The Honorable Gordon England Deputy Secretary of Defense and The Honorable Gordon Mansfield Deputy Secretary of Veterans Affairs

Statement for the Record by
The Honorable Gordon England
Deputy Secretary of Defense and
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Deputy Secretary of Veterans Affairs
Before the Senate Committee on Veterans' Affairs
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Chairman Akaka, Senator Burr, Members of the Senate Committee on Veterans' Affairs, we deeply appreciate your steadfast support of our military and veterans and welcome the opportunity to appear here today to discuss improvements implemented and planned for the care, management, and transition of wounded, ill, and injured service members. We are pleased to report that while much work remains to be completed, meaningful progress has been made.

The Administration has worked diligently - commissioning independent review groups, task forces, and a Presidential Commission to assess the situation and make recommendations. Central to our efforts, a close partnership between our respective Departments was established, punctuated by formation of the Senior Oversight Committee (SOC) on May 8, 2007, to identify immediate corrective actions and to review and implement recommendations of the external reviews. The SOC continues work to streamline, deconflict, and expedite the two Departments' efforts to improve support of wounded, ill, and injured service members' recovery, rehabilitation, and reintegration.

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

The recommended shift in the fundamental responsibilities of the Departments of Defense and Veterans Affairs, however, remains one of the most significant recommendations from the many task forces and commissions. This shift in the fundamental responsibilities would take the Department of Defense out of the disability rating business. Creating this clear line between the responsibilities of the two Departments, as specifically recommended by the Dole/Shalala Commission, would allow DoD to focus on the fit or unfit determination and streamline the transition from service member to veteran.

Senior high-level cooperative efforts between DoD and VA pre-date the SOC. The Joint Executive Council (JEC), which was established by the Departments in 2002 and later codified in law, is the nexus for senior leadership management of communications, coordination, and resource sharing between VA and DoD. The JEC was the starting point for the SOC. Today, the JEC continues to direct appropriate resources and expertise to specific operational areas through its two sub-councils, the Health Executive Council and the Benefits Executive Council, as mapped out in the VA/DoD Joint Strategic Plan.

Senior Oversight Committee

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

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

Major Initiatives and Improvements

The two Departments are in the process of implementing more than 400 recommendations of five major studies, as well as implementing the Wounded Warrior and Veterans titles of the recently enacted National Defense Authorization Act (NDAA) for Fiscal Year 2008, Public Law No. 110-181. We continue to implement recommended changes through the use of policy and existing authorities. For example, in January 2008, a joint DoD/VA Federal Recovery Coordination Program was instituted to provide the ultimate, long term case/care management oversight for our recovering severely Wounded, Ill and Injured Service members, Veterans, and their families across multiple, multi-disciplinary teams, and across the continuum of care from recovery to rehabilitation to reintegration. Described below are the major SOC initiatives now underway.

Disability Evaluation System

The fundamental goal is to improve the continuum of care from the point-of-injury to community reintegration. To that end, in November of last year, a Disability Evaluation System (DES) Pilot test was implemented for disability cases originating at the three major military treatment facilities in the National Capital Region (NCR) (Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Malcolm Grow Medical Center). The pilot is a service member-centric initiative designed to eliminate the often confusing elements of the two current disability processes of our Departments. Key features include both a single medical examination and single disability rating for use by both Departments. A primary goal is to reduce by half the time required to transition a member to veteran status and receipt of VA benefits and

compensation.
The pilot addresses those recommendations that could be implemented without legislative change from the reports of the Task Force on Returning Global War on Terror Heroes, the Independent Review Group, the President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala Commission), the Veterans' Disability Benefits

Commission (Scott Commission), and the DoD Task Force on Mental Health. Its specific objectives are to improve timeliness, effectiveness, transparency, and resource utilization by integrating DoD and VA processes, eliminating duplication, and improving case management practices. To ensure a seamless transition of our wounded, ill, or injured from the care, benefits, and services of DoD to VA's system, the pilot is testing enhanced case management methods and identifying opportunities to improve the flow of information and identification of additional resources to the service member and family. The VA is poised to provide benefits and compensation to the veterans participating in the pilot as soon as they transition from the military.

