S. HRG. 110–374

HEARING ON VA AND DOD COLLABORATION: REPORT OF THE PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS; REPORT OF THE VETERANS DISABILITY BENEFITS COMMISSION; AND OTHER RELATED REPORTS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

OCTOBER 17, 2007

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OCTOBER 17, 2007

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HEARING ON VA AND DOD COLLABORATION: REPORT OF THE PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS; REPORT OF THE VETERANS DISABILITY BENEFITS COMMISSION; AND OTHER RELATED REPORTS

WEDNESDAY, OCTOBER 17, 2007

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 9:30 a.m., in room 562, Dirksen Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Tester, Webb, Burr, Craig, Isakson, and Hutchison.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. The oversight hearing on DOD–VA Collaboration and Cooperation will come to order.

With a big smile, I want to say aloha and welcome. Welcome to all of you to the Committee's hearing on issues relating to the findings of the President's Commission on Care for America's Returning Wounded Warriors, known as the Dole-Shalala Commission for its two distinguished Co-Chairs, the Veterans Disability Benefits Commission, and other groups that have recently examined matters regarding coordination and collaboration between the Departments of Defense and Veterans Affairs in the care and treatment of veterans from Operations Enduring Freedom and Iraqi Freedom.

Today's hearing is the latest in a series of hearings we have held this year that focus on the issue of coordination and collaboration between the two departments. Since our first hearing last January on this subject, the problems that gained public attention involving Walter Reed Army Medical Center brought more energy to this issue. Our committee and the Armed Services Committee have worked together toward achieving the goal of wounded warriors receiving optimal care and experiencing a truly seamless transition from DOD to VA, but there is much more that needs to be done.

The problems at Walter Reed led to the creation of the Dole-Shalala Commission, the Task Force on Returning Global War on Terror Heroes, and DOD's Independent Review Group, each of which we will hear from today. We will also hear from the Vet-

erans Disability Benefits Commission, which had been in existence for some time when the stories about Walter Reed first broke. I note that the Commission earlier this month issued a comprehensive report on the overall Disability Compensation System. The Committee will hold a subsequent hearing to take testimony on that report.

General Scott, the Chair of the Commission, has been invited here today to provide the views of the Commission on the recommendations of the Dole-Shalala Commission and to discuss areas of overlap between the Disability Benefits Commission and other entities which were created in response to the stories about Walter Reed.

It is important to recall that the problems identified at Walter Reed were not about the quality of health care provided by DOD, but more about a process that created confusion and inequities in the delivery of disability benefits to wounded warriors. The stories about Walter Reed also highlighted existing problems in the organization of medical holdover detachments and in the hand-off between the military services and VA for wounded or seriously injured or ill servicemembers.

The good news is that since this spring, much hard work has been done by DOD, VA, and the military services in seeking to resolve these problems. However, lately DOD and VA may have been recognizing the significant problems of adapting the departments to the stresses of the current conflicts, I am satisfied that real work is now underway.

I am particularly impressed by the work of the Joint VA and DOD Senior Oversight Committee, co-chaired by VA's Deputy Secretary Gordon Mansfield, and DOD's Deputy Secretary Gordon England, that meets every Tuesday to work on a wide range of ongoing transition issues. This, as you know, is an unprecedented level of attention to the issue of DOD–VA cooperation and collaboration.

Today's hearing gives us an important opportunity to review the recommendations of the Dole-Shalala Commission, the Disability Benefits Commission, and other reports that impact the interaction between DOD and VA, especially in those areas which still need improvement and where there is overlap or potential disagreement. I hope to gain a better understanding of the relationship among all the various recommendations with a particular focus on how the recommendations may relate to legislation developed by the White House and the response to the Dole-Shalala Commission. Senator Burr and I, along with the Chairman and Ranking Member of the Armed Services Committee, were briefed on this draft legislation earlier this month and I have many questions and concerns about it.

I thank Senator Dole and Secretary Shalala and our other distinguished witnesses for joining us today. Their testimony will allow us to better understand the many recommendations and help identify areas where Congressional action is required.

At our first hearing in January, I spoke about the stress that a new veteran with a life-altering wound or injury endures when faced with the challenge of applying for benefits and transitioning from one health care system to another while still in the process

of recovery and rehabilitation. With the input of the many recommendations that we will hear about today, I believe that we can continue to make progress toward achieving the goal of a truly smooth and seamless transition.

I have a longer statement that I will place in the record, which is available at the press table.

[The prepared statement of Chairman Akaka follows:]

PREPARED STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Aloha and welcome to the Committee's hearing on issues relating to the findings of the President's Commission on Care for America's Returning Wounded Warriors, known as the Dole-Shalala Commission for its two distinguished co-chairs; the Veterans' Disability Benefits Commission; and other groups that have recently examined matters regarding coordination and collaboration between the Departments of Defense and Veterans Affairs in the care and treatment of veterans from Operations Enduring Freedom and Iraqi Freedom.

Today's hearing is the latest in a series of hearings we have held this year that focus on the issue of coordination and collaboration between the two Departments. That series began with this Committee's first hearing of the 110th Congress on January 23. Later, when stories broke about conditions at the Walter Reed Army Medical Center, this issue became more energized, and, since that time, our Committee has worked in close collaboration with the Senate Armed Services Committee to find appropriate legislative solutions for the many problems that have been identified. On March 2, 2007, Chairman Levin and I visited Walter Reed to gain a first-hand understanding of the problems. Our visit highlighted matters involving overlapping jurisdiction and a real need for our Committees to work closely together.

On April 12, the two Committees held an unprecedented joint hearing to review and explore issues and problems relating to how those returning from combat in Iraq and Afghanistan were receiving care and services. That hearing set the foundation for the development of the Senate's proposed Wounded Warrior legislation which is currently in conference with the House as part of the 2008 National Defense Authorization bill.

I could not be more pleased with the cooperative manner in which the staffs of the two Committees worked to develop this extremely important and comprehensive legislative package that addresses health care, benefits, and transition issues involving both DOD and VA. In crafting this legislation, the staffs met on a regular basis, received briefings from Army and VA leadership, visited Walter Reed to meet with Army and VA representatives, and were briefed on the findings of groups created by the Administration to look into the Walter Reed problems.

It is important to remember that the problems identified at Walter Reed were not about the quality of health care provided by DOD, but about an overall process that created confusion and inequities in the delivery of disability benefits to wounded warriors. The stories about Walter Reed also highlighted existing problems in the organization of medical hold/medical holdover detachments and in the hand-off between the military services and VA of wounded or seriously injured or ill servicemembers.

The good news is that, since this spring, much hard work has been done by DOD, VA, and the military services in seeking ways to resolve the problems which were identified. However late DOD and VA may have been in recognizing the significant problems of adapting their Departments to the stresses of the current conflicts, I am satisfied that real work is now underway. I am particularly impressed by the work of the joint VA and DOD Senior Oversight Committee, co-chaired by VA's Deputy Secretary Gordon Mansfield and DOD's Deputy Secretary Gordon England, that meets weekly to work on a wide range of ongoing transition issues. This is an unprecedented level of attention to the issue of DOD–VA cooperation and collaboration.

Nevertheless, it is clear that much hard work lies ahead and that the problems faced by individual veterans and their families continue to demand attention and solutions. Today's hearing gives our Committee the opportunity to continue our work in this area.

The problems highlighted by the situation at Walter Reed led to the creation of a number of entities—the Dole-Shalala Commission, which was established by the President on March 6, 2007, and presented its report on July 30, 2007; the Task Force on Returning Global War on Terror Heroes, also established by the President on March 6, 2007, which issued its report on April 19, 2007; and DOD's Independent

Review Group, established by Secretary Gates on February 23, 2007, and which completed its report on April 19, 2007. The Committee will be hearing from each of these groups today.

The Committee will also be hearing today from the Veterans' Disability Benefits Commission (VDBC), which was established by Congress in 2004, and which, on October 3, issued its report. The VDBC report provides an in-depth analysis of the benefits and services available to veterans, servicemembers, their survivors, and their families to compensate and provide assistance for the effects of disabilities and deaths attributable to military service. The VDBC was invited today to present its views on the recommendations of the Dole-Shalala Commission and the other entities which were created in response to the stories about Walter Reed and to discuss areas of overlap between its recommendations and those of the other groups. The Committee will have other hearings, beginning early next year, on the VDBC's overall report and recommendations.

Among the issues that the Committee will focus on today are those relating to the existing DOD and VA systems for providing compensation and other benefits to servicemembers injured during their service. This is a key area of overlap between the Dole-Shalala Commission and the VDBC.

The Dole-Shalala Commission, on the basis of its work over a relatively short period of time—their first public meeting was in mid-April and they issued their report in late July—recommended a complete restructuring of the DOD and VA disability systems, as one element of its report that includes six recommendations focused primarily on collaboration between DOD and VA and on the needs of newly injured servicemembers. It is not clear from the Commission's report what outside expertise the Commission relied on to reach this conclusion. The only suggestion we have received thus far on how this comprehensive revision might be carried out came in the form of draft legislation on which Senator Burr and I, along with our counterparts on the Armed Services Committee, were briefed last week. This draft legislation, apparently developed by the White House, would have the Congress cede the responsibility for the proposed comprehensive retooling of VA's compensation system to the Secretary of Veterans Affairs and require the Secretary to accomplish this monumental task over a very few months.

The VDBC, in contrast, took a more systematic approach, carried out over a period of two and a half years, that focused exclusively on the complex and often inefficient service-connected disability structure. The VDBC conducted 26 public meetings, carried out extensive research, and received significant input from outside entities, including the CNA Corporation and the Institute of Medicine.

As part of its effort, the VDBC articulated eight principles that it believes should guide the development and delivery of future benefits for veterans and their families. It structured its analysis by developing 31 research questions. The Commission's staff drafted 11 white papers that analyzed 16 of those questions and presented options to the Commission for their deliberation. Attorneys conducted legal analyses of several of these issues and gave the Commission a historical context for much of the legislation that sets forth the benefits available to disabled veterans, their families, and survivors.

On the basis of its analysis and considerations, the VDBC made 113 recommendations designed to improve VA's disability compensation program for the 21st century. These recommendations collectively address the appropriateness and purpose of benefits, the benefit levels and payment rates, and the processes and procedures used to determine eligibility for benefits.

Many significant recommendations made by the VDBC are not contemplated in the Dole-Shalala report and warrant further review before any action is taken on the Dole-Shalala recommendation related to the overall disability benefits system and on how the Dole-Shalala recommendation may relate to the legislation developed by the White House that I mentioned earlier.

With respect to that draft White House legislation, I have many questions and concerns about it, but wish to make two general points about it. First, whatever legislation is finally submitted by the White House will not have my support as a replacement for the Wounded Warrior legislation that is now pending in the NDAA conference. Our Committee and the Armed Services Committee, and our counterparts in the House, have worked diligently on the Wounded Warriors legislation and I see no basis to scrap that effort this late in the Session. The second point I wish to make about the draft legislation is this: As Chairman of the Veterans' Affairs Committee, I will unequivocally oppose any proposal that would abdicate the role and responsibility of the Congress for dealing with the VA compensation system by giving that task to the VA Secretary. On that point, it is worth noting that there is no confirmed Secretary of Veterans Affairs at present. It is inconceivable to me

that there would be any significant support for giving such a monumental task to VA, especially when there is no leadership in place.

There are a number of other recommendations from the Dole-Shalala Commission that I hope to learn more about today, including those relating to care coordination, treatment for PTSD, providing support for family members who have to take time off from their jobs to be with their wounded family members, and recommendations relating to VA's vocational rehabilitation program.

With regard to coordination of care, I am pleased by the Dole-Shalala Commission's recommendation that each seriously injured servicemember be provided with a "Recovery Coordinator" to serve as the patient and family's primary point of contact throughout their treatment and to ensure that the servicemember is getting the care he or she needs. This is a concept the Committee has already embraced in our health care omnibus legislation, S. 1233, which is currently pending passage by the full Senate. It is clear that the need exists for care coordinators to assist patients in navigating through the two systems. However, I believe that if every servicemember is to be provided with a Recovery Coordinator, we must also ensure that their efforts are managed efficiently. Basic questions such as which agencies will hire and train them must be answered.

We must also uncover what the real impediments are to accessing treatment for Post Traumatic Stress Disorder that prompted the Dole-Shalala Commission to recommend improvements in this area. Is it identifying servicemembers with more severe symptoms, and getting them in the door, or is it that when they do present themselves at a DOD or VA facility, they are not being given proper care? The Dole-Shalala Commission says that Congress should enable VA to provide aggressive PTSD care, but it is my belief that VA already has the authority to provide the care, and that our role in Congress is to ensure that VA has the resources to do the job.

In addition, the Dole-Shalala Commission recommended that the Family Medical Leave Act should be amended to allow up to 6 months' leave for a family member of a servicemember who has a combat-related injury. Though the Commission's recommendation as formulated does not fall within the jurisdiction of our Committee, other proposals addressing the need to support the families of those who are recovering from combat injuries have been made that do, so we will be looking at the ramifications of these approaches.

And finally, I find the President's Commission's recommendations relating to VA's Vocational Rehabilitation and Employment Program confusing, especially the proposal to offer individuals a monetary incentive to complete a program of rehabilitation and the subsequent effect that completion would have on an individual's level of service-connected compensation. Since the Committee has an oversight hearing of this program scheduled for later this month, I do not intend to pursue these issues at today's hearing in great depth. I will have some questions on these recommendations for the record and perhaps later on in connection with the oversight hearing at the end of the month.

In closing, I note that, at the Committee's first hearing in January, I spoke about the stress that a new veteran with a life altering wound or injury endures when faced with the challenge of applying for benefits and transitioning from one health care system to another, while still in the process of recovery and rehabilitation. With the input of the many recommendations that we will hear about today, I believe that we can continue to make progress toward achieving the goal of a truly smooth and seamless transition.

Chairman AKAKA. In the interest of time and to allow others to speak, I will stop here and turn to the Committee's Ranking Member, Senator Richard Burr, for his opening remarks.

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

Senator BURR. Aloha, Mr. Chairman. I didn't know it would be quite as challenging linguistically on this Committee as it is to serve with Senator Akaka, but he has challenged me to learn more than just what we need to do as it relates to changes in the disability system. Mr. Chairman, thank you.

I welcome all of our distinguished panelists and I appreciate you being here this morning. You have all spent many hours with one thought in mind, and that is improving the lives of those who served our country in the Armed Forces. You have given us policy

suggestions that I believe can help shape how we care for our servicemen and women for decades to come. For your commitment to them and for your advocacy on their behalf, I am here this morning to say thank you to each and every one of you.

Let me begin by making two very broad points. First, we are here today to review recommendations on how best to deliver health care, disability compensation, and rehabilitative benefits to those who have been injured in military service to our country. As we look at our strengths and our inefficiencies in getting the job done right, we have to keep in mind that the opportunities for today's professional warrior are fundamentally different than in earlier generations. Today, all-volunteer forces know that injury, even serious injury, need not be an impediment to continuing on with a productive and fulfilling life.

I am amazed when I hear over and over how some soldiers with very serious injuries are able to return to their units, or how they plan to resume fully active lives, go to school and get a job. Modern technology and modern attitudes about disabilities not only give them that hope, they appropriately give them that expectation.

Our job, then, is to give these brave men and women the tools they need and to remove the stumbling blocks that are in their way. In fact, they demand that from their government.

