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Mr. Chairman and Members of the Committee:

On behalf of the four co-authors of The Independent Budget, AMVETS, the Veterans of Foreign Wars, and the Paralyzed Veterans of American, the Disabled American Veterans (DAV) is pleased to present our views relating to the work of the joint Department of Defense (DoD) and Department of Veterans Affairs (VA) Senior Oversight Committee.

In February 2007, the Washington Post published a series of articles regarding deficiencies in the medical care services and housing at Walter Reed Army Medical Center (WRAMC), which raised concerns regarding the care of injured Operations Enduring and Iraqi Freedom (OEF/OIF) servicemembers. In March, the Army began development of the Medical Action Plan (AMAP) to address the continuum of care, the Army's disability evaluation system and coordination with the VA.

By May of 2007, the DoD established the Wounded, Ill, and Injured Senior Oversight Committee (SOC). Chartered and co-chaired by the Deputy Secretaries of VA and DoD, the SOC is to identify immediate corrective actions, and to review, implement and track recommendations from a number of external reviews. Reports to be considered include the DoD Inspector General Review of DoD/VA Interagency Care Transition , DoD Task Force on Mental Health , the Independent Review Group, the Veterans Disability Benefits Commission , the President's Interagency Task Force on Returning Global War on Terror Heroes, and Commission on Care for America's Returning Wounded Warriors. In addition, the SOC is to implement and track the Wounded Warrior and Veterans titles of the National Defense Authorization Act, Public Law No. 110-181.

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 VA Under Secretary for Benefits and composed of senior officials from both agencies. The OIPT reports to the SOC and coordinates, integrates, and synchronizes work and makes recommendations regarding resource decisions. Working under a very short timeline, eight discrete Lines of Action (LOAs) were established. An owner for each LOA was assigned and tasked to outline planning and track milestones, identify needed resources, and develop legislative language to improvement a specific element of the overall treatment of injured servicemembers. A different LOA owner briefs the OIPT and SOC at each bi-weekly meeting.

As the sunset for the SOC approaches, we note progress made by VA and DoD on the four common areas of concern for The Independent Budget veterans service organizations (IBVSOs) and identified by the aforementioned reports and studies: Disability Evaluation System , Mental Health (Posttraumatic Stress Disorder) and Traumatic Brain Injury , Care Management and Data Sharing .

Disability Evaluation System

DoD and VA launched a disability evaluation pilot program in November 2007 at WRAMC, the National Naval Medical Center (NNMC), and Malcolm Grow Medical Center at Andrews Air Force Base, Maryland. Using performance measures, site assessment, case management and a phased expansion, the pilot project is to specifically improve timeliness, effectiveness, transparency, and resource utilization by integrating two separate disability evaluation processes, eliminating duplication, and improving case management practices.

The pilot project uses a single physical examination conducted on VA standards by a VA physician in a defense facility. VA assigns percentage ratings on all identified disabilities which DoD will accept in determining disability benefits. DoD will make a decision on whether the servicemember will or will not remain on active duty. If the service component makes the decision that the servicemember cannot continue to serve, the package goes to VA, who in turn notify the service component of the rating for each condition listed.

The defense disability system handles about 20,000 cases each year of various degrees of disability, and of those found unfit nearly 90 percent leave with a severance payment. All others are judged 30 percent or more disabled and are medically retired. According to the Army, the total number of servicemembers completing the medical evaluation board process increased about 19 percent from the end of 2006 to the end of 2007. With an average caseload target established by the Army of 30 servicemembers per board liaison, the IBVSOs believe this has not been met due to shortages of board liaisons. Like the board liaison staffing shortage, legal staff as well as board physicians assigned to help injured servicemembers navigate the disability process are not sufficiently staffed. We also remain concerned with the number of injured servicemembers served by this pilot project compared to the number of actual injured servicemembers who would otherwise quality for participation.

According to Government Accountability Office (GAO), DoD and VA have not finalized their criteria for expanding the pilot beyond the original sites. Current evaluation plans lack key elements, such as an approach for measuring the performance of the pilot-in terms of timeliness and accuracy of decisions-against the current process, which would help planners manage for a successful expansion. The IBVSOs can appreciate the need for satisfaction surveys being conducted on veterans and servicemembers who have gone through the system; however, ensuring due process, and reducing variability and timeliness to ensure decisions are consistent will greatly lend to fairness and confidence in the process.

Case/Care Management

Warrior Transition Units: The Army's new organizational structure for providing an integrated continuum of care for its returning servicemembers is called Warrior Transition Units. These units were designed as the center piece of the Army's Medical Action Plan. The warrior-transition program assigns each injured servicemember, or "Warriors in Transition," a "Triad" which consists of a nurse case manager to coordinate needed services and appointments, a squad leader to ensure compliance to treatment plan and a primary care provider who oversees the treatment plan. A typical Warrior Transition Unit company will have a commander, executive officer, first sergeant, six platoon sergeants and 18 squad leaders. The workload for a squad leader will be 12 patients as opposed to 50 in Medical Hold companies.

