDES each year FY 2012–FY2014.

b. Of those military personnel, what portion is expected to be from active components and what portion is expected to be from the Guard and Reserves?

VA Response. [VA defers to DOD.]

DOD Response. Army has dedicated new resources to assist in preparing and processing Reserve Component disability cases and expects the percentage of Servicemembers entering the IDES who are from the Reserve Components to increase temporarily beyond the current 30 percent.

The Army does not yet have an estimate of the proportions of cases expected from the Reserve Components from FY 2012 to FY 2014. Of the additional expected IDES cases beyond current levels, the Navy expects 89 Reserve Component members to enter the IDES in FY 2012, 38 in FY 2013, and 38 in FY 2014. Of the additional expected IDES cases beyond current levels, the Air Force expects 60 Reserve Component members to enter the IDES each year between FY 2012 and FY 2014.

c. Are all IDES cases treated with the same priority level or are there certain categories of cases that are expedited above other cases? For example, are there procedures to expedite cases based on financial hardship or if the servicemember has received a civilian job offer?

VA Response. [VA defers to DOD.]

DOD Response. The Military Departments expedite the cases of catastrophically ill or injured Servicemembers who choose to waive the IDES process and participate in the Expedited DES process.

In addition, the Military Departments, where possible, expedite IDES cases of Servicemembers with extenuating circumstances.

Question 8. According to VA's written testimony, "VA can deliver benefits in the shortest period allowed by law following discharge thus reducing the 'benefit gap.'"

a. For the record, please explain what is the "shortest period allowed by law" for making VA disability payments following discharge or release from the military.

VA Response. The "shortest period allowed by law" for making VA disability payments following discharge or release from the military is the first day of the second month after a Servicemember separates. 38 U.S.C. § 5111 states that payment of monetary benefits may not be made for any period before the first day of the calendar month following the month in which the award became effective. For example, if the Servicemember separates on July 27, the award is effective the day following discharge, or July 28. Benefits begin to accrue on the first day of the next calendar month, or August 1. Payment for the month of August occurs on September 1.

DOD Response. U.S. Code prohibits VA from providing disability compensation prior to the first day of the second month following discharge or release from the military. For example, if the Servicemember separates on July 27, the earliest date VA can compensate the Veteran for disability is September 1.

b. Currently, how long on average is it taking for VA to issue a benefits decision after an IDES participant is discharged or released from the military? As requested at the hearing, please provide any statistics on how long after service IDES participants receive their first VA disability compensation payment (not the VA decision letter, but the actual arrival of the first check/deposit).

VA Response. As of June 8, 2012, VA has processed 7,707 disability payments for Servicemembers who have completed the IDES process during fiscal year 2012. Currently, VA is averaging 54 days from the date of separation to process a payment.

DOD Response. [DOD defers to VA.]

c. As requested at the hearing, please provide any statistics on how long after service IDES participants receive their first VA disability compensation payment (not the VA decision letter, but the actual arrival of the first check/deposit).

VA Response. VA's benefits letter is mailed within one business day of the date on which the Veteran's compensation award is authorized. Payments are released from the Treasury Department within 48 hours of award authorization.

DOD Response. [DOD defers to VA.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO JO ANN ROONEY, ACTING UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE

Question 1. At what point did DOD realize that it needed to 1,400 additional staff?

DOD Response. The Army, Navy and Air Force continuously monitor their DES staff requirements and implemented hiring actions to fill shortages beginning in 2008. After fully implementing theIDES at all locations in October 2011, the Military Departments recognized that caseload exceeded staff capacity. In response, the Departments accelerated hiring in late 2011 and efforts to hire and train the additional staff are nearing completion.

Question 2. What occupations do these additional civilian staff members hold?

DOD Response. The Military Services are hiring additional IDES civilian staff as Medical Evaluation Board and Physical Evaluation Board members and staff, Physical Evaluation Board Liaison Officers (PEBLOs), PEBLO assistants, legal and paralegal professionals, physicians, psychologists, social workers, and management analysts.

Question 3. Were any Wounded Warriors hired for these new positions?

DOD Response. The Services do not have readily available information on the numbers of wounded warriors hired for these positions. But, the Army reports it hired qualified wounded warriors who applied for these positions. The Navy and Air Force report that they did not receive any applications from wounded warriors in connection with the job announcements advertised for their positions.

Question 4. What factors determine where these additional staff members will be assigned?

DOD Response. The Military Departments determine the assignment of additional staff members based on case workload and complexity, the co-location of supporting functions and established MTF staffing models.

Question 5. What formal training does the PEB Liaison Official receive and what is his or her normal caseload?

DOD Response. DOD policy requires the Military Departments, at a minimum, to train IDES personnel on the statutory and policy requirements of the DES; the electronic and paper record keeping policies of the Military Department; customer service philosophies; familiarization with medical administration processes; the role and responsibilities of a Servicemember's assigned military legal counsel, an overview of the services and benefits offered by the VA; knowledge of online and other resources pertaining to the DES, DOD and VA departments; knowledge of the chain of supervision and command; and knowledge of Inspector General hotlines for resolution of issues.

DOD policy recommends that PEBLOs manage no more than 20 cases simultaneously. Because active PEBLO case management is concentrated in the MEB portion of the disability evaluation process, DOD defines PEBLO case ratio for a military treatment facility as the number of trained PEBLO staff divided by 100/365 multiplied by the total number of new cases at the location per year, where 100/365 is the fraction of time devoted to active case management during the MEB portion of the IDES during the year.

Question 6. When Reservists and National Guard personnel go through the IDES process, are they on Federal active-duty orders?

DOD Response. Severely ill or injured Reserve Component Servicemembers can be on Active Duty orders for the entire IDES process. Other Reserve Component Servicemembers may be placed on Active Duty orders to complete IDES activities (exams, interaction with PEBLO's, participation at boards, etc.) to accommodate their civilian job requirements and family commitments.

Question 7. Why are there two different timelines for active-duty and Reservists?

DOD Response. DOD policy defines different timelines for active and reserve component members to provide more time to coordinate active duty periods with Reserve and National Guard members, generate active duty orders, and gather medical records from Reserve units and civilian doctors. Active Component Servicemembers typically do not require this additional time and thus have a shorter overall IDES timeline goal.

Question 8. If a servicemember expresses no desire to remain on active-duty at the beginning of the IDES process, is he or she processed any differently?

DOD Response. The IDES process requires that participants be in an Active Duty status during all portions of the process to qualify for appropriate pay and benefits. Reservists may coordinate periods of Active Duty to comply, but generally must be available, and in an active duty status ("on orders") during those portions of the IDES process that requires their participation.

Question 9. When a servicemember exceeds the goal for an IDES phase, how is that flagged to draw attention to the delay in that phase of the process?

DOD Response. DOD and VA IDES staff monitor case timeliness through a number of reports available from VA's Veterans Tracking Application (VTA). These reports identify cases exceeding IDES goals in all IDES stages.

Question 10. Why can't the Medical Evaluation Board and Physical Evaluation Board be consolidated into one Board?

DOD Response. The law (National Defense Authorization Act of Fiscal Year 2008, Section 1602(3)(A)), defines the Disability Evaluation System as "A system * * * comprised of medical evaluation boards, physical evaluation boards, * * *" which requires the Department to maintain separate medical and physical evaluation board processes.

Chairman MURRAY. Mr. Gingrich?

STATEMENT OF JOHN R. GINGRICH, CHIEF OF STAFF, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. GINGRICH. Good morning, Chairman Murray. I have a cold so I have to speak up. Ranking Member Burr, Members of the Committee, I am pleased to be joined this morning by Under Secretary Jo Ann Rooney to discuss the IDES system. We have come a long way since the issues of Walter Reed Army Medical Center were identified in 2007. At that time, VA and the DOD were miles apart. Simply stated, the lack of integration and cooperation between the Departments did not serve wounded servicemembers well.

Since that time, together we have committed to achieve a seamless transition through a multi-pronged approach with IDES as one of the critical initiatives. The joint IDES process was designed to eliminate time consuming and often confusing elements of the separate disability processes. The goals of the joint process were to increase transparency, reduce the processing time, improve consistency, and reduce the benefits gap.

To achieve greater transparency for servicemembers, we have enhanced our online tools, the My Health Vet and benefits, to allow servicemembers in IDES to view appointments and lab results and to track their claim. Internally, we have increased transparency through the IDES Dashboard that tracks performance at each IDES site.

The Secretaries have charged us to reach a combined performance goal of 295 days for 60 percent of the servicemembers by the end of this year. To ensure that we reach this goal, I hold biweekly reviews with all 116 stations. In a relatively short period of time, we have seen positive results.

In January, the oldest case being worked for proposed disability rating was 254 days. Today there are no cases over 180 days. From February 2011 to April 2012, we have reduced the average claim development time by 62 percent and the medical examination and admin time by 60 percent.

On April 5th, I committed to the Army Vice Chief of Staff that VA would clear, within 60 days, the entire inventory of Army cases

awaiting proposed rating decisions. We have cleared 76 percent of those cases and are well on our way to deliver on that promise not only for the Army, but for all the services.

For both preliminary and final ratings, the combined productivity of our three Disability Rating Activity Sites, DRAS, increased 15 percent in the last month. We have several projects to enhance our efficiency and effectiveness such as the Veteran Tracking Application that will increase the flow of information electronically from DOD to VA, and the electronic case file transfer system.

We have made progress in improving transparency, improving consistency, and reducing process time. But our biggest achievement to date has been closing the benefit gap. Servicemembers no longer wait six to 9 months to receive compensation they have earned. Yet, with all these achievements, we are not satisfied because we are not meeting the requirement for every single servicemember.

We will continue to work with DOD to improve our systems and processes until we achieve all of our objectives in 100 days for each servicemember. I will often refer to cases or claims here today, but let me assure you, I never lose sight of the fact that behind a claim is a servicemember and his or her family who depend on VA to get it right.

We will continue to partner with DOD to effectively and efficiently get him or her back to their unit to continue military service, or if discharged, provide the benefits they have earned. As partners, we will overcome the remaining challenges together to achieve the seamless transition servicemembers deserve. This is a commitment we must meet.

I look forward to answering any questions that you may have.

[The prepared statement of Mr. Gingrich follows:]

PREPARED STATEMENT OF JOHN R. GINGRICH, CHIEF OF STAFF, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning Chairman Murray, Ranking Member Burr, and Members of the Committee. I am pleased to be joined this morning by Jo Ann Rooney, Ed.D., J.D., Acting Under Secretary for Personnel and Readiness, Department of Defense (DOD) to discuss the progress being made by the VA and the DOD toward meeting the needs of injured Servicemembers. My testimony will focus on the status of our progress toward improving the Integrated Disability Evaluation System (IDES) used to transition wounded, ill, and injured Servicemembers from DOD to VA or, if found fit, return them quickly to their units to continue their military service.

INTRODUCTION

VA and DOD have a shared goal: ensuring that Servicemembers' transition between VA and DOD is as smooth as possible and honors their sacrifice for the greater good. To create a truly seamless transition, we have a multi-pronged approach that includes developing a single Integrated Electronic Health Record (iEHR), improving our Federal Recovery Coordination Program (FRCP) and having an efficient IDES system. If we are to truly achieve the seamless transition that we both agree is necessary, it will be through measurable progress in all three core programs.

Our commitment is not to create a program or a process; our commitment is to create a new paradigm. The old paradigm of two big bureaucracies with completely different processes, systems and programs did not work in the past and will not work in the future. Seamless transition is the new paradigm; not a slogan. At the James A. Lovell Federal Health Care Center (JALFHCC), both Servicemembers and Veterans are served by a joint VA/DOD team. JALFHCC embodies this new paradigm. While there are still issues that we must work through at JALFHCC, it is strong evidence that we can overcome barriers when the needs of Servicemembers, Veterans and their families are our priority.

Our Departments understand that we are responsible for the same men and women, though at different periods of their lives, and that together our Departments can help improve their transition experience as they move from one stage to the next. I will focus my remarks today on IDES as one piece of a larger transformation.

IDES

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

The DES Pilot was launched at three operational sites in the National Capital Region (NCR): Walter Reed Army Medical Center, National Naval Medical Center, and Malcolm Grow Medical Center on Andrews Air Force Base. The DES Pilot was recognized as a significant improvement over the legacy DES process, and, as a result of the Senior Oversight Committee (SOC) findings and the desire to extend the benefits of the Pilot to more Servicemembers, VA and DOD expanded the Pilot. By the end of March 2010, the DES Pilot had expanded to 27 sites and covered 47 percent of the DES population. In July 2010, the co-chairs of the SOC agreed to expand the DES Pilot and rename it IDES. Senior leadership of VA, the Services, and the Joint Chiefs of Staff strongly supported this plan and the need to expand the benefits of this improved process to all Servicemembers. Expansion and full implementation of IDES was completed by September 30, 2011. Currently, there are 139 IDES sites operational worldwide, including the original 27 DES Pilot sites.

In contrast to the DES legacy process, IDES provides a single set of disability examinations and a single-source disability rating, for use by both Departments in executing their respective responsibilities. This results in more consistent evaluations, faster decisions, and timely benefits delivery for those medically retired or separated. As a result, VA can deliver benefits in the shortest period allowed by law following discharge thus reducing the "benefit gap" that previously existed under the legacy process, i.e., the lag time between a Servicemember separating from DOD due to disability and receiving his or her first VA disability payment. This lag time used to be 6 to 9 months; it now is reduced to 30 to 60 days, with our goal being to reach no more than 30 days. The DOD/VA integrated approach has also eliminated many of the sequential and duplicative processes found in the legacy system.

VA is responsible for four core processes within IDES: claims development, medical examination, proposed disability rating, and VA benefits estimate letter. VA's target for combined processes is 100 days of the 295 day combined VA/DOD target. While VA is currently meeting the 10-day goal for claims development and the 45-day goal for medical examinations, VA is not meeting the 15-day goal for completion of the proposed rating and the 30-day standard for delivery of VA benefits estimate letters, which currently are 46 and 26 days beyond the target, respectively. To address increased volume at the rating sites during FY 2011, VBA temporarily placed on site help teams at the Baltimore and Seattle VA Disability Rating Activity Sites (DRASs) and brokered IDES work to other stations. VBA increased the number of Rating Veterans Service Representatives (RVSRs) at the Seattle DRAS in March 2012 and now has a total of 174 RVSRs dedicated to the IDES mission at Baltimore, Providence, and Seattle. Increased staffing levels and maturation of skills for newer RVSR trainees will aid VBA in meeting the expected goals for the preliminary rating and final benefits stages. The combined productivity of the three DRASs for completion of preliminary and final ratings was 3,125 for the month of April 2012, which represents a 15 percent increase over March performance of 2,708 completed cases. VA will begin to receive military separation data electronically in Veterans Tracking Application (VTA) in June 2012. It is expected this enhancement will reduce the time it takes the DRASs to verify separations, character of service, and severance or other pay issues, which must be verified prior to issuance of VA benefits.