The pilot covers all non-clinical care and administrative activities, such as case management and counseling requirements associated with disability case processing, from the point of service member referral to a Military Department Medical Evaluation Board (MEB) through compensation and provision of benefits to veterans by the VA. Expansion of the pilot is being considered to address:

x Performance measures - The pilot evaluation plan includes extensive quantitative and qualitative performance measures to ensure our service members obtain all benefits and entitlements due by law. Although no service members have completely transitioned from the pilot to veteran status, we expect a reasonable sample population to have processed through by mid-June. We'll complete our initial analysis at that time and make a determination regarding expanding the pilot. As of April 7, 2008, over 287 service members were enrolled in the pilot, and we expect the first service member to separate within the next 30 to 60 days.

x Site assessment - The following criteria will be thoroughly analyzed by both Departments: resources, IT architecture development and fielding, case management effectiveness, training requirements, DES workload (for DoD and VA) in expansion areas, and costs.
x Case management - Most importantly, pilot expansion to a broader population will require training and certification of DES and VA administrative and case management personnel. It is anticipated that certification of the case managers and determination of the appropriate case manager staff size will be overriding factors that limit or allow expansion of the pilot to other areas.
x Phased expansion - Unlike the pilot's Physical Evaluation Board phases, which are consolidated in the NCR, the medical assessment and MEB phases occur across the Departments at numerous Medical Treatment Facilities (MTFs) and Veterans Health Administration (VHA) sites. Phased expansion of the pilot should allow MTF site preparation and training on a manageable timeline. The first in a series of meetings involving both VA and DoD personnel to address expansion of the pilot was held on March 12 and 13, 2008. VA and DoD created specific workgroups to develop recommendations for the expansion of the pilot.

The pilot is part of a larger effort including medical research into the signature injuries of the war and updating VA's Schedule for Rating Disabilities (VASRD). Proposed regulations to update the disability schedule for Traumatic Brain Injury and burn scars were published in the Federal Register on January 3, 2008. We anticipate the final rule will be published later this summer and we appreciate the review and recommendations by this Committee in support of this change.

Beyond the Pilot, the Veterans Benefits Administration (VBA) is processing claims from Very Seriously Injured (VSI) and Seriously Injured (SI) Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF) veterans on a priority basis. Claims from all returning war veterans are expedited.

Psychological Health and TBI

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

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

VA's Vet Centers, operated by the Readjustment Counseling Service in the Veterans Health Administration (VHA), provide community outreach and professional readjustment counseling services for war-related psychological readjustment problems, including PTSD counseling. Vet Centers may treat PTSD, family relationship problems, lack of adequate employment, lack of educational achievement, social alienation and lack of career goals, homelessness and lack of adequate resources, and other psychological problems such as depression or substance use disorder. Vet Centers are community-based facilities located outside of the larger VA medical centers in convenient easy-to-access settings. The Vet Center service mission goes beyond medical care in providing a holistic mix of services designed to treat the veteran as a whole person in his/her community setting.

Vet Centers provide an alternative to traditional mental health care that helps many combat veterans overcome the stigma and fear related to accessing professional assistance for military-related problems. Eligibility for Vet Center services is based on military service in a combat theater and does not require the veteran to go through the enrollment process.

VA is currently expanding the number of its Vet Centers. In February 2007, VA announced plans to establish 23 new Vet Centers increasing the number nationally from 209 to 232. This expansion began in 2007 and is planned for completion in 2008. More than half of the new Vet Centers are operational based on having signed a lease, having hired staff, and providing services to veterans. The remaining Vet Centers are actively pursuing and/or completing staff recruiting and lease contracting. They will all be open by the end of the fiscal year.

Since hostilities began in Afghanistan and Iraq, the focus of the Vet Center program has been on aggressive outreach at military demobilization and at National Guard and Reserve sites, as well as at other community locations that feature high concentrations of veterans and family members. To promote early intervention, the Vet Center program hired 100 OEF and OIF veteran returnees to provide outreach services to their fellow combatants. These fellow veteran outreach specialists are effective in mitigating veterans' stigma and establishing immediate rapport. From early in FY 2003 through the end of FY 2007, Vet Centers have provided readjustment services to over 268,987 veteran returnees from OEF and OIF. Of this total, more than 205,481 veterans were provided outreach services, and 63,506 were provided substantive clinical readjustment services in Vet Centers. The Readjustment Counseling Service operated a budget of $110 million in FY2007.

