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Prepared Statement

of

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Chairman Murray, Ranking member Burr, and members of this distinguished Committee, thank you for inviting us to testify before you on the care and transition of our wounded warriors from the Department of Defense to the Department of Veterans Affairs. Taking care of our wounded, ill and injured Service members is one of the highest priorities of the Department, the Service Secretaries and the Service Chiefs. The Secretary of Defense has said, other than the War itself, there is no higher priority. Reforming cumbersome and sometime confusing bureaucratic processes is crucial to ensuring Service members receive, in a timely manner, the care and benefits to which they are entitled. The Department's leaders continue to work to achieve the highest level of care and management and to standardize care among the Military Services and Federal agencies, while maintaining focus on the individual.

DISABILITY EVALUATION SYSTEM/ INTEGRATED DISABILITY EVALUATION SYSTEM

The genesis of the Disability Evaluation System (DES) is the Career Compensation Act of 1949, after which the system went relatively unchanged for 58 years, until 2007. As a result of concern within the Department of Defense (DoD) and the Department of Veterans Affairs (VA), as well as Congressional and public concern, the Senior Oversight Committee (SOC) chartered the DES Pilot in November 2007.

We have several goals for the DES Pilot. We are determined to stop making Service members go through the disability evaluation process twice – once before discharge and once after discharge while awaiting benefits. The DES Pilot accomplished this by assigning the Military Services the tasks they do best – determining fitness for duty – and VA the tasks they do best – performing medical evaluations in accordance with the VA Schedule for Rating Disabilities and assigning

proposed disability ratings for use by DoD and VA -- all while the Service members and their families were receiving military pay and benefits.

We are also determined to eliminate inconsistent disability ratings between VA and the Military Services. The Pilot achieves this because VA- provides a proposed disability ratings that can be used to determine eligibility for both military and VA compensation and benefits. This was effective because the conditions the Military Services are allowed by law to include in their disability ratings are a subset of the disabilities for which VA is allowed to compensate. In the Pilot, both ratings were presented and explained to Service members to ensure transparency.

And, we are determined to enable Service members to complete the integrated processes more quickly than they could complete the processes one after the other. The DES Pilot accomplished this, cutting out steps that Service members previously had to perform twice.

To test our ability to meet these goals consistently, we expanded the DES Pilot from the original three major military treatment facilities (Walter Reed, Bethesda, and Malcolm Grow) in the National Capital Region to 18 more locations in October 2008. The Pilot continued to meet all five of these goals. In January 2010, we expanded the test to six more locations. The Pilot continued to meet all five of these goals.

DoD and VA found the integrated DES to be a faster, fairer, more efficient system and, as a result, the SOC Co-chairs (the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs) on July 30, 2010, directed worldwide implementation of the process beginning in October 2010 to be completed at the end of September 2011. On December 15, 2010, the first Integrated Disability Evaluation System (IDES) site became operational, which marked the end of the pilot, and the name was formally changed to the IDES.

As in the Pilot, the IDES continues to meet the five primary goals. Service members in the IDES receive their disability benefits as soon after discharge as VA is legally permitted to provide them, know before discharge what level of VA disability compensation and benefits they will receive, they only have to go through the process once, receive ratings that are consistent between VA and the military Services, and complete the integrated processes more quickly than they could complete them one after the other.

In designing the integrated system, we tried to move Service members through the integrated processes even faster than they move through just the military process in the existing system. At first, we succeeded. However, we are discovering obstacles as we deploy IDES through the entire force. Thus far in May 2011, Active Component Service members completed the IDES process in an average of 404 days from referral to post-separation VA Benefits decision, including Service-department appeals and pre-separation leave. This exceeds the 295-day IDES goal, but is still 27 percent faster than the 540 day benchmark for the Legacy disability process. We attribute the lengthening queue time to the fact that more complex and intricate cases are matriculating in the system, and Service members are opting for more due process and administrative reviews, as well as opting to take leave while on active duty versus selling it back at date of separation. However, the Service members and families who are methodically processing through the IDES continue to receive full pay, allowances, compensation, medical and base support care and benefits as they prepare transition to civilian life and VA care. As of

May 15, 2011, cumulative IDES enrollment is 23,350 Service members with 7,546 completing the program by medical separation, retirement, or return to duty.

We will never rest on the fact that we have historically improved the DES in almost four short years. We know we can and ought to do even better. The Departments are continuously exploring new ways to improve the current system. The Secretaries of Defense and Veterans Affairs are currently exploring several options to shorten the overall length of the disability evaluation process from its current goal of 295 calendar days. We are looking closely at the stages of the IDES that are outside of timeliness tolerances and developing options to bring these stages within goal. Examples of items we are working on are: streamlining medical case narrative summary to improve Medical Evaluation Board (MEB) timeliness; improving IDES disability examination timeliness by increasing VA capacity; and providing better expectation management service and transparency to Service members. The Secretaries have also commissioned a group of operational subject matter experts to take a fresh look at additional avenues (both requiring changes in statute and those that can be accomplished with quick policy changes) to make the system more efficient. The group hopes to conclude their work in October of this year and provide the Secretaries with actionable recommendations.