Both SECDEF and SECVA have directed their respective Departments to reduce the combined processing time to 295 days for 60 percent of Servicemembers in IDES by the end of this calendar year with the ultimate goal of 100 percent. We have already made great progress toward that end. For example, at the Disability Rating Activity Sites in January 2012, the oldest case being worked for Proposed Disability Rating was 254 days. Today, there is not a single case over 180 days. Additionally, it is important to note none of these cases are impacting DOD's ability to move forward with their fitness decision. Today we find ourselves required to process many more claims per month than we had originally anticipated. As demand has increased we have adjusted to meet the Servicemember's needs. In January 2012 VA completed 1,254 Proposed Disability Ratings and in April 2012 VA completed 2,363 Proposed Disability Ratings. That is an 88 percent increase in monthly performance, which allowed for a reduction of more than 5,500 of the backlogged claims. We are proud of the advancements we have made, but to meet the overall 295-day goal, we will need to focus our efforts on ensuring accountability through staffing and governance, utilizing technology, process improvements, and increased management oversight to endure successful delivery.

ACCOUNTABILITY

First, we have institutionalized accountability mechanisms. At each IDES site VA has instituted the concept of a lead VA executive, a senior VA official who is directly responsible for the overall IDES mission, operations and performance at his/her specific site. With a single individual charged with performance responsibility we believe management will be able to drive change more quickly and resolve problems as they arise. To appropriately track our performance in the field, VHA and the Office of VA/DOD Collaboration Service in VA developed the "IDES Dashboard," a comprehensive management chart that tracks performance in each of VA's four IDES phases at each IDES site. Use of the "IDES Dashboard" has led directly to improved performance tracking and enabled VA's leaders to spot trouble spots and allocate resources more effectively.

MANAGEMENT OVERSIGHT

With any project, the appropriate amount of leadership and oversight must be applied. VA has elevated oversight to the most senior levels of the VA. SECVA and SECDEF meet quarterly, and IDES has always been on the agenda and they both receive monthly updates. On a monthly basis, I meet with the Vice Chief of Staff of the Army to review performance at Army IDES sites. These meetings are attended by senior personnel from VA, Office of the Secretary of Defense (OSD), and the Army. IDES performance data is reviewed at a very detailed level and senior officials in the field are expected to present plans to improve performance if standards are not met. Additionally, since May 2011, I have been leading a Video Teleconference (VTC) every two weeks with senior Veterans Benefits Administration (VBA) and Veterans Health Administration (VHA) officials at 116 sites in the field who are directly responsible for IDES at their respective sites. During these VTCs I review IDES performance at a very detailed level and ask the responsible senior official for his/her plan to improve performance.

VA's office of VA/DOD Collaboration Service also leads a weekly telephone conference call with VBA and VHA and a weekly telephone conference call with the OSD and the Military Services to review IDES performance and problems. Senior VA officials also meet on a monthly basis with Navy Bureau of Medicine officials to review performance at Navy and Marine Corps IDES sites. IDES performance data is reviewed at a very detailed level and senior officials in the field are expected to present plans to improve performance if standards are not met. At every level of VA, leadership is engaged with our partners in DOD and our management team in the field.

TECHNOLOGY AND PERFORMANCE IMPROVEMENT

Our continuous review of the IDES process revealed two consistent issues: access to information and reducing the movement of paper files. In both instances, we believe technology will play a key role. The next series of enhancements to the Veterans Tracking Application (VTA 2.0) will leverage our ability to electronically share DD–214 data via VA/DOD Identity Repository (VADIR) to automatically trigger work flow in a way that will reduce overall processing time. VADIR database was established to support a One VA/DOD data-sharing initiative in order to consolidate data transfers between DOD and VA to assist in determining Veteran benefits. The expanded data feed will also include key data elements to assist VA Disability Rating Activity Sites (DRAS) in determining entitlements to VA benefits such as: date

of separation and character of service, among others. VTA 2.0 will also include additional reporting capabilities that will allow VBA's Office of Field Operations to better manage the workflow of VBA employees and provide the ability to record the occurrences of diagnostic differences on IDES exams to identify inconsistencies. Based on demonstration performance to date, we believe that the new version of VTA, scheduled for release in June 2012 will greatly improve performance management.

VA is also collaborating with DOD to accomplish the Secretaries' joint goal of achieving electronic case file transfer (CFT) for IDES by July 2012. The planned solution will be a single system that will avoid development time and costs. CTF will remove the costly and inefficient transfer of paper records from DOD to VA by eliminating the need for shipping. Our system will accommodate both computable data and scanned paper to ensure that the solution we adopt assists both the younger Servicemembers with large portions of their records in electronic format and older Servicemembers who may still have a significant portion of their records in paper.

CONCLUSION

Despite these efforts, we know challenges remain, and there is room for significant improvement in IDES. VA and DOD are committed to supporting our Nation's wounded, ill, and injured Warriors and Veterans through an improved IDES, and we are taking steps to prepare for future demand for this system. As such, VA believes that its continued partnership with DOD is critical and is nothing less than our Servicemembers and Veterans deserve.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO VA, OFFICE OF POLICY AND PLANNING, INTEGRATED DISABILITY EVALUATION SYSTEM AND DOD, OFFICE OF WOUNDED WARRIOR CARE AND TRANSITION POLICY

[Due to their interrelated nature, the responses to the pre-hearing questions submitted by Senator Burr to the Department of Veterans Affairs were merged in with the responses from the Department of Defense appearing earlier in this transcript.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY AND HON. RICHARD BURR TO THE U.S. DEPARTMENT OF VETERANS AFFAIRS

[Due to their interrelated nature, the responses to the posthearing questions submitted by Senators Murray and Burr to the Department of Veterans Affairs were merged in with the responses from the Department of Defense appearing earlier in this transcript.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO JOHN R. GINGRICH, CHIEF OF STAFF, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. From the VA perspective, what would you change in the IDES process?

Response.

a. Implement some of the remodeled IDES improvements concepts identified below:

- Reduce the number of physical case-file handoffs from 8 to 3.
- Make fitness decision for further military service up front, before VA enters into the process.
- Ensure VA receives a complete case-file from the Military Services after the fitness decision is made.

b. Automate the IDES process from beginning to end, and enhance the management reporting capabilities to enable IDES sites to effectively manage their cases.

c. Identify and implement best practices and implement electronic data sharing throughout the IDES process.

Question 2. What formal training does a VA case manager receive and what is his or her normal caseload?

Response. VA Military Service Coordinators (MSCs) receive the same core technical training for claim processing as Veterans Service Representatives (VSRs) as well as IDES process training. Disability Rating Activity Site (DRAS) personnel receive the same national level training as all other claims adjudicators in a regional office. As a guide for determining sufficient resources, VA uses a staffing model in which each MSC has 30 new cases per month.

Question 3. Are servicemembers enrolled in the VA health care system upon completion of the IDES process?

Response. No. However, the enrollment in the VA health care system is highly encouraged to Servicemembers receiving disability examinations through IDES. VA has worked closely with DOD to implement an online VA Form 10–10EZ, Application for Health Benefits, which is completed by Servicemembers at the time of demobilization or termination of service. Additionally, active duty Servicemembers transitioning through TAP are briefed routinely by VA staff and informed on how to apply for VA benefits, including enrollment in the VA health care system.

Question 4. How is a servicemember discharged with mental health issues seamlessly transferred from DOD to VA mental health care providers?

Response. VA has a formal process in place to transition wounded, ill and injured Servicemembers from DOD to VA. VA has 33 VA Liaisons for Healthcare, registered nurses or licensed social workers, stationed at 18 Military Treatment Facilities (MTFs) with concentrations of recovering Servicemembers returning from Iraq and Afghanistan to transition ill and/or injured Servicemembers from DOD to the VA system of care. VA Liaisons are co-located with the DOD case managers at the MTFs, and provide onsite consultation and collaboration regarding VA resources and treatment options. Each referral from the DOD treatment team, including referrals for Servicemembers being medically discharged with mental health issues, utilizes a standardized referral form completed by the DOD Nurse Case Manager identifying the ongoing treatment needs. In addition, each referral to a VA medical center (VAMC) includes supporting medical documentation such as progress notes and narrative summaries. While VA Liaisons participate in discharge planning at the MTF, they are dependent on a referral from the DOD case manager prior to engaging with Active Duty Servicemembers to coordinate ongoing healthcare needs at VA. At MTFs without an onsite VA Liaison, DOD Case Managers refer Servicemembers directly to the Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Program Manager at the Servicemember's home VAMC. These referrals also utilize the standardized referral form identifying the ongoing treatment needs as well as the supporting medical documentation. Servicemembers may elect to seek care in the private sector using TRICARE, in which case they would not be referred to VA and the transition not managed by the VA Liaison.

In addition, OEF/OIF/OND Clinical Case Managers screen all returning combat Veterans for the need for case management services, including those referred from an MTF as well as those, self-presenting for initial care at a VAMC. This screening identifies Veterans who may be at risk so VA can intervene early and provide assistance before the Veteran is in crisis. In addition to prevalent medical and mental health issues related to deployment such as Post Traumatic Stress Disorder (PTSD), this screening includes the risk factors for psychosocial issues such as homelessness, unemployment, and substance abuse. Case management needs are identified early, a plan of care is developed, and follow up is provided as long as needed. OEF/OIF/OND case managers are experts at identifying and accessing resources within their health care system as well as in the local community to help Veterans recover from their injuries and readjust to civilian life.

Question 5. What outreach services does VA provide veterans immediately after discharged through the IDES process?

Response. Like all Servicemembers, individuals released through IDES receive the Welcome Home Package, which contains information about all VA benefits for which they may be eligible. VA also assigns case managers, who assist in outreach services, to individuals whom DOD classified as seriously injured before discharge.

Chairman MURRAY. Thank you very much. Mr. Bertoni?

STATEMENT OF DANIEL BERTONI, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. BERTONI. Chairman Murray, Ranking Member Burr, Members of the Committee, good morning. I am pleased to discuss the Departments of Defense and Veterans Affairs' efforts to improve the performance of their Integrated Disability Evaluation System, or IDES, which is now the standard process for assessing servicemember disabilities worldwide.

Since its start, GAO has monitored the evolution of this process and made several recommendations to address design and other

challenges. My statement today is based on our ongoing work for this Committee and focuses on the extent to which IDES is meeting key performance goals and ongoing efforts to improve performance.

In summary, we found that overall timeliness has worsened, with the average number of days to complete claims for active duty servicemembers increasing from 283 days in 2008 to 394 days last year, which is well above the stated goal of 295 days. During the same period, the proportion of active duty cases that met timeliness goals also decreased very steeply from 63 percent to just 19 percent.

With the exception of the physical evaluation board phase, IDES claims also fell consistently short of interim timeliness goals with the medical evaluation board, transition, and benefits phases. Processing delays were most significant in completing the medical evaluation board process. In 2011, only 20 percent of active duty cases met the targeted goal for obtaining a medical board decision.

In addition to timeliness, DOD and VA assess servicemember satisfaction via telephone surveys, which we found to have shortcomings in both design and administration such as unduly limiting who actually receives a survey and computing average scores in a way that may overstate satisfaction, and limit the usefulness of this data as a performance management tool.

In fact, using an alternative calculation that eliminates neutral responses, we found satisfaction rates several times lower than DOD reports. DOD and VA have undertaken a number of actions to address IDES challenges, many of which we have identified in prior work.

For example, per our recommendation top leadership has developed a more robust monitoring and oversight process to improve communication and accountability, which includes more frequent contacts between the Secretaries of the Departments to discuss progress in various fronts, regular meetings chaired by the Army's Vice Chief of Staff and VA's Chief of Staff that include reviews of site performance and a forum for local and regional facility commanders to provide feedback on best practices and current challenges.

VA also holds its own biweekly conferences with local staff responsible for their portion of the process. The Departments are also working to address long-standing medical board and VA rating staff challenges. In fact, the Army is in the midst of a hiring effort to more than double medical board staff, including liaisons, physicians, and support personnel, while VA has more than tripled staffing at IDES rating sites.

The Departments are also working to address limitations in their automated systems, including taking steps to improve the ability of local facilities to electronically track and monitor case progress, and to improve the quality of case data which we found to be problematic. However, key upgrades are still pending and various sites continue to rely on ad hoc, local, and potentially redundant processes to manage their cases.

Moreover, despite efforts by DOD and the services to improve data quality, the current IDES tracking system lacks controls to prevent staff from entering erroneous data; thus keeping caseload data accurate will remain a challenge going forward.

And finally, in order to further improve and expedite case processing, DOD has initiated an in-depth business process review to better understand how each step impacts processing times and identify further IDES streamlining opportunities. Such an effort could yield short and long-term recommendations for improvement. However, a timetable for completion is yet to be established.

In conclusion, the merger of two duplicative disability evaluation systems shows promise for expediting benefits to servicemembers. However, nearly 5 years out, delays continue to affect progress and their causes are not fully understood. Recent initiatives to improve processing and isolate bottlenecks are promising; however, it remains to be seen what their long-term impacts will be.

And we will continue to assess DOD's and VA's progress in these areas as we proceed to do this work for your Committee. Chairman Murray, this concludes my statement. I will be happy to answer any questions you might have. Thank you.

[The prepared statement of Mr. Bertoni follows:]

PREPARED STATEMENT OF DANIEL BERTONI, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY, U.S. GOVERNMENTACCOUNTABILITY OFFICE

United States Government Accountability Office

GAO

Testimony
Before the Committee on Veterans' Affairs, U.S. Senate

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MILITARY DISABILITY SYSTEM

Preliminary Observations on Efforts to Improve Performance

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

G A O
Accountability * Integrity * Reliability

GAO-12-718T

May 23, 2012

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Highlights

Highlights of GAO-12-718T, a testimony before the Committee on Veterans' Affairs, U.S. Senate

MILITARY DISABILITY SYSTEM

Preliminary Observations on Efforts to Improve Performance

Why GAO Prepared This Testimony

Since 2007, the DOD and VA have operated the IDES—which combines what used to be separate DOD and VA disability evaluation processes and is intended to expedite benefits for injured servicemembers. Initially a pilot at 3 military treatment facilities, IDES is now DOD's standard process for evaluating servicemembers' fitness for duty and disability worldwide. In previous reports, GAO identified a number of challenges as IDES expanded, including staffing shortages and difficulty meeting timeliness goals.