At the time of the announcement in June 2007, the Army Medical Command expected to staff Warrior Transition Units with 2,419 cadre by January 2008 (the target date for new units to become fully operationally). The staffing was projected to ultimately include 743 active-component soldiers, 381 National Guard soldiers, 381 Army Reserve soldiers, and 914 Army civilians, to support an estimated population of 10,000 "Warriors in Transition." As of this writing, the Army's organizational chart maps out the Warrior Transition Unit structure serving approximately 8,000 soldiers. More non-commissioned officers are still needed to staff units and mental health professionals are needed.

According to GAO, as of September 2007, 17 of the 32 units had less than 50 percent of staff in place in one or more of these critical positions. In a subsequent report GAO notes, "the Army has made considerable progress in staffing this structure, increasing the number of staff assigned to key positions by almost 75 percent. However, shortfalls continue to exist in some areas-11 of the 32 U.S. Warrior Transition Units had less than 90 percent of needed staff for one or more key positions." Moreover, the data generated on meeting the needs of servicemembers and families remain suspect. Greater oversight is needed to ensure benchmarks are clearly indentified and defined, and that progress is measured and reported.

Federal Recovery Coordination Program (FRCP): A Federal Recovery Coordinator Director, a Federal Recovery Coordinator Supervisor, and eight Federal Recovery Coordinators were hired, trained, and deployed in January 2008. Employed by VA, the Federal Recovery Coordinator (FRC) is intended to complement VA and DoD's existing case management approach. VA's care management program includes the OEF/OIF Program Manager, Transition Patient Advocates and OEF/OIF Nurse and Social Worker Case Managers, and other case and care managers (Women Veterans, Spinal Cord Injured, Visual Impairment Service Team, Polytrauma Support Clinic Teams). DoD's military wounded warrior programs include the Wounded Warrior Transition Units of the Army Medical Action Plan, the Army Wounded Warrior (AW2) program, the Navy's Safe Harbor Program, the Marine Corps' Marine for Life Program and the Air Force Palace HART Program.

According to our most recent data, for each of the 67 injured servicemembers who are currently enrolled in the FRCP, there are 6 FRCs. The FRC is intended to be the ultimate resource to oversee the development and implementation of services. The FRC is responsible for each enrolled servicemember the Federal Individual Recovery Plan (FIRP), which provides an individualized, integrated, longitudinal, clinical/non-clinical service plan across the continuum of care for injured servicemembers, veterans and their families. Also, the FRC is to monitor and regularly modify the FIRP in conjunction with all Multi-Disciplinary Teams to meet the requirements and needed services to ensure successful transition of servicemember and family.

In addition to the recovery plan, the FRC will have at their disposal a National Resource Directory , Family Handbook, MyEBenefits, and access to Veterans Tracking Application to assist in their work to help injured servicemembers and their families. The IBVSOs are encouraged that the current number of six FRCs will be expanded to 10 this May; however, many questions remain such as the effectiveness of this program in meeting the need of severely injured servicemembers. For as much emphasis as was placed on the need for a single recovery coordinator, we are deeply concerned with small size and the number of injured servicemembers

currently being served by this program. Another cause for concern is the enrollment into the FRCP and number of servicemembers who may be eligible for the program. The potential workload and expansion of this program should be accompanied by appropriate resources being allocated.

Posttraumatic Stress Disorder and Traumatic Brain Injury

In November 2007, the DoD Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury (TBI) was established to improve the care provided to servicemembers. The SOC has developed a policy for DoD and VA to establish a National Center of Excellence for Psychological Health and TBI at Bethesda that will include VA and the Department of Health and Human Services 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. In addition, it will coordinate the efforts across agencies to facilitate coordination and collaboration for Posttraumatic Stress Disorder (PTSD) and TBI related services among the military compents and VA, promoting and informing best practice development, research, education and training.

We applaud DoD's program to collect baseline neurocognitive information before 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. Such information could address the National Defense Authorization Act of 2008 provision regarding creation of a TBI registry. However, we are concerned about the lack of evidence base regarding servicemembers and veterans suffering from mild to moderate forms of TBI. The emerging literature strongly suggests that even mildly injured TBI patients may have long-term mental and physical health consequences. According to DoD and VA mental health experts, mild TBI can produce behavioral manifestations that mimic PTSD or other conditions.