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

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

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

Rehabilitative Services and Polytrauma System of Care. VA provides clinical rehabilitative services in several specialized areas that employ the latest technology and procedures to provide our veterans with the best available care and access to rehabilitation for polytrauma and TBI, spinal cord injury, visual impairment, and other areas. Over the past two years, VA has implemented an integrated system of specialized care for veterans sustaining TBI and other polytraumatic injuries.

The Polytrauma System of Care consists of four regional TBl/Polytrauma Rehabilitation Centers (PRC) located in Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA.

A fifth PRC is currently under design for construction in San Antonio, TX, and is expected to open in 2011.
The four regional PRCs provide the most intensive specialized care and comprehensive rehabilitation for combat injured patients transferred from military treatment facilities. As veterans recover and transition closer to their homes, the Polytrauma System of Care provides a continuum of integrated care through 21 Polytrauma Network Sites, 76 Polytrauma Support Clinic Teams, and 54 Polytrauma Points of Contact located at VAMCs across the country.

Throughout the Polytrauma System of Care, we have established a comprehensive process for coordinating support efforts and providing information for each patient and family member. The care coordination process between the referring DoD military treatment facility and the PRC begins weeks before the active duty service member is transferred to VA for health care. The PRC physician monitors the medical course of recovery and is in contact with the MTF treating physician to ensure a smooth transition of clinical care.

We have come to appreciate the importance of support to family caregivers whose severely injured loved ones transition into VA health care. To that end, we are currently evaluating caregiver needs, and options to strengthen their ability to care for their loved ones.
TBI Screening. Beginning on April 14, 2007, VA has screened all OEF/OIF veterans receiving medical care within the VA for possible TBl. VHA staff received training in administering the screening tool and follow-up evaluation, and the computerized medical record system was modified to include the TBI screening clinical reminder. The clinical reminder (1) identifies veterans who need screening, (2) presents the screening tool to the provider, and (3) enters results into progress notes and into the electronic health record. VA policy requires that veterans who screen positive on the TBI screening tool be offered a follow-up evaluation with a specialty provider who can determine whether the veteran has a TBI.

To ensure appropriate staffing levels for PH, a comprehensive staffing plan for psychological health services has been developed based on a risk-adjusted, population-based model and the Services have received resources to staff that model. In addition, DoD has partnered with the Department of Health and Human Services (HHS) to provide uniformed Public Health Service officers in Medical Treatment Facilities to increase available mental health providers for DoD. The Memorandum of Agreement between the two Departments is near completion, with startup anticipated shortly. DoD program expansions, documented in an updated report to Congress submitted in February 2007, include:

x Addition of telephone-based screening for those who do not have access to the Internet including a direct referral to Military OneSource for individuals identified at significant risk;
x Availability of locally tailored, installation-level referral sources via the online screening;

x Introduction of the evidence-based Suicide Prevention Program for Department of Defense Education Activity schools to ensure education of children and parents of children who are affected by their sponsor's deployment;
x Addition of a Spanish language version for all screening tools, expanded educational materials, and integration with the newly developed pilot program on web-based self-paced care for PTSD and depression; and
x Enhancement of the web based Mental Health Self Assessment Program.

In November 2007, the Department of Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury was established as a national Center of Excellence for PH and TBI. It includes VA and HHS liaisons, as well as an external advisory panel organized under the Defense Health Board, to provide the best advisors across the country to the military health system. The center facilitates coordination and collaboration for PH and TBI related services among the Military Services and VA, promoting and informing best practice development, research, education, and training. The DCoE is designed to lead clinical efforts toward developing excellence in practice standards, training, outreach, and direct care for our military community with psychological health and TBI concerns. It also serves as a nexus for research planning and monitoring the research in this important area of knowledge. Functionally, the DCoE is engaged in several focus areas, including:

x Mounting an anti-stigma campaign (Army's Mental Health Advisory Team V survey shows that stigma and fears of seeking help are being reduced, but there is more to do);
x Establishing effective outreach and educational initiatives;
x Promulgating a tele-health network for clinical care, monitoring, support, and follow-up;
x Coordinating an overarching program of research including all DoD assets, academia and industry, focusing on near-term advances in protection, prevention, diagnosis, and treatment;
x Providing training programs aimed at providers, line leaders, families, and community leaders; and
x Designing and planning for the National Intrepid Center of Excellence (anticipated completion in fall 2009), a building that will be located on the Bethesda campus adjacent to the new Walter Reed National Military Medical Center.