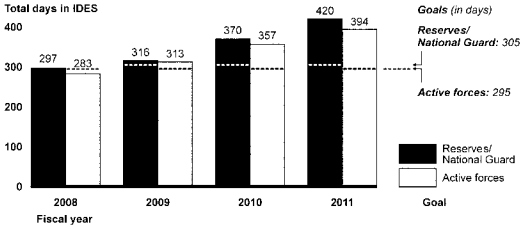
In this statement, GAO discusses initial observations from its ongoing review of the IDES, addressing two key topics: (1) the extent to which DOD and VA are meeting IDES timeliness and servicemember satisfaction performance goals, and (2) steps the agencies are taking to improve the performance of the system. To answer these questions, GAO analyzed IDES timeliness and customer satisfaction survey data, visited six IDES sites, and interviewed DOD and VA officials. This work is ongoing and GAO has no recommendations at this time. GAO plans to issue its final report later in 2012.

View GAO-12-718T. For more information, contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov.

What GAO Found

Case processing times under the Integrated Disability Evaluation System (IDES) process have increased over time, and measures of servicemember satisfaction have shortcomings. Each year, average processing time for IDES cases has climbed, reaching 394 and 420 days for active and reserve component members in fiscal year 2011—well over established goals of 295 and 305 days, respectively. Also in fiscal year 2011, just 19 percent of active duty servicemembers and 18 percent of guard or reserve members completed the IDES process and received benefits within established goals, down from 32 and 37 percent one year prior. Of the four phases comprising IDES, the medical evaluation board phase increasingly fell short of timeliness goals and, within that phase, the time required for the military's determination of fitness was especially troubling. During site visits to IDES locations, we consistently heard concerns about timeframes and resources for this phase of the process. With respect to servicemember satisfaction with the IDES process, GAO found shortcomings in how these data are collected and reported, such as unduly limiting who is eligible to receive a survey and computing average satisfaction scores in a manner that may overstate satisfaction. Department of Defense (DOD) officials told us they are considering alternatives for gauging satisfaction with the process.

Timeliness for IDES Cases Resulting in VA Benefits (by year case completed)



Source: GAO analysis of DOD and VA data.

DOD and Veterans Affairs (VA) have taken steps to improve IDES performance, and have other improvement initiatives in process, but progress is uneven and it is too early to assess their overall impact. VA increased resources for conducting disability ratings and related workloads. The Army is hiring additional staff for its medical evaluation boards, but it is too early to see the impact of these additional resources. DOD and VA are pursuing system upgrades so that staff and managers at IDES facilities can better track the progress of servicemembers' cases and respond to delays more quickly; however, multiple upgrades may be causing redundant work efforts. DOD officials also told us they have been working with the military services to correct case data that were inaccurately entered into VA's IDES tracking system, but have not yet achieved a permanent solution. Finally, DOD is in the early stages of conducting an in-depth business process review of the entire IDES process and supporting IT systems, in order to better understand how each step contributes to overall processing times and identify opportunities to streamline the process and supporting systems.

Chairman Murray, Ranking Member Burr, and Members of the Committee:

I am pleased to be here today to discuss our preliminary observations on the efforts of the Departments of Defense (DOD) and Veterans Affairs (VA) to integrate their disability evaluation systems. DOD and VA began piloting the Integrated Disability Evaluation System (IDES) in 2007 in response to concerns that wounded, ill, or injured servicemembers had to undergo two separate and complex disability assessments, and in order to expedite the delivery of benefits to servicemembers. As of October 1, 2011, IDES had replaced the military services' existing—or "legacy"—disability evaluation systems for almost all new disability cases. GAO has monitored the evolution of IDES since its pilot phase and our past work highlighted a number of challenges. For instance, we reported in December 2010 that insufficient staff and logistical challenges contributed to delays in completing IDES cases, and recommended the agencies take steps to ensure adequate staffing levels and develop a systematic process for monitoring caseloads.[1]

My statement today focuses on initial observations from our ongoing review for this committee and examines (1) the extent to which IDES is meeting performance goals and (2) DOD and VA efforts to improve its performance. To examine these issues, we analyzed IDES timeliness data from the Veterans Tracking Application (VTA)[2] and customer satisfaction data collected from DOD surveys;[3] interviewed DOD and VA officials responsible for overseeing IDES; visited six military treatment facilities to speak with local military and VA staff who administer the program as well as servicemembers in the IDES process;[4] and reviewed supporting policies and plans. In our ongoing work, we will further review performance data and improvement plans in greater detail. We plan to issue our final report later in 2012. We conducted this performance audit

[1]GAO, *Military and Veterans Disability System: Pilot Has Achieved Some Goals, but Further Planning and Monitoring Needed*, GAO-11-69 (Washington, D.C.: Dec. 6, 2010).

[2]VTA is a VA computer system that is used to track, among other things, the dates at which servicemembers complete the different stages of IDES.

[3]We analyzed VTA cases and surveys completed from fiscal year 2008 (program's inception) through fiscal year 2011.

[4]We visited facilities at Andrews Air Force Base, Bremerton Naval Hospital, Fort Hood, Fort Lewis, Fort Meade, and Fort Sam Houston.

in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The IDES process begins at a military treatment facility when a physician identifies one or more medical conditions that may interfere with a servicemember's ability to perform his or her duties. The process involves four main phases: the Medical Evaluation Board (MEB), the Physical Evaluation Board (PEB), transition out of military service (transition), and VA benefits.

MEB phase: In this phase, medical examinations are conducted and decisions are made by the MEB regarding a servicemember's ability to continue to serve in the military. This phase involves four stages: (1) the servicemember is counseled by a DOD board liaison on what to expect during the IDES process; (2) the servicemember is counseled by a VA caseworker on what to expect during the IDES process and medical exams are scheduled; (3) medical exams are conducted according to VA standards for exams for disability compensation, by VA, DOD, or contractor physicians; and (4) exam results are used by the MEB to identify conditions that limit the servicemember's ability to serve in the military.[5] Also during this stage, a servicemember dissatisfied with the MEB assessment of unfitting conditions can seek a rebuttal, or an informal medical review by a physician not on the MEB, or both.

PEB phase: In this subsequent phase, decisions are made about the servicemember's fitness for duty, disability rating and DOD and VA disability benefits, and the servicemember has opportunities to appeal those decisions. This includes: (1) the informal PEB stage, an administrative review of the case file by the cognizant military branch's PEB without the presence of the servicemember; (2) VA rating stage, where a VA rating specialist[6] prepares two ratings—one for the conditions

[5]This evaluation is based on the results of the medical exams, the member's medical records, and input from the servicemember's commanding officer.

[6]The VA IDES rating sites are at the Baltimore, Maryland; Providence, Rhode Island; and Seattle, Washington regional offices.

that DOD determine made a servicemember unfit for duty, which DOD uses to provide military disability benefits, and the other for all service-connected disabilities, which VA uses to determine VA benefits.[7] In addition, the servicemember has several opportunities to appeal different aspects of their disability evaluations: a servicemember dissatisfied with the decision on whether he or she is fit for duty may request a hearing with a "formal" PEB; a member who disagrees with the formal PEB fitness decision can, under certain conditions, appeal to the reviewing authority of the PEB;[8] and a servicemember can ask for VA to reconsider its ratings decisions based on additional evidence, though only for conditions found to render the servicemember unfit for duty.

Transition phase: If the servicemember is found unfit to serve, he or she enters the transition phase and begins the process of separating from the military. During this time, the servicemember may take accrued leave. Also, DOD board liaisons and VA case managers provide counseling on available benefits and services, such as job assistance.

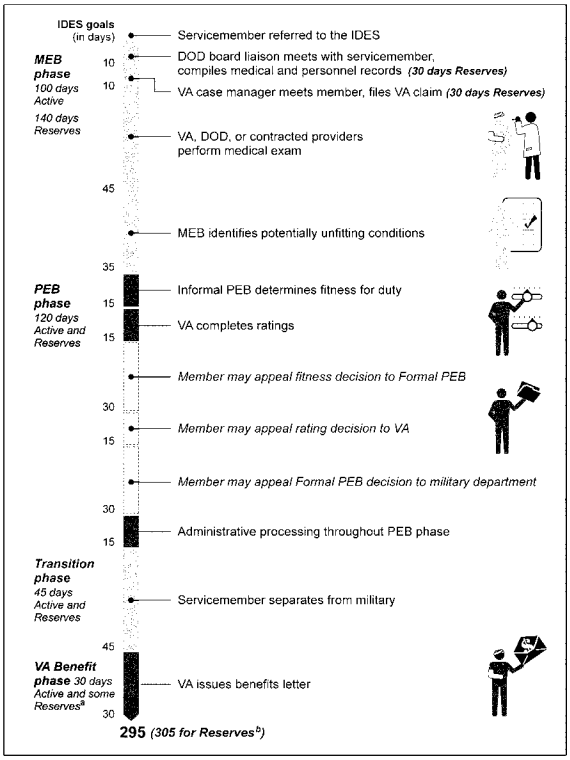
VA benefits phase: A servicemember found unfit and separated from service becomes a veteran and enters the VA benefits phase. VA finalizes its disability rating after receiving evidence of the servicemember's date of separation from military service. VA then starts to award monthly disability compensation to the veteran.

DOD and VA established timeliness goals for the IDES process to provide VA benefits to active duty servicemembers within 295 days of being referred into the process, and to reserve component members within 305 days (see fig. 1). DOD and VA also established interim timeliness goals for each phase and stage of the IDES process. These time frames are an improvement over the legacy disability evaluation system, which was estimated to take 540 days to complete. In addition to timeliness, DOD surveys servicemembers on their satisfaction at several points in the process, with a goal of having 80 percent of servicemembers satisfied.

[7]VA determines the degree to which veterans are disabled in 10 percent increments on a scale of 0 to 100 percent. If VA finds that a veteran has one or more service-connected disabilities with a combined rating of at least 10 percent, the agency will pay monthly compensation.

[8]The reviewing authorities of PEBs in the respective services are the Air Force Personnel Council, the Army Physical Disability Agency, and the Navy Council of Review Boards.

Figure 1: Steps of the IDES Process and Timeliness Goals



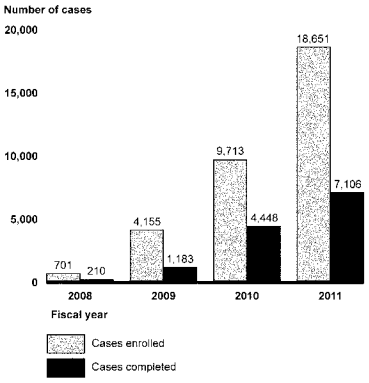
Source: GAO analysis of DOD and VA policies and guidance.

[a]DOD applies the 30-day goal for the VA benefits phase to some but not all reservists, depending on their active duty status.

[b]DOD guidance allows 40 more days for reserve component members than for active duty members in completing the first two steps of the process, in to provide sufficient time for employer notification, establish orders for active duty, and compile medical records. However, DOD and VA's goal for total IDES processing time is only 10 days longer for reserve component members than for active duty members because the VA benefit phase time of 30 days is not included in the 305 days for reserve component members.

Enrollment in IDES continued to grow as IDES completed its worldwide expansion. In fiscal year 2011, 18,651 cases were enrolled in IDES compared to 4,155 in fiscal year 2009 (see fig 2). IDES caseload varies by service, but the Army manages the bulk of cases, accounting for 64 percent of new cases in fiscal year 2011. Additionally, active duty servicemembers represent the majority of IDES cases, accounting for 88 percent of new cases in fiscal year 2011.

Figure 2: New IDES Cases Enrolled and IDES Cases Completed by Fiscal Year



Source: GAO analysis of DOD data.

Note: Cases completed include those where servicemembers exited the IDES process, such as those who received benefits or returned to duty.

IDES Processing Times Increased over Time, While Measures of Servicemember Satisfaction Have Shortcomings

Overall IDES Case-Processing Times Steadily Increased Since the Start of IDES

Overall IDES timeliness has steadily worsened since the inception of the program. Since fiscal year 2008, the average number of days for servicemembers cases to be processed and to receive benefits increased from 283 to 394 for active duty cases (compared to the goal of 295 days) and from 297 to 420 for reserve cases (compared to the goal of 305 days). Relatedly, the proportion of cases meeting timeliness goals decreased from more than 63 percent of active duty cases completed during fiscal year 2008 to about 19 percent in fiscal year 2011 (see table 1).[9]

Table 1: Timeliness for IDES Cases Resulting in Receipt of VA Benefits

Fiscal year (of case completion)	2008	2009	2010	2011
Average processing time in days				
Active duty (goal = 295)	283	313	357	394
Reserve/National Guard (goal = 305)	297	316	370	420
Percent of cases meeting timeliness goals				
Active duty	63.4	50.2	31.6	18.8
Reserve/National Guard	65.0	51.7	37.2	18.0

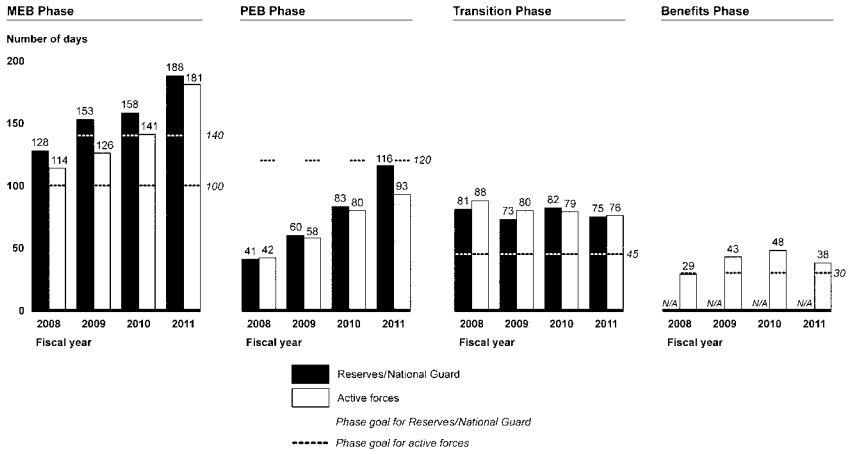
Source: GAO analysis of DOD and VA data

Note: For purposes of this testimony, GAO opted to not include reserve component time spent in the VA benefit phase in our calculations for overall time because the 30 days allotted for this phase is not included in the 305days overall goal for the reserve component.

[9]Analyzing timeliness by year of case completion necessarily results in lower processing times in fiscal year 2008 because the IDES process began in fiscal year 2008 and only those cases that were resolved quickly would be included in the first year average processing time. We also analyzed case timeliness by year of enrollment, which generally showed the same overall trends in longer processing times and fewer cases meeting goals. Analyzing timeliness by year of enrollment generally results in lower processing times in fiscal year 2011 because only those cases that were resolved quickly would be included in the last year average processing time.

When examining timeliness across the four phases that make up IDES, data show that timeliness regularly fell short of interim goals for three—MEB, Transition, and VA Benefits (see fig. 3). For example, for cases that completed the MEB phase in fiscal year 2011, active and reserve component members' cases took on average of 181 and 188 days respectively to be processed, compared to goals of 100 and 140 days. For the PEB phase, processing times increased over time, but were still within established goals.