Nonetheless, the IDES, which has proven to be faster, fairer (based on customer satisfaction surveys) and substantially reduced the DoD-VA benefits gap, constitutes a major improvement over the legacy DES and both DoD and VA are fully committed to the worldwide expansion of IDES. Both Departments are partnering closely as we aggressively move toward IDES implementation at all 139 CONUS and OCONUS sites by September 30, 2011.
The impact of each stage of the IDES expansion and cumulative DES population is shown below:
• Stage I-West Coast & Southeast (October-December 2010) - (Completed) 58%
• Stage II-Rocky Mountain & Southwest Region (January-March 2011) – (Completed) 74%
• Stage III-Midwest & Northeast (April - June 2011) - 90%
• Stage IV-Outside Continental United States (OCONUS)/CONUS (July – September 2011) -- 100%

We are committed to working closely with Congress in exploring new initiatives that can further advance the efficiency and effectiveness of the disability evaluation process.

RECOVERY COORDINATION PROGRAM
The DoD Recovery Coordination Program (RCP) was established by Section 1611 of the FY2008 National Defense Authorization Act. This mandate called for a comprehensive policy on the care and management of covered Service members, including the development of comprehensive recovery plans, and the assignment of a Recovery Care Coordinator for each recovering Service member. In December 2009, a Department of Defense Instruction (DoDI 1300.24) set policy standardizing non-medical care provided to wounded, ill and injured Service members across the military departments. The roles and responsibilities captured in the DoDI are as follows:
• Recovery Care Coordinator: The Recovery Care Coordinator (RCC) supports eligible Service members by ensuring their non-medical needs are met along the road to recovery.

• Comprehensive Recovery Plan: The RCC has primary responsibility for making sure the Recovery Plan is complete, including establishing actions and points of contact to meet the Service member's and family's goals. The RCC works with the Commander to oversee and coordinate services and resources identified in the Comprehensive Recovery Plan (CRP).
• Recovery Team: The Recovery Team includes the recovering Service member's Commander, the RCC and, when appropriate, the Federal Recovery Coordinator (FRC), for catastrophically wounded, ill or injured Service members, Medical Care Case Manager and Non-Medical Care Manager. The Recovery Team jointly develops the CRP, evaluating its effectiveness and adjusting it as transitions occur.
• Reserve/Guard: The policy establishes the guidelines that ensure qualified Reserve Component recovering Service members receive the support of an RCC.

There are currently 147 DoD trained RCCs in 69 locations placed within the Army, Navy, Marines, Air Force, United States Special Operations Command (USSOCOM) and Army Reserves. Care Coordinators are hired and jointly trained by DoD and the Services' Wounded Warrior Programs. Once placed, they are assigned and supervised by Wounded Warrior Programs but have reach-back support, as needed, for resources within the Office of Wounded Warrior Care and Transition Policy. DoD RCCs work closely with FRCs as members of a Service member's recovery team.

In the DoDI, we have codified that severely injured and ill who are highly unlikely to return to duty and will most likely be medically separated from the military (Category III) will also be assigned an FRC. The DoDI 1300.24 establishes clear rules of engagement for RCCs. The RCC's main focus is on Service members who will be classified as Category II. A Category II Service member has a serious injury/illness and is unlikely to return to duty within a time specified by his or her Military department and may be medically separated. The FRC's main focus is on the Service members who are classified as Category III. A Category III Service member has a severe or catastrophic injury/illness and is unlikely to return to duty and is likely to be medically separated.

While defined in the DoDI, Category I, II and III are all administrative in nature and have been difficult to operationalize. The intent of the controlling DoDI is to ensure that wounded, ill, and injured Service members receive the right level of non-medical care and coordination. DoD is working with the FRCP to make sure that Service members who need the level of clinical and non-clinical care coordination provided by a FRC are appropriately referred.

Earlier this year, the SOC directed the Recovery Coordination Program (RCP) and the Federal Recovery Coordination Program (FRCP) leadership to establish a DoD-VA Executive Committee on Care/Case Management/Coordination to identify ways to better coordinate the efforts of FRCs and RCCs and to look to where to better integrate our two programs where possible in order to avoid the problems of duplicative or overlapping case management. The Committee conducted its first meeting in March and its final two-day meeting May 10 - 11. The results of the Committee's efforts will be briefed to the SOC at its June meeting.

In March 2011, DoD also conducted an intense 2 ½ day Wounded Warrior Care Coordination Summit that included focused working groups attended by subject matter experts who discussed and recommended enhancements to various strategic wounded warrior issues requiring attention.

One working group focused entirely on collaboration between VA and DoD care coordination programs. Another group focused on best practices within recovery care coordination and a third group focused on wounded warrior family resiliency, employment and education. Actionable recommendations are currently being reviewed, have been presented to the Overarching Integrated Product Team (OIPT) and will continue to be worked until approved recommendations and policies are implemented.

DoD is committed to working closely with the Federal Recovery Coordination Program leadership to ensure a collaborative relationship exists between the DoD RCP and the FRCP. The Military Department Wounded Warrior Programs will also continue to work closely with FRC's in support of Service members and their families.