Similarly, VA's commitment to mental health has been evidenced by rapid response and action. From the beginning of Operation Enduring Freedom in Afghanistan until the end of FY 2007, nearly 800,000 service men and women separated from the armed forces. Almost 300,000 of them have sought care in a VA medical center or clinic. Of these, about 120,000 received at least a preliminary mental health diagnosis, with PTSD being the most common seen diagnosis (nearly 60,000). Although PTSD is the most frequently identified of the mental health conditions that can result from deployment to OEF/OIF, it is by no means the only one. Depression, for example, is a close second.

Care for OEF/OIF veterans is among the highest priorities of VA's mental health care system. For these veterans, VA has the opportunity to apply what has been learned through research and clinical experience about the diagnosis and treatment of mental health conditions to intervene early and to work to prevent the chronic or persistent courses of illnesses, especially PTSD that

have occurred in too many veterans of prior eras.
VA has increased its support of mental health funding from $2 billion in 2001 to a projected amount of over $3.5 billion this year. As a result of focused efforts to build mental health staff and programs, VA has hired over 3,800 new mental health staff in medical centers and clinics over the past two and a half years for a total mental health staff of nearly 17,000.

VA and DoD have continued to work collaboratively in the area of PTSD. VA's programs in PTSD are informed by the research supported through its Office of Research and Development, and by the research, educational programs, and clinical demonstrations of its National Center for PTSD (NCPTSD) headquartered in White River Junction, Vermont; its Mental Illness Research Education and Clinical Centers, especially those in Seattle and Portland, Palo Alto and San Francisco, and Durham, as well as the Centers of Excellence for Mental Health and PTSD in Canandaigua, New York, San Diego, and Waco.

NCPTSD has been critical in conducting research establishing the effectiveness of evidence-based psychotherapies for PTSD, and for working with the clinical services in both VA and DoD to translate research findings into large scale training programs for mental health providers. In this way, VA and DoD are conducting research to develop new knowledge on effective treatments, and then organization of the programs necessary to allow veterans and service members to benefit from them.

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

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

New comprehensive practices for better care, management, and transition are being implemented. These efforts include responses to requirements of the National Defense Authorization Act 2008 regarding the improvements to care, management, and transition of recovering service members. Progress is being made toward an integrated continuity of quality care and service delivery with inter-Service, interagency, intergovernmental, public, and private collaboration for care, management, and transition, and the associated training, tracking, and accountability for this care. Our efforts include important reforms such as uniform training for medical and non-medical care/case managers and recovery coordinators, and a single tracking system and a comprehensive recovery plan for the seriously injured.

The joint FRCP trains and deploys Federal Recovery Coordinators (FRCs) to support medical and non-medical care/case managers in the care, management, and transition of seriously wounded, ill, and injured service members, veterans, and their families. The

FRCP will develop and implement web-based tools, including a Federal Individual Recovery Plan (FIRP) and a National Resource Directory for all care providers and the general public to identify and deliver the full range of medical and non-medical services. To date, the Departments have:

x Hired, trained, and placed eight Federal Recovery Coordinators (FRCs) at three of our busiest Medical Treatment Facilities as recommended by the Dole/Shalala Commission. FRCs are located at Walter Reed Army Medical Center, National Naval Medical Center in Bethesda, Brooke Army Medical Center. Recruitment efforts are ongoing to place a FRC at Naval Medical Center Balboa.
x Developed a prototype of the Federal Individual Recovery Plan (FIRP) as recommended by the Dole/Shalala Commission; and
x Produced educational/informational materials for FRCs, Multi-Disciplinary Teams, and service members, veterans, families, and caregivers.
We are also in the process of:
x Developing a prototype of the National Resource Directory in partnership with Federal, state, and local governments and the private/voluntary sector, with public launch this summer;
x Producing a Family Handbook in partnership with relevant DoD/VA offices;
x Identifying workloads and waiver procedures for Medical Case/Care Managers, Non-Medical Care Managers, and Federal Recovery Coordinators; and
x Developing demonstration projects with states such as California for the seamless reintegration of veterans into local communities.