Figure 3: Average Processing Time for Each IDES Phase (in Days)



Source: GAO analysis of DOD and VA data.

Note: Data shown are for servicemember cases that completed a phase in a particular year. For purposes of this testimony, we opted to not include reserve component time spent in the VA benefit phase in our calculations phase because this goal applies to some but not all reservists, depending on their active duty status.

MEB phase: Significant delays have been occurring in completing medical examinations (medical exam stage) and delivering an MEB decision (the MEB stage). For cases completing the MEB phase in 2011, 31 percent of active and 29 percent of reserve cases met the 45-day goal for the medical exam stage and 20 percent of active case and 17 percent of reserve cases met the 35-day goal for the MEB stage. Officials at some sites we visited told us that MEB phase goals were difficult to meet and not realistic given current resources. At all the facilities we visited, officials told us DOD board liaisons and VA case managers had large case loads. Similarly, some military officials noted that they did not have sufficient numbers of doctors to write the narrative summaries needed to complete the MEB stage in a timely manner. Monthly data produced by DOD subsequent to the data we analyzed show signs of improved timeliness for these two stages: for example, 71 percent of active cases met the goal for the medical exam stage and 43 percent met the goal for the MEB stage in the month of March 2012. However, it is too early to tell the extent to which these results will continue to hold.

PEB phase: PEB processing times goals were also not met in fiscal year 2011 for the informal PEB and VA rating stages. For cases that complete the PEB phase in fiscal year 2011, only 38 percent of active duty cases received an informal PEB decision within the 15 days allotted, and only 32 percent received a preliminary VA rating within the 15-day goal. Also during this phase, the majority of time (75 out of the 120 days) is set aside for servicemembers to appeal decisions—including a formal PEB hearing or a reconsideration of the VA ratings. However, only 20 percent of cases completed in fiscal year 2011 actually had any appeals; calling into question DOD and VA's assumption on the number of expected appeals and potentially masking processing delays in other mandatory parts of the PEB phase.

Transition phase: The transition phase has consistently taken longer than its 45-day goal—almost twice as long on average. While processing times improved slightly for cases that completed this phase in fiscal year 2011 (from 79 days in 2010 to 76 days in fiscal year 2011 for active duty cases), timeliness has remained consistently problematic since fiscal year 2008. DOD officials suggested that it is difficult to meet the goal for this phase because servicemembers are taking accrued leave—to which they are entitled—before separating from the service. For example, an Army official said that Army policy allows servicemembers to take up to 90 days of accrued leave prior to separating, and that average leave time was about 80 days. Although servicemember leave is skewing the performance data, officials said that they cannot easily back this time out

from their tracking system, but are exploring options for doing so, which would be more reflective of a servicemember's actual total time spent in the evaluation process.

VA benefits phase: Processing time improved somewhat for the benefits phase (48 days in fiscal year 2010 to 38 days in fiscal year 2011), but continued to exceed the 30-day goal for active duty servicemembers.[10] Several factors may contribute to delays in this final phase. VA officials told us that cases cannot be closed without the proper discharge forms and that obtaining these forms from the military services can sometimes be a challenge. Additionally, if data are missing from the IDES tracking system (e.g., the servicemember already separated, but this was not recorded in the database), processing time will continue to accrue for cases that remain open in the system. Officials could not provide data on the extent to which these factors had an impact on processing times for pending cases, but said that once errors are detected and addressed, reported processing times are also corrected.

Shortcomings in the Design and Administration of Servicemember Survey

In addition to timeliness, DOD and VA evaluate IDES performance using the results of servicemember satisfaction surveys. However, shortcomings in how DOD measures and reports satisfaction limit the usefulness of these data for making IDES management decisions.

- *Response rates*: Survey administration rules may unnecessarily exclude the views of some servicemembers. In principle, all members have an opportunity to complete satisfaction surveys at the end of the MEB, PEB, and transition phases; however, servicemembers become ineligible to complete a survey for either the PEB or transition phases if they did not complete a survey in an earlier phase. Additionally, by only surveying servicemembers who completed a phase, DOD may be missing opportunities to obtain input from servicemembers who exit IDES in the middle of a phase.

[10]DOD and VA did not set a goal for reserve component servicemembers.

- *Alternate measure shows lower satisfaction:* DOD's satisfaction measure is based on an average of responses to questions across satisfaction surveys. A servicemember is defined as satisfied if the average of his or her responses is above 3 on a 5-point scale, with 3 denoting neither satisfied nor dissatisfied. Using an alternate measure that defines servicemembers as satisfied only when all of their responses are 4 or above,[11] GAO found satisfaction rates several times lower than DOD's calculation. Whereas DOD's calculation results in an overall satisfaction rate of about 67 percent since the inception of IDES, GAO's alternate calculation resulted in a satisfaction rate of about 24 percent. In our ongoing work, we will continue to analyze variation in satisfaction across servicemember cases using both DOD's and GAO's measures of satisfaction.

In our ongoing work, we will continue to assess survey results and their usefulness for measuring performance. In the meantime, DOD is reconsidering alternatives for measuring satisfaction, but has yet to come to a decision. Officials already concluded that the survey, in its current form, is not a useful management tool for determining what changes are needed in IDES and said that it is expensive to administer—costing approximately $4.3 million in total since the start of the IDES pilot. DOD suspended the survey in December 2011 because of financial constraints, but officials told us they plan to resume collecting satisfaction data in fiscal year 2013.

[11]Using DOD's satisfaction measure, GAO found less than expected variation in satisfaction over time and across key case characteristics, such as component, military branch, final rating and final disposition. To better understand factors that may drive servicemember satisfaction, GAO eliminated neutral responses to arrive at a measure that more strongly reflects satisfaction and might be more sensitive indicator of factors affecting satisfaction for performance management purposes. This is a more conservative measure of satisfaction, because it rules out the possibility that a servicemember is called "satisfied" even when he or she is dissatisfied on a large number of questions in the scale. Our measure is an important complement to DOD's scale, which can mask pockets of servicemember dissatisfaction. Nevertheless, the inverse of our measure should not be read as a higher level of dissatisfaction.

Recent Actions and Ongoing Initiatives May Improve IDES Performance, but It Is Too Early to Assess Their Overall Impact

DOD and VA Took Steps to Address Previously Identified IDES Challenges

DOD and VA have undertaken a number of actions to address IDES challenges—many of which GAO identified in past work. Some actions—such as increased oversight and staffing—represent important steps in the right direction, but progress is uneven in some areas.

- *Increased monitoring and oversight:* GAO identified the need for agency leadership to provide continuous oversight of IDES in 2008, and reported the need for system-wide monitoring mechanisms in 2010. Since then, agency leadership has established mechanisms to improve communication, monitoring, and accountability. The secretaries of DOD and VA have met several times since February 2011 to discuss progress in improving IDES timeliness and have tasked their agencies to find ways of streamlining the process so that the goals can be reduced. Further, senior Army and Navy officials regularly hold conferences to assess performance and address performance issues, including at specific facilities. For instance, the Army's meetings are led by its vice-chief of staff and VA's chief of staff, and include reviews of performance where regional and local facility commanders provide feedback on best practices and challenges. Further, VA holds its own biweekly conferences with local staff responsible for VA's portion of the process. For example, officials said a recent conference addressed delays at one Army IDES site and discussed how they could be addressed. VA officials noted that examiner staff were reassigned to this site and examiners worked on weekends to address the exam problems at this site.

- *Increased staffing for MEB and VA rating:* In 2010, we identified challenges with having sufficient staff in a number of key positions, including DOD board liaisons and MEB physicians. DOD and VA are working to address staffing challenges in some of the IDES processes that are most delayed. The Army is in the midst of a major hiring initiative to more than double staffing for its MEBs over its October

2011 level, which will include additional board liaison and MEB physician positions. The Army also plans to hire contact representatives to assist board liaisons with clerical functions, freeing more of the liaisons' time for counseling servicemembers. Additionally, VA officials said that the agency has more than tripled the staffing of its IDES rating sites to handle the demand for preliminary ratings, rating reconsiderations, and final benefit decisions.

- *Resolving diagnostic differences:* In our December 2010 report, we identified differences between DOD physicians and VA examiners, especially regarding mental health conditions, as a potential source of delay in IDES. We also noted inconsistencies among services in providing guidance and a lack of a tracking mechanism for determining the extent of diagnostic differences. In response to our recommendation, DOD commissioned a study on the subject. The resulting report confirmed the lack of data on the extent and nature of such differences, and that the Army has established guidance more comprehensive than guidance DOD was developing on how to address diagnostic differences, and recommended that DOD or the other services develop similar guidance. A DOD official told us that consistent guidance across the services, similar to the Army's, was included in DOD's December 2011 IDES manual. Also, in response to our recommendation, VA plans to modify the VTA database used to track IDES to collect this information on cases, although the upgrade has been delayed several times.

DOD has other actions underway, including efforts to improve sufficiency of VA examinations, MEB written summaries and reserve component records. We plan to review the status of these efforts as part of our ongoing work, which we anticipate completing later in 2012.

DOD and VA Are Working on Shortcomings in Information Systems, but Efforts to Date Are Limited

DOD and VA are working to address shortcomings in information systems that support the IDES process, although some efforts are still in progress and efforts to date are limited.

- *Improving local IDES reporting capability*: DOD and VA are implementing solutions to improve the ability of local military treatment facilities to track their IDES cases, but multiple solutions may result in redundant work efforts. Officials told us that the VTA—which is the primary means of tracking the completion of IDES cases—has limited reporting capabilities and staff at local facilities are unable to use it for monitoring the cases for which they are responsible. DOD and VA

have been developing improvements to VTA that will allow board liaisons and VA case managers to track the status of their cases. VA plans to include these improvements in the next VTA upgrade, currently scheduled for June 2012. In the meantime, staff at many IDES sites have been using their own local systems to track cases and alleviate limitations in VTA. Further, the military services have been moving ahead with their own solutions. For instance, the Army has deployed its own information system for MEBs and PEBs Army-wide. Meanwhile, DOD has also been piloting its own tracking system at 9 IDES sites.[12] As a result, staff at IDES sites we visited reported having to enter the same data into multiple systems.

- *Improving IDES data quality*: DOD is taking steps to improve the quality of data in VTA. Our analysis of VTA data identified erroneous or missing dates in at least 4 percent of the cases reviewed. Officials told us that VTA lacks adequate controls to prevent erroneous data entry, and that incorrect dates may be entered, or dates may not be entered at all, which can result in inaccurate timeliness data. In September 2011, DOD began a focused effort with the services to correct erroneous and missing case data in VTA. Officials noted that the Air Force and Navy completed substantial efforts to correct the issues identified at that time, but Army efforts continue. While improved local tracking and reporting capabilities will help facilities identify and correct erroneous data, keeping VTA data accurate will be an ongoing challenge due to a lack of data entry controls.

DOD and VA are also pursuing options to allow the electronic transfer of case files between facilities. We are reviewing the status of this effort as part of our ongoing work.

DOD and VA are Pursuing Broader Solutions to Improve IDES Performance

Based on concerns from the agencies' secretaries about IDES delays, DOD and VA have undertaken initiatives to achieve time savings for servicemembers. The agencies have begun a business process review to better understand how IDES is operating and identify best practices for possible piloting. This review incorporates several efforts, including,

[12] A DOD official told us that based on recent negative feedback, DOD is considering cancelling this pilot project.

- *Process simulation model*: Using data from site visits and VTA, DOD is developing a simulation model of the IDES process. According to a DOD official, this process model will allow the agencies to assess the impact of potential situations or changes on IDES processing times, such as surges in workloads or changes in staffing.

- *Fusion diagram*: DOD is developing this diagram to identify the various sources of IDES data—including VA claim forms and narrative summaries—and different information technology systems that play a role in supporting the IDES process. Officials said this diagram would allow them to better understand and identify overlaps and gaps in data systems.

Ultimately, according to DOD officials, this business process review could lead to short- and long-term recommendations to improve IDES performance, potentially including changes to the different steps in the IDES process, performance goals, and staffing levels; and possibly the procurement of a new information system to support process improvements. However, a DOD official noted that these efforts are in their early stages, and thus there is no timetable yet for completing the review or providing recommendations to senior DOD and VA leadership.

Concluding Observations

By merging two duplicative disability evaluation systems, IDES has shown promise for expediting the delivery of DOD and VA benefits to injured servicemembers and is considered by many to be an improvement over the legacy process it replaced. However, nearly 5 years after its inception as a pilot, delays continue to affect the system and their causes are not yet fully understood. Recent initiatives to better understand factors that lead to delays and remedy them are promising, however it remains to be seen what their effect will be. Given the persistent nature of IDES performance challenges, continued attention from senior agency leadership will be critical to ensure that delays are understood and remedied.

We have draft recommendations aimed at helping DOD and VA further address challenges we identified, which we plan to finalize in our forthcoming report after fully considering both DOD and VA's comments.

Chairman Murray and Ranking Member Burr, this concludes my prepared statement. I would be pleased to respond to any questions that you or other Members of the Committee may have at this time.

GAO Contact and Staff Acknowledgments

For further information about this testimony, please contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. In addition to the individual named above, key contributors to this statement include Michele Grgich, Daniel Concepcion, Melissa Jaynes, and Greg Whitney. James Bennett, Joanna Chan, Douglas Sloane, Vanessa Taylor, Jeff Tessin, Roger Thomas, Walter Vance, Kathleen van Gelder, and Sonya Vartivarian provided key support.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO DANIEL BERTONI, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

Question 1. In your opinion, are the IDES Process and Timeliness goals realistic?

Response. More information is needed to determine if and how the current IDES timeliness goals can be met. While IDES processing times increased as the system expanded, the contribution of various factors to timeliness is complex and not fully understood. In its testimony and in previous work, GAO highlighted issues, such as insufficient staffing and logistical challenges, that contributed to delays in processing cases. In the meantime, the number and range of IDES facilities and enrolled cases steadily increased since the inception of IDES in 2007 through the completion of its worldwide deployment in 2011, complicating the understanding of whether IDES goals are reasonable. DOD and VA are now increasing resources devoted to IDES and are at various stages of implementing process improvements. Some of these changes are in their early stages and it is too soon to know their impact on timeliness. DOD is also undertaking a business process review, which may allow it to better understand how different IDES processes and resource levels contribute to timeliness. These efforts, along with a fully deployed and more stable IDES process, may provide the departments with an opportunity to reassess resources and timeframes, and make adjustments if needed.

Question 2. Is there any reason why active-duty and Reservists should be held to a different timeline in the IDES Process?