TRANSITION ASSISTANCE FOR SERVICE MEMBERS

Transition Assistance Program (TAP)

To strengthen our Transition Assistance Program (TAP) and reinforce its value to Service members and their families, the Department, in collaboration with our partners at the Departments of Veterans Affairs (VA) and Labor (DOL), is committed to moving TAP from a traditional event-driven approach to a modern, innovative lifecycle approach. We are shifting from an end of military life-cycle event to an outcome based model that will measure success not only on the number of Service members who use the TAP process, but also on the number of transitioning service members and their families who find the TAP process beneficial in assisting them with their life goals, military career progression, and/or new careers/meaningful employment outside of uniformed service. We will be implementing this strategic plan with focuses on information technology, strategic communications, and resources and performance management. The end-state for the TAP overhaul will be a population of Service members who have the knowledge, skills, and abilities to empower themselves to make informed career decisions, be competitive in the global work force and become positive contributors to their community as they transition from military to civilian life.

As part of this effort, we launched the DoD Career Decision Toolkit in August 2010. Available both online and in CD format, the Toolkit was developed in collaboration with the Military Services and our TAP partners at the Department of Veterans Affairs and Department of Labor to help simplify the learning curve for transitioning Service members with the information, tools, and resources they need to succeed in the next phase of their lives. The toolkit uses the latest technology to consolidate the very best teaching materials from all the Service branches and provides thousands of on-demand resources to Service members. It is interactive, simple to use and portable. The toolkit includes:

- More than 3,000 on-demand information and planning resources
- Transition subjects such as career exploration, financial planning, resume creation, interviewing skills and compensation negotiation
- Tools that enable Service members to catalogue their military skills, training, and experience in ways that transfer to civilian sector
- Post-Service benefits and resources
- Resources that allow users to self-assess individual transition needs and plan personalized options

In addition to the Toolkit, we began offering a series of virtual learning opportunities to transitioning Service members and military spouses on March 1st of this year. The free online classes are available to any Service member worldwide and provide them with an interactive educational forum to delve into employment and career related topics, such as "Building Better Resumes" and "Financial Planning for a Career Change." The classes are highly encouraged for any Service members looking bolster their transition-related knowledge, especially rurally located members of the National Guard and Reserves and Wounded Warrior in recovery. To date, there have been more than 900 hundred registrations for these online seminars including registrations by military personnel stationed overseas in Diego Garcia, BIOT; Guantanamo Bay, Cuba; Italy, Japan, Korea, Germany and members deployed to Afghanistan and Iraq. Military spouses are also among the many participants who have enjoyed this new delivery methodology.

The TAP Virtual Learning Seminars have also been enthusiastically embraced by senior military leadership and prominent figures in business and academia. Some of which now participate in online seminars as "surprise celebrity guests". Leaders such as Army Reserve Command Sergeant Major Michael D. Schultz; Navy Reserve Force Master Chief Ronney A. Wright; Philip Dana, Amazon's Military Recruiting HR Manager; and Dr. Timothy Butler, Harvard Business School's Director of Career Development Programs have made guest appearances to motivate the attendees, stress the importance of proper transition planning, and also to participate in the online classes along with the Service members and families.

The Toolkit and the virtual classes are just the beginning of our effort to move TAP into the digital spectrum. We are developing an "end-to-end" virtual TAP delivery vehicle delivery platform that will provide the back-bone of the transformed TAP program, integrating the Guard and reserve components, as well as expanding services available to family members.

DoD is partnering with the Office of Personnel Management and the Departments of Labor, Veterans Affairs and Homeland Security on President Obama's Veteran's Employment Initiative. The Initiative directs 24 large and independent Federal agencies to improve employment opportunities for veterans in their agencies. TAP is one of the programs we will use to educate and inform Service members about federal Service career opportunities.

DoD has also played a supporting role with the Office of Personnel Management on the initiative to increase hiring veterans in all federal agencies. This is now recognized as President Obama's Veterans Employment Initiative that directs all Executive Agencies to increase veteran employment. TAP is one of the programs we will use to educate and inform Service members about federal Service career opportunities.

Focus on Credentialing

The Department continues to provide licensure and certification information in a range of ways and in different formats in order to appeal to individual learning styles and ensure the widest possible dissemination. It is important to note, the Department of Defense does not serve as a credentialing body. These bodies are typically well-defined for licensure requirements by Governmental agencies—federal, state, or local—who grant licenses to individuals to practice a specific occupation, such as a medical license for doctors. State or federal laws or regulations define the standards that individuals must meet to become licensed.

Non-governmental agencies, associations, and even private sector companies grant certifications to individuals who meet predetermined qualifications. These qualifications are generally set by professional associations (for example, National Commission for Certification of Crane Operators) or by industry and product-related organizations (for example, Novell Certified Engineer). Certification is typically an optional credential; although some state licensure boards and some employers may require certification. For many occupations, more than one organization may offer certifications.

Verification of Military Experience and Training

The Verification of Military Experience and Training (VMET) document was established by Public Law 101-510, Section 1143(a), 5 November 1990, National Defense Authorization Act for Fiscal Year 1991 to assist departing service members transitioning to civilian life by providing a verification of their military skills and training and translating them into civilian terms. Eligibility was all military (Army, Navy, Marine Corps, and Air Force) members on active duty on or after 1 October 1990. The Defense Manpower Data Center (DMDC), a Department of Defense activity that supports the Office of the Under Secretary of Defense for Personnel & Readiness (OUSD/P&R), has the responsibility for producing the VMET documents and maintaining the VMET web site.