Today's soldier chooses a military career and their expectation is the same as it would be for any professional working in any organization in America. If one is hurt on the job, one expects quick, effective, and relatively hassle-free physical, vocational restoration and supportive services from the employer.

My second point is about our system of benefits and services for our veterans, servicemembers, and their families. Rather than use my words, I will read the Dole-Shalala Commission report where they said the Commission learned that, on the whole, we are a generous and giving Nation when it comes to providing for our servicemembers and veterans. Benefits include health care for veterans through the VA, for retirees through the Military Health System, and through civilian providers through TRICARE. In addition, we pay retirement and disability benefits and provide for education, adaptive equipment, employment hiring preferences, and more.

The total cost of these benefits was well over $127 billion in 2006. So as of last year, we had a budget of over $127 billion to assist veterans and servicemembers, more than double what it was just a decade ago.

I highlight this information to suggest that the challenges facing many veterans today have as much to do with confusing bureaucratic programs operated by many different offices of the government as they do with the lack of benefit programs or the lack of resources. I will never shy away from providing our military men and women and our veterans with the resources they need, but I expect and these citizens expect that these resources will be used effectively to deliver needed benefits and services.

There is a saying that goes, if you aren't part of the solution, then you must be part of the problem. So let us commit to talking today about meeting the challenges ahead of us. Secretary Shalala and Senator Dole, when you briefed us 2 weeks ago, I was pleased to hear that officials and staff at the Department of Veterans Af-

fairs and the Department of Defense were beginning to implement 90 percent of your Commission's recommendations.

Mr. Chairman, I am committed to you, and I look forward to working with you, to conduct oversight of the Departments of Veterans Affairs and Defense to ensure that the best of these recommendations to improve veterans' care are implemented without delay.

Senator Dole and Secretary Shalala, you also said in our recent briefing that 10 percent of your Commission's recommendations require legislative action. You called this the hard part. Of course, I am speaking about the recommendations to reform the Disability Compensation System. As you know, the Veterans Disability Benefits Commission has also spent the better part of 3 years looking at the hard part. I expect everyone calls it the hard part for a very good reason, and I think this Committee will soon find that out. I am fully aware that reforming the disability system will require a large up-front cost, but if done properly, it would also be an investment.

Chairman Akaka, once again, I pledge to you as the Committee works to better the lives and well-being of those wounded in defense of the country, knowing that the character of men and women of our Armed Forces is an investment that comes with little risk and great reward.

One final thought before I conclude my statement. Almost every Member of Congress has had the opportunity to visit soldiers, Marines, sailors, and airmen who are fighting in the war on terror. In my own conversations with them, I can't help but be inspired by their love of country, their commitment to duty, their extraordinary optimism in the face of adversity. We have all referred to men and women who served with Senator Dole in the Second World War as "The Greatest Generation," and my encounters with today's heroes remind me that greatness—when we talk about risking one's life for the freedom of others—is of every generation. Greatness belongs to the few whose deeds merit that title.

To all who have served in combat, to the families who have sacrificed so that their loved ones could serve the rest of us, and to all who have been injured or who have died for our freedoms, you have my enduring respect and gratitude. No matter when you served or on what continent you fought, you have made the most supreme sacrifice. For that, and I know I speak for everyone in this room, we are eternally grateful.

Again, I thank our distinguished guests this morning for their willingness to share their knowledge with this Committee and I think I speak for the Chairman when I say that we are anxious to go forward and to begin this process.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burr. Using what we call "the early bird system," I am going to call next on Senator Craig, and he will be followed by Senator Murray.

Senator BURR. Mr. Chairman, could I ask my colleagues to indulge me for one additional minute? We have been joined by a very special person and I just want to highlight that for our audience today. Sarah Wade, would you stand up for a second? I just want you to meet a very special person.

Sarah Wade is the wife of Retired Army Sergeant Edward "Ted" Wade. Following Ted's serious injury in Iraq on February 4, 2004, Sarah suspended her studies at the University of North Carolina at Chapel Hill to serve as an advocate for her husband and has recently become a public policy intern for the Wounded Warrior Project, a nonprofit organization dedicated to assisting military personnel injured in Iraq and Afghanistan.

She was born and raised in Washington, D.C. Sarah currently resides in Chapel Hill, North Carolina, a constituent of mine and the wife of a very brave U.S. soldier. Thank you for being here, Sarah.

[Applause.]

Chairman AKAKA. Thank you, Senator Burr.

Senator Craig?

STATEMENT OF HON. LARRY E. CRAIG,
U.S. SENATOR FROM IDAHO

Senator CRAIG. Mr. Chairman, Richard, I will be brief, but I do want to welcome both Secretary Shalala and Senator Dole before this Committee and to reminisce only briefly. If Bob hadn't said, Larry, there is work to be done on the Veterans Affairs Committee a good number of years ago, and you ought to go do it, I might not be here. And that work has continued. Thank you, Bob, for appointing me to this Committee a good number of years ago, and we have continued to work according to your wishes.

I want to thank all of the panelists and the Commissions who are before us today. The work you do is critically important to veterans, to soldiers who will become veterans soon across this Nation, and we thank you for it.

Earlier this year, Mr. Chairman, I asked a Member of the staff here on the Veterans Affairs Committee to submit testimony before Secretary Shalala and Senator Dole's Commission regarding the DOD–VA collaboration, especially as it relates to the overlapping health benefits systems. I have been very involved over the past few years in examining ways that DOD and VA can work together closely.

We early on began to use the word "seamless," but it became pretty obvious to me that it was a word, it was not a reality, not in the way we want it to be. And I would hope, Mr. Chairman, Richard, that as we work through this, seamless becomes a system and simply not a phrase, because that is exactly what is doable today if we can cause DOD and VA to come together in a way that recognizes what we want to achieve for America's veterans.

I have used testimony from General Omar Bradley's Commission in 1956. I know Senator Dole has referred to it on occasion. I would hope that 51 years after today, that this Committee has not convened in a way that it is referring to the Dole-Shalala Commission as goals that should have been achieved but were not accomplished.

I know government is a daunting system and sometimes very, very difficult to change, Mr. Chairman. We can and we must change it. And for the sake of America's veterans, I hope we can.

So to meet that challenge, Mr. Chairman and Senator Burr, I accept your challenge to do just that, to look back a few years from now and say that we have accomplished what we set out to do. It

is now a seamless system. When one transfers from active to veteran, it is simply the push of a button and the movement of a system. We have watched the failure too long. We have watched the bureaucracy be too daunting. It shouldn't require the wife of a soldier to become an advocate simply to work their way through a system that is impossible or nearly impossible to penetrate.

We are moving in those directions. Now our challenge from the Commissions is to revisit it and revisit it on an annual basis, to challenge it, to oversee it, and to force it to change. Thank you for being with us.

Chairman AKAKA. Thank you very much, Senator Craig.

Now we will hear from Senator Murray.

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

Senator MURRAY. Thank you very much, Chairman Akaka, Ranking Member Burr, for holding this really important hearing.

Secretary Shalala, Senator Dole, welcome to our Committee. Thank you for the work you have done and for being here today to present the recommendations of your Commission as well as the other three reports that we are going to hear about today about how we can improve the care for our servicemembers and veterans as they transition from the military to the VA.

It has been 8 months now since the Washington Post exposed the scandalous conditions that all of us read and were shocked by, mice running in walls and moldy walls and holes in ceilings and the bureaucratic maze that our men and women who fought so bravely for us faced when they got home. Obviously, no one should have to endure those kinds of conditions, but most of all, the men and women who fought so courageously for all of us.

I think it is important to remember that it wasn't just Walter Reed. I think, as you well know, it was many of our facilities that were facing very bad conditions. This was symptomatic of the entire system, and it wasn't just infrastructure. It was a long time waiting to see a doctor. It was bureaucratic ineptitude. It was VA claims backlogs that were taking months and years that were really harming our men and women's ability to be able to take care of their families when they come home.

I think all of us know that, without hesitation, these men and women take on the task that this Nation has given them. They answer the call to serve in Iraq or Afghanistan or wherever we send them. They have left their loved ones for years. They have put their careers on hold. They put their lives on the line, and the least we can do is make sure when they come home, they get prompt, respective, comprehensive support for the work that they have done.

I have said, Mr. Chairman, many times that no matter how divided this country may be over this current war in Iraq, this country is extremely united behind making sure that the men and women who have fought for us get the care that they deserve. We have taken that and used it this year, and the first time in the Iraq supplemental war bill, putting in funding for veterans, $1.8 billion in emergency funding, for the first time counting the care of veterans as part of the cost of war, which I think is extremely impor-

tant to do. Of course, this year's VA military construction bill increased funding $3.6 billion over the President's request as a recognition of the costs that we are responsible for.

But I do think this environment that the country is in today, where we are all so supportive of these men and women, gives us a chance today to do these fundamental reforms to the VA and DOD that are so badly needed, and we need to really strike while the iron is hot.

The Senate has already done that. We passed the Dignified Treatment of Wounded Warriors Act, which deals with the seamless transition process. That bill is now being worked out with the House and hopefully will be enacted soon so we can begin to provide some real solutions. I am interested today in how the Commission report ties in with that and how we can make sure we are doing that correctly together.

But I am especially pleased that we are now actually looking at all of this and we are seeing studies and commission reports and recommendations by a number of different groups who are going to be in front of us today and I look forward to hearing from all of our witnesses and having a chance for us to really do the best with the best information we have.

Senator Dole, Secretary Shalala, I am especially looking forward to your thoughts on the administration's proposed legislation to carry out your recommendations and I am very glad to see the President come to the table on this issue and to work with us, I hope, as part of moving forward the Dignified Treatment of Wounded Warriors Act, as well.

So, Mr. Chairman, this is a very important hearing. The country is waiting. They want to know what we are doing and how we are moving forward and it is incumbent upon all of us to act well, so thank you very much.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator Tester?

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

Senator TESTER. Thank you, Mr. Chairman and Ranking Member Burr. I really, really appreciate the fact that you are having this hearing. I think it is long overdue to really take a look at what families and veterans have gone through to navigate through the bureaucracy of the DOD and the VA.

I also want to thank everybody who is on these panels here today. It truly is an all-star cast of expert witnesses and I want to tell you I appreciate Senator Dole, Secretary Shalala coming today and I look forward to your testimony, as I am sure we all do.

I would ask, Mr. Chairman, that my entire statement be put in the record, but I do want to talk about a few things.

Over the last 10 months, I have held ten listening sessions with veterans throughout the State of Montana. The last one was last weekend in Mile City, Montana. At these listening sessions, I have heard about good things that have happened with the VA and I have heard about some things that have been, quite honestly, unacceptable with the VA.

As we go forth in what we are doing here in this Committee, I think it is critically important that we take all the necessary steps. I have heard just this morning issues or words like complex, impenetrable, bureaucratic, ineptitude. I think we all know that there is room for improvement and I think that the people who fought for this country and put their lives on the line and protected us in times of war and even not deserve it and we owe it to them.

Just yesterday, a fellow by the name of Dan Gallagher from Missoula, head of the VFW in Missoula—in fact, he is here in the audience today—stepped into my office and said it is just a matter of course that when people first apply for benefits, they get turned down, right out of the chute. It is just the way things are done. That is a bad way to do business and we cannot accept that kind of work ethic, quite honestly. It is almost like the VA is working against the veterans instead of working for the veterans. So, we need to make sure that good health care and good benefits that happen for some of our veterans, occur for all of our veterans.

With that, I very much look forward to your testimony, Senator Dole, Secretary Shalala. And thank you, Mr. Chairman and Ranking Member Burr.

[The prepared statement of Senator Tester follows:]

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

Thank you, Mr. Chairman. I am glad that we are having this hearing—it is long overdue for us to take a look at what families are going through when it comes to navigating the DOD and VA bureaucracies.

We've all heard the stories about the current system being complicated for injured servicemembers to navigate and stretched beyond the capabilities of the doctors and claims processors.

I met yesterday with the head of the American Legion Post in Missoula—Dan Gallagher. Dan has spent his entire adult life helping Montana veterans get the care and the benefits that they're entitled to.

He brought me a letter and in it, he said this:

"Our veterans and our returning warriors have a right to the care their service has earned them. We cannot let the yellow ribbons to, once again, become red tape."

My friend, Dan Gallagher, has it exactly right. But that is exactly what is happening to a number of vets. Not just the catastrophically injured vets that we've all read so much about at Walter Reed and other places, but all throughout the DOD and the VA.

I want to thank the witnesses for being here, because I think they all share a real desire for change in the system. We've got to simplify where we can, and make this process a lot less painful for veterans and their families.

Above all, I think this is going to require a lot more resources. And it will require a real attitude change within the bureaucracies. Folks are there to help servicemembers and families, not tell them what can't be done.

With that, Mr. Chairman, let me stop and let the witnesses have their say.

Chairman AKAKA. Without objection, your statement will be included in the record.

Senator Brown?

STATEMENT OF HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Thank you very much, Mr. Chairman, Ranking Member Burr. Senator Dole, thank you for your service to our country, both in wartime and in the Senate, and fellow Clevelander Madam Secretary, nice to see you today. Thank you for your service.

Everyone always says the right thing about veterans at hearings like this and as elected officials and at all the right veterans' halls and all the right celebrations and all the patriotic gatherings. Yet this institution has made some terrible mistakes and some terrible choices when it comes to veterans' health care, I think. We have always had plenty of money for war. We have always had plenty of money for tax cuts, for especially the top one or two or 5 percent in this country.

Yet the sacrifice in this war that we are in now has hardly been spread evenly in the population and so many of the people that have gained the most have sacrificed the least. There has not been enough money for body armor, not enough money for MRAP, not enough resources, as Senator Murray's comments point out, not enough resources for VA health care. We have a lot of work to do.

By passing the Veterans' Organizations Independent Budget, the military construction bill that Senator Murray played such a major role in, it is very much an important first step. Coordination, as several have said, including Senator Craig, coordination and making it really seamless, more than just a word of DOD and VA, is so very, very important. Extending, as the Commission recommends, extending family and medical leave, establishing a caseworker that will work with families of soldiers to coordinate care and services is so very important. A timely and accurate disability rating is so very important.

Particularly, we need to improve the diagnosis and treatment of PTSD and all that we have seen coming from this war, and I know that Senator Dole's feelings and Secretary Shalala's feelings are so strong about that. I have spent, as so many of us have, much of the last 4 years meeting with soldiers, welcoming the troops home, encouraging them to get the treatment they need when they resist for good reason: because they want to integrate themselves back into their workplace; their families; their communities. It is so very important that this transition be done right and this Commission's recommendations will help there.

One last point. Ohio has one of the lowest average payments for disability compensation—well below the national average. We are a large State with a huge veteran population and we need to do better. That is partly an issue we can help fix within the VA. It is partly an Ohio issue. We need to work together to do all of that.

I am so appreciative of the service of not just Senator Dole and Secretary Shalala, but our other panelists, too; and I thank the Chairman.

Chairman AKAKA. Thank you very much, Senator Brown. Now we will hear from Senator Hutchison.

STATEMENT OF HON. KAY BAILEY HUTCHISON,
U.S. SENATOR FROM TEXAS

Senator HUTCHISON. Thank you, Mr. Chairman. First, I want to say to Secretary Shalala and Bob Dole, there has not been a better, more committed advocate for veterans in this Nation in our history than you, Bob Dole, and thank you so much for continuing from your great service in World War II to helping those who have followed you. Thank you. And Madam Secretary, you had another full-time job. You didn't need to take this on, but you did and we

all so appreciate it, that you would once again suit up for your service outside of your regular duties, which we all know are huge. So thank you both very much.