Response. DOD guidance allows for more time in some parts of the IDES process to accommodate additional work that may be needed to address circumstances that reserve component servicemembers (reservists) face. Overall, DOD and VA established a goal of 305 days for reservists as compared to 295 days for active duty servicemembers. In the medical evaluation board (MEB) phase—during which records are compiled and exams conducted—timeliness goals allow an additional 40 days for processing reservists' cases. The additional MEB time is to accommodate reservists that may need to be placed on active duty orders and travel to military treatment facilities to undergo the IDES process. Also, additional time may be needed to compile medical records for reservists. While the MEB goal for reservists is 40 days longer, the 30-day goal for the VA benefits phase does not apply to all reservists and therefore was subtracted from the reservist overall goal for the IDES process. As such, the net effect is that the overall reservist goal (305) is 10 days longer than for active component servicemembers (295).

Chairman MURRAY. Thank you very much, Mr. Bertoni.

I just wanted to let our Committee Members know that following the revelation that possibly hundreds of soldiers at Joint Base Lewis-McChord had their PTSD diagnosis changed because a group of people did not want to spend money on the care and benefits that these servicemembers would receive, I asked our Committee staff to conduct an investigation into the Joint Disability Evaluation System.

We are at an interim point in this investigation. Up to today, staff have reviewed 121 cases from 23 different IDES sites. They have focused on cases involving mental health diagnosis in general and PTSD diagnoses in particular.

I am very troubled by what they found. They have found evaluations that focus on perceived malingering or exaggeration of symptoms, similar to what we saw at Madigan, without documentation of appropriate standardized interview techniques. They have encountered inadequate VA medical examinations, especially in relation to Traumatic Brain Injury, and VA rating decisions issued as part of this joint process contained errors, which in some cases impacted the level of benefits the veteran should have received.

So before we begin today's questions, I am entering the results of this interim investigation into the record at this point and there will be more to come.

[The report referred to follows:]

United States Senate
Committee on Veterans' Affairs

Senator Patty Murray

Chairman

Interim Committee Staff Report:

Investigation of Joint Disability Evaluation System

May 21, 2012

INTERIM COMMITTEE STAFF REPORT
INVESTIGATION OF JOINT DISABILITY EVALUATION SYSTEM
SENATE COMMITTEE ON VETERANS' AFFAIRS
May 21, 2012

During the past two months, Committee staff has reviewed 121 claims from 23 different Integrated Disability Evaluation System (IDES) sites involving mental health diagnoses in general and Post-Traumatic Stress Disorder (PTSD) diagnoses in particular. Preliminary results from this investigation have indicated the following:

1. Some Inconsistency Identified Between Military and VA Decisions

Evaluations were inconsistent in about 34% of the claims reviewed. In some cases, the data available in an electronic format was insufficient to assess consistency.[1]

2. Inconsistencies in Diagnosis by Military and VA Examiners and Treating Providers

The frequency and severity of inconsistencies between military mental health providers, military disability evaluators, and VA was less frequent at locations other than the Forensic Psychiatry Reviews at Madigan. However, evaluations at some other military sites focused on perceived "malingering" (which requires intent to deceive) or exaggeration of symptoms without documentation by appropriate standardized interview techniques and recommended psychometric tests.

- For example, providers at Fort Bragg found malingering, lack of cooperation and exaggeration of symptoms without evidence of a structured interview and multiple psychometric measures. Some clinicians focused on tests for malingering without other diagnostic tests for PTSD. When the same servicemembers were examined by other clinicians, they were diagnosed with compensable mental health disabilities, documented by multiple psychometric tests including those that assess for false responses.

- In some locations servicemembers were found fit for duty with mental health conditions rated at 50% or higher by VA rating decisions.

3. Military Providers Did Not Always Use Structured Interview Techniques or Appropriate Testing

Military medical providers did not regularly use widely accepted best practices, such as the Clinician Administered PTSD Scale or CAPS which is considered the "gold standard"

[1] Evaluations were considered consistent if the VA rating was 50% or greater for mental health conditions (including those for which 38 C.F.R. section 4.129 would not apply) and the military found the servicemember unfit or the VA rating was less than 50% and the service found the member fit.

in PTSD assessment, for structured interviews or a multi-faceted testing protocol in their diagnosis and assessment of PTSD.[2]

4. DoD is Not Recognizing Chronic Adjustment Disorder as a Disability

Servicemembers diagnosed with a chronic adjustment disorder due to stressors in military service are not considered disabled by the military services, but are recognized by VA and the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) as disabling conditions.[3] The refusal of DoD to recognize the stress-related condition of chronic adjustment disorder as an unfitting disability has resulted in the denial of disability retired pay to servicemembers whose persistent symptoms due to a combat-related stressor do not meet the full criteria for PTSD.

In some of the cases reviewed, an initial diagnosis of adjustment disorder was subsequently found at discharge or after review of the Madigan Forensic Psychiatry opinions to meet all of the relevant criteria for PTSD due to combat or military sexual trauma.

The DoD policy concerning chronic adjustment disorders is inconsistent with the criteria in the DSM-IV-TR and the VA rating schedule which requires service-connection of chronic adjustment disorder incurred in or aggravated by military service.[4]

5. Incorrect Application of VA Regulation May Lead to More Soldiers on Temporary Disability Retirement List

Servicemembers who are being considered for medical separation due to behavioral health disorders not related to stress may be processed by the military services and VA rating decisions under the criteria of a VA Regulation (38 C.F.R. section 4.129) that applies only to mental health disorders resulting from a highly stressful event. This incorrect interpretation and application may lead some servicemembers, who are otherwise qualified for Permanent Disability Retirement, to be placed on the Temporary Disability Retirement List (TDRL) and be subjected to additional examinations and reviews.[5] This results in an increased workload for an already stretched group of behavioral health providers. VA identified one regional office which had erroneously

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[2] See, Chapter 2 "Assessment and Diagnosis of Adults" in Effective Treatments for PTSD: Practice Guidelines form the International Society for Traumatic Stress Studies. Second Edition (ed. Edna B. Foa et al).

[3] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (2000). An example of a chronic stressor is a "general disabling medical condition". DSM-IV-TR at 679.

[4] DSM-IV-TR Diagnostic criteria for Adjustment Disorders at 683.

[5] In some cases it appears that the VA rating decision incorrectly identified section 4.129 as being applied to mental health disabilities when no stressor was identified. MEB medical staff indicated that they have been instructed to apply section 4.129 in all mental health cases where the servicemember is separating due to a behavioral health diagnosis.

applied section 4.129 to any mental health condition. VA provided training on the correct application of section 4.129 to that office. Medical Evaluation Board (MEB) physicians indicated a belief that the Army required the application of section 4.129 to all behavioral health unfitting mental health conditions, although Army command reports that this is not the policy. It appears that both VA and the military services need clearer instructions on the applicability of section 4.129.

6. Errors Were Identified in VA Rating Decisions

Approximately 45% of 24 rating decisions reviewed at a military Physical Evaluation Board (PEB) site contained errors. Some of these errors adversely affected the benefits awarded by the military and by VA to separating servicemembers. Others were likely to lead to appeals because of erroneous notices, but may not necessarily change the result of the claim. VA Regional Offices were notified of such errors and indications of potential errors.

Examples of errors identified during the review of claims include:

- A servicemember with a lung condition who was being treated with steroids and immunosuppressive drugs was incorrectly rated at 0% rather than 100%.
- A servicemember who had multiple hospitalizations for psychotic episodes within his last year of service was erroneously rated at 50% when his condition warranted a higher evaluation.
- A servicemember who suffered a blast injury and who had frequent post-traumatic headaches with photophobia was incorrectly denied service-connection for headaches related to a Traumatic Brain Injury (TBI).
- Other servicemembers were erroneously rated at 0% for conditions the military found unfitting.

7. Some VA Medical Examinations Failed to Evaluate TBI Residuals

Some VA medical examinations involving TBI failed to address findings on detailed neuropsychological testing conducted during service. TBI facets such as memory are reported as "normal" based on "general conversation" without repeating or referencing prior tests, which identified the type and severity of the servicemember's TBI deficits. In a number of cases, TBI and PTSD conditions were rated together when the evidence suggested that some of the TBI conditions should have been considered separately. For example:

- Testing that would help to differentiate between TBI and mental health conditions was not conducted despite indications of deficits, such as visual-

spatial orientation and memory loss due to organic injuries (such as trauma to a specific part of the brain associated with certain deficits).

- VA claims for TBI residuals were denied or received a lower rating based on the absence of objective testing. If testing had been conducted, objective evidence of TBI for symptoms complained of by the servicemember, might have changed the result.

- Conclusions by VA examiners were inconsistent with the medical evidence, such as an examination for TBI which found no TBI to support a diagnosis of post-traumatic headaches, but indicated that the same veteran's dizziness following an IED blast injury was due to his TBI.

- A servicemember diagnosed with anxiety disorder prior to separation was erroneously denied service-connection for PTSD when the disability had been diagnosed as anxiety disorder due to combat.

8. Military Services Failed to Consider the Combined Effect of Related Disabilities

In some cases, the military service did not consider the combined effect of closely related disabilities in determining fitness. For example, a servicemember was found unfit due to a musculoskeletal condition of the lower back but was found fit for the related radiculopathy related to the same disability.

9. Errors Were Identified in VA Rating of Conditions Not Unfit for Military Service

Ratings provided by VA contained a number of errors which were not considered unfitting by the PEB, but which adversely impacted the rating provided by VA. For example:

- A servicemember who had documented nerve injuries due to a combat wound was not rated for the disability by VA.

- A servicemember who was diagnosed with Gastroesphogeal Reflux Disease (GERD) on the VA examination was denied benefits due to "no diagnosis".

- A servicemembers who had claimed a condition not considered unfitting by the military service did not have the condition evaluated in the rating decision for VA benefits.

Chairman MURRAY. Dr. Rooney, let me start with you. We have had discussions in the past regarding this Joint Disability Evaluation System and the number of challenges servicemembers face while they are going through this process. Recently, it has come to my attention that some of our servicemembers involved with the disability evaluation process are facing retribution and unsupportive behavior from their chains of command while on limited duty and waiting for a disability decision.

I have heard from servicemembers who were forced to participate in activities in direct violation of doctors' orders, who have been disciplined while struggling with behavioral health conditions, and who have struggled to get access to care because their leadership would not cooperate with their treatment requirements.

I think you agree with me that is completely unacceptable. Whether in a Warrior Transition Unit or not, leaders have to understand these medical issues and the difficult process that these servicemembers are going through and they have to provide the leadership and support that these men and women need.

So I wanted to begin with you by asking you, Dr. Rooney, what needs to be done to provide supportive and compassionate leadership for these injured servicemembers that are forced to wait for a disability decision?

Ms. ROONEY. Senator, clearly the information you just shared is troubling on many levels, and I would be very interested in speaking with you or your staff or that we can actually determine where those issues are occurring and make sure that, in fact, the leadership does know, which is the Department's position and the leadership at many levels that I am familiar with, that that cannot be tolerated, that we must understand what is necessary for the care, that there are no stigmas associated with being able to address behavioral health or mental health issues, and that really is the Department's position.

So in those cases, if there are those substantive issues that you mentioned, not only do we need to find out where those are so we can work directly with that leadership and correct that situation, but we will continue with our ongoing work at all levels of commands, not just at the senior level in the Department, but we understand that needs to go right through the command level of every installation to ensure that, in fact, the situations you have described are not occurring.

Chairman MURRAY. Well, we need to make sure that is happening, because as we all know, these are very challenging situations for these soldiers and any kind of retribution should not be tolerated, whether it is one case or many. But I will share those with you. But I want to make sure that systemwide, that leaders throughout the chain of command all the way to the bottom, are clearly understanding what these soldiers are going through and are not having any kind of repercussions on those individuals.

Ms. ROONEY. Absolutely.

Chairman MURRAY. Mr. Gingrich, from the perspective of someone who has served in many leadership positions within the military, what can we do to educate our military leaders on not only this process, but really on the medical issues facing so many of these young men and women?

Mr. GINGRICH. Madam Chairman, I see a lot of things the Army is doing and I know that because I have been to their BTCs. They have started, as we were told by GAO, they are now bringing in layers all the way up to the Vice Chief of Staff. So they have involved the colonel level discussion groups, brigadier general, major general, all the way up, and they have included VA in every one of those discussion groups.

So I think getting the information out is the biggest key that we have got to go and the biggest challenge we have. The Secretary right now, yesterday, spoke to the Sergeant Major Academy in the Army and the sergeant majors are now understanding that this is a problem that we have to take on as two Departments and not just as one, and I think that education is happening.

Chairman MURRAY. Well, we still have a lot of work to do.

Mr. GINGRICH. Yes, ma'am, we do.

Chairman MURRAY. OK. Dr. Rooney, there is no doubt that the events at Madigan have shaken the trust and confidence of servicemembers who are in the disability evaluation system. I believe that transparency and sharing information about the ongoing reevaluations that are happening today, and actions that the Army and DOD are taking to remedy this situation will go a long ways toward restoring some trust in this system.

I wanted to ask you today what we have learned from the investigations that the Army is conducting into the forensic psychiatry unit at Madigan.

Ms. ROONEY. Well, as you pointed out earlier, there have been 196 reevaluations completed to date, of which 108 of those have been diagnosed as having PTSD where before they had not. We also identified——

Chairman MURRAY. Let me just say that they had been diagnosed with PTSD. When they went through the evaluation system, they were told they did not. Now going back and re-evaluating them once they have gone out, we are saying, yes, you did indeed have PTSD.

Ms. ROONEY. Correct. 108 of those 196.

Chairman MURRAY. More than half.

Ms. ROONEY. Correct. There are 419 that have been determined to be eligible for reevaluation, 287 from the original group that was looked at, and as you know, the Army actually opened the aperture up to see anybody else that would have gone through the process while forensic psychiatrists were being used. So that was 419 totally eligible for reevaluation.

And at this point, there are three in progress and 12 being scheduled. So what we have learned from that is clearly that the process that was put into place at that time did not function as originally designed. Evidence did not show that there was a mean-spirited attempt, but really to create similar diagnoses. Obviously that was not something that occurred.

So the Army has taken the lessons from here and is actually going back to 2001 to reevaluate all of the cases where we might have a similar situation. What we are doing from that point is not only learning from what Army is doing and looking at these reevaluations where we are using the new standards, in many ways advances in the medical and the behavioral health areas to better

diagnose PTSD, but also then we will be taking those lessons learned across the other services as well.

So since Army has the greatest majority of people going through, currently about 68 percent of the people in the disability evaluation process are from Army, we will take the lessons learned from there and apply those across to all of the services.

Chairman MURRAY. Well, I really appreciate the Army's announcement that they are now going to do a comprehensive review of PTSD and behavioral health systemwide throughout the Army. I believe that is a first and important major step for the Army to be doing.

But I did want to ask you, Dr. Rooney, I had been told by Secretary McHugh about the issues that we were seeing at Madigan were not systemwide. And then the Secretary announced a comprehensive review across all systems. So if we did not believe this was a systemwide problem, what led the Army to look into a comprehensive review?