The issuance of the DD Form 2586 Verification of Military Experience and Training has been enhanced and now available on demand directly from the Defense Manpower Data Center website at www.dmdc.osd.mil/vmet. Access to the document is protected by secure login protocols. The document is an "all-services" integrated form which displays demographic, training, and experience information that is retrieved from various automated sources, including the master military personnel records of each Service.

The VMET document lists military experience and training which may have application to employment in the private sector. The document was designed as a tool to prepare resumes and job applications, in concert with evaluation reports, training certificates, awards, transcripts, and other pertinent documents. It is not an official transcript for purposes of granting college credit, but it can be used to support verification of having met training and/or course requirements to qualify for civilian occupations, certificates, licenses, or programs of study. Credit recommendations from the American Council of Education (ACE) for occupations and/or courses are listed when they are available; academic institutions determine which credits are applicable to a program of study.

A Lifecycle of Credentialing Education

The Department has realized that the key feature of effective licensure and certification programs are that they are introduced to Service members early in their careers, not just at the time of separation. We continue to provide licensure and certification information in a range of ways and in different formats in order to appeal to individual learning styles and ensure the widest possible dissemination. The information is provided through classroom delivery from an instructor, by online interaction and internet research, and through one-on-one coaching. This ensures that Service members have current and accurate information at their fingertips in order to make informed decisions about their future. We are taking full advantage of the Department of Labor's Career One Stop (www.careeronestop.org) online resource as promoting utilization

throughout the entire military lifecycle to reinforce the value of military training and experience. In this application, Service members link to the Credentials Center, which they can use to locate State-specific occupational licensing requirements, agency contact information and information about industry-recognized certifications. There are also associated workforce education and examinations that test or enhance knowledge, experience and skills in related civilian occupations and professions.

WOUNDED, ILL AND INJURED SERVICE MEMBER EMPLOYMENT INITIATIVES

Operation Warfighter (OWF)

OWF is a DoD-sponsored internship program that offers recuperating wounded, ill and injured Service members meaningful activity that positively impacts wellness and offers a process of transitioning back to duty or entering into the civilian workforce. The main objective of OWF is to place recuperating Service members in supportive work settings that positively benefit the recuperation process.

OWF represents a great opportunity for transitioning Service members to augment their employment readiness by building their resumes, exploring employment interests, developing job skills, benefiting from both formal and on-the-job training opportunities, and gaining valuable Federal government work experience that will help prepare them for the future. The program strives to demonstrate to participants that the skills they have obtained in the military are transferable into civilian employment. For Service members who will return to duty, the program enables these participants to maintain their skill sets and provides the opportunity for additional training and experience that can subsequently benefit the military. OWF simultaneously enables Federal employers to better familiarize themselves with the skill sets of wounded, ill and injured Service members as well as benefit from the considerable talent and dedication of these transitioning Service members.

To date, the program has placed approximately 1,800 Service members across more than 100 different Federal employers and sub-components. The program currently has 390 active internship placements.

Education and Employment Initiative (E2I)

Contributing factors to unemployment among wounded warriors include the lack of a focused employment, educational, and rehabilitation process that engages Service members as soon as they begin treatment at a Medical Treatment Facility (MTF), as well as a lack of qualified career counselors who can administer career assessments and match Service members to careers. DoD, in collaboration with VA, DOL, and the Office of Personnel Management (OPM), is developing E2I to address these shortfalls. E2I will leverage best practices and the good work already being done from existing employment and training initiatives in both federal and private sectors. The first phase is a tiered pilot program scheduled to launch in by this summer.

The goal of the E2I pilot is to engage Service members early in their recovery to identify skills they have, the skills they need and the employment opportunities where those skills can be put to good use. The E2I process will begin within 30-90 days of when a Recovering Service Member (RSM) arrives at a MTF, taking advantage of a recovery time that averages 311 days but can be as long as five years. At the very beginning of the E2I process, all applicants will be administered a comprehensive skills assessment that includes understanding their current

disability, Military Occupational Specialty (MOS) experience, career desires, education and training background, and special accommodations that may be required for a particular type of position. This assessment will be conducted by a trained career and vocation counselor who has extensive knowledge of the issues facing wounded warriors.

The E2I counselor will work with the RSM from the initial stages of creating an individual development plan (IDP), setting goals, course selection, and education requirements, through to the completion of training/certification and their return to duty or an alternate job placement. A Mentor and Coach will be assigned to all E2I applicants at the beginning of the process to provide personalized assistance and guidance throughout the E2I process from recruitment at the MTF into the program, through placement in their new MOS or chosen career.

Our plan is to evaluate the E2I program over the next 12 months to 18 months and refine the process with new ideas and best practices. Once this evaluation is complete, our plan is to continue our E2I roll-out, which will include partnering with OPM, VA and DOL to ensure we have standardized practices and comprehensive handoffs as the RSM leaves the responsibility of the DoD.

INTERAGENCY ELECTRONIC HEALTH RECORD

The collaborative Federal partnership between DoD and VA has resulted in increased integration of healthcare services to Service members and Veterans. DoD and VA spearhead numerous interagency electronic health data sharing activities and are delivering IT solutions that significantly improve the secure sharing of appropriate electronic health information.