Let me say a couple of things. I am the Ranking Member on the Veterans Affairs and Military Construction Appropriations Subcommittee, so I have been dealing with the issues of funding, of course, for veterans, but also trying to make sure that we have the seamless transition. Now, you did in your report address this issue, suggesting that we have the rapid transfer of patient information between DOD and VA. But I do want to say that this is something where the VA is really leading.

We have the state-of-the-art electronic medical records in the VA system. It was never brought home better than after Katrina in New Orleans when the whole Veterans' Hospital had to be vacated and not one record was lost—not one. So our veterans in New Orleans got superb treatment wherever they were, wherever they evacuated, and that is a testament to the system. Of the 155 VA hospitals, every one is set with the electronic records, so we know there is a system that works.

However, as has been said here, it is the transition to DOD, and the anecdotal information that we get is phenomenal. In Houston, for instance, I was called because our veterans who were injured and therefore retired with disabilities were waiting months and even almost a year for their disability benefits. So we immediately went to the VA and they tasked people to go down to try to fix that hiatus because we just didn't have enough people processing.

I know that because the VA system is so good, if we put our minds to it and we take your direction, which you also saw, and bring DOD up to the same standards so that people can have a seamless transition, that everyone will be ahead. It is inexcusable for someone injured in Iraq or Afghanistan to go on medical disability and not get their benefits for three to nine or 10 months. It is just inexcusable. So that is the issue that I think we have to address immediately and I really think it is in DOD and matching those up.

So thank you for your service. Thank you for being here to report to us, and we will follow up, I assure you, on your recommendations. Thank you.

Chairman AKAKA. Thank you very much, Senator Hutchison.

Now we will hear from Senator Isakson.

STATEMENT OF HON. JOHNNY ISAKSON,
U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Well, thank you very much, Chairman Akaka. I appreciate you and the Ranking Member doing this. Senator Dole, it is a pleasure to see you again. Secretary Shalala, thank you for your service to the country.

My remarks will be limited to the seamless transition issue. I want to commend you on your recommendations and the focus on that and point out what I have in a couple of previous hearings that we have had.

General Schoomaker did a great job in Augusta with the Augusta VA, called the Uptown VA Hospital, and the DOD facility, Eisenhower Medical Center, created a seamless transition of treatment

and rehabilitation for wounded warriors coming back that is really second to none. In fact, I told the story previously, and I will tell it one more time at the risk of being repetitive because I think it is so important.

I met a Sergeant Harris when I was at the Augusta VA. She had gone to Iraq and on the second day of her deployment had a Traumatic Brain Injury from an exploding IED. She came back to the States. DOD treated her. They could not correct it, so she was severed from the military and went to the VA hospital. They corrected the Traumatic Brain Injury and reenlisted her in the military and she was on active duty at the Augusta Eisenhower Medical Facility, which shows when you have a good seamless transition and continuous care it is of immeasurable benefit to our wounded warriors.

So I commend you on your recommendations on that, your recommendations on electronic records and evaluations. All are critically important to seeing to it our veterans get the very best and the timeliness of care, and I thank you again for both of your service to the country.

Chairman AKAKA. Thank you very much, Senator Isakson. I am pleased to welcome our first panel. We are fortunate to have two highly distinguished public servants testifying before the Committee today.

I am honored to welcome the Co-Chairs of the President's Commission on Care for America's Returning Wounded Warriors, former Senator Bob Dole of Kansas and Donna Shalala, Secretary of Health and Human Services during the Clinton administration.

Senator Dole and Secretary Shalala were called by the President to lead an evaluation of the care and services provided to America's wounded servicemembers when they return home from battle. They are here today to share their findings and recommendations with the Committee.

Senator Dole and Secretary Shalala, we are pleased to have you here today and look forward to your testimony. Your full statements will appear in the record of the hearing and you may begin with your statement, Secretary Shalala.

STATEMENT OF HON. DONNA E. SHALALA, CO-CHAIR, PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S, RETURNING WOUNDED WARRIORS

Ms. SHALALA. Thank you very much, Chairman Akaka, Ranking Member Burr, distinguished Members of this Committee. Before I begin, let me introduce one member of the Commission who has joined us, Ed Eckenhoff, who runs the National Rehabilitation Hospital, a private rehabilitation hospital here in Washington, D.C., one of the leading experts on rehabilitation in this country; and Marie Michnich, who was our Executive Director, who is at the Institute of Medicine of the National Academy of Sciences; and Dr. Sue Hosek from the RAND Corporation, one of the leading experts in military health, who was our Research Director; and Dr. Karen Geiss from the Medical College of Wisconsin, who was the Deputy Executive Director of our Commission. We had a very short period of time so we literally grabbed talented people from all over this country to come join us to do our work.

It was a privilege to serve on the President's Commission with Senator Dole. We never had a disagreement. He is fun to work with, but more importantly, he knows this system and cares deeply about what happens to these young men and women who come back from conflict.

Of our nine Commissioners, four were severely injured in current or past conflicts and one was the wife of a soldier from Iraq. This was not a Commission of the usual suspects. It was a Commission that had a very high percentage of young people who had current information and current experiences and included people who had not been on commissions before but took a fresh look at these issues.

We presented six groundbreaking patient- and family-centered recommendations, and one of the important things about our recommendations is they were not bureaucracy-centered. They were patient-centered and family-centered. We tried to look at the issues from the point of view of the people that were directly affected, as opposed to the people that provided just the services.

Our report, which is called "Serve, Support, and Simplify," we believe is not only short, but it is a blueprint for and certainly a very clearly outline for the kinds of changes we believe must take place.

Let me also emphasize, as General Scott will, that our recommendations stand on the report of others. We built upon other recommendations. We looked carefully at the Bradley Commission and all the previous commissions as well as more recent commissions.

Our six recommendations do not require massive new programs or a flurry of new legislation. We identified with the six recommendations 34 specific action steps that must be taken to implement the six recommendations. Only six of the 34 require Congressional action, and that is what I want to focus on today. I want to talk about those six that require action by Congress and then Senator Dole will discuss how the recommendations will work together to create a new system.

The first action step calls for Congress to simplify the DOD and VA disability systems. I realize in this town the word "simplify" is not often used, but I think that our point here is it ought not to take an expert to understand the system. Any injured soldier or member of their family ought to be able to understand what is going to happen to them and what benefits are available to them and how the disability system works.

Right now, DOD and VA assess each servicemember's disability for completely different reasons. DOD needs to determine if they can continue to do their job despite their medical condition. If they can't, then they must discharge the servicemember. The degree of disability, the length of time spent in service depends on the amount of military compensation and benefits.

DOD generally only rates a condition that prevents the servicemember from doing their job. The VA determines how disabled a veteran is based on every medical condition that occurred was made worse while in the military service. The degree of disability is part of how the VA determines what benefits, services, and the amount of compensation the veteran will get.

Over the years, this evaluation system has become really convoluted as we tried to fix problems and that is the point we are making today. People of good will in this Congress and in the agencies, every time they had a problem they added a new regulation, a new requirement, a new piece of legislation, and that is why the system is so convoluted and so complex today.

We recommend simplifying the system. DOD retains their authority to determine fitness to serve. If a servicemember whose health conditions make them unfit for duty, they would be separated from the military with a lifetime annuity payment based on their rank and years of military service. They don't have to wait 20 years. If they get severely injured, they have been in for 11 years, they can't any longer serve in the military. They would leave the military with an annuity payment based on their rank and that 11 years of service.

This recommendation brings DOD in line with other employers of choice. That is the way the employment system works where you have an annuity system in this country, and it is a very important step in maintaining a volunteer Army, from our point of view.

We also believe that only one physical exam should be performed rather than the two required now—one by each department—and that that physical should be performed by DOD. The VA then would assume all responsibility for establishing the disability rating based on that physical and for providing all disability compensation.

So you split the two responsibilities based on their expertise and the appropriate role for each department, but it is the VA that makes the disability determination. It is a much simpler system. It supports those that are transitioning between active duty and veteran status and it puts the DOD in the right frame. They provide the necessary military strength and expertise to keep our Nation safe and secure. They can determine their own fitness standard for serving.

Now, obviously, there are some soldiers that the DOD will find a job for even though they have an injury—an amputation, for example—and that is really for them to work out with those soldiers. They have an interest in doing that. They would like to keep people employed. But if the decision is that that soldier, sailor, or Marine should go over to the VA system, they would leave with an annuity. They would go to the VA system and get their disability rating, the disability payment, and some other things that we recommend.

The second action step out of the six is that we recommend health coverage for servicemembers who are found unfit because of conditions that were acquired in combat, supporting combat, or preparing for combat. We believe that Congress should authorize comprehensive lifetime health care coverage and pharmacy benefits for those servicemembers and their families through DOD's TRICARE program, and the important phrase here is "and their families."

Many of these young people can take a job, but finding a job that has benefits that will cover their families is probably a real challenge. This will change their lives if this benefit is available. We really believe it will help them to find employment because they will have a lot more choices.

Our third action step is to ask Congress to clarify the objectives for the VA disability payment system by revising the three types of payments which are currently provided to many veterans. The primary objective should be to return the disabled veteran to normal activities insofar as possible and as quickly as possible by focusing on education, training, and employment. We recommend changing the existing disability compensation payments for injured servicemembers to include three components: Transition support, earnings loss, and quality of life.

Transition payments are, of course, temporary payments to help with expenses as disabled veterans integrate into civilian life. Veterans should receive either 3 months of base pay if they are returning to their communities and not participating in further rehabilitation, or an amount to cover living expenses while they are participating in education or work training programs. We also believe that the time for participating in these training programs should be expanded to 72 months for those who may need to attend part-time. Most of the students in this country are not going to school full-time. They are going to school part-time, and our veterans, our investments in these veterans ought to reflect what is happening in the larger society.

Second, earnings loss payments. We should make up for any lower earning capacity remaining after transition and after training. That is what we mean by modernizing the system. Earnings loss payments should be credited to Social Security earnings and would end when the veteran retires and claims Social Security benefits. Now, the President has a slightly different recommendation in this area.

In addition, we believe that quality of life payments should be provided to disabled veterans, and these payments are based on a more modern concept of disability, and that is our point about the current disability system. It is very old fashioned. No one except this government is paying disability payments this way any longer. Everybody has quality of life payments as part of the payment scheme. We need to take into account an injury's impact on an individual's total quality of life, independent of the ability to work. And if you look at the private sector payments, they combine these two when someone has a disability.

We also call for the disability status of veterans to be reevaluated periodically, and we see this as a positive provision that would ensure that all disabled veterans are seen by a health professional at least every few years. What we don't want is for the payment to go out of date for an individual veteran.

By simplifying and modernizing the DOD and VA disability systems, we will make the systems less confusing, we will eliminate payment inequities, and we will provide a foundation with appropriate incentives for injured veterans.

Our fourth action step asks you to authorize the VA to provide lifetime treatment for PTSD for any veteran deployed to Iraq or Afghanistan that needs such services. This presumptive eligibility for the diagnosis and treatment of PTSD should occur regardless of the length of time that has transpired since the exposure to combat events.

One of the things that we learned from talking to young veterans is that when they get out, they want to get out, and many of them are asked but they don't answer because they want to go home. They have got to be able to come back and get evaluated. We are involved in very intense urban fighting, often against civilian combatants, and many servicemembers witness or experience acts of terrorism. Many of these servicemembers have deployed multiple times. We need to make sure that those services are available forever for these servicemembers.

Next, we ask Congress to strengthen support for military families. The fact that a wife has to give up whatever she is doing, whether it is school or a job, and other family members—we met husbands, we met mothers that were giving up their positions. We have asked that they be provided benefits, as well, as caregiving benefits. We have asked for more intensity in the family support systems that are made available. We have asked that the Family and Medical Leave Act, which Congress has been supportive of, goes from 12 weeks to up to 6 months for a family member of a servicemember who has come back with a related injury and meets the eligibility requirements.

The military does a very good job of getting family members to the bedside of an injured servicemember. That is not the problem. It is once they get there and the kinds of services that we provide for them and what we say to them about their lifetime responsibilities in attendant care. That is our responsibility as a Nation. They will do it if they must, but it seems to us fundamentally unfair that we are not providing more support to these family members, and we have made a series of recommendations.

Mr. Chairman, I believe the government can work to improve the lives of its citizens. I also believe that when we fix problems, we often add to their complexity. I, of course, had to manage the Medicare program, which is an example of that kind of complexity. Here, we have a chance to think clearly about the system and to simplify it, make it more straightforward, make it fairer, and invest resources where they will really make a difference.

Thank you very much, and I will yield to my colleague, Senator Dole.

[The prepared statement of Ms. Shalala follows:]

PREPARED STATEMENT OF DONNA E. SHALALA, CO-CHAIR, PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS

Good morning Chairman Akaka and distinguished Members of the Committee. Thank you for the opportunity to testify today, along with my fellow Co-Chair, Senator Bob Dole, about the recommendations our Commission presented to the President, Congress and the public in late July.

It was a true privilege to serve on the President's Commission on Care for America's Returning Wounded Warriors, especially with Senator Dole, whose knowledge of and experience with veterans' issues was invaluable during our short Commission tenure. We were joined by a remarkable group of commissioners, with their own unique experiences and expertise. Of our nine commissioners, four were severely injured in current or past conflicts and one was the wife of a soldier from Iraq who was severely burned.

The Commission presented six groundbreaking patient and family centered recommendations that make sweeping changes in military and veterans' health care and services. At the heart of these recommendations is our belief in a system of care and benefits that enables injured or ill service men and women to maximize their successful transition, as quickly as possible, back to their military duties or civilian

life. Our report—Serve, Support, Simplify—is a bold blueprint for such a system. I respectfully request that this report be submitted for the record.

Let me take a moment here to emphasize that our efforts built upon the recommendations and reports of others—most of them here today. We are united in our call for change. We were not duplicative of these recommendations, but added to them in significant ways.

Our six recommendations do not require massive new programs or a flurry of new legislation. We identify 34 specific action steps that must be taken to implement the six recommendations. Only six of these 34 items require legislation, and that's what I will focus on today.

I will summarize the actions that require legislation, and, then, Senator Dole will discuss how all of our recommendations would work together to create the best system of care to return our wounded warriors to optimal health and productivity.

Our first action step calls for Congress to simplify the DOD and VA disability systems. Right now, these Departments assess each servicemember's disability for different reasons. DOD needs to determine if servicemembers can continue to do their job despite their medical condition. If they can't, then the DOD must discharge the servicemembers. The degree of disability and the length of time spent in service determine the amount of military compensation and benefits. DOD generally only rates the condition that prevents the servicemembers from doing their job. VA determines how disabled a veteran is based on every medical condition that occurred or was made worse while in military service. The degree of disability is part of how the VA determines what benefits, services, and amount of compensation the veteran will get. Veterans can ask the VA to rate additional disabilities at any time.

Over the years, the disability evaluation system has become convoluted as we tried to fix problems. What we created is a system that is confusing and takes too long. In our national survey of injured servicemembers, less than half understood the DOD's disability evaluation process. And, only 42 percent of retired or separated servicemembers who had filed a VA claim understood the VA process. The system is dysfunctional and we need to fix it.

We recommend that DOD retain authority to determine fitness to serve. Servicemembers whose health conditions make them unfit for duty would be separated from the military with a lifetime annuity payment based on their rank and years of military service. This recommendation brings the DOD in line with other employers of choice—an important step in maintaining an all volunteer professional military force.