Ms. ROONEY. Secretary McHugh and I have had numerous conversations, and I believe the use of the forensic psychiatrists was primarily isolated to Madigan, and that is where I believe that comment of that it was not systemwide, because that type of additional part of the process——

Chairman MURRAY. So the forensic system was not systemwide, but systemwide we have issues with people who are not being diagnosed correctly?

Ms. ROONEY. What we want to do is look across the system and ensure if we do have issues, that we identify those and we are able to get those individuals back into the system. So I believe at this point, it was very much a forward leaning approach to say, We need to look across the system, not that we are convinced that similar problems existed, but that it is the right thing to do for the individuals, since as you pointed out, we saw a number of these reevaluations ended up with diagnoses changed. So it is the right thing to do for our people to look across.

Chairman MURRAY. OK. I think it is extremely important that we find anybody who was misdiagnosed and get them care. So we will be continuing to focus on this.

Ms. ROONEY. Absolutely.

Chairman MURRAY. With that, let me turn it over to Senator Boozman.

Senator BOOZMAN. Yes, ma'am. With your permission, what I would like to do is go ahead and defer to Senator Burr and then come back when it is appropriate.

Chairman MURRAY. OK, great.

Senator BURR. I thank my colleague. Madam Chairman, thank you for this hearing, and Mr. Gingrich, I share your cold. It is not fun.

Dr. Rooney, do you disagree with the GAO's testimony today?

Ms. ROONEY. Sir, we look at the GAO as a partner to help us evaluate how we are doing. I think they brought up some very good points in their report. Of course, when you are using statistics, we may look a little differently at a particular statistic.

However, I will say that there was nothing in there that we did not think really helped us further understand where our emphasis

needs to be, that there are improvements. We have been very open about saying that this is a system that needs significant improvements. I think the GAO very much said the same thing.

So we are looking to continue to work with them, take the information they provided, and it gives us a roadmap to make sure, as we are putting resources to it, we take their report, plus our own internal analysis that goes even deeper than theirs, to ask, are these improvements making—are the resources making improvements to this system, which we all know and totally agree is not where we want it to be.

Senator BURR. Mr. Gingrich, do you disagree with any of the testimony of GAO?

Mr. GINGRICH. No, sir. In fact, I look forward to the discussions we had before the testimony and the report, because I believe any time that somebody gives you insights into what you are doing, that you can take care of one more veteran or servicemember to make their life better in this transition process, we need to look it and make it happen.

Senator BURR. So we are all in agreement that we are just south of 400 days in the cycle of an applicant being processed, 395, I think, 394. In May 2011, the Secretary of Defense and the Secretary of Veterans Affairs committed to revising the IDES so that it could be completed in 150 days, and went further to agree to explore options for it to be 75 days.

Now, I have had too many of these hearings. We have them every year. And we hear the same thing, Oh, gosh, look at what we are doing. I have heard the most glowing progress report from both of you. And then I get the realities that the days had not changed. You have met some improvement in certain areas. I commend you on that, the timeliness goals in areas have been better.

But the reality is that we have got a broken system, and we are 5 years into it. And I hear testimony where we are starting to begin to review our business processes. Well, you know, why did it take 5 years to get to this? What can you convey to me today that is concrete that tells me a year from now we are not going to be at 393 days?

When you said earlier we are instituting IT changes this summer that will improve our times by 30 or 40, I thought you were going to say percent, and you said days. So now my expectations are that if we implement what you just said, we are going to be down to 360 days, which exceeds the DECSEF (Secretary of Defense) and Secretary of VA by 110 days over what their goal was for today.

So share something with me that will tell me we are actually going to do this.

Ms. ROONEY. Sir, that was one of the steps. The IT solutions are not the only steps. In addition, it was indicating that Army has hired 1,218 people, so we are also adding people to the process.

Senator BURR. Are these the first individuals that we have hired in the 5 years to plus up?

Ms. ROONEY. It is the largest group of people that we have hired.

Senator BURR. OK. We have hired people, we have plussed up, and the overall time of completion went up, not down.

Ms. ROONEY. Many of these changes, sir, are fairly recent.

Senator BURR. OK. Lt. Gen. Bostick, the Army Deputy Chief of Staff, recently called the IDES process fundamentally flawed, adversarial, and disjointed. Do you agree with him?

Ms. ROONEY. I have sat next to my colleague many times, and we have had these discussions. I believe that we are both acknowledging that it is a system that, while initially conceived to be one that was smooth, transparent, and easy, we have not achieved that result.

Senator BURR. So what are we doing to change it?

Ms. ROONEY. As my colleague and I have indicated, at this point we are literally looking case-by-case. We are following cohorts through each step of the process to see when we add people to it, are we actually improving the times? I am not saying that we are not able to improve it for those already in the system, but we have to make sure that we are also tracking the new ones in to say, Did we, in fact, cut that time down? And it is going step-by-step through that process.

Senator BURR. I do not want to seem adversarial, doctor. I think we are all after the same goal. But you just agreed with a statement that General Bostick made where he basically said that this system cannot be fixed. Now, if you agree with that, my question is very simple.

Is it time for us to start over again, to take a blank sheet of paper and say, How do we design this in a way for the benefits of the servicemembers—the number 1 priority and the number 1 priority for both, I do not question that—who are caught in a system that is unacceptable today from a standpoint in the length of time, from a standpoint of the accuracy that Senator Murray talked about.

I guess, you know, my question to you would be, if given a blank slate, would the Army design IDES the same way or would you do it differently? And if your answer is differently, then for God's sakes, let us do it. Tell us what we can do to be partners to change this in a way that it works, versus to keep a structure of something that individuals who are involved in like General Bostick says, is "Fundamentally flawed, adversarial, disjointed." That is not the relationship we want with our servicemembers that are going through this.

The Chairman has been very kind to me. I just want to ask one last question and this is to Mr. Gingrich. You made the statement, I think, in your testimony that VA has the capacity to make compensation as early as they choose to after a servicemember is discharged. Is that accurate?

Mr. GINGRICH. We can make compensation the day after they are discharged. That is correct, Senator.

Senator BURR. The day after they——

Mr. GINGRICH. Right. By law, we cannot do compensation until they have been discharged.

Senator BURR. How long, on average, is it taking for the first VA check to arrive after a servicemember who went through the IDES is discharged from the military, not the decision letter from the VA, but the actual check?

Mr. GINGRICH. Right now it is taking too long. It is taking about 60 days. Part of the reason—and it is not an excuse—but part of

the reason is we do it by month. So if the person is discharged before the pay system is set up, you have eaten 30 days. We are working through that, and I think one of the things that the VTA will give us is that they will give us the information we need electronically at the discharge so that we can speed that process up.

I am very confident that we are going to get very close to the 30-day goal. By the way, VTA—Dan and I talked—VTA will be in place in June and that process will not only allow us to track the payment, it will also allow us to track the ratings and the discrepancies in the ratings.

Senator BURR. The Chair has been very kind, and I appreciate it. I would ask, would you share with us the data that shows us that 60-day average for payment?

Mr. GINGRICH. I will do that, sir.

Senator BURR. Thank you. Thank you, Chair.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. RICHARD BURR TO JOHN R. GINGRICH, CHIEF OF STAFF, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question. Ranking Member Burr requested data showing that there is an average 60-day time period for a discharged Servicemember whose claim has been processed by IDES to begin receiving compensation.

Response. As of June 8, 2012, VA has processed 7,707 disability payments for Servicemembers who have completed the IDES process during fiscal year 2012. Currently, VA is averaging 54 days from the date of separation to process a payment. The "shortest period allowed by law" for making VA disability payments following discharge or release from the military is the first day of the second month after a Servicemember separates. For example, if the Servicemember separates on July 27, the earliest date the Servicemember could be paid is September 1. If payment is due at the time of award authorization, it is released from the Treasury Department within 48 hours of award authorization.

Chairman MURRAY. Thank you very much. Senator Tester?

Senator TESTER. Thank you, Madam Chair. I want to go back to what Senator Burr was asking about, and I will start with you, Dr. Rooney. Do things need to be changed in IDES?

Ms. ROONEY. Yes.

Senator TESTER. Mr. Gingrich, do things need to be changed in IDES?

Mr. GINGRICH. Yes, sir.

Senator TESTER. Could you—and I do not want to know them now, but could you get back to the Committee with your recommendations on what needs to be changed in IDES?

Ms. ROONEY. Yes.

Mr. GINGRICH. Yes, sir.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JON TESTER AND HON. JOHN BOOZMAN TO JO ANN ROONEY, ACTING UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE

Question. Senator Tester and Senator Boozman requested that Dr. Rooney give recommendations to the Committee on what changes need to made to improve IDES.

Response. IDES is a significant leap forward for our Servicemembers and Veterans, but more can be done. Since 2007, IDES has allowed the Departments of Defense (DOD) and Veterans Affairs (VA) to simultaneously complete disability evaluations before DOD separates a Servicemember so both Departments can provide disability benefits at the earliest point allowed under law. It is faster, equitable, and has greatly reduced the pay gap that disabled Veterans previously experienced fol-

lowing their separation from military service and the start of Veterans compensation benefits. Secretary Panetta directed that an internal DOD task force review the IDES process, with VA's support, and report to him by the end of September 2012 on improvement recommendations. The task force is:

- Examining methodologies to stratify IDES groups and thus reflect different outcome based measurements depending on the nature of the group.
- Analyzing the current IDES population and those that have completed it since the launch of the pilot effort in 2007 to determine both the points in the process where the most failures occur and correlating process events with the illness/injuries of the Servicemember.
- Reviewing the current Expedited DES process to identify methods to increase its usage rate among qualified Servicemembers.

Separately, DOD and VA are developing an end-to-end strategy IDES Information Technology (IT) to enhance case management and data sharing.

Senator TESTER. OK. I would anticipate that those changes would add to this simplifying and consolidating as your goals were when this was set up between the VA and DOD, would it not? I just want to make sure that changes would add to the simplification.

Ms. ROONEY. Yes.

Mr. GINGRICH. Yes, sir.

Senator TESTER. Mr. Bertoni, as you look at IDES right now, its goal was to simplify and consolidate. Has it simplified, was the first question?

Mr. BERTONI. I would say yes.

Senator TESTER. OK.

Mr. BERTONI. When you look at what was happening under the Legacy system versus now, it is much more simple.

Senator TESTER. Much simpler. Is there an opportunity through this system to get feedback from servicemembers and address their questions and concerns about this? Is that part of the system?

Mr. BERTONI. There is a survey mechanism whereby servicemembers are surveyed after each phase of the process, the medical evaluation board, physical evaluation board, and transition phase, yes.

Senator TESTER. OK. And so—and that is pretty user-friendly from your perspective?

Mr. BERTONI. I do not know about user-friendliness. It is four questions per phase, 12 questions. Our concern is the limited number of folks who are actually receiving that survey. In principle, everyone is eligible to receive it, but if you do not opt to do that early on at the med phase, you are excluded at the latter phases.

So we are really limiting the number of folks who are having an opportunity to weigh in here on their experience in regard to timeliness, transparency, and some other factors.

Senator TESTER. Do you think it is important to get that input?

Mr. BERTONI. Absolutely.

Senator TESTER. Should we be expanding those opportunities?

Mr. BERTONI. I think it would be absolutely a good idea to revise and relook at how they are surveying servicemembers right now.

Senator TESTER. I do not want to get out of my lane here, but I am going to for a second with Madigan. You said there was 198 folks, 108 had their diagnosis changed. Were those people—was their rating done under IDES?

Ms. ROONEY. Many of them were. Some of them were under the old process, so those that were before roughly 2008 would have been under the old process.

Senator TESTER. OK. So how many of the 198 were—do you have those figures broken out? I guess what I want to get at is, to have over half the folks not get the proper rating, to say that it does not match up with our goals, is an understatement. The question is, is IDES actually doing an accurate job of making the assessment for the disability, or is it not doing as good a job as the old system?

Ms. ROONEY. Actually those people before, since I said most of them were before 2008, that would be the old system, and it also was adding the forensic psychiatrists in it, which was a different aspect of the system. So the new process, and frankly, the protocols and the fact that our Departments have an integrated mental health strategy for how to do this, should have, and by all data that we have seen, improve that significantly under the new process.

Senator TESTER. OK. So does that mean all the folks that got rated before 2008 we should call them back up and have them re-rated?

Ms. ROONEY. In essence, that is what the Army is doing at this point, and we are going to take the lessons learned, as I indicated to Senator Murray, and see if we need to do that across the other services.

Senator TESTER. And what about the other branches of government?

Chairman MURRAY. Senator, let me just clarify: a large number of the ones who were misdiagnosed, or had their diagnosis changed inaccurately, were after 2008, after the forensic psychology system was put in place.

Senator TESTER. OK. Appreciate that. I mean, we get a lot of calls on this kind of stuff, and although I appreciate folks calling their Senator to get this squared away, I mean, what it tells me is there is an inherent problem here. And then when you combine that with the fact that we have got misdiagnosis over 50 percent, that is not acceptable. It has got to be fixed.

And if it is the fact that we bring in a forensic psychologist and that fixes the problem, that tells me then we are talking one person, right?

Ms. ROONEY. Actually that was the issue, was adding that additional layer. That is when the initial diagnoses were changed and then we had a review again. So that piece, adding forensic psychiatrists in the process, has been stopped and that does not occur any place across the Department.

Senator TESTER. OK. All right. I mean, look, I have got a lot of questions and my time is long passed. Well, I look forward to your recommendations on what can be done to improve IDES. I certainly appreciate the work you are trying to do, but we are not where we need to be, by a long shot, and so, I mean, when I heard your testimony, there was good stuff here, and you should be touting the stuff you do well. But man, oh man, we have got a long ways to go, do you not think?

Ms. ROONEY. Absolutely.

Senator TESTER. And so, how do we get to a point—I mean, what do we need to do? Is it manpower? Is it more professional people? What is it? I mean, we have got folks coming back and the numbers are going to get more and more with the Afghanistan draw-

down. But the question is, these folks need help, they need help early. That really saves money long-term, especially with unseen injuries, and where do we go? I mean, where do we go to get this fixed?

Ms. ROONEY. Sir, as you indicated earlier on, I believe we are going to get back to you with specific recommendations that we are seeing from our teams going out as to how we continue to move this forward.

Senator TESTER. I look forward to that. Thank you very much. Thank you for your testimony. Thank you for your work.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JON TESTER TO JOHN R. GINGRICH, CHIEF OF STAFF, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question. Senator Tester and Senator Boozman requested that Mr. Gingrich give recommendations to the Committee on what changes need to be made to improve IDES.

Response:

a. Implement some of the remodeled IDES improvements identified below:
- Reduce the number of physical case-file handoffs from 8 to 3.
- Make fitness decision for further military service up front, before VA enters into the process.
- Ensure VA receives a complete case-file from the Military Services after the fitness decision is made.

b. Automate the IDES process from beginning to end, and enhance the management reporting capabilities to enable IDES sites to effectively manage their cases.

c. Identify and implement best practices and implement electronic data sharing throughout the IDES process.