Additionally, TBI and PTSD can be coexisting conditions in one individual. Much is still unknown about the long-term impact of these injuries and the best treatment models to address mild-to-moderate TBI. We believe more research should be conducted into the long-term consequences of brain injury and development of best practices in its treatment; however, we suggest that any studies undertaken include older veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed or misdiagnosed, and untreated. Their medical and social histories could be of enormous value to VA researchers interested in the likely long-term progression of these new injuries. Likewise, such knowledge of historic experience could help both the DoD and VA better understand the policies needed to be put into place to improve screening, diagnosis, and treatment of mild TBI in combat veterans of the future.

Another issue of concern to the IBVSOs are unidentified TBI veteran patients with undiagnosed and untreated visual-related conditions. Servicemembers and veterans suffering from undiagnosed visual impairments pose a risk for incomplete rehabilitation which can significantly affect one's ability to function independently for life. It is clear the SOC is not tracking or taking action on this issue. Moreover, it is unclear whether DoD providers are assessing and treating subtle visual-related conditions or neuro-optometric dysfunctions. The IBVSOs are concerned

VA and WRAMC have limited knowledge and resources to meet the demand and that there are a number of untreated visual-problems that delay and hinder rehabilitation.

It is evident families provide the "front line" of the support network for returning veterans. Spouses are often the first to identify readjustment issues and facilitate veterans' evaluation and treatment when concerns are identified. The IBVSOs strongly believe that VA and the DoD must embrace new models of support for this generation of combat veterans. Family counseling support services that are needed by recently returning OEF/OIF veterans are only available on a limited basis in VA despite increasing need for such services. The Mental Health Advisory Team V report shows that while stigma among servicemembers seeking health is reduced, this problem continues to persist. Meanwhile the Mental Health Task Force highlighted the need for marital and family counseling, however, it appears the SOC has not adopted any action to enhance TRICARE benefits to include marital and family counseling. Although geographic coverage is a major limitation, we note that the Vet Center program is one of the few VA programs to address the veteran's full range of needs within family and community where family counseling is provided when needed for the readjustment of the veteran.

Data Sharing Between Defense and Veterans Affairs

The SOC's Line of Action to expedite VA-DoD data sharing stands in the shadow of both the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans report in 2003 regarding the need for an interoperable electronic medical record and the two agencies working for almost 10 years to facilitate the exchange of medical information. The IBVSOs believe the need for sharing patient information is critical particularly for the FRC and local VAMC OEF/ OIF Care Management Team that require timely and reliable patient information to ensure continuity of care across the many organizational seams between VA and DoD. We understand that the SOC has approved initiatives to ensure health and administrative data, such as DoD provider/clinical notes, problem lists, and theater health data (recently added), automated Federal Individual Recovery Plan, and the My eBenefits Web Portal based on the VA's My HealtheVet website, are made available and are viewable by both agencies.

Success in sharing outpatient data, most recently with outpatient pharmacy (government and retail) data has lead to progress in sharing inpatient data such as inpatient laboratory and radiology reports, inpatient discharge summary data from Landstuhl Regional Medical Center, consults, admission, disposition and transfer data, allergy information, and ambulatory coding data. Moreover, the one-way transfer of information has lead to the bi-directional sharing of information including outpatient pharmacy and allergy data, laboratory results and radiology reports. Progress notes, problem lists, and history data will round off the list and by June 2008, it is expected that VA will have access to data from all DoD locations.

The IBVSO's believe VA and DoD should capitalize on their ability to share computable bi-directional allergy and pharmacy information between next-generation systems and data repositories. Computable information permits the VA and DoD systems to conduct automatic drug¬-drug and drug-allergy interaction checking. The IBVSOs believe the DoD and VA must continue to develop electronic medical records that are computable, interoperable, and bidirectional, allowing for a two-way electronic exchange of health information. Furthermore, these electronic medical records should also include an easily transferable electronic DD214

forwarded from the DoD to VA. This would allow the VA to expedite the claims process and give the servicemember faster access to health care and benefits.

Conclusion

The IBVSOs applaud efforts and accomplishments made by both agencies over the past 14 months to ensure a seamless transition for injured servicemembers and veterans to receive benefits and services they need, whether provided by VA or DoD. It is clear however, that these accomplishments are a good first step and that many challenges remain as outlined above. The IBVSOs believe the momentum generated should be sustained as the SOC sunsets. Also, the transition to whichever entity will be responsible for tracking current LOAs should be handled with the same vigor and transparency as the SOC. The IBVSOs recommend a permanent office be established and staffed with full time employees from both agencies. Furthermore, unlike the current structure in the SOC we believe VA should take the lead for several reasons, chief of which is that injured servicemembers and their families will eventually come to VA, many for a lifetime of care.

Again, we thank this Committee for its unwavering diligence in conducting oversight on this important matter on behalf of our nation's most recent generation of disabled veterans and servicemembers.