We believe that only one physical exam should be performed, rather than the two required now—one by each Department—and it should be performed by the DOD. The VA should assume all responsibility for establishing the disability rating based on that physical and for providing all disability compensation.

It is a much simpler system that better supports the needs of those transitioning between active duty and veteran status. It modernizes the system and allows the two Departments to focus on their unique and separate missions. DOD must provide the necessary military strength and expertise to keep our Nation safe and secure. DOD should determine fitness standards and provide for the health and readiness of the military workforce. As an employer, DOD must also provide retirement benefits. The VA's mission is to care for our Nation's veterans by providing appropriate benefits and services.

In our second action step, we recommend health care coverage for servicemembers who are found unfit because of conditions that were acquired in combat, supporting combat, or preparing for combat. Congress should authorize comprehensive lifetime health care coverage and pharmacy benefits for those servicemembers and their families through DOD's TRICARE program.

We believe this action item would help these individuals find employment that best fits their needs and talents instead of making a career choice based on whether family health care coverage is provided.

In our third action step, we would like Congress to clarify the objectives for the VA disability payment system by revising the three types of payments currently provided to many veterans. The primary objective should be to return disabled veterans to normal activities, insofar as possible, and as quickly as possible, by focusing on education, training, and employment. We recommend changing the existing disability compensation payments for injured servicemembers to include three components: transition support, earnings loss, and quality of life.

"Transition Payments" are temporary payments to help with expenses as disabled veterans integrate into civilian life. Veterans should receive either 3 months of base pay, if they are returning to their communities and not participating in further rehabilitation; or an amount to cover living expenses while they are participating in education or work training programs. We also believe that the time allowed for par-

ticipating in these training programs should be expanded to 72 months for those who might need to attend part-time.

"Earnings Loss Payments" make up for any lower earning capacity remaining after transition and after training. Initial evaluation of the remaining work-related disability should occur when training ends. Earnings loss payments should be credited as Social Security earnings and would end when the veteran retires and claims Social Security benefits.

In addition, we believe that "Quality of Life Payments" should be provided to disabled veterans. These payments are based on a more modern concept of disability that takes into account an injury's impact on an individual's total quality of life—independent of the ability to work.

We also call for the disability status of veterans to be reevaluated every 3 years and compensation adjusted, as necessary. We see this as a positive provision that would ensure all disabled veterans are seen by a health professional at least every few years.

By simplifying and modernizing the DOD and VA disability systems, Congress will make the systems less confusing, eliminate payment inequalities, and provide a foundation with appropriate incentives for injured veterans to return to productive life.

Our fourth action step calls on Congress to authorize the VA to provide lifetime treatment for PTSD for any veteran deployed to Iraq or Afghanistan in need of such services. This "presumptive eligibility" for the diagnosis and treatment of PTSD should occur regardless of the length of time that has transpired since the exposure to combat events.

The current conflicts involve intense urban fighting, often against civilian combatants, and many servicemembers witness or experience acts of terrorism. Five hundred thousand servicemembers have been deployed multiple times. The longer servicemembers are in the field, the more likely they are to experience events—which can lead to symptoms of PTSD. The consequences of PTSD can be devastating. The VA is a recognized leader in the treatment of combat-related PTSD, with an extensive network of specialized inpatient, outpatient, day hospital, and residential treatment programs. Therefore, we ask that any veteran of the Iraq or Afghanistan conflicts be able to obtain prompt access to the VA for diagnosis and treatment.

Next, we ask Congress to strengthen support for our military families.

In our travels across the country, it become abundantly clear that we not only needed to help the severely injured, we needed to help their loved ones too. These loved ones are often on the front lines of care and they are in desperate need of support. Therefore, we call upon Congress to make servicemembers with combat related injuries eligible for respite care and aide and personal attendant benefits. These benefits are provided in the current Extended Care Health Option program under TRICARE. Presently, DOD provides no other benefit for care-giving. Yet we know that many families are caring for their injured servicemember at home—and many of these servicemembers have complex injuries. These families, forced into stressful new situations, don't need more anxiety and confusion, they need support. Families are unprepared to provide 24/7 care. Those that try, wear out quickly. By providing help for the caregiver, families can better deal with the stress and problems that arise when caring for a loved one with complex injuries at home.

We also recommend that Congress amend the Family and Medical Leave Act (FMLA) to extend unpaid leave from 12 weeks to up to 6 months for a family member of a servicemember who has a combat-related injury and meets other FMLA eligibility requirements. According to initial findings of research conducted by the Commission, approximately two-thirds of injured servicemembers reported that their family members or close friends stayed with them for an extended time while they were hospitalized; one in five gave up a job to do so.

Getting family members to the bedside of an injured servicemember is not the problem. The services have developed effective procedures to make this happen, and the private sector has stepped up to provide temporary housing. Because most injured servicemembers recover quickly and return to duty, the family member's stay may be short. However, for those whose loved one has incurred complex injuries, the stay may last much longer. Extending the Family and Medical Leave Act for these families will make a tremendous difference in the quality of their lives. Congress enacted the initial Family and Medical Leave Act in 1993, when I was Secretary of Health and Human Services. Since then, its provisions have provided over 60 million workers the opportunity to care for their family members when they need it most—without putting their jobs on the line.

We are pleased to see that many Members of Congress have embraced this proposal and we hope to see it enacted soon.

Mr. Chairman, I believe that government can work to improve the lives of its citizens. But sometimes, we fix problems by adding more complexity that in turn creates problems. What we've done with the Commission's recommendations is strip some of that away to simplify the system, to go back to basic principles and to make necessary programs more patient and family centered.

We have been truly heartened by the response our report has received in the White House, the halls of Congress and throughout the country. The Nation has rallied behind the need to help those who have put their lives on the line in service to our country. We have met with the White House and the Departments of Veterans Affairs and Defense and are pleased to report that they are moving forward on implementing those recommendations requiring administrative action. We are optimistic that Congress will do the same for those recommendations that require legislation.

On behalf of the Commission, I want to thank the Committee again for the opportunity to discuss our recommendations. I look forward to joining Senator Dole in answering your questions.

STATEMENT OF HON. BOB DOLE, CO-CHAIR, PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS

Senator DOLE. Mr. Chairman, thank you very much, and my colleagues, thank you very much. I want to tell you, Senator Isakson, I talked to Doug Bernard yesterday about what is happening in Augusta and it really appears to be a great program. I think what you need are more participants. You have got the facilities. I am not sure there is anything we can do about that, but I am going to meet with the Executive Director tomorrow.

And I want to thank Senator Brown because my Great Grandfather comes from Montpelier, Ohio, so I have got a little Ohio strain in my system somewhere.

And Mr. Chairman, Senator Inouye and I were both in Italy in World War II and we were wounded a week apart and a hill apart and we ended up in the same hospital—in Percy Jones General Hospital in Michigan—with former Senator Phil Hart, whom the Hart Building is named after. Phil Hart was a remarkable guy and he wasn't so badly injured, so he used to run errands for us and do all these things. He is married to Jane Briggs, and, at that time, the Briggs family owned the Detroit Tigers. So, we were able to go to baseball games—had free tickets and all that. Now they have renamed that facility the Hart-Dole-Inouye Building. Not that that gets us anywhere, but if we are ever there, I assume we can get in. [Laughter.]

So, that is a little history. What I am trying to point out here: it is a different generation. And let me say right up front, because you are going to hear from maybe some of the veterans' groups who have some problems—and we suggest that is a good thing to have a discussion—some are pushing back a little because of the changes we are making. There is always a fear that somebody may lose something or that somebody may gain from our recommendations.

And I will confess, we believe we are talking about a different generation. If you can see these young men and women—we met with some yesterday at the White House—their attitude, and you have got Ted Wade and his wife in the audience, and what they want to do with their future. So, we front-loaded these recommendations with more money for education, more money for family services, recognizing for the first time that quality of life should be compensable. If you lose your sight or lose a limb, you

have gone from a ten to, what, a five, four, three. I don't know. But we recognize that may be considered now by some, and we are going to directly address the issue, as Secretary Shalala has already pointed out.

So, if these young men and women who are making sacrifices today, and as Senator Murray said, we can have different views on what is happening in Iraq, but we ought to have the same view on how we treat those who return. And one thing we never discussed in our Commission was politics. I knew the Secretary's affiliation and she knew mine. I don't think we ever knew the others, and we didn't really care. And we never talked about cost. Cost is never an object. Whatever you think of the war, President Bush, or whatever, the President gave three words, said, "whatever it takes," and that was sort of our charge.

I must say, I have been around a long time. I have been around the White House a long time, as I said yesterday, not as long as I wanted to be around the White House——

[Laughter.]

Senator DOLE [continuing]. But, I was around a long time—many administrations. But the White House staff is really working hard on our recommendations and recommendations from the Disability Commission in hopes that Congress will take some action this year, if possible. There is a conference report floating around that if the Veterans Committee would sign off, some of these provisions might be included in that conference report. What is the number, S. 1606? It is the defense authorization bill. But in any event, that is a technical matter that you can take care of.

But as Secretary Shalala pointed out, what we didn't want to do is load you up with 350 recommendations. Secretary Gates told us when we met with him a couple of months or 3 months ago, he had 351 recommendations on his desk at that time—just DOD recommendations. So, we felt the best way to approach this is to try to simplify it, as the Secretary said, and reduce the number of recommendations and have some action steps and put the pressure on the administration to do about 90 percent of these things without legislation.

So we come to Congress with a fairly limited list of things to do, and there is some push-back. It may be that this generation of young men and women, who I believe are now the greatest generation—I think we passed the baton to this generation—if they would do a little better than we did, that is OK. These are grandsons and sons of Vietnam veterans and World War II veterans, and if their son or grandson does a little better, has better educational opportunities, better family opportunities, that is good. That shows we are making progress. It shows we recognize the sacrifices that these young men and women make.

So there shouldn't be any dollar costs, and we never talked about dollars. We didn't have anybody to ask, what is all this going to cost? I assume somebody here will think of that. We guessed maybe a billion dollars the first year and maybe more the second and third years. But again, we just wanted to do it right.

One thing that I want to stress before I forget it, we also believe that if you can't find the best care at a VA facility or a DOD facility, you ought to be able to go to a private facility. If you live in

Idaho or Kansas or Montana or wherever, you may not have a facility close by, but if there is a facility close to some disabled veteran where they can provide—whether it is PTI or PTSD or whatever it might be—excellent treatment, that ought to be available. You shouldn't have to drive 400 or 500 miles and spend the night and do all those things in order to get excellent treatment. And I say that because Ed Eckenhoff here, who was on our Commission and who has a serious disability, is the Director of the National Rehabilitation Center and he has treated—how many?

Mr. ECKENHOFF. Last fiscal year, 46.

Senator DOLE. But how many Iraqi-Afghan veterans have you treated?

Mr. ECKENHOFF. 46.

Senator DOLE. Oh, 46. So they get excellent care, and you can look at some of the recoveries that are remarkable, because I am not downgrading the VA or the DOD, but I was saying in some cases, the private sector opportunity ought to be available.

One thing we found, because I think the *Washington Post* story was a wake-up call for all of us, regardless of our party or whatever, veterans or non-veterans, it pointed out that we had a problem. It was primarily a facilities problem, but it became a patient problem if you were an outpatient and had to stay in a place like that. Building 18 is not part of the Walter Reed campus, but it is part of Walter Reed and it never should have happened. So the President appoints a commission. Congress has hearings. A lot of good things have happened, but we still haven't passed anything that is going to make a real difference.

I don't want to take a lot of time, and you have already put my statement in the record, but I want to recite just three cases to give you an example of what can happen.

First is a soldier injured when his Bradley Fighting Vehicle rolled over on an improvised explosive device and he was airlifted to Baghdad and received the first of over 40 operations. He was then taken to Landstuhl Regional Medical Center for additional medical care. And then he ended up at Brooke Army Medical Center's burn center, which is the best in the world. It is a great place and I am certain many of you have visited there. In addition to his burn injury, he also had Traumatic Brain Injury and his wife joined him and left their son with his grandmother in Kansas.

Over the next 2 years—some of the things that Senator Murray has pointed out—the family had to deal with many issues including military pay and a permanent change of station move, while maintaining their personal support, much needed to help their soldier get better. Then, when the soldier finally came home, he was severely limited in what he could do. The wife became his full-time caregiver. Now, obviously she doesn't object to that, but it shouldn't be necessary. She should be able to pursue her job, her school, her education. So, there are some provisions for care: we provide for respite care and additional benefits to make certain that a spouse—it could be a husband or a wife—can move on with their life and still be there.

The second story is about a Marine corpsman who was hit by a rocket when his base in Iraq was attacked and he woke up a few days later in Bethesda Naval Medical Center, and after several op-

erations and amputation of his left arm, he was transferred to Walter Reed for therapy and eventually retired.

The third story is about an officer whose convoy is ambushed by insurgents and rocket-propelled grenades and one grenade exploded in the leg well of the vehicle and severely injured his right leg. The second exploded at the rear of the vehicle, causing shrapnel wounds of his neck, shoulders, arms, and back, and he was evacuated and finally reached Landstuhl. After his two-and-a-half years at Walter Reed, they were able to salvage his leg and he is on the temporary disability retired list.

Now, the reason I cite these three stories, they have several things in common. The medical care and compassion that these individuals received in the theater was exceptional. You go back and look at World War II. For every one killed, there was maybe one survivor. For every one killed today, I think the number of survivors is 14 or 16. It is way up there. We have made a lot of progress from the battlefield, and you want to give a lot of credit to these medics who are out there on the battlefield rescuing these young men and women.

So, the survival rate is very high because of improved technology, improved care, improved transportation. It took me 8 weeks to get from Italy to Miami, Florida—my first stop—and now you can be wounded in Baghdad on a Tuesday and be in bed at Walter Reed on a Friday. That is just how it has improved. It meant life for many people who would have otherwise not made it.

But, here are some of the things that happened. Each of these individuals encountered problems with difficult and inflexible systems. They had complex injuries and required lengthy rehabilitation. They each had case manager after case manager. We had a young man on our Commission, José Ramos, who lost an arm in Iraq. He had so many case workers, he couldn't remember their names. Now, you wonder why they don't keep their appointments and don't see the doctor and don't get out on time. José is just a great guy, and I want to thank the initiator of the provision of the Recovery Care Coordinator, which Secretary Shalala initiated, where this one care coordinator will follow that patient from the time they walk into Walter Reed Hospital, or wherever it may be—and about 26 percent of people go to Walter Reed, that is their first stop—and they will follow them all the way through until they go back to the unit, go home, or go to the VA.

To me, that is a big, big improvement as far as moving the process along—giving that person not only the responsibility, but the authority to be there on the take-off and be certain that they are part of the team. And, I think that it is not expensive. We are talking about 50 to 100 Recovery Coordinators. It is not a big, big bureaucracy. And they are going to be trained by the Public Health Service and the DOD and the VA, and to the credit of the administration, that program is already underway. They have already started the training. I don't know when the first ones are going to be available, but very soon. I thank Secretary Shalala for that.

In addition, they had trouble scheduling outpatient visits and follow-up care was difficult. The amount of paperwork, as somebody mentioned, was enormous. The VA does have the best IT system of anyplace, any hospital, but DOD is a little behind. We had a

very fine man on our Commission, Dr. Martin Harris from the Cleveland Clinic, and that is what he does. He is an expert. And he is working now with the DOD and the VA, and we think we can make their systems compatible without spending a lot of big money and do it very quickly.