Data Sharing Between Defense and Veterans Affairs

Steps have been taken to improve the sharing of medical information between our Departments to develop a seamless health information system. Our long-term goal is to ensure appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information technology. The SOC has approved initiatives to ensure health and administrative data are made available and are viewable by both agencies. DoD and VA are securely sharing more electronic health information than at any time in the past. In addition to the outpatient prescription data, outpatient and inpatient laboratory and radiology reports, allergy information, access to provider/clinical notes, problem lists, and theater health data have recently been added. In December 2007, DoD began making inpatient discharge summary data from Landstuhl Regional Medical Center immediately available to VA facilities. The plan for information technology support of a recovery plan for use by Federal Recovery Coordinators was approved in November 2007. A single web portal to support the needs of wounded, ill, or injured service members, commonly referred to as the eBenefits Web Portal, is planned based on the VA's successful eVet website. The Veterans Tracking Application (VTA) is a data management tool utilized by both VBA and VHA staff to track VSI and SI veterans and assist in case management and prioritizing care for all OEF and OIF veterans.

Medical Facilities Inspection Standards

Progress has made to ensure our wounded warriors are properly housed in appropriate facilities. Using the comprehensive Inspection Standards, all 475 military Medical Treatment Facilities (MTFs) were inspected and found to be in compliance although deferred maintenance and upgrades were cited. The Services are continuing an aggressive inspection of MTFs on a semi-annual basis to ensure continued compliance, identify maintenance requirements, and sustain a world-class environment for medical care. In the event a deficiency is identified, the commander of the facility will submit to the Secretary of the Military Department a detailed plan to correct the deficiency, and the commander will periodically re-inspect the facility until the deficiency is corrected. All housing units for our wounded warriors have also been inspected and determined to meet applicable quality standards. The Services recognize that existing temporary medical hold housing is an interim solution and have submitted FY 08 military construction budgets to start building appropriate housing complexes adjacent to MTFs. They will also implement periodic and comprehensive follow-up programs using surveys, interviews, focus groups, and town-hall meetings to learn how to improve housing and related amenities and services.

In the wake of reports last year about poor physical conditions in some non-VA health care facilities that housed wounded and injured service members, then Secretary Nicholson ordered a national review. The snapshot revealed that the problems identified were primarily related to normal wear and tear that are continually addressed through regular inspections and maintenance. Facility leadership conducts weekly environment of care (EOC) rounds to promptly identify and correct problems. Each Veterans Integrated Service Network (VISN) has an EOC review committee that conducts random, unannounced inspections of facilities in the Network at least once a year. In addition, there are cyclic inspections, e.g., by the Office of the Inspector General. The Joint Commission makes unannounced visits to VA health care facilities as well.

Transition Issues/Pay and Benefits

VA has significantly expanded its outreach efforts to separating service members to ensure they are fully informed about their VA benefits. From FY 2003 through February FY 2008, VBA military services coordinators conducted more than 41,700 VBA benefits briefings, reaching a total of more than 1.6 million active duty service members. These briefings include 8,013 pre- and post-deployment briefings attended by over 493,400 activated Reserve and National Guard service members. During FY 2007 alone, VBA military services coordinators provided more than 8,150 benefits briefings to over 296,800 separating and retiring military personnel. As of February of this year, we had already provided more than 3,200 briefings to about 132,600 separating service members.

Service members transitioning from military to civilian life can also benefit from a collaborative effort between DoD and the Department of Labor (DoL). The DoL Pre-Separation Guide, which informs service members and their families of available transition assistance services and benefits, is now available at http://www.TurboTAP.org. VA's military service coordinators encourage its use during their VA benefits briefings to separating service members.

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

DoD and VA have executed a Memorandum of Understanding for sharing of information concerning active duty service members receiving inpatient care at VA medical centers. This expanded data sharing assists DoD pay specialists in their efforts to ensure that service members and their families are receiving appropriate pay and travel benefits.