Today's interagency health information exchange (HIE) capabilities leverage the existing electronic health records (EHRs) of each Department. Both Departments are currently addressing the need to modernize their EHRs. We are working together to synchronize EHR planning activities and identify a joint approach to EHR modernization.

Current HIE sharing capabilities support electronic health data sharing between DoD and VA. The Federal Health Information Exchange (FHIE), Bidirectional Health Information Exchange (BHIE), and the Clinical Data Repository/Health Data Repository (CHDR) support continuity of care for millions of Service members and Veterans by facilitating the sharing of health care data as beneficiaries move beyond DoD direct care to the VA. The data shared includes information from DoD's inpatient documentation system which is in use in DoD's inpatient military treatment facilities, including Landstuhl Regional Medical Center, Germany, the evacuation and treatment center Service members pass through if they have a medical problem while deployed in the current theater of operations. The health data shared assists in continuity of care and influences decision making at the point of care.

The Blue Button is another example of how DoD and VA are working together to shape the future of health care IT collaboration, interoperability and transparency for the patients and families we serve. The Blue Button allows beneficiaries to safely and securely access personal health data at TRICARE Online, the Military Health System's Internet point of entry.

The Blue Button capability allows beneficiaries to safely and securely access and print or save their demographic information, allergy and medication profiles, lab results, patient history and

diagnoses, and provider visits. The level of data available is dependent on where treatment occurs – with the most data available to those who regularly get care at military hospitals and clinics.

Transmission of Data from Point of Separation

At separation, the Federal Health Information Exchange (FHIE) provides for the one-way electronic exchange of historic healthcare information from DoD to VA for separated Service members since 2001. On a monthly basis DoD sends: laboratory results; radiology reports; outpatient pharmacy data; allergy information; discharge summaries; consult reports; admission/ discharge/transfer information; standard ambulatory data records; demographic data; pre- and post-deployment health assessments (PPDHAs); and post-deployment health reassessments (PDHRAs). DoD has transmitted health data on more than 5.6 million retired or separated Service members to VA. Of these 5.6 million patients approximately 2.1 million have presented to VA for care, treatment, or claims determination. This number grows as health information on recently separated Service members is extracted and transferred to VA monthly.

Access to Data on Shared Patients

For shared patients being treated by both DoD and VA, the Departments maintain the jointly developed Bidirectional Health Information Exchange (BHIE) system that was implemented in 2004. Unlike FHIE, which provides a one-way transfer of information to VA when a service member separates from the military, the two-way BHIE interface allows clinicians in both Departments to view, in real-time, health data (in text form) from the Departments' existing health information systems. Accessible data types include allergy, outpatient pharmacy, inpatient and outpatient laboratory and radiology reports, demographic data, diagnoses, vital signs, problem lists, family history, social history, other history, questionnaires and Theater clinical data, including inpatient notes, outpatient encounters and ancillary clinical data, such as pharmacy data, allergies, laboratory results and radiology reports.

Use of BHIE continues to increase. The number of patients, including Theater patients, available through BHIE increased during FY 2010 by approximately 400,000 shared patients. There are more than 4.0 million shared patients including health data for over 243,000 Theater patients, available through BHIE.

To increase the availability of clinical information on a shared patient population, VA and DoD collaborated to further leverage BHIE functionality to allow bidirectional access to inpatient discharge summaries from DoD's inpatient documentation system. Use of the inpatient documentation system at Landstuhl Regional Medical Center plays a critical role in ensuring continuity of care and supporting the capture and transfer of inpatient records of care for wounded warriors. Information from these records is accessible stateside to DoD providers caring for injured Service members and inpatient discharge summaries are available to VA providers caring for injured Service members and Veterans. As of April 2011, discharge summaries are available for all DoD inpatient beds. DoD's inpatient documentation system is now operational at all 59 DoD inpatient sites.

Recent improvements to BHIE include the completion of hardware, operating system, architecture, and security upgrades supporting the BHIE framework and its production

environment. This technology refresh, completed in January 2011, resulted in improved system performance, and reliability.

Exchange of Computable Pharmacy and Allergy Data

The Clinical Data Repository/Health Data Repository (CHDR) supports interoperability between AHLTA's CDR and VA's HDR, enabling bidirectional sharing of standardized, computable outpatient pharmacy and medication allergy data. Since 2006, VA and DoD have been sharing computable outpatient pharmacy and medication allergy data through the CHDR interface. Exchanging standardized pharmacy and medication allergy data on patients supports improved patient care and safety through the ability to conduct drug-drug and drug-allergy interaction checks using data from both systems.

In FY 2010, the Departments exchanged computable outpatient pharmacy and medication allergy data on over 250,000 patients who receive healthcare from both systems. This was a more than 400 percent increase from the 44,000 patients whose computable pharmacy and medication allergy data was being exchanged in FY 2009. By the second quarter of FY 2011 the Departments have exchanged computable outpatient pharmacy and medication allergy data on over 741,000 patients who receive healthcare from both systems.

Wounded Warrior Image Transfer

To support our most severely wounded and injured Service members transferring to VA Polytrauma Rehabilitation Centers for care, DoD sends radiology images and scanned paper medical records electronically to the VA Polytrauma Rehabilitation Centers. Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Brooke Army Medical Center are providing scanned records and radiology images electronically for patients transferring to VA Polytrauma Rehabilitation Centers in Tampa, Richmond, Palo Alto, and Minneapolis. From 2007 to the present, images for more than 375 patients and scanned records for more than 470 severely wounded warriors have been sent from DoD to VA at the time of referral.