We are also going to have a Web site where you just punch a button and you can find out all the services that may be available for a particular veteran. When is that going to be available? They are testing it right now. I have to check with the experts—we call them the three wise ladies—behind me here.

In any event, the rest of my statement is in the record. We know that Congress may not agree with everything we recommended. We both have been around government a long time and members of our Commission are certainly aware of that. We would like to think it is a perfect product, but we know that is not the case. And, certainly we want the VSOs, the Veteran Service Organizations, to weigh in. But we want to make certain that everybody understands that we are talking about a new generation of young men and young women who are making sacrifices. It is a different time, different opportunities, different injuries, different technologies, and we think, maybe, some different compensation. They may get a few more dollars than maybe somebody in Vietnam. But our charge was only Iraq and Afghanistan. We only had 4 months. We didn't have time to go back and look at the other 25 million veterans and say, well, we ought to do this, this, and this.

I am just very honored. We have a great staff and we had a lot of help from the DOD and the VA. I think they really try. I have been going to Walter Reed as a patient for, I don't know, 30 years or more. I think it is a great place and they have great doctors. One thing we were concerned about, since they are going to close, is: during the transition the quality of care would drop off and some poor guy coming here from Iraq with a bad injury would not get first-rate treatment.

So, our sixth recommendation is—and I am certain everybody agrees with—that you keep Walter Reed up and running as a first-class A–1 hospital until somebody finally turns off the lights. So, up until that final day when the move is made, they are available to take care of anybody with any kind of an injury that they deal with at Walter Reed. We also say that if they need—you know, a lot of these doctors don't want to stay on a ship that is going to sink in about 4 years—so, we want to provide some incentives, some additional pay, to keep those doctors—whether they are Army doctors or contract doctors or nurses or therapists—keep them there during this transition.

But, I know most everybody here and I know that you are concerned about veterans. We all are. It is not a partisan issue. Some veterans have problems. I started working with veterans when I was a young county attorney in Russell County, Kansas, as a service officer for the VFW and the American Legion, and later, the Disabled American Veterans. And so, we have had problems. We have always had problems. That is why they had the Bradley Commission. That is why we have had about ten commissions since then. It is always a work-in-progress.

Obviously, we think we can fix it. It probably won't be perfect, but we need your help. Nothing is going to happen unless Congress steps up to the plate and says, you know, this is a pretty good idea, or maybe we ought to change it, or maybe it is not a good idea. But, I really believe you are going to like most of it, and it is because of the hard work and dedication of the staff members.

We had two amputees on the Commission. Ed is disabled. I have a slight disability, and then we had the wife of this young sergeant who was burned over 70 percent of his body. So we had a representative Commission, as Secretary Shalala said, and I think we are going to continue working. We are volunteers. We will be happy to come back. We will be happy to sit down with staff. I know Karen and Sue and Marie will be happy to sit down with staff and go into details. We want to thank you for giving us this opportunity.

[The prepared statement of Senator Dole follows:]

PREPARED STATEMENT OF BOB DOLE, CO-CHAIR PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS BEFORE THE UNITED STATES SENATE

Good morning Mr. Chairman and Members of the Committee. It is a pleasure to appear before you today, along with my fellow Co-Chair Donna Shalala.

We look forward to working with you, and the other individuals here today, to support this Nation's goal of assuring that our service men and woman receive the benefits and services they deserve.

It has been an honor to serve on this Commission, especially with Secretary Shalala. I have said it before and I will say it here today, she's been a "Triple A" co-chair. She has boundless energy and kept us going as we tackled this important challenge. It has been a great experience to work with her and our fellow commissioners.

Our recommendations were guided by the Commission chaired by General Omar Bradley in 1956, which said: "Our philosophy of veterans' benefits must be modernized and the whole structure of traditional veterans' programs brought up to date."

Problems accompany change—wars change, people change, techniques change, injuries change, and we need to keep our military and veterans health care system up-to-date. I find it remarkable that 50 years later we are finding so much of what General Bradley had recommended is still relevant today.

Secretary Shalala has outlined the action steps to be taken by Congress. I will now tell you how our recommendations—all of them—work to create a system that serves, supports, and simplifies.

First, let me review our recommendations:

1. Immediately Create Comprehensive Recovery Plans to Provide the Right Care and Support at the Right Time in the Right Place
2. Completely Restructure the Disability Determination and Compensation Systems
3. Aggressively Prevent and Treat Post Traumatic Stress Disorder and Traumatic Brain Injury
4. Significantly Strengthen Support for Families
5. Rapidly Transfer Patient Information Between DOD and VA
6. Strongly Support Walter Reed by Recruiting and Retaining First Rate Professionals Through 2011.

Now let me tell you how they would work using the experiences of three wounded warriors.

The first is a soldier who was injured when his Bradley Fighting Vehicle rolled over an improvised explosive device. He was airlifted to Baghdad where he received the first of over 40 operations. He was then taken to Landstuhl Regional Medical Center for additional medical care and stabilization, after which he was taken to Brook Army Medical Center's burn center. In addition to his burn injuries, he also had a Traumatic Brain Injury. His wife joined him at Landstuhl and traveled with him to Brook, leaving their son with his grandmother in Kansas.

Over the next 2 years, this family had to deal with many issues including military pay and a permanent change of station move, while maintaining the personal sup-

port needed to help their soldier get better. When the soldier finally came home, severely limited in what he could do, the wife became his full time caregiver.

My second story is about a Marine corpsman who was hit by a rocket when his base in Iraq was attacked. He lost consciousness and woke up a few days later at Bethesda Naval Medical Center after several operations and amputation of his left arm. He was transferred to Walter Reed for occupational and physical therapy and eventually medically retired.

My third story is about an officer whose convoy was ambushed by insurgents using small arms fire and rocket-propelled grenades. One RPG exploded in the leg well of his vehicle, severely injuring his right leg. The second RPG exploded at the rear of his vehicle causing shrapnel wounds to his neck, shoulders, arms, and back. He was evacuated to Al Assad, then Balad, and finally Landstuhl with operations on his leg at each stop. He was ultimately evacuated Walter Reed. After 2½ years of rehabilitation and additional operations to salvage his leg, he is on the temporary disability retired list.

These stories have several things in common. The medical care and compassion that these individuals received in theater was exceptional. Today's military trauma care saves lives that would have been impossible in previous wars. The military medical evacuation system that removes injured servicemembers from the field of battle to a military treatment facility in the U.S. within 36 hours after the injury is nothing short of remarkable.

However, each of these individuals encountered problems with difficult and inflexible systems. They each had complex injuries and required lengthy rehabilitation.

They each had case manager after case manager. One told us he had over 10 and could never remember what they were managing, never mind their names. Communication between the providers of care and services and the servicemember were spotty at best and, often, didn't happen at all.

Scheduling outpatient visits for necessary follow up and care was difficult. The amount of paperwork was enormous, never ending, and redundant. Patients and their families had no single point of contact. Processing for a medical discharge took months and delayed patient and family decisions. At Walter Reed, outpatients exceeded the facility's capacity to house them, creating the problems of Building 18.

Had our recommendations been in place, each of these individuals would have had a recovery coordinator assigned at the time they arrived at a stateside military hospital. The recovery coordinator would have developed a recovery plan along with the patient's medical team and other personnel designed to return the patient to optimal functioning.

The recovery plan would make the best treatment and services available—including those in the VA or the private sector. The plan would not stop after the patient's discharge from the hospital, but continue to guide recovery through outpatient care, rehabilitation, and any necessary retraining or education. The recovery coordinator would serve as a single point of contact for the patient and family.

We recommended that the recovery coordinator be part of an elite unit of the Public Health Service. We did so because we thought it best to place these individuals outside of either the DOD or VA. Part of this reasoning was because we were concerned that VA or DOD employees would not be allow to effectively reach out to the other Department, marshalling needed services, with any degree of authority.

We also recommended that Walter Reed be supported until it closes. Perhaps some of the difficulties with outpatient clinic appointments and medical hold and holdover at Walter Reed would not have been so problematic if our recommendation had been in effect.

Fortunately, only one of the individuals I mentioned had a Traumatic Brain Injury and none have developed Post Traumatic Stress Disorder. We recommended that the DOD and VA aggressively prevent and treat TBI and Post Traumatic Stress Disorder.

New ways of protecting our servicemembers from these devastating conditions would be developed and implemented. Military leaders, VA and DOD medical providers, family members and caregivers would have access to educational programs to better understand these problems and how to help.

Health care providers in both the DOD and the VA would be using the most contemporary clinical practice guidelines to assess and evaluate servicemembers and veterans for these conditions.

More mental health professionals would be available in the DOD and VA. Anyone concerned he or she might have PTSD could go to the VA, an internationally recognized expert in combat related PTSD, to get care.

Families, such as the one in my first story, also need support and help. With our recommendations, the grandmother, who took a leave of absence from her job to

stay with her grandson, would be able to take an additional 3 months under an enhanced provision within the Family Medical Leave Act.

The wounded warrior's wife would be able to get respite care or aid and attendant care through the ECHO program within TRICARE. As the primary caregiver for her wounded husband, she needs assistance, assistance that currently does not exist in the DOD.

She would also get training and counseling to help care for her husband.

All three injured individuals had to deal with mountains of paperwork—paperwork that was frequently lost or unavailable at critical process decision points. In this day of electronic everything, it is frustrating to fill out form after form, repeating the same information over and over again.

But the problem with information technology should not be solved by starting over—that will just delay things. Instead, we have recommended that DOD and VA be held to a scorecard for documenting the progress of information sharing. While we all want interoperability of medical records, we don't have to wait for this goal to become reality. Much can be made visible now.

We have also recommended the development of a web portal that will provide tailored information to each servicemember and veteran specific to their situation. We understand that this effort is currently underway and we are ready to try the product.

We have also recommended a complete reform of the current disability evaluation and compensation system as Secretary Shalala has just told you.

Under this recommendation, each of our wounded warriors would be evaluated as to whether they could perform any military duty by the DOD. If not, each would be medically discharged with an annuity based on rank and time in service. They each would get TRICARE for themselves and their family.

The single medical exam performed by the DOD to determine fitness to serve would also serve as the exam used by the VA to determine the disability rating using an updated rating schedule. The disability rating determines what VA benefits and services the veteran could receive, and the VA's disability compensation.

Each would get to select one of two transition payments to take effect upon discharge. They could elect to get 3 months of basic pay, or enroll in an educational or training program with an enhanced stipend for up to 72 months.

At the end of the 3 months or after completing the educational program, each would get a quality of life payment based on their specific injuries. They would also get an additional payment to make up for any earnings loss.

We realize that adopting a new system requires a leap of faith for many. We are therefore, recommending that two studies be done in the short term. We need to determine the right amount of transition pay. We also need to determine what a quality of life payment would look like. Once these are completed, and we should not take forever, reforming the current disability evaluation and compensation system should move forward.

For those of you familiar with the Commission's members, you will recognize the individuals in the stories. One is Chris Edwards, whose wife, Tammy Edwards, served as a Commissioner. The other stories belong to José Ramos and Marc Giammatteo, two of our other Commissioners. I want to personally thank all the Commissioners for their dedication and hard work.

I have one last story. This soldier was hit by machine gun fire when he tried to assist a wounded comrade. It took 9 hours to evacuate him from the battlefield and 24 hours to further evacuate him to a field hospital. It took almost 2 months after his injury to evacuate him to a stateside Army Hospital. He underwent 9 operations, survived a blood clot and, over a period of 3 years learned to adapt to his disability through rehabilitation, with his mother at his side. His community chipped in to pay his hospital bills and one private sector surgeon performed 7 additional operations at no charge.

Of course, this last guy is me. I only bring my story up to show the differences between now and then. We should always try to improve on what has gone before. This may mean that some of the more recent wounded warriors get benefits that I don't and that's OK.

I really believe that these are really bold recommendations and doable, but it requires a sense of urgency and strong leadership.

We stand ready to assist you in any way as we work together to create a system that serves our bravest men and women who have made the ultimate sacrifice for our Nation.

Thank you.

RESPONSES TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO SENATOR BOB DOLE AND SECRETARY DONNA SHALALA

Comprehensive Recovery Plans

Question 1. The idea of a coordinated recovery plan is one I embrace fully. The Committee-reported bill on traumatic brain injury includes this concept. However, I am trying to understand more fully the Commission's recommendation for a single recovery coordinator. The final report of the Commission urged the development of a corps of recovery coordinators within the Public Health Service. At the hearing, you talked about a much larger role for VA in this process, with VA taking the lead in all respects. When did this change and was the Commission involved in this change?

Response. In our recommendations regarding the Recovery Plan and Coordinator, we recommended placing the Coordinators within an elite unit of the Public Health Services. Since our report was issued, we understand that the VA has requested that the Coordinators be placed within the VA and trained by a cadre of personnel from the PHS, VA and DOD. The Commission was not involved in this change.

Question 2. Should VA assume the responsibility for the Recovery Care Coordinators, does this mean that VA will be responsible for coordinating the care of seriously injured servicemembers upon their arrival at a military hospital? As I understand it, some of these servicemembers will either return to active duty and not be enrolled in the VA system for years or spend months or years in the DOD medical system going through recovery and rehabilitation. My question is, do you believe this care coordination role is one VA should be performing prior to a servicemember's separation from the military?

Response. We thought long and hard before placing the Coordinators outside of the two Departments. We were concerned that placing the individuals wholly within either the VA or the DOD would make it unlikely that the Coordinators would be able to function as we envisioned. The Coordinators must be able to operate across the two Departments and the private sector to access the best care and services for an injured servicemember. Their work should commence as soon as possible after the injury and continue throughout the recovery period, which can indeed be quite long. We were concerned that if the Coordinators resided within the VA, the services would not allow them full access to DOD/service resources or the ability to bring them to bear for the injured servicemember (and vice versa). We were also concerned that belonging to either department might constrain the use of private sources of care.

Impact on VA Claims Process

Question 3. Your report recommends that VA update the entire disability rating schedule to reflect current injuries and modern concepts of the impact of disability on quality of life. Given that a comprehensive overhaul of the rating schedule has not been done in over 50 years, I agree that such an endeavor is long overdue. However, at a time when VA already faces a sizable claims backlog, imposing a new rating schedule would require an expansive commitment to re-training staff to use the new schedule. Did your study consider the impact such a enormous undertaking would have on the already overburdened claims process?

Response. Most of the current backlog is from veterans already receiving disability compensation and applying for an increase. Under our system, with the 3-year automatic review, the workload would be more predictable and more easily managed. Failing to update, and appropriately maintain, the current disability rating system is a disservice to our injured servicemembers. PTSD and TBI are not adequately addressed in the current VASRD. Quality of life is reflected in some of the ratings, but not others. The schedule does not reflect significant advances in medical technology for amputation and other conditions. Yes, current raters would need to be trained in a new system—a system that will ultimately benefit veterans. The added resources needed to make the transition would be modest in comparison to the budget for veterans' disability programs.

Expert Consultation

Question 4. As you noted in your Op-Ed in Tuesday's Washington Post, the VA disability system is confusing. The Veterans' Disability Benefits Commission had the support of Mr. Robert Epley, who has served in various capacities at VA, including former Director of the Compensation and Pension Service. Can you please tell me who from VA was available to assist the Commission by providing expert advice?