To meet the needs of families, DFAS implemented a pilot program in October 2007 to provide family members of wounded service members another option to immediate access of travel advance funds. A Family Support Debit Card with a pre-loaded advance from their travel entitlement is provided to the family giving them immediate access to funds. This debit card method was proposed to eliminate the delays and security issues associated with other travel advance methods-cash, check, and Electronic Funds

Transfer-and is being tested in three locations.

As authorized in the NDAA, the TRICARE Management Agency will implement coverage comparable to the Extended Care Health Option (ECHO) for service members who incur a serious injury or illness on active duty. The respite care benefit has attracted the most interest and will provide short-term care for the service member in order to provide rest for those who care for the service member at home. To further address the needs experienced by families or the service member's designated caregiver, DoD has launched a study to identify the extent and amount of the costs borne by families or designated caregivers when they assume the responsibility of non-medical care to their service member or veteran. Initial numbers and costs from this study will be provided to DoD by July 2008 with validating surveys and interviews to follow in October 2008.

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

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

Transition

Collaboration between VA and DoD gained substantial momentum over the past year as we partnered to establish a seamless continuum to meet the needs of our wounded, ill, and injured service members and their families in transition to continued military service or veteran status. The SOC is scheduled to stand down in 2009, at which time the Joint Executive Council (JEC) will be responsible for SOC initiatives. The Departments are committed to maintaining the momentum created by the SOC through the JEC. It is the intent of the JEC to honor this commitment by ensuring that all of the initiatives that were developed and tracked by the SOC are fully and successfully implemented. The SOC will establish a clear direction for the two Departments before standing down, which will be incorporated into the next iteration of the JEC's Joint Strategic Plan. A number of the positive efforts have been produced under the auspices of the JEC: Dental care for reserve and national guard, realization of a joint Federal health care facility at North Chicago, traumatic injury protection benefit under the Servicemembers' Group Life Insurance/TSGLI, Benefits Delivery at Discharge (BDD), VBA Counselors stationed at MTFs, enhanced data sharing between VA and DoD, and more than 66 projects funded from 160 million in the Joint incentive Fund.

Conclusion

The Senior Oversight Committee and its Overarching Integrated Product Team continue to work diligently to resolve the many outstanding issues while aggressively implementing the recommendations of Dole/Shalala, the NDAA, and the various aforementioned task forces and commissions. These efforts will expand in the future to include the recommendations of the DoD Inspector General's report on DoD/VA Interagency Care Transition, which is due shortly.
As previously stated, one of the most significant recommendations from the task forces and commissions is the shift in the fundamental responsibilities of the Departments of Defense and Veterans Affairs. The core recommendation of the Dole/Shalala Commission centers on the concept of taking the Department of Defense out of the disability rating business so that DoD can focus on the fit or unfit determination, streamlining the transition from service member to veteran.
We have made four fundamental changes in our support and care for wounded warriors:

x Integrated the DoD and VA into a single team.
x Identified new approaches to support outpatients (e.g., Warrior Transition Units and American's with Disabilities Act compliant barracks).

x Developed new approaches to address psychological health and the challenges of TBI.
x Revolutionized customer care.

We envision five major changes that need to be addressed:

x Create and deploy an effective performance management structure that will be functional when handed off to the JEC. The structure will be a sensor suite to ensure the system is operating as intended.
x Rationalize DoD/VA roles and responsibilities in accordance with Dole/Shalala. x Define a solution for the Reserve Component.
x Define the path toward an interoperable information environment.
x Drive home the changed approach to psychological and customer care.

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to do. We also believe that the greatest improvement to the long-term care and support of America's wounded warriors and veterans will come from enactment of the provisions recommended by Dole/Shalala. We have, thus, positioned ourselves to implement these provisions and continue our progress in providing world-class support to our warriors and veterans while allowing our two Departments to focus on our respective core missions. Our dedicated, selfless service members, veterans, and their families deserve the very best, and we pledge to give our very best during their recovery, rehabilitation, and return to the society they defend.

Chairman Akaka, Senator Burr, and Members of the Committee, thank you again for your generous support of our wounded, ill, and injured service members, veterans, and their families. We look forward to your questions.