Virtual Lifetime Electronic Record

The Departments are firmly focused on enhancing our electronic health data sharing and expanding capabilities to share information with the private sector through Nationwide Health Information Network (NwHIN) and the Virtual Lifetime Electronic Record (VLER). NwHIN will enable the Departments to view a beneficiary's healthcare information not only from DoD and VA, but also from other NwHIN participants. To create a virtual healthcare record—and achieve the VLER vision—data will be pulled from EHRs and exchanged using data sharing standards and standard document formats. A standards based approach will not only improve the long-term viability of how information is shared between the Departments, but will also enable the meaningful exchange of information with other government providers and with civilian providers, both of which account for a significant portion of care delivered to the Departments' beneficiaries.

The VLER pilot projects are demonstrations of exchanges of electronic health information between VA, DoD and participating private sector providers. The pilots continue to provide evidence of the power and effectiveness of coordinated development between the Departments for increasing the secure sharing of electronic health information while leveraging existing EHR capabilities. DoD's VLER pilots are underway in San Diego, California; Tidewater, Virginia;

and Spokane, Washington. The fourth and final pilot will be launched in Puget Sound, Washington in late FY 2011. In addition, VA is participating in seven other pilots with the private sector to expand the VLER capability. Those pilots are in Asheville, NC, Richmond, VA, Rural Utah, Indianapolis, IN and three other sites that have not yet been publicly announced. By September 2011, VA will be operational in a total of 11 pilot sites, with at least 50,000 Veterans participating who have provided written consent to share records with the private sector.

Modernizing the EHR – The Foundation for Interagency Data Sharing

We believe there are many benefits in pursuing a joint way ahead for EHR. The Departments will be able to delivera seamless health record from accession through end of life for all service members and veterans. Improvements to the quality of care delivery will reduce errors and improve adherence to care guidelines. Strategic organizational use of health information, including evidence-based alerts and reminders, will improve effectiveness. Improved enterprise-wide use of health information will also lead to enhanced management of population health, resulting in improved health status and reduced need for health care services. Savings in staff time and materials associated with system support of transactional tasks will be achieved by replacing manual, paper-based processes.

While significant data sharing has existed between DoD and VA for years, until recently both Departments were embarked upon separate paths to replace our legacy EHR systems. Faced with a need to modernize these systems to enhance clinical decision making capabilities and improve the quality of care for service members and veterans, DoD and VA have agreed to implement a joint, common EHR platform going forward, purchasing commercially available components for joint use whenever possible and cost effective.

The Departments expect to benefit from increased interoperability and reduced sustainment costs by implementing a common architecture, data and services, data centers, interface standards, and presentation layer. Alignment to a common data model will enable the exchange of information at unprecedented levels between the Departments and serve as an example for the nation. Both Departments will use common data centers run by our Defense Information Systems Agency, which is tasked with continuously operating and assuring DoD's global net-centric enterprise. We have also agreed to use common measures of success and establish standard end-to-end business processes.

In order to oversee the planning and execution of this critical endeavor across both Departments, we have agreed to a high-level joint governance structure. The effort will be led by a Program Executive and Deputy Director selected by the Secretary of Defense and Secretary of Veterans Affairs, and will leverage existing statutory authorities. An Advisory Board will be established and co-chaired by the DoD Deputy Chief Management Officer and the VA Assistant Secretary for Information and Technology, and will also include key stakeholders and functional leaders from both DoD and VA.

North Chicago

Activated in October 2010, the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois is currently testing a unique management concept of full vertical integration of all DoD and VA health care functions in a single location. On an annual basis, the JAL FHCC in North Chicago will be responsible for ensuring the medical readiness of nearly 40,000 Navy recruits and caring for nearly 67,000 eligible military and retiree beneficiaries.

In standing up the JAL FHCC, the Departments developed reusable capabilities to address

challenges in both DoD and VA health systems. Joint Patient Registration enables users to register and search for patients using a common graphical user interface. Medical Single Sign On with Context Management enables role-based access to both DoD and VA systems using a single login process with the ability to maintain patient context. Orders Portability enables users to order laboratory or radiology procedures from one Department's system and have that order fulfilled in the other's with the status and results returned to the ordering system. These groundbreaking capabilities are in demand throughout our respective enterprises, and will be fully leveraged by our joint EHR modernization activities.

TRAUMATIC BRAIN INJURY (TBI)

The DoD has made significant advancements in TBI management and has implemented numerous programs during the past several years to ensure early detection and state of the science treatment in those who sustain a TBI from concussion to more severe and penetrating brain injuries. The Department is aggressively working to improve the diagnosis and treatment of TBI in-theater. In June of 2010, the Directive Type Memorandum (DTM) 09-033, "Policy guidance for the management of concussion/mild TBI in the deployed setting" was released. This guidance ensured comprehensive evaluation of service members who were exposed to potential concussive events.