Response. Dr. Gail Wilensky, one of our Commissioners, was the co-chair of the 2003 President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. This 2-year effort focused considerable attention on improving the seamless

transition to veteran status. As one of the nation's leading health economists and policy experts, Dr. Wilensky also has expertise in disability systems. The three Commissioners who were in the system and became advocates for other servicemembers—Tammy Edwards, Marc Giammatteo, and José Ramos—gave us a most important servicemember's perspective. Our recommendations covered both the DOD and VA disability (and retirement) systems and our staff included senior staff from both systems. In addition, we consulted with the Veterans' Disability Benefits Commission senior staff, Admiral Cooper and his senior staff, GAO's veterans' disability analysts, several of the experts who served on the Institute of Medicine panels, and officials in the Office of the Undersecretary of Defense for Personnel and Readiness and the military services. Our research director, Susan Hosek, had significant expertise from her 35 years as a RAND researcher, including 6 years as director of RAND's preeminent defense manpower research group. She was also a member of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans.

Survey

Question 5. Over 40 percent of those who responded to the survey were active duty servicemembers and thus not yet eligible for VA disability compensation. These servicemembers would likely not have had the sort of contact with VA to be able to make a knowledgeable response to survey questions regarding the VA compensation system.

- How were their responses weighted in comparison to recently separated or medically retired veterans who had actual experience with VA?
- Do you know how many survey respondents had actually sought VA disability compensation?
- I understand that the response rate to the telephone survey was less than thirty percent and that, for some subsets of the survey, the response rate was in the single digits. How does such a low response rate affect the validity of the survey?

Response. As of the end of May 2007, 10,185 servicemembers met the criteria for our survey: (1) medically evacuated from theater to the U.S. for deployment-related injuries or illnesses or (2) subsequently diagnosed with PTSD and (3) separated/retired for no more than 2 years. The last criteria was necessary because of DOD survey regulations but data on the flow of casualties out of theater indicated that this criterion eliminated very few. Of these, only 1,715 had separated or retired from military service. We included all of these individuals in the sample for the survey and they accounted for 29 percent of the sample and 26 percent of the responses. We developed weights so that we could present findings that were representative of the population we sampled. The survey's questions about VA disability evaluation were asked only to the separated/retired group. We also separately tabulated the results for the other questions since we knew that this group—most of whom were injured relatively early—may have had different experiences.

Among survey respondents who had separated or retired, 89 percent had filed a VA disability claim and almost all the others planned to do so. Of those who had filed, 58 percent had completed the process by the time of the survey.

The overall response rate was 30 percent and there was almost no difference across sub-groups (e.g., military service, component, age, rank, sex, category of injury). There were two reasons for non-response: inability to locate the respondent during the 2–week period the survey was in the field and refusal by those we were able to locate. We located 50 percent of the sample and completed interviews with 60 percent of them. Only 15 percent refused the survey outright. Our response rates were at least comparable to rates on similar DOD surveys of military personnel, even though these surveys are in the field for months, not weeks, and involve more follow-up. The response rates were well above what we anticipated based on experience with this population.

Different Eras vs. Different Systems

Question 6. Should the disability system be changed in the manner in which you recommended, how do we reconcile veterans from different eras receiving different benefits? Do we run the risk of disadvantaging older veterans from World War II, Korea and Vietnam?

Response. As with all transitions, some individuals may be more comfortable with their current status and not wish to change. This should be allowed. For those that wish to come under the new system, they should be allowed an election period. Going forward, all medically discharged servicemembers would come under the new system. Ultimately, the decision rests with Congress.

Disability Appeals

Question 7. Should VA be given responsibility for making the sole disability determination for servicemembers being medically retired from the military, what process did you envision for servicemembers to appeal a VA disability decision with which they disagree?

Response. Under our recommendations, the DOD determines fitness to serve and, when a member is found medically unfit and no longer "employable" in any military capacity, provides a retirement annuity. Prior to discharge, the servicemember could appeal the finding of unfit and petition for retention, as they do now. The discharged servicemember, now technically a veteran, would get his or her disability rating from the VA. The current system of disability rating appeal within the VA can still be used to adjudicate any challenge.

Question 8. What do you believe would be the impact on VA's resources if it took on the responsibility for handling these claims that are now managed by DOD?

Response. While we were not able to actually quantify the exact impact, we believe that there is a net efficiency in having only one physical exam (by DOD) and one disability evaluation determination (by VA). As our survey shows, all servicemembers who are medically discharged from military service currently file a VA disability claim and the number of new VA claims will not change under the new system. Since DOD will conduct a physical exam that meets VA requirements for disability evaluation, there will be many fewer physical exams performed by the VA.

VA Information Technology

Question 9. I could not agree more with the Commission's assessment that VA and DOD need to move quickly to get clinical and benefit data to users. I note your action plan established a 12-month time line for VA and DOD to make this happen. This is certainly a noble goal but, as I am sure you know, DOD and VA have been working toward sharing health information for the past decade without great success and VA internally has been working a similar process for benefits information for well over a decade.

How does the Commission envision the Departments meeting such a short time line for comprehensive data sharing?

Response. Commissioner Martin Harris, CIO for the Cleveland Clinic and an expert in health information systems, worked closely with our staff experts to evaluate the two departments' plans for information interoperability and progress in implementing those plans. Given progress to date, the Departments agreed with Dr. Harris' conclusion that they most information can be made available in the short term (viewable), thus the year time line. The departments should be held accountable for data-exchange outcomes, not process. We have provided a scorecard to use in this regard. We fully understand the frustration with the slow progress in achieving interoperability. We were encouraged with the recent electronic availability of the DD214.

Unemployment Compensation for Ex-Servicemembers

Question 10. With respect to your Commission's suggestion for "transition payments" during the first 3 months following discharge from active duty. How do those payments relate to the benefits available through the Unemployment Compensation for Ex-Servicemembers (UCX) program?

Response. The UCX is a state based and run unemployment compensation program. It provides income for ex-servicemembers after active duty while they search for a job. Because this is a state run program, eligibility and benefits vary. Our recommendation was for those servicemembers found unfit and medically retired. They would receive a standard 3 months of full pay while transitioning between active duty and work. This would supplement UCX for those who meet the state requirements.

Chairman AKAKA. Thank you very much, Senator Dole. Without objection, your statement will be included in the record.

Senator DOLE. I don't know what it says. I forgot to read it. [Laughter.]

Chairman AKAKA. Thank you both for your statements and we do have questions here.

One of the Commission's recommendations is that Congress enable all veterans who need PTSD care to receive it from VA. We have worked very hard this year to ensure a solid level of resources so that VA could continue to improve their efforts in PTSD. But,

I am unaware of any existing impediment in law or otherwise which now bars veterans from getting care for PTSD. My question to you is, what exactly is the basis for this recommendation?

Ms. SHALALA. Well, I think we want to make sure that there is a presumption that anyone can walk in forever, whether or not they have gotten care before, and we want to make it clear that there ought not to be a time constraint, because we know that PTSD can show up a year later or 2 years later.

And one of the points that Senator Dole keeps making is that this is a different generation. Many of them want to go home immediately. They are asked the question, is there something we should know? Are you feeling, you know, any symptoms after coming back? They all answer no, and then a year later or 6 months later or 2 years later, it shows up. So, I think that making it very clear that they have access to services, lifetime services, is extremely important.

Chairman AKAKA. Thank you.

Senator DOLE. Could I ask Sue to make a point on that?

Chairman AKAKA. Please state your name, also.

Senator DOLE. Sue Hosek with the RAND Corporation.

Ms. HOSEK. Yes. Currently, veterans get 2 years' eligibility at the VA after they leave the service, but after that time—and PTSD symptoms can appear after that time—they first have to go through the process of being declared eligible, and our concern was that some of these people need to be seen immediately and not wait for the disability evaluation to occur.

Chairman AKAKA. Thank you. Thank you very much. You know that——

Ms. SHALALA. It ought to be clearly a walk-in service so that people can be seen right away.

Senator BURR. Well, we have a polytrauma center in Richmond which does a good job with PTSD and TBI.

Ms. SHALALA. Which we visited.

Chairman AKAKA. I do appreciate that your Commission was tasked with focusing on improving the care and benefits for those returning from the wars in Iraq and Afghanistan. My question to both of you gets to the crux of the challenge we face as we work to effect meaningful disability reform. Do you believe there should be a separate disability process for servicemembers who are wounded, injured, or become ill in a combat zone versus those who suffer disabilities elsewhere?

Senator DOLE. No. Our view is once you are in uniform, you don't have to be shot at to be injured, or while in the line of duty. If it is somebody who is derelict in his duties and, you know, drugs or something like that are involved, then there is a question. But, I think I have gotten it right—it is across-the-board.

And "combat-related" is not a narrow definition. Maybe General Scott can elaborate on that when he comes up here. But, as soon as you sign up in the Army, you are getting ready for combat. You may never get there, but you are training for it, so it is a pretty broad term.

Chairman AKAKA. What is your opinion—this has to do with quality of life—what is your opinion of the recommendation made by the Veterans Disability Benefits Commission that until a sys-

tematic methodology is developed for evaluating and compensating for the impact of disability on quality of life, that there should be an immediate interim 25 percent increase to compensation rates?

Senator DOLE. My view is that we are going to—this is going to be done very quickly. There is going to be a commission determining what a quality of life payment would be for, say, an amputee or someone who lost sight, somebody with severe burns; and that commission is going to report back to Congress. Congress has to have a say, and should have a say. And that is not going to be very far off. So, I think by the time we start one system, getting ready for the other system, I am not certain—if it is going to take 4 or 5 years, I would say maybe it is a good idea. But this ought to be done in 6 months.

Ms. SHALALA. Quality of life payments are well established in the private sector. An internal study ought to set some standards for us, and I agree with Senator Dole to keep the pressure on, getting the facts and getting this set up.

Senator DOLE. You know, this is going to be a significant amount added to somebody's loss of earnings. We have got two new benefits here. The transition payment, which Secretary Shalala discussed—there is going to be a commission to look at that, whether it ought to be 3 months of base pay, whether it will be something else.

And then we have got this quality of life payment, which is based on, I assume, the kind of injury. But we are talking about things that maybe you won't be able to do. You know, people have a social life. Maybe you won't be able to dance, or maybe you can't play the piano like before. Maybe there are things you can't do that really affect your quality of life. We think it is time it is recognized and paid for.

Chairman AKAKA. Thank you. Senator Burr?

Senator BURR. Thank you, Mr. Chairman.

Let me just point to the fact that I think this is a great team. Both of you bring unusual experience and expertise and you have a passion that blends very well. I sat here listening to the Chairman and your comments. It reminded me of the words of Thomas Jefferson when he said, "I am not an advocate of frequent changes in laws and constitutions, but laws and institutions must advance to keep pace with the progress of the human mind."

Really, the heart of what you have talked about recognizes the fact that we have got generations in this system. And are we the ones that are going to recommend—do you put the focus on the current and the future ones and begin to distinguish the challenges that our troops are faced with coming out of the conflicts today, and the types of wounds that they have got and the uniqueness of that, in comparison to everybody else in the system. And isn't it time that we begin to recognize that there are two systems, because there are two sets of injuries.

Senator DOLE. Now that is—go ahead.

Senator BURR. No. I want to go to the fact that some of the veterans' organizations have expressed concern with creating a new disability system even though it only applies prospectively, and I——

Senator DOLE. If you like what you are in, you can stay there.

Senator BURR. That is right. What are the challenges that you two see associated with a swift implementation of the recommendations to this new disability system?

Senator DOLE. For you to persuade these people who are opposed to it to get on board. There are not many. I mean, I think there are some legitimate concerns that I think you can all address. But just to say that, "Well, we don't want any change, we like this 600 pages of band-aids we have been putting on over the years"—but again, I want to make the generational divide. Somebody has to stand up and say it is a different kind of warfare; it is a different generation. We have got to look ahead, as General Bradley did in 1956, and say, well, it is about time after, what, 51 years or whatever it is. Maybe we ought to move ahead.

What you need to do, really, is to get a group of these young men and women, the Wades, for example, and others, to tell you how they feel about it, because they are different than our generation. I never thought I got enough money, of course. I am an average American veteran. You never think you get quite enough. But we think we have addressed some of those concerns and we want to work with the veterans' groups.

Have you got anything to add there?

Ms. SHALALA. You know, the problem with change is that everybody thinks you are doing it because you are trying to save money. You start out with this kind of attitude that if you take on a system, particularly a complex system, you are trying to reduce the budget. In this case, that is not what we are trying to do at all.

Are there managerial challenges to creating this transition? Not really. I have implemented very complex changes—welfare reform, for example; major changes in the Medicare system; Social Security Disability went through a major change. It is possible at a managerial level to implement a transition, because you are only dealing with new people coming in. Anyone that has the current system and loves it can keep it—anyone who has already been evaluated. What you are doing is introducing a new system, and if it is only focused on the new people, it is relatively easy to put in place.

And, as I have indicated, there is private sector experience here. You are not inventing something that hasn't been tried in the private sector. In the case of family support, we are simply saying, add more resources. Be more sensitive to women and to heads of households. Don't think of the family members as people who have to coordinate care. Give them the option of going on with their professional lives, in many cases, and having the kind of support system and quality support system they think their loved one deserves and needs.

So, some of it is an investment in resources, but most of it is things that we know how to do. We certainly have to work with the definitions. But the numbers will be relatively small in the transition.

Senator BURR. Secretary Shalala, did any of the Commission members worry about whether the VA could handle two disability systems?

Senator DOLE. I don't think so, and we had VA people detailed to us. Top-level people worked with our three wise ladies and I don't think——

Senator BURR. So, we can be fairly confident that the Commission came to a consensus that this was not a problem. We can handle two systems.

Let me ask one last thing. My time has run out, but the White House made a proposal yesterday—they publicly made their proposal. There were differences. There were changes from that of your recommendation. Could you highlight those changes? I know you alluded to one of them dealing with the Social Security earnings.

Ms. SHALALA. Right. They spend more money. They eliminate—they allow you to keep your Social Security at the same time, for example, was one change that they recommended. I am not sure that I have all of them——

Senator DOLE. They expand TRICARE, too.

Ms. SHALALA. They expand TRICARE more dramatically than we did. Whatever they did, they added as opposed to restricted our recommendations, and while we discussed that at some point—yes, the main thing was the earnings loss component, that that earnings loss component should disappear when the veteran begins to receive Social Security. The administration has altered that proposal and not made the loss of earnings subject to the FICA tax and they don't stop that earnings—that income when the person gets on Social Security. So they make it for a lifetime.

Senator DOLE. That is one big objection one or two of the VSOs had, so that has been resolved.

Senator BURR. Well, my hope, and I believe I can speak for the entire Committee, is that we know if we can find consensus between the VSOs and the administration and both of the Commissions that are recommending, we can get legislation as quickly as what you said, Senator Dole.

Ms. SHALALA. And, I think we want to be very clear about the veterans' groups who we have all worked with. I haven't worked as extensively as Senator Dole. We would not have the kind of substantial system we have in this country without their advocacy. I fully understand that they should question every proposal rigorously, because they are absolutely in the right place in terms of who they represent.

We are simply saying, look, we think that we can make it even better for future generations. We can simplify it. We all ought to be able to understand this. This system took me—I spent a lifetime understanding health care systems and complex organizations. It took me a while to kind of get my arms around and try to understand it. We ought not to have government programs that require expertise to understand.

Senator BURR. Thank you both.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Murray?

Senator MURRAY. Thank you, Mr. Chairman.