Chairman MURRAY. Thank you very much.

Senator Boozman?

Senator BOOZMAN. Thank you, Madam Chair. Mr. Bertoni, who is in charge of this? We have DOD here, we have VA. Is there a person that is actually in charge of the whole process?

Mr. BERTONI. I would say the Secretaries would say that they were in charge of this process.

Senator BOOZMAN. The Secretary of Defense and the——

Mr. BERTONI. In partnership with capable folks under them tasked with doing a very difficult——

Senator BOOZMAN. So I guess the question I have got, generally, things work better when there is a person to oversee. Is there a person that the Secretary of Defense and the Secretary of VA have designated to have the authority to get some of these things worked out?

Mr. BERTONI. I know Mr. Gingrich has been pegged as the man to address many aspects of this process.

Senator BOOZMAN. So do you have authority over DOD, also, or just VA?

Mr. GINGRICH. Sir, I do not have authority over DOD, but we have been working remarkably well in partnership, and I do not say that loosely. As I sit down with the Vice Chief of Staff of the Army, for example, because that is 68 percent, and we sit down monthly. We sit down at different levels in VA with the Army, and we are working through this.

I think part of the issue to address the problem is, we did not have a very good dashboard mechanism prior to when we fully im-

plemented IDES in September of last year. We now have a mechanism. We can go to every single facility, 116 of our senior executives get up on the—for my VTCs, the Army has the same thing where we do it together. We can go installation by installation, individual by individual, which we could not track before.

And I know it sounds something like we are not moving, but when we get the VTA in place, we will be able to track every single individual, where they are in the system, what kind of rating they got, and where they are going. We have got——

Senator BOOZMAN. I do not mean to interrupt. I guess, you know, in business and in general things, you like for a person to be accountable.

Mr. GINGRICH. I am accountable directly to Secretary Shinseki for the VA portion of this.

Senator BOOZMAN. I understand that, but I guess I would like to see somebody accountable for the whole system. And you may be that person, but it is not fair to you, you know, if you really do not have the authority to see it through. So I personally think that the two Secretaries need to designate somebody that has got the authority.

Now, we do not do that very well in government at all, but that is a basic thing. Where do you see the bottleneck, Mr. Bertoni? Is it that they cannot be seen or is it a decisionmaking process after they are seen?

Mr. BERTONI. I think going—I have sat here many times since 2007 and talked about this whole program process. It comes down, I think, to three critical things: people, processes, and technology. On many of these sites, there was a sense of urgency following Walter Reed. There was a rush to stand them up.

They did not have proper technology, did not have proper people and sufficient processes in place. Staff to servicemember ratios was insufficient in many respects. They were stood up anyway. The servicemen came, they were overwhelmed, and I think this system is paying for it to this day.

Processes. We have identified throughout the last several years areas of the process that appeared to be inefficient. Clearly, we are causing backlogs in inefficiencies. In partnership, DOD and VA have addressed some of them; not all. We keep pressing that they do.

And last, technology. We have an Integrated Disability Evaluation System, but the system's part has not caught up. We have processes that are combined, we have decisionmaking that is combined, but the systems have not caught up with the process or the demands of the end user.

Senator BOOZMAN. So do you feel like, in followup to Mr. Burr's comments, do you feel like the framework that we have now, the IDES, is such that we can meet the goals that we are wanting to get to?

Mr. BERTONI. It is a simpler system. It is more transparent in how it operates. It is sort of like a funnel. If you take a funnel, you pour water into it, water comes out the other end, it works. But if you pour water in that funnel too quickly, too fast, you will very quickly find out where the inefficiencies are. That is what is happening.

We have had rapid increases in inputs, in enrollments, and the inefficiencies and bottlenecks in this system are becoming readily apparent, and they need to get behind that with some of this mapping and business process redesign.

Senator BOOZMAN. My concern is, you know, that we have a culture somewhat that just is difficult to deal with these things. I am approached by people all the time that are just separating out of VA, just retiring, and it is not uncommon, you know, to wait a year before you start drawing your retirement. That is without all of this other stuff going on.

So again, I think we have got some real problems that we need to look at, and I would welcome, also—and I think it is important that you understand that I am with you, but I do think that it is important that we get some feedback as to how we can help you to streamline that process and similar processes. Thank you. Thank you, Madam Chair.

Chairman MURRAY. Thank you. Senator Johanns?

STATEMENT OF HON. MIKE JOHANNS, U.S. SENATOR FROM NEVADA

Senator JOHANNS. Madam Chair, thanks for holding this hearing. You can tell the frustration of the Committee Members. In this town sometimes it is hard to find bipartisanship, as we all know. I will guarantee that frustration here is very bipartisan. Everybody is frustrated, regardless of which end of the dais you sit on.

Here is my concern. I was looking through some of the numbers and, Mr. Bertoni, you talked about them a little bit in your testimony. Overall average time to complete IDES active components of military, the goal is 295 days; we are at 395. But at Fort Belvoir, it is 537 days. That is stunning. I cannot even believe that. Percentage of active duty members who complete IDES within the 295-day goal, the goal is 60 percent; actual results are 18 percent. At Fort Meade, it is 0 percent, nobody, nobody.

Overall average time to complete IDES for Guard members, excluding those who return to duty, agency's goal is 305 days; 408 days is the actual. 651 days at Fort Carson. It is just nearly embarrassing to go through these statistics.

The concerning thing for me is that I do not hear anything today that makes me feel, Gosh, we are going to turn the corner here. In fact, I must admit quite the opposite. I am going to walk away from this hearing very, very worried that the system is imploding, that whatever we have done to try to get on top of this system just is not working.

So, Mr. Bertoni, let me ask you just a very, very direct question. How long is it going to take, 1 year, 2 years, 5 years, to actually see progress in meeting these goals?

Mr. BERTONI. I cannot give you a specific timeframe. I would say that one thing that the services and VA are dealing with is enrollments are up significantly, doubling each year. In 2009, there were 4,000 enrollments; 2010, about 9,000; and last year, 19,000. So we have multitudes coming into this program very rapidly and that is going to increase going further.

So they really do need to continually look at their processes and look for streamlining opportunities. We have said all along they

need to get their staff to servicemember ratios aligned with what they think they need to be doing.

Again, automation. You can leverage so much with automation, accounts for many people. So there are things in play. They must continue to look at what they are doing and to look for efficiencies. And to their credit, more recent data in the MEB phase shows that the data is trending more positively over the last 6 months.

The VA medical exam, they had never been able to meet that goal. At the time of our review it was 70 days. As of this month, they are at 39 days, under the 45-day goal. So there is some positive trending in MEB. That is the good news.

The bad news is, those cases are being pushed further to the PEB, and those processing times are rapidly increasing. They have a 120-day goal and they are starting to push against that threshold. So what is going on in the PEB, what is causing inefficiencies there, what did they do in the MEB to create efficiencies, what can you learn from those?

This mapping exercise, this process, re-engineering exercise, I think, could be valuable. Should they have done it earlier? Yes, they could have done it before each major phase, and I think they would have been in a better position. So I cannot give you a timeframe, but I am hopeful next year the numbers will be better, if I am here.

Senator JOHANNS. Do you agree with—let me ask the two other witnesses. Do you think you are turning the corner?

Mr. GINGRICH. Sir, I am absolutely convinced we are turning the corner. We have gotten our production up where we are going to do about 2,500 cases a month, which we believe is looking at the flow that is coming in and the flow that is going out, that it is about 2,500. If we can sustain that starting in August, we will be able to move forward.

He is right. We did not get our claims—none of our processes in VA last year were meeting the standard. We are now 62 percent, in April, of the servicemembers that we processed in the process were on time. That is up from 20. Now, one of the things we have done to take some risk here is we decided, with at least the Army, to say, Let us get all the old jobs—that is why I said the one at 254 days—and let us get them out of the system because they are just holding up everybody and it is extending it.

So numbers will go up a little bit when you start taking the older cases out, but those individuals have been in the system way too long. And so, I think we are making progress into a turning phase. Will we get to 295 days and 60 percent of the servicemembers by 31 December? There are risks there, but I think the services and DOD and VA, as partners, have come together and said, How are we going to get there?

The Secretary said to us 3 months ago now when we were sitting at the meeting of the two Secretaries, We want to get to 60 percent. We want to get to 100 percent, but instead of trying to bite the whole thing, let us get to 60 percent by December 31st and then we will take on the rest of it to get to 100 percent.

Because every single one of these servicemembers we are doing this to, when they become veterans, as we have talked before, we have had them for 50, 60, 70 years and we have got to get them

in the system right. We have got to take care of them and make sure they transition correctly.

The other part that I would say, to answer your question, if we do not get this right by this summer, we are going to be challenged when we go to the VOW Act, because this is 10 percent of the population going through, and the VOW Act that you—that Congress so graciously gave us to be able to implement, will have a process that is even bigger.

And I think the things that we are putting in place today in VA and DOD will help us get both those systems done correctly.

Senator JOHANNS. I have run out of time, so I hate to cut you off, Dr. Rooney, because I am sure you had a thought here, too. Feel free to submit that in writing if you would like. But I will just wrap up my questions with a request to Mr. Bertoni. I think it would be good if you could assess this for us on some kind of periodic basis, just to give us some indication that progress is, in fact, being made.

It would be terribly unfortunate if we showed up in 6 months and nothing is happening, and that would be terribly unfortunate. So that would be my individual request. The Chair runs the Committee, but it would be something that I certainly would like to see.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MIKE JOHANNS TO DANIEL BERTONI, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Question. Senator Johanns requested periodic assessments on whether VA and DOD are making progress in improving IDES.

Response. At this time GAO does not plan to conduct ongoing assessments of IDES. We will continue to work with your staff to assure that GAO is meeting the needs of the Committee regarding our review of IDES.

Mr. BERTONI. And we have been in this mix since it was a tabletop exercise in 2007. I have testified numerous times, multiple products. It would be worse, I think, if we were not in there. And I think in regard to your issue of diagnostic differences, 2 years ago, I said this was an issue. It could be problematic in terms of the treatment of servicemembers in terms of backlogs of the cases.

If you have a diagnostic difference, you have to keep going back, new exams. You get caught on this medical exam hamster wheel and cases age out, you have to do it all over again. We asked that this issue be looked at. A consultant went in and looked at it, but did not do what we thought should be done.

What should have been is what you are doing now, in-depth case file reviews to get extent of nature and extent of these diagnostic differences. Then you have guidance around that, you have training around that, and then you capture data going forward so you can identify hot pockets in trouble areas going forward.

Had VTA been in place with the data indicating where they were having diagnostic differences, it would not have taken servicemembers to come forward making noise about treatment at Madigan. You could have that MI data at your fingertips and decide whether you need to get out there, see what is going on, do some remedial training, et cetera.

Senator JOHANNS. Thank you.

Chairman MURRAY. And I would just add, Senator Johanns, as a result of what we have looked at at Madigan, that is being reviewed back to 2007, I believe, all cases. But Army-wide now, as a result of the work I have done, they are now going back to 2001 to review all Army cases. But it still is not systemwide. And I think that that has to be part of it. So it is something I am very focused on. We will work with you on making sure we continue to stay on top of this.

I want to go back, Dr. Rooney. I am very concerned about what I continue to hear about the Warrior Transition Units and the IDES experience itself. I hear from servicemembers who are in the disability process, that they are languishing in this process without any meaningful or productive things to do.

Servicemembers tell us that they feel that their commanders are out to get them. And on the other hand, we hear from commanders that they feel these servicemembers are being deliberately obstructive in delaying the process in order to be more difficult. That kind of adversarial relationship cannot be beneficial for either the unit or the servicemember who is trying to move on with their life.

And worse, frankly, I continue to hear about servicemembers who are overdosing on drugs, committing suicide, committing serious crimes, and at Joint Base Lewis-McChord in my homestate of Washington, six servicemembers have died from suicide, auto accidents, or drugs while they are in the IDES process. That is happening at bases across the Nation.

So I hope you share my belief that we can do this better, but I wanted to ask you, what is the Department going to do to make sure that there is an effective, supportive leadership at all levels to make sure that this is not happening?

Ms. ROONEY. Some of the specifics you pointed out, in terms of making sure that we are looking at that transition process proactively, working with those servicemembers going through that process so that they can identify skills and possible career opportunities, those programs, some of those are already in place. We will be doing more and piloting more not just for those in the disability process, but throughout transition, as we have talked before, starting this summer. That is one piece of it.

The second one, as we indicated earlier, is really making sure that the communication is not just at the senior leadership, but absolutely is translated down through the chains of command right to the base. I believe Mr. Gingrich pointed out some meetings with the Sergeant Majors and other senior enlisted and that is going on in the Department as well.

Each of the service chiefs have been going out to meet directly with various commands. As you know and I have mentioned to you, I spend probably about half of my time on issues surrounding this and have been back out to Washington State, have been down to San Antonio and others so that I could also go out to the bases and help reinforce and see what is happening there so we can identify where there are those disconnects and get that message consistently across the Department.

So it is not only across DOD, but it is also with our partners in VA that we are continually sending the message and working at this, and where there are issues, not looking aside from those, but

going right out and identifying where are they, what is the problem. And whether that is because there seems to be a backlog in cases and why is that at certain installations, we will target efforts to find out, is that a process issue, is it a command issue? What are the various pieces to do this? And we do have it broken down that succinctly and that is the way we are following through.

Chairman MURRAY. I appreciate that, and I appreciate your sitting before this Committee and saying this. We want results from this, as I am sure you do, too. So it has to be a lot more than just testimony before this Committee. It has to be real action all the way down and we will be closely following that. We cannot have these hearings every 6 months or every year and keep hearing the same things.

One of the things that I hear most often from servicemembers in this joint process is that they do not have any idea of when they are going to separate from the service. They want to make plans to move or go to school or get back with their families or whatever they are doing, and as we heard today, those numbers of days keeps rising.

Last fiscal year, the average processing time, as we heard, was 394 days for active duty, 420 for Guard and Reserve. That is unacceptable for someone who is just waiting to figure out what they are going to do with the rest of their lives.

I really believe that these servicemembers would benefit from knowing what the time is actually going to be at the installation where they are, rather than just saying we have a goal here of so many days, but what is it at your installation? We need an honest approach even if it is not what we like, but at least telling them a real number.

I would like both of your Departments to look into that and report back to this Committee on the possibility of having real information for these men and women.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO JOHN R. GINGRICH, CHIEF OF STAFF, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question. Chairman Murray requested that Mr. Gingrich report back to the Committee on giving Servicemembers in WTU's a realistic estimate of how long it will take for their claims to be processed at their installation and for them to be discharged.