TBI research continues to be fast-tracked to assist our Service members with close collaboration among the line, medical, and research communities. Key areas of promise include understanding blast dynamics, rapid field assessment of mild TBI to include objective biomarkers to be used in the diagnosis of concussion and TBI innovative treatment modalities. In addition, the DoD created the National Intrepid Center of Excellence (NICoE), a new state-of-the-art facility dedicated to advancing the treatment, research, and diagnosis of complex combat related psychological health and TBI conditions.

Clinical care instructions, representing the state of the art care, for all levels of TBI severity have been developed and cover both the deployed and the non-deployed environments. Educational materials include a pocket guide for CONUS TBI care, Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health, and web-based case studies in TBI diagnosis and treatment and education modules. Family resources for TBI include an Online Family Caregiver Curriculum and educational materials available at dvbic.org, brainline.org and www.traumaticbraininjuryatoz.org. All materials are aimed at line commanders, providers, Service members and their families.

MENTAL HEALTH

Maintaining and enhancing the psychological health of Service members and their families is a top priority for DoD. Screening for mental health conditions before and after deployment on a periodic basis is essential for force health protection and readiness and for the well-being of Service members. We recently established guidance to administer a person-to-person mental health assessment for each member of the Armed Forces who is deployed in connection with a contingency operation. The purpose of the mental health assessment is to identify mental health

conditions including Posttraumatic Stress Disorder, suicidal tendencies and other behavioral health conditions that require referral for additional care and treatment.

To ensure that suicide prevention is a coordinated, joint Service effort, we have consolidated standard surveillance information about suicide events, risk and protective factors across the Services. In addition, we have strengthened the Suicide Prevention and Risk Reduction Committee (SPARRC), and have created a Web-based information clearinghouse called www.suicideoutreach.org.

The Department has developed clinical support tools and guidance that establish DoD standards of care for mental health. Clinical guidance packages have been created for depression, substance abuse, and mild TBI and co-occurring psychological health disorders. In addition, there are clinical tools such as the VA/DoD Major Depressive Disorder Toolkit and the Co-occurring Conditions Toolkit.

DoD and VA are working together on the Integrated Mental Health Strategy – a joint effort to implement 28 strategic actions, to provide ready access to quality clinical services, and to better align and coordinate the mental health services of the two Departments.

Training for health care providers is offered on topics such as: PTSD, sleep disorders, depression, substance misuse, virtual reality, and prolonged exposure therapy. We have developed guidelines for training providers in evidence-based practices for PTSD. In addition, clinical consultation, education and dissemination of deployment health care best practices are available from the Deployment Health Clinical Center (DHCC). DHCC developed the RESPECT-Mil program, a collaborative care model, to enable health care providers to screen patients for posttraumatic stress and depression in primary care clinics.

The Department is exploring the use of telehealth services to increase access to care for Service members and their families, focused on establishing a collaborative network to rural and underserved locations. We have developed Mobile Telehealth Units to expand mental health care services to DoD beneficiaries who might not otherwise have access to or seek care; developed a web-based assistance program; developed smart phone applications to aid in the management and treatment of PTSD, and fielded the Virtual PTSD Experience - an immersive, interactive learning activity that educates users about combat-related post-traumatic stress.

Service member and family services include: the Defense Centers of Excellence for Psychological Health and TBI (DCoE) Outreach Center, a 24/7 resource available by phone, online chat or email; online self-help tools at www.militarypathways.org and www.afterdeployment.org; and inTransition, a coaching and assistance program to bridge the potential gaps in mental health treatment during transitional periods for Service members and veterans. DCoE partnered with Sesame Workshop to develop outreach programs to help children cope with deployments and injured parents, including the Sesame Street Family Connections website, which allows families and friends to stay in touch throughout deployments.
The Real Warriors Campaign and Military Pathways online self-screening program are two of DoD's public education initiatives that encourage help-seeking behavior among Service members and veterans for psychological health concerns. Both campaigns provide regular public service announcements—featuring real Service members who have reached out, obtained

care, and continue to lead productive military and civilian careers -- reach over 1.5 million service members each week.

SUICIDE PREVENTION

DoD is very concerned about the number of suicides in the Total Force over the past decade. While the overwhelming majority of Service members effectively cope with the stress of serving in a military at war, there are those who have difficulty adapting to the stress and strain that an increased operational tempo often places on them and their families. The loss of even one life to suicide is heartbreaking; it degrades the readiness of the force and has a profound impact on both the unit and the family members left behind. In 2010 there were 293 Service members who died by suicide while on active duty, down from a total of 310 in 2009. While this is not a significant decrease, we have slowed the steady increases in overall active duty suicides that began in 2006. We believe this is due largely to the focus of Service senior leaders on this issue and the increasing emphasis on resilience across the Department highlighted by programs such as the Army's Comprehensive Soldier Fitness. This program is designed to develop and institute a holistic fitness program for Soldiers, families, and Army civilians in order to enhance performance and build resilience. To date, the Army has trained 3,253 Master Resilience Trainers to facilitate this goal. The other Services are developing or enhancing similar programs.