Thank you both for really taking the time to look at this through the patients' eyes and the veterans' eyes rather than through the bureaucratic lens that too often, I think, gets focused on the system. I really appreciate the work that you and the Commission did on this.

I heard Senator Tester say earlier, too often, it is like the veteran is fighting the system rather than the system working for you, and just listening to it, it sounds like you are trying to change that mindset of the VA, which is really important.

One of my concerns is we do not have a Secretary of the VA currently. We haven't received a recommendation from the administration or anyone sent over here for that position. Are you concerned that the implementation of this, which is going to put a lot of pressure on the VA to do, it is going to take somebody at the top to really keep that culture that you are talking about, are you concerned that we don't have a head of the VA right now and are you working with the administration to get someone?

Ms. SHALALA. I am not.

Senator DOLE. I think we were asked that question yesterday, which is a good question. Right now, Deputy Secretary Gordon Mansfield meets every week with Gordon England of DOD and they have these weekly meetings and they are really moving ahead with these recommendations. In fact, they have been given a mandate by the White House to move ahead. But obviously, the sooner we have somebody on board who is really going to push this program——

Senator MURRAY. And who comes with the right mindset, too.

Senator DOLE. I think that is going to be very soon.

Senator MURRAY. Okay.

Senator DOLE. It will be up to, of course, your confirmation, but I think you will have a nominee——

Senator MURRAY. Well, I would assume, though, that you would want the nominee to have that culture and mindset that you are speaking about, as well, so——

Senator DOLE. We hope the nominee is asked before he is nominated or she is nominated that they have looked at this and they have looked at the other commission and they can support it vigorously.

Senator MURRAY. Some of the critics are concerned that a lot of your recommendations are Executive Branch implemented, not Legislative Branch implemented. Are you concerned about that at all?

Ms. SHALALA. Well, I think that reflects a certain shrewdness on our part to try to make sure——

Senator MURRAY. Oh, you trust us less than them?

Ms. SHALALA. No. No, not that. But we wanted to move immediately. We actually divided up what required legislation and what didn't require legislation.

Senator MURRAY. Is there a time line for the administration——

Ms. SHALALA. We expect, I think, almost everything to be done within a year. We did not give them a lifetime for implementation, and each of us is checking on—for instance, Dr. Harris is right on top of the IT recommendations. Senator Dole has been over on a regular basis to ask questions. Our staffs have been over to see how the implementation is going. So, we did not walk away from this and we did divide up the recommendations so that—I am a big believer in identifying the short-term things that you can do internally and then the longer-term things that require legislation——

Senator DOLE. Right. We could probably provide a list to the Committee of what the administration——

Senator MURRAY. Has done already?

Ms. SHALALA. And an update on all of that.

Senator MURRAY. I think that would be helpful.

Ms. SHALALA. But we actually thought about it, to make sure that things were getting done.

Senator MURRAY. OK. Well, specifically, I wanted to ask you, one of the biggest differences between your report and the report produced by the Veterans Disability Benefits Commission is the way in which you do compensate combat-injured versus non-combat-injured veterans. The way I hear you, your approach creates benefits specifically for combat and combat-related injuries and the Veterans Disability Benefits Commission compensates veterans based on the severity of their disability, not on the circumstances or the location. I am a little bit confused about what you consider to be combat injury. Is everything—if you are training for combat and you are here—is that considered combat injury?

Ms. SHALALA. Our definition of combat-related is very broad and it only applies to two provisions under our disability plan. The first is: that those found unfit due to combat-related injury or illness would receive a lifetime TRICARE coverage; and the second is, that these individuals would receive quality-of-life payments from the VA for life, as well. That definition includes those training for combat——

Senator MURRAY. So, if you are training here, that would be——

Ms. SHALALA. If you are training for combat its part of our definition. So it is very broad.

Senator MURRAY. What if you——

Senator DOLE. We tried line of duty; we tried combat-related. We want to make it broad. And we were told by DOD, well, once you sign up for whatever it is, whatever service, you are, in effect, training for combat someday. So——

Senator MURRAY. Okay, so it includes training. What about in-theater non-combat——

Ms. SHALALA. Yes.

Senator MURRAY. Your vehicle rolls over——

Ms. SHALALA. Yes.

Senator MURRAY [continuing]. Is that considered combat?

Ms. SHALALA. Absolutely. Absolutely. And you could look at the two systems we recommended. We were focused on these Afghanistan and Iraqi wars, trying to set up a system. But again, we believe we have one plan and we used as broad a definition as we could. But, that is, in part, for Congress to decide.

Senator MURRAY. OK. One other quick question. You have recommended a single medical exam, which I think makes a whole lot of sense. But, I am worried that that means, perhaps, the government could arbitrarily cut off a veteran without giving him a chance to appeal. Can you tell me how a veteran would deal with an appeal? Do they have the opportunity to disagree with the disability rating?

Ms. SHALALA. They would always have an appeal. We asked DOD to do the exam based on standards that they and the VA agree to. So there is a single exam——

Senator MURRAY. And once they leave DOD, they have that exam——

Ms. SHALALA. They have that exam. They take it over to VA——

Senator MURRAY. Do they have a chance then——

Ms. SHALALA [continuing]. And VA then looks at the whole person.

Senator MURRAY. OK. Do they have a chance then to appeal that?

Ms. SHALALA. There is always an appeal process. I don't know of a program without an appeal process.

Senator DOLE. In fact, we make certain that the DOD examiner understands that one can have disabilities and still be fit for duty. But, we want that examiner to hand over to the VA everything that may be wrong with that individual, so they can make an appropriate rating.

Ms. SHALALA. And that is why the two agencies define what is covered in the physicals. So, the whole thing goes over to VA and then the disability determination is done over there.

Senator MURRAY. Okay.

Senator DOLE. I think there is a feeling, Senator Murray, that the VA is a little more generous, too, with the ratings, so from the standpoint of the veteran, I think that is a plus.

Ms. SHALALA. And the advantage is there, because DOD is only making a fit/unfit [determination], though they are making a comprehensive exam. But you don't leave the DOD without your annuity in hand——

Senator MURRAY. Okay.

Ms. SHALALA. Even if you have only had 5 years or 3 years, based on your rank, you leave with an annuity that you have forever, no matter what happens over at the——

Senator MURRAY. And just so I understand, too, you have this one-time decision that you can stay with the current system or transition to this. Is there any provision for somebody who decides down the road a couple of years that that doesn't work for them, or do you just say—I mean—it is going to be a very confusing time for people to have to make that decision.

Ms. SHALALA. It is soldiers and sailors and Marines from October 1 of 2001 on, and what you are asking is if they have already had their rating, if they decide later they want to come into the new system whether they could. We didn't stipulate——

Senator DOLE. We left it open.

Ms. SHALALA. We left that question open and that obviously is something that Congress——

Senator MURRAY. I believe in the administration's draft legislation they are saying——

Ms. SHALALA. The administration said, "no." We left that open.

Senator MURRAY. You didn't——

Ms. SHALALA. Our recommendation was to leave it——

Senator MURRAY [continuing]. Are you——

Ms. SHALALA [continuing]. We left it open for Congress to make that decision.

Senator MURRAY [continuing]. Are you concerned, then, with a massive——

Ms. SHALALA. No.

Senator MURRAY [continuing]. With a big change——

Ms. SHALALA. I am not concerned with big numbers if you go from 2001 on. I think most people will probably stick with their current system if they have already gone through the evaluation process, and——

Senator DOLE. We have a young man on the Commission, José Ramos, who is in the current system and I think it is working for him. If he wanted to change——

Ms. SHALALA. He could.

Senator DOLE. He could do that, right?

Senator MURRAY. He has a one-time chance to make that decision under the administration's legislation.

Ms. SHALALA. Yes, under the administration's legislation. Under ours, we left that open, which means the Congress just makes a judgment about that. And, when you are in a transition period, you may make a different decision, just for the transition period of maybe a certain number of years, as opposed to long-term.

Senator MURRAY. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator Webb?

STATEMENT FROM HON. JIM WEBB,
U.S. SENATOR FROM VIRGINIA

Senator WEBB. Thank you, Mr. Chairman, and Senator Dole and Secretary Shalala. I did watch your testimony from my office. I have a couple of questions from the testimony, and I want you to know that I am not walking in here cold right now. Further, I didn't move down to this seat to get away from Senator Tester. It is the only seat that has a microphone.

With respect to PTSD, I, as many know, worked on the Veterans Committee on the House side for four years as a committee counsel and when we were doing a lot of pioneering of that program and I would support what you are doing on that because PTSD sort of oscillates through your life. There are relatively few, in the experiences that we had, who would be leaving the military and be diagnosed with PTSD, and yet down the road, in my experience, it sort of popped up in about an 8-year cycle and then about a 20-year cycle with people who had served in Vietnam, so I would fully support that.

I would like to make a point just from having watched the testimony and having worked in this area off and on all of my adult life. It is one I hope we don't lose as we start analogizing to the civilian employment structure, and that is that a volunteer force is not per se a career force. This is not a direct analogy to civilian employment. There are a lot of people who enlist in the military for reasons other than normal employment opportunity—because they love their country or they have got a family tradition, people who don't really intend to stay for a career.

It is for that reason that I have very strong feelings about readjustment assistance in addition to the types of things that we have been talking about here. I know, Senator Dole, you mentioned many times in your testimony about the need to focus on education, the fact that cost shouldn't be an issue when we look at

that. You mentioned these people since 9/11, we keep calling them the new greatest generation.

I introduced a bill—this is not directly under the purview of your recommendations, but it is important when we are talking about how we are going to help people transition into the future. I introduced a bill to give the people who have served since 9/11 the same G.I. educational benefits as the people who came back from World War II received. It is not true today, and I think that it is a great oversight in the veterans' law that we have not done that.

I was wondering, Senator Dole, if you could mention to us how important the educational piece was for you in terms of putting together your life after having served.

Senator DOLE. Well, there were 16 million of us in World War II and I think 8.5 million took advantage of the G.I. Bill. The G.I. Bill was signed down in the Mayflower Hotel, in room 320, and one of the big principals happened to be the National Commander of the American Legion, who happened to be a Kansan at that point. In any event, it made a big difference—not only the education piece, but the other benefits that were in the G.I. Bill; and it barely passed the Congress, as you probably remember, no more than four or five votes. It wasn't something that just sort of swept through the Congress. There was a lot of debate about it, and I don't know what the objections could have been.

I think it is the single most important piece of legislation when it comes to education, in how it changed America, than anything I can think of. Because, if you get a college education, then you want your children to get a college education, and a lot of us didn't have any money. Our parents didn't have any money. And suddenly, we had this opportunity. They even gave me a left-handed typewriter, a recording machine that I could take to class because I wasn't able to write then with my left hand. I had the best notes in class. I was very popular around test time every year. And they ought to take the same care of the veterans today.

Senator WEBB. Well, the program they have today is basically a peacetime program. The individual sort of has to pay in $100 a month for the first year. They all pretty much have to, even though it is supposedly voluntary. We have been doing analysis. It doesn't even take care of, say, 20 percent of what the costs would be at one of the better institutions, where after World War II, people got everything.

We had the VA testifying in front of us when I mentioned this and they said that to do the World War II G.I. Bill today would be too complicated because you had to look at different tuition payments and different schools, and I just have a hard time believing that. We put, I think, 7.8 million people through regular college after World War II and they did it with a stubby pencil on the back of a memo pad, they were able to figure it out. So I can't——

Senator DOLE. I am reminded that the vocational rehabilitation program provides, I think—one of our Commission members is a Harvard student, and, of course, it costs quite a bit to go to Harvard. I have never known why, but——

[Laughter.]

Senator DOLE [continuing]. So, there is money there——

Senator WEBB. I benefited from that program after Vietnam. I was in vocational rehabilitation when I went to law school. I think we can—I hope we can—get your support for this for all people. For instance, on something like PTSD, there are a lot of these things that aren't manifesting themselves immediately that would come under the rubric of the type of issues that you are talking about today, and the No. 1 thing that I can think of in terms of trying to help people readjust back into civilian life is a good education.

Ms. SHALALA. And Senator Dole came out with a great idea, and that is for every year people stay in, we increase the stipend, which actually incentivizes people to stay in for longer than a year in the program. I think that is very important.

Senator DOLE. Ten percent a year. We give them a 10-percent increase.

Ms. SHALALA. You look at the drop-out rate in the education programs that you are currently funding and it looks like an inner-city high school.

Senator WEBB. People can't keep up. They can't go to community college on the Montgomery G.I. Bill.

Ms. SHALALA. And I had a young man who contacted me because he wanted to go to the University of Miami. When he called, he was in Miami, though he called up to Tampa. They offered him enough money to go to a community college, but he wanted a specialized kind of course. Now, we have made an effort to accommodate him and get him fit together with our programs, because I was hardly going to turn him away.

Those kinds of investments will make a huge difference in the long run for us, and we just have to fit it with modern systems. There is lots of aid available in the States and from the Federal Government, but it is the wrap money to make sure it is possible for them to go full-time. So, that is why we want to extend the time for those that go part-time, but we also have to know what we are doing and it should not be to keep people down at a certain income level.

But the incentive system, I think is terrific, because it encourages—you get more resources as you stay in school.

Senator WEBB. Thank you very much. Mr. Chairman, if I may say one other thing, years ago when I worked on the veterans' programs, Senator Dole had an incredible reputation. I am not saying anything people don't already know, but wherever he was traveling, he was known to go to the VA hospitals in that area and not allow media to go with him, just to go in and talk to veterans. Again, I am not saying anything people don't know, but we couldn't have a better person and a greater national treasure doing this job. Thank you.

Chairman AKAKA. Thank you very much, Senator Webb.

Senator Tester?

Senator TESTER. Thank you, Mr. Chairman, and I want to apologize to the panel for having to go to a Banking markup meeting. There are some things that I want to visit and I will be as brief as possible.

Montana, as you both know, is a very rural State. You both know we have a high percentage of folks in the military. We have a high percentage of veterans. I think out of 930,000 people, we have

about 110,000 veterans. It is extremely rural. And I think, Senator Dole, in your comments, you talked about disabled veterans in rural areas being able to access private care in the areas of TBI and PTSD. Do you see that being applicable in other areas? I am talking about specialty care, routine care, anything like that—do you see any benefits of allowing that to happen in rural or frontier areas?

Ms. SHALALA. I do certainly. I visited some of the conversions and actually helped fund some of the conversions of hospitals to rehabilitation centers in Montana. You have some very interesting ways of using existing facilities, and there is no question in my mind that for certain kinds of rehabilitation that you would have some facilities. We would have to do a treatment plan and make sure that it fits with whatever the treatment plan is, so that people go home and use existing facilities and take advantage of doctors in rural areas or in the small towns. But, I certainly have spent enough time in Montana looking at the health care system to know that if you had a treatment plan, a way of getting accountability to make sure that you are measuring progress, we certainly should take advantage of what is available.

Senator DOLE. There is a Sergeant Edmondson that I think maybe Senator Burr is familiar with in New Bern, North Carolina, who has a bad TBI. He was able to negotiate to go to the Rehabilitation Institute of Chicago for treatment, where he made remarkable progress. Now, I know we don't have any cities like that in Kansas or Montana, or facilities like that. Then again, Ed Eckenhoff on our Commission has had 46 Iraq-Afghan veterans in the rehabilitation center here. So, the answer is, we live out in the country and we have got to make it easy for these people from the standpoint of their cost; and some are in wheelchairs, so it is hard to travel. We would like to have them get there and back in the same day, if possible.