Response. Currently, VA is averaging 54 days from the date of separation to process a payment. VA does not have control over the discharge dates.

Chairman MURRAY. Let me also say that the only way that we are going to restore trust, which is really important, is by focusing on consistency and accuracy of decisions, and I hope that both the VA and the DOD have really learned from VA's claim system struggles with how important it is to get the disability decisions correct the first time.

I am concerned because Committee oversight has revealed, as I talked about earlier, IDES rating decisions with errors. Given that the military relies on the disability level assigned by the VA, these errors could impact the benefits that servicemembers will receive from the military, and also the benefits from the VA.

So, Mr. Gingrich, when the VA identifies an error in a rating decision, do you alert DOD that the error can be fixed before separation?

Mr. GINGRICH. Madam Chairman, there are two things we do. If it is before separation, we notify the PEB and we notify the individual, and we get the correction done before. If it is after and the person is now a veteran and we discover it—we know one case so far we found, that the individual had a discrepancy in the rating and they would have changed the rating, we have helped that individual and gone back to the service and helped that individual get their records corrected.

Chairman MURRAY. If a servicemember believes that there is an incorrect rating or whose claim has been identified as incorrect, what recourse do they have to go back and get the DOD rating changed?

Mr. GINGRICH. If we substantiate it, it would be fairly simple for them to get it corrected. If it is not a mistake that we made or it is not an error that was made at the time and it is the condition that has changed later, then it would be very much more difficult.

But we talked about it yesterday, and we decided that we needed to make sure the process is such that the veteran or the active duty servicemember does not have to do anything. We take care of it and we do it for them. To get it started, we give them the information they need and then they work the system. So we will be proactively involved in any of these that we find.

Chairman MURRAY. OK. Well, we will have more information on what we are finding and expect to work with you on that.

Mr. GINGRICH. And ma'am, we look forward to that and we will work each and every case you give us.

Chairman MURRAY. OK. I have several other questions for the record, but I did want to focus on the Integrated Electronic Health Record. We know that delays in IDES are driven, in part, by problems accessing information and sharing paper files between the Departments. Those challenges are not unique to IDES, but they do affect every aspect of a servicemember's transition to VA, including how their health and benefits information is shared.

Now, we have heard a lot of talk from VA and DOD that they are making progress on data sharing through their work on the Integrated Electronic Health Record and the Virtual Lifetime Electronic Record. But according to this week's press release, only two sites will have initial joint electronic health record capabilities by 2014, with 2017 actually being the target date for implementation of this.

Now, the Departments have both said that the key to their collaboration and key to the success or failure of disability evaluations and transition are these electronic health records. It seems to me that this should be a priority for absolutely everybody. The project has been plagued, as you well know, by false starts and budget issues, and planning is not complete.

I understand that a lot of positions at the office responsible for staffing and managing these projects are unfilled yet. I understand it is only 30 percent staffed. But how can the Departments say this is a priority when it is only 30 percent staffed, and we are talking about 2017 as the target date?

Ms. ROONEY. I believe regarding staffing—and we will get you the most recent numbers—we continually add staff so that we are fully staffed up, but that is not impeding progress at the current point. There has been substantial progress made in terms of this Inter-Agency Program Office with a new director actually named within the past 3 months with extensive experience.

And you are right. Both Secretaries announced jointly this week that by 2014, both in San Antonio and at Hampton Roads, we will have initial operating capability of this system, which will have multiple areas from pharmacy on down to medical records that are functional.

I think they also pointed out when they announced it that we are moving forward, but we are also moving forward deliberately because we cannot afford to have any errors in these actual records going forward. So this is both safety and concern for individuals, to be able to get this right.

We do have some systems currently and one of the things that both Secretaries viewed when they were in north Chicago was an example where we have been able to use existing systems, and it is not the long-term solution, but it is one that is working now, and begin to exchange data much better. So we are learning from that and integrating that into this electronic health record.

So it is a priority. We are growing the staff, but we also want to make sure that there is no chance for errors because these are people and their information, and we cannot afford to have any errors.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO JO ANN ROONEY, ACTING UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE

Question. Dr. Rooney stated she would provide the most recent data to Chairman Murray on number of new hires to more quickly implement the integrated electronic health records system.

Response. Below is an extract from a larger, more detailed presentation that was delivered to SVAC staff to satisfy a due-out from a 23 April 2012 SVAC/SASC briefing.

The following provides a staffing summary as of 31 July 2012:

- IPO TOTAL FILLED = 48 DOD + 58 VA = 106 / 236 = 44.91%
  - DOD Total Filled = 48 / 116 = 41.37%.
  - VA Total Filled = 58 / 120 = 48.33%.
    - o VA-OIT Total = 2 filled, 31 detailed = 33 / 120 = 27.5%.
      - – 31 Details to be extended until transfer or hiring action completed.
    - o VA-VHA Total = 25 pending reassignment in June 16, 2012 + 1 additional detailed (not pending assignment) = 25 / 120 = 20.83%.
- The chart below illustrates that the IPO will achieve 100% staffing (236 FTE's) by March 2013.
- Currently the IPO staffing level is evaluated and tracked on a monthly basis, and progress is evaluated by the following criteria:
  - *Red: >25% under staffing projections over time.*
  - *Yellow: 12.5% < Yellow < 25% (half the red criteria).*
  - *Green: <12.5%.*

Chairman MURRAY. Mr. Gingrich, do you want to comment?

Mr. GINGRICH. I agree with Secretary Rooney. This is a priority of this Department. The Secretary has made it his number 1 priority. He has pushed it hard. And we do see—it sounds like it is

not much, but its ability to be able, with a single sign-on, be able to look at a screen and get data from either VistA or Alta and be able to do a medical evaluation, it is clear, it is clean, and it is doable.

We are looking at how do we do that other places. I also think the integration of the hospital pharmacy has to be done, as we are going to talk about. That is very complicated, but they are doing it there, and they are making it work. So we are making progress. Are we making progress as fast as both Secretaries like? Probably not, but we are making progress, and we are pushing it.

That is why we talked about things like the VTA. That is not the electronic health record, but it will inform the electronic health record and it will also inform VBMS and things like that that we will have. So we are doing little pieces as we are going along in addition to the full electronic health record, ma'am.

Chairman MURRAY. Senator Boozman?

Senator BOOZMAN. Well, I really do not have any more questions, but I think the point that you made, Madam Chair, about if we could really give these folks a realistic idea of what is going on, I know in my life, I think all of our lives, the most difficult time is when you are in a period of uncertainty. And, you know, these are professionals that are used to bureaucracy and this and that, being in the service they have been in, but I do think that that is such a little thing, but it is a huge deal. And so, if we can work on that?

The other thing is, is that we have a situation where this is the number 1 goal of the Secretaries and things to try and get this sorted out. They are meeting on a monthly basis. Something that we might consider is maybe you and the Ranking Member, Senator Burr, and perhaps Chairman Miller, Ranking Member Filner—I know they are as concerned as we are about this—that maybe on some sort of a basis—maybe monthly, bi-monthly, whatever—you all feel is appropriate, or somebody that you designate, for you all to get together and basically, you know, let us talk about how things are going.

And the other thing is how we, as a Congress, if there are things that we can do to again facilitate and just really all work together—I know that you all want, in all of your capacities, to get this worked out as much as anybody, and certainly we want to be there to help you. But it is something that we have to get worked out. Thank you, Madam Chair.

Chairman MURRAY. Thank you very much. Let me just say that ensuring an accurate, efficient, and seamless disability evaluation process for our servicemembers really is a critical part of making sure that they receive the care and benefits that they deserve.

Clearly, there is a lot more work to be done. We have seen some steps in the right direction, but it is going to take continued engagement and cooperation from both Departments to get this right. So that is the message that I would really urge both of you, Dr. Rooney and Mr. Gingrich, to share with Secretaries Shinseki and Panetta.

We also need to share this message with the lower levels, too. It is very clear squad member leaders and squad leaders who interact every day with these servicemembers need to get the message as well. So I hope you follow up on that. This system has been experi-

encing a lot of challenges for a very long time, but we owe it to our military members who have served this country to get this right and that is what this Committee is focused on, and we want to urge you to really, really, from the top all the way to the bottom, work to get this done right.

So thank you very much for your testimony today and your work on this. With that, this hearing is adjourned.

[Whereupon, at 11:34 a.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

Chairman Murray, Ranking Member Burr, and Members of the Committee, Paralyzed Veterans of America (PVA) appreciates the opportunity to submit a Statement for the Record regarding Seamless Transition of servicemembers to veteran status and the effect the Integrated Disability Evaluation System (IDES) is having on the transition process. This is not only important to PVA, but was also an issue identified in *The Independent Budget* that was recently published by AMVETS, Disabled American Veterans, PVA and the Veterans of Foreign Wars. While in many ways the IDES can provide benefits to veterans, PVA has identified potential serious issues with the system.

When the President's Commission on Care for America's Returning Wounded Warriors recommended that the Department of Defense (DOD) and the Department of Veterans Affairs (VA) create a single, comprehensive, standardized medical examination that DOD would administer, Veterans Service Organizations (VSO) supported the recommendation. This exam would serve DOD's purpose of determining fitness for duty and VA's purpose of determining initial disability level. PVA believes this should be a mandatory examination and an integrated element of the military separation process and VA should be responsible for handling this duty as VA has the expertise to conduct a more thorough and comprehensive examination.

The Disability Evaluation System (DES) is the mechanism used to evaluate a servicemember for fitness for duty by the DOD and to compensate for injury or disease incurred in the line of duty which inhibits a servicemembers' ability to perform their duties. DES includes a medical evaluation board (MEB) which is an informal process of the medical treatment facility, a physical evaluation board (PEB) which is an informal and formal fitness for duty and disability determination, an appellate review process, and a final disposition. A PEB Liaison Officer (PEBLO) is assigned to assist the servicemember through the process. The PEB recommends the servicemember either return to duty, be placed on temporary disabled/retired list, separate from active duty, or be medically retired. While the DOD Legacy DES process only rates those disabilities that directly impact continued military service, the VA evaluation takes into account all disabilities incurred or aggravated during military service warranting a disability rating of 10 percent or higher.

The DES pilot project premised on the President's Commission on Care for America's Returning Wounded Warriors recommendation was launched by the DOD and VA in 2007. Based on servicemembers' high satisfaction rates with the revised program, the DOD and VA designed an integrated disability evaluation system (IDES), with the goal of speeding the delivery of VA benefits to all transitioning servicemembers. The current 27 locations participating in the pilot program examine about 47 percent of servicemembers (12,735 in 2010) who enter the DOD disability evaluation system annually.

The IDES allows servicemembers to file a VA disability claim when they are referred for evaluation. VA provides a disability rating for each condition found during the medical exam, and the PEB uses these ratings to determine the type of separation or retirement for which the member is eligible. Under the system, the DOD can only consider conditions that are unfitting when determining disability ratings, while VA determines disability ratings for all service-connected conditions, even the ones that would not result in a finding of unfit for continued military service. The

DOD uses the VA disability percentages for each condition, but may have a different combined disability rating than VA awards because conditions that are not unfitting are not considered in the DOD calculations. Thus, a servicemember's disabilities and their functional impact must be delineated for accurate evaluation against the VA Combined Rating Table. PVA is concerned that the system does not ensure servicemembers' records accurately describe numerous possible disabilities.

While VSOs have been pleased at the progress of the IDES to date, servicemembers who are participating in the new approach to discharge evaluation are not systematically being encouraged to seek representation from a VSO Service Representative. Most are relying instead on the advisory services of military counsel, yet each service provides access to military legal counsel in different manners and circumstances.

From the outset, PVA does not believe the system was set up for success. VA and DOD engaged in working groups early on that did not include input from the VSO community. It appears that attorneys and paralegals, who function under Title 10, replaced the function of VSO Service Officers, who derived their authority from Title 38. But since active duty servicemembers fall under Title 10 authority, VSOs are essentially cutoff from these men and women until they become veterans. This creates a problem where VSOs are essentially left to clean up and attempt to correct a improperly completed claim that was preventable with adequate initial counseling and claims development.

IDES attempts to reconcile the PEB and Compensation and Pension (C&P) processes by having the servicemember submit to one medical exam or series of exams serving both purposes. The problem is PEB is meant to determine fitness for duty while C&P determines total disability for compensation purposes. Conditions that are often not regarded for PEB purposes, such as diabetes, sleep apnea, mild musculoskeletal degeneration, and tinnitus for examples, can have major implications in a VA disability rating. When a question or conflict arises, it is unclear whether VA or DOD has jurisdiction to resolve the matter before it flowers into a protracted, system-clogging appeal once the veteran realizes the mistake. This is often only after later consulting with a VSO service officer. Not only will this potentially delay proper compensation for the new disabled veteran, it adds an additional strain to an already horribly backlogged claims system.

Finally, PVA questions whether those designated as Soldiers Counsel possess the requisite knowledge of VA law and the claims processes to adequately function as accredited representatives. Servicemembers have no choice but to rely on the expertise ostensibly wielded by these individuals. If knowledge is lacking, the effects are felt downstream, after the servicemember is discharged and it's too late. What level of training are these individuals required to undergo, both initially and continually, that meets the same standard directed under Title 38 for service officers? While there is no doubt that these are dedicated and conscientious individuals, if the MEB staff and PEBLOs are expected to participate in the development of a servicemember's co-existent fitness-for-service evaluation/VA claim, then these individuals should also have some familiarity with the VA claims process insofar as their intervention could impact entitlement to benefits. The end result is a severe disservice to the discharged veteran.

The most important issue should be the best care and support to the servicemember. With this goal, PVA recommends that the DOD and VA provide greater information to all military personnel going through IDES about the advantages and benefits of using a VSO service officer. They should be provided the option to choose between the legal counsel offered by the military and that available at no cost through the system of national service officers of chartered Veterans Service Organizations.

To facilitate this process, it will be critical that DOD allow access to military installations for chartered Veterans Service Organizations to provide services to active duty personnel. This should include their incorporation in all Transition Assistance Programs. This is in no way to detract from the services being provided by the military, but should be one more resource to better prepare servicemembers for their transition to veteran status.

And finally, even as the current military conflicts drawdown, members of the Reserve and National Guard continue to play a major role in military operations and deployments. The DOD mandatory separation physical examination should be required for all demobilizing National Guard and Reserve members, not just active duty personnel. In many ways, this may be even more important to these servicemembers who rapidly depart from the support and medical care structure of active duty and return to their communities, often widely dispersed rural areas with limited medical care opportunities.

PVA supports the IDES and believes it is an important program that benefits transitioning servicemembers. As with many programs, once implemented unforeseen issues and consequences begin to appear and need to be addressed. It is critical that America's military be provided the best services and support as they leave the military and we ask Congress to ensure that both DOD and VA work to correct these issues so that our newest veterans have the best opportunity for a new life and brighter future as they transition to the civilian community.

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