We are concerned as well about the number of suicides recently in our Reserve Component. The Army National Guard and Reserve reported a combined 145 suicides in 2010 which was up significantly from the previous year (80 total Army Guard/Reserve). This already complex issue becomes even more complex when dealing with our Reserve Component because of their continuous transition from military to civilian life. Nevertheless, the Department is committed to addressing this issue. We currently have a Director of Psychological Health in each of our 54 states and territories who acts as the focal point for coordinating the psychological support for Guard members and their families. We have also embedded behavioral health counselors in a small number of our high risk Guard units and are exploring the possibility of increasing this practice much more widely. The National Defense Authorization Act (NDAA) for Fiscal Year 2010 mandated that the Department expand suicide prevention and community healing and response training under the Yellow Ribbon Reintegration Program. . We have made some progress here and are in the process of reinvigorating this effort with input from a Reserve Component Stakeholder Group comprised of all of the Reserve and National Guard Components, Reserve Affairs Yellow Ribbon representatives and members of the Defense Centers of Excellence. Additionally, we are examining "peer-to-peer" programs to see what role these types of programs can play in reducing suicides.

There have been several studies and task force reports (DoD, Army and RAND) released over the past year, each with multiple observations and recommendations. The Deputy Assistant Secretary of Defense for Readiness is currently leading a team of senior Officers and Executives from the Department in an effort to examine these reports and devise an implementation plan based on the recommendations that will enhance our suicide prevention efforts across the Department. We plan to act quickly on one of the main recommendations contained in the Congressionally mandated Final Report of the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces and establish an OSD office on suicide prevention to provide

strategic direction, oversight, and policy standardization to enhance and better coordinate the Department's efforts in this area with a focus on the Total Force.

BURN PIT SMOKE EXPOSURES IN THEATER

A topic of concern over the past several years has been the possibility of long-term health risks to our Service members and other deployed individuals associated with inhalation of burn pit smoke. DoD fully understands the importance of addressing this issue and takes very seriously the concerns of our Service members and veterans concerning burn pit smoke exposures. Because accumulated solid waste can result in health risks by attracting disease-carrying insects and vermin, engineers determined it was necessary to implement an expedient means of waste disposal. Burn pits provided the means with the lowest risk to personnel.

Over the past four years, there has been an ongoing and very successful effort in US Central Command to reduce the number of burn pits and replace them with incinerators or other waste disposal technologies and practices. All U.S. operated burn pits in Iraq at locations with greater than 100 U.S. personnel were closed effective December 31, 2010. There are presently 29 incinerators operating in Afghanistan, an additional 58 on order, and 11 in the planning stages.

U.S. Central Command Regulation 200-2, "Contingency Environmental Guidance," requires that when a basing location exceeds 100 U.S. personnel for at least 90 days, a plan must be developed for installation of adequate waste management technologies, including incinerators, to replace any burn pits. On February 15, 2011, the DoD published DoD Instruction 4715.19 "Use of Open Air Burn Pits in Contingency Operations" that established policy for burn pit use in contingencies and implements Section 317 of Public law 111-84. When burn pits are used, they must be located away from occupied areas and where prevailing winds blow smoke away from those areas. In addition, there is a prohibition against burning any hazardous materials in the burn pits that might generate any hazardous exposures.

Epidemiological studies accomplished in May 2010 by the Armed Forces Health Surveillance Center and the Naval Health Research Center entitled "Epidemiological Studies of Health Outcomes among Troops Deployed to Burn Pit Sites" do not provide evidence at this time on a population-wide basis that burn pit smoke exposures pose long-term health risks for smoke-exposed individuals. While no long-term health risks have yet been identified, we believe it is plausible that some Service members may be affected by long-term health effects, possibly due to combined exposures (such as sand/dust, industrial pollutants, tobacco, smoke and other agents) and individual susceptibilities, such as preexisting health conditions or genetic factors. This population will continue to be followed and monitored for any future health effects that have not yet manifested.

In the meantime, DoD is continuing to reduce exposures to burn pit smoke by closing burn pits, installing incinerators and ensuring the elimination of potentially harmful materials from the waste streams. DoD will continue to study inhalational exposures in theater, including the contribution from the smoke and any resulting health conditions in our Service members in order to determine the extent of any long-term health risks that may exist. DoD is working closely with VA to ensure care for those who are possibly affected.

Additional monitoring of burn pit emissions in Afghanistan is planned for 2011. The Defense Health Board and the Institute of Medicine are reviewing the Armed Forces Health Surveillance Center's report, and we are looking forward to their suggestions on how we can improve our studies as well as the frequency that they should be repeated.

CONCLUSION

We cannot overstate how far DOD has come with our VA partners in the past four years since the SOC and other governance processes were put in place. Each of the Services has stood up a very comprehensive and 'stand alone' Wounded Warrior Care program. Yet we still have much progress to make. And as we close, we would like to be clear: One mistake, undue delay or any other aberration in the care or transition of our wounded ill or injured service members is one too many. We will continue to work with our team-mates at the VA and throughout the interagency to do anything and everything we can to provide our Service members with the absolute best care and treatment that they so rightfully deserve in return for their selfless service and sacrifice to our Nation. We continue to be awed and grateful for their service and that of their Families.

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to do. We have thus positioned ourselves to implement these provisions and continue our progress in providing world-class support to our warriors and veterans while allowing our two Departments to focus on our respective core missions. Our dedicated, selfless service members, veterans and their families deserve the very best, and we pledge to give our very best during their recovery, rehabilitation, and return to the society they defend.

Mr. Chairman, thank you again for your generous support of our wounded, ill, and injured service members, veterans and their families. We look forward to your questions.