Ms. SHALALA. We have a lot of experience in telemedicine. Senator Murray has been interested in it a long time, and taking advantage of that. Medicine has changed, so the key is the treatment plan, the accountability, and our ability to tailor it to what works for an individual.

Senator TESTER. Thank you. Thank you for your answers. I couldn't agree more, although I will tell you from a telemedicine standpoint, when it comes to PTSD or TBI, I have some concerns about that.

Ms. SHALALA. In fact, you need a place with expertise in those areas. I also want to make it clear that most of the expertise in this country in TBI and PTSD is in the veterans hospitals and in the military. The research that is going on, the clinical research that is going on, while there are some private sector centers, there's nothing like what is going on in the military and in veterans hospitals in this country.

Senator TESTER. Well, I certainly appreciate that. I can tell you that my opinion has changed dramatically over the last—since the first of January—in that, I think that in rural areas there is a real need that is not being met because of distance; and so, thank you for your answers and thank you for your testimony, too.

Chairman AKAKA. Thank you very much, Senator Tester.

Before going to panel two, let me ask the Members if anyone has any questions for a second round.

[No response.]

Chairman AKAKA. Thank you very much. I want to thank our first panel very, very much. Your testimony, your comments, your advice and recommendations have been very helpful.

Senator DOLE. Thank you.

Chairman AKAKA. Thank you.

I now welcome our second panel. Lieutenant General Terry Scott joins us today as Chairman of the Veterans Disability Benefits Commission. Under General Scott's leadership, the Veterans Disability Benefits Commission recently completed an extensive 2-year review of the benefits and services provided to disabled veterans by the Departments of Defense and Veterans Affairs.

Patrick Dunne is Assistant Secretary for Veterans Affairs for Policy and Planning. He appears before this Committee today representing the Task Force on Returning Global War on Terror Heroes, an interdepartmental panel assembled to address administrative barriers to the care of wounded servicemembers.

Former VA Secretary Togo West joins us today as Co-Chair of the Department of Defense's Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center. Secretary West served as Secretary of the Army and Secretary of Veterans Affairs during the Clinton Administration. He will present the Independent Review Group's perspective on how DOD can improve the care of wounded servicemembers.

I thank all of you for joining us today and look forward to your testimony. Your full statements will appear in the record of the hearing, and in the interest of time, please try to limit your direct statement to 5 minutes.

So at this time, I would like to call on General Scott for your statement.

STATEMENT OF LIEUTENANT GENERAL JAMES TERRY SCOTT, U.S. ARMY (RET.), CHAIRMAN, VETERANS DISABILITY BENEFITS COMMISSION

General SCOTT. Chairman Akaka, Ranking Member Burr, Members of the Committee, it is a great pleasure to appear before you again today representing the Veterans Disability Benefits Commission. I had the opportunity to testify before you in the joint session with the Armed Services Committee last April and it is a real pleasure to be back.

I would like to introduce some of the Commissioners who were able to be present here today, Commissioner Brown, Commissioner Carroll, Commissioner Cassiday, Commissioner Grady, Commissioner Jordan, Commissioner McGinn, Commissioner Surratt, and Commissioner Wynn. This lady and gentlemen devoted a lot of time to the two-and-a-half years that the Commission was meeting, and we met once a month in Washington until the last couple of months and we met twice a month from then on. Also, I would like to recognize the efforts of the Executive Director, Mr. Ray Wilburn, who has done a tremendous job of keeping things moving when the Commissioners were not present.

Sir, you asked today that I focus directly on areas of overlap between the recommendations of our Commission and those of the President's Commission on Care for America's Wounded Warriors, the Dole-Shalala Commission, and the Task Force on Returning Global War on Terror Heroes (also known as the Nicholson Task Force), and the DOD Independent Review Group (known as the Marsh-West Group).

You also asked for our views on how to improve the VA and DOD collaboration and cooperation, and how could we resolve the long-standing issue of creating a VA–DOD Electronic Health Record. So, per your request, sir, that is what I am going to address here today.

First, let me say that there is a tremendous amount of consistency in the findings and recommendations of these four reports. I prepared for the record, and passed to your staff, a matrix that listed the four commissions and the subject areas that they covered. I commend that to the staff and to the Members if they have the time to read it, because it lays out in detail how each of the four commissions addressed each of the important issues.

It is, of course, well known that the scope of these four commissions was quite different, and this resulted in some variations in some areas of the recommendation. For instance, our commission was not chartered to address the issues at Walter Reed, per se, and we did not.

All of us want to see improvements in benefits and services for the injured and disabled servicemembers and veterans. I might make a couple of points here. We found nine areas with considerable overlap among the reports and some areas with some limited overlap or some differences, or perhaps it was differences of interpretation.

The Veterans Disability Benefits Commission believes that all disabilities and injuries should be compensated based on the severity of the disability, and I believe that was covered in the question and answer portion of the last session, so I will go on from that.

Our Commission also believed that VA disability compensation should not end and be replaced with Social Security at retirement age, and we provided some hypotheticals as to what effect that would have on the severely-disabled veterans. So, I will be glad to respond to questions on that later, but that may be a moot issue since, apparently, the legislation will not have that in it.

I will talk briefly, sir, about the VA and DOD disability process. All four reports address the problems with the process used when servicemembers are determined to be fit or unfit for military duty. We conducted a detailed analysis of those separated or retired as unfit for duty during the 7-year period from 2002 to 2006 and compared their ratings with ratings subsequently completed by the VA. We found that the combined ratings by the VA were higher, on average, than the ratings by the services. When comparing the ratings for individual diagnosis, VA ratings were statistically significantly higher than those of the services.

We concluded that there should be a realignment of the process, and that is essentially the same conclusion reached by the Dole-Shalala Commission, the Independent Review Group, and the Nicholson Task Force. We also believe that the services should deter-

mine if the servicemember is fit or unfit, and VA should be responsible for assigning disability ratings. The Dole-Shalala Commission made the same recommendation.

In redesigning the VA disability process and specifying the benefits available for those servicemembers, we should recognize that the overwhelming proportion of servicemembers medically discharged as unfit do not meet the several definitions of severely disabled.

Our Commission did not specify which department should conduct this single examination. In fact, we believe that in some locations, it might be best determined by the capabilities of the two departments at that local level.

All four study groups recommended developing a case management system for severely injured servicemembers and their families to ensure that the right care and support at the right time and in the right place. A single case manager should have overall responsibility. The other commissions agreed.

Family support is addressed by all of the study groups except the Nicholson Task Force. The families of the severely injured are assisting in the care and rehabilitation of these wounded warriors. Our Commission recommended that VA be authorized to provide similar services to those provided by DOD to families of the severely injured. We also recommended extending the CHAMP VA medical care to caregivers of 100 percent disabled veterans, and providing a caregiver allowance. We recommended eliminating any TRICARE co-pays and deductibles for the severely disabled because we do not believe the injured should have to pay in any way for their injuries.

Regarding Post Traumatic Stress Disorder and Traumatic Brain Injury.—All four reports recommend improvements in awareness; research; treatment; staffing; and diagnosis examination of Post Traumatic Stress Disorder and Traumatic Brain Injury. Our Commission focused more on compensating and rating these conditions, and we recommend a holistic approach to PTSD be established that couples compensation, treatment, and vocational assessment. We also believe that reevaluation should occur every 2 to 3 years to gauge treatment effectiveness and encourage wellness. Regarding Traumatic Brain Injury, we recommend including medical criteria for this diagnosis as a priority in the revision of the VA schedule for rating disabilities.

Regarding ancillary benefits.—Our Commission recommended increases to several benefits that have not kept pace with the cost of living, extending eligibility in some cases to burn victims, and expanding the auto and housing allowances. We also recommended eliminating the premiums for Traumatic Servicemembers Group Life Insurance, as we do not believe that the servicemember should have to insure themselves for traumatic injuries. Perhaps most importantly, our Commission recommends establishing a pre-stabilization allowance similar in theory to that recommended by the Dole-Shalala Commission.

Regarding quality of life.—As was mentioned in the Q and A before, both our Commission and the Dole-Shalala Commission recommend a compensation payment for the impact of disability on quality of life. Current compensation payments do not provide pay-

ment above that required to offset earnings loss. Therefore, there is currently no compensation for the impact of disability on quality of life for most veterans. While permanent quality of life measures are developed and implemented, we recommend that compensation payments should be increased up to 25 percent with priority to the more severely disabled, and we provide some hypotheticals that show how that might be.

In other words, the 100 percent disabled person might get a 25 percent boost for quality of life, whereas the 10 percent disabled might get a very much smaller boost in payments for quality of life. So, it would be scaled based on the severity of the disability—it is an "up to 25 percent," not a flat 25 percent across the board, as has been quoted in some of the media.

Vocational rehabilitation.—All but the Independent Review Group addressed vocational rehabilitation. Both the Dole-Shalala Commission and our Commission found that the effectiveness of the program is not currently assessed and that graduates are not followed except for a very brief time period. Both Commissions recommend either an incentive bonus of up to 25 percent—that would be the Dole-Shalala—or exploring incentives as a way to encourage completion of vocational rehabilitation. The Nicholson Task Force focused on using existing programs and opportunities in that regard.

Concurrent receipt.—Regarding concurrent receipt of military retirement and VA disability, our Commission found that these two are different programs with entirely different missions. DOD retirement recognizes years of service and VA disability payments compensate for impairment in earnings and should compensate for impact on quality of life. Over time, Congress should eliminate the ban on concurrent receipt for all military retirees and for all servicemembers who are separated from the military due to service-connected disabilities. Priority should be given to those veterans who separate or retire with less than 20 years of service, with a disability rating of greater than 50 percent, or a disability as a result of combat.

Payment offsets should also be eliminated for survivors of those who die in service or retirees who die of service-connected causes so that these survivors can receive both the VA Dependency and Indemnity Compensation, known as DIC, and DOD survivors' benefit, known as SBP.

The Dole-Shalala Commission also recommends that DOD compensate for years of service, while VA compensates for disability.

Hazards exposures and presumptions.—Our Commission and the Nicholson Task Force both addressed hazards and exposures, but in different ways. Our Commission recommended a new presumption process as proposed by the Institute of Medicine. The new process includes enhanced registries of servicemembers and veterans based on exposure, deployment, and disease histories. And sir, I commend, particularly to the staff but also to the Members, this report done by the IOM. This subcommittee was chaired by Dr. Jonathan Simmet from Johns Hopkins, and I think that he provided all of us with some truly innovative ideas about how to address the issue of presumptions of disability.

Improving VA and DOD collaboration.—In addition to assessing the areas of overlap among the four reports, you asked my views on how to improve collaboration and cooperation between VA and DOD. We found many encouraging signs and also areas which need improvement. The Joint Executive Council has demonstrated how both departments can benefit from coordinated planning and increased cooperation. The results are evident in specific initiatives, including the integration of the North Chicago VA Medical Center and the Naval Health Clinic-Great Lakes. This coordinated treatment of severely injured in dedicated polytrauma centers is also very effective. However, we believe the JEC planning effort can be significantly improved by including specific milestones and designating responsible officials for each.

Successfully transitioning servicemembers to civilian life is crucial and ensuring that servicemembers understand the benefits and services that are available to them is essential. The Transition Assistance Program and the Disabled Transition Assistance Program briefing should be mandatory and adequately funded.

After leaving service, many veterans find it difficult to prove that injuries and diseases that occur later in life are the result of military service. We believe that all separating servicemembers should receive a separation examination to establish a baseline for medical conditions.

There is one way of expediting disability benefits in effect now. It is called a Benefits Delivery at Discharge process. It is available at 140 military facilities and these claims are processed at two VA locations. We believe that this Benefits Delivery at Discharge should be available to virtually all separating members, including Guard and Reserve.

One cause for delay in claims processing, even in the BDD process, is the availability of the discharge document. Our Commission recommends that DOD immediately provide VA with an authenticated electronic document so that processing can begin right away.

Lastly, sir, on IT compatibility.—All the reports address the absolute necessity for the VA and the DOD to have compatible information systems, but also to recognize that this will not solve all problems. Much has been said about the goal of seamless transition, which is not a current reality. Not all of DOD's medical and personnel records are electronic, and those that are electronic are not yet fully compatible between the services, much less between VA and DOD. There has been an agreement to create a joint Inpatient Electronic Record that would be instantly accessible. We do believe that development and implementation of this information system should be expedited and that a detailed management plan should be developed with a lead agent designated and with specific milestones and plan completion dates.

In conclusion, VA and DOD have much to gain by greater coordination. Servicemembers and veterans have even more to gain by the two departments working together. A lot of valuable work has been done. However, a great deal of work remains, and the only way the goal of a reasonably seamless transition will ever be realized is if the two departments are required to develop realistic challenging goals with specific milestones.

Congress should review these plans and oversee progress. Congress also has a responsibility to ensure that sufficient funding is provided to accomplish the goals and objectives contained in these IT plans.

Sir, that ends my oral statement and I will gladly answer any questions after the other presentations.

[The prepared statement of General Scott follows:]

PREPARED STATEMENT OF JAMES TERRY SCOTT, LTG, USA (RET), CHAIRMAN, VETERANS' DISABILITY BENEFITS COMMISSION

Chairman Akaka, Ranking Member Burr, and Members of the Committee: It is my pleasure to appear before you today representing the Veterans' Disability Benefits Commission.

You asked that I focus directly today on areas of overlap between the recommendations of our Commission and those of the President's Commission on Care for America's Returning Wounded Warriors (the Dole-Shalala Commission), the Task Force on Returning Global War on Terror Heroes (the Nicholson Task Force), and the DOD Independent Review Group (the Marsh/West Group.) You also asked for views on how to improve VA and DOD collaboration and cooperation and to resolve the long standing issue of creating a VA/DOD electronic health record.

First, let me say that there is a tremendous amount of consistency among the findings and recommendations of the four reports. The scope of the four efforts was quite different and this resulted in variations in some areas. But we all want to see improvements in benefits and services for injured and disabled servicemembers and veterans. Our Commission generally agrees with the advice provided by the Independent Review Group and the Task Force and more recently by the Dole-Shalala Commission, but we differ with two of the Dole-Shalala suggestions. We believe that all disabilities and injuries should be compensated based on severity of disability and not be limited to combat or combat-related injuries. Nor does our Commission believe that VA disability compensation should end and be replaced with Social Security at retirement age.

For our own purposes, we prepared a matrix comparing the findings and recommendations of the four reports which I am pleased to share with the Committee. I caution that the matrix is not intended to be exhaustive nor a verbatim listing of all findings and recommendations. Rather it is a broad overview that I found useful.

The matrix contains a description of each study group's focus and a brief summary of findings and recommendations and a summary of topics that overlap. The major topics with considerable overlap are: VA/DOD Disability Process; Case Management; Family Support; IT Compatibility; PTSD; TBI; Ancillary Benefits; Quality of Life; and Vocational Rehabilitation. Other topics with limited overlap include: Concurrent Receipt; Hazards and Exposures; Combat/Combat Related, Social Security, and Walter Reed. Our Commission addressed all of these topics except Walter Reed, which was not within the scope of our charge.

VA/DOD DISABILITY PROCESS

All four reports addressed the problems with the process used when servicemembers are determined to be fit or unfit for military duty. Our Commission conducted a detailed analysis of those separated or retired as unfit for duty during the 7-year period from 2000 through 2006 and compared their ratings with ratings subsequently completed by VA. We found that the combined ratings by VA were higher, on average, than ratings by the Services. For example, individuals rated zero percent by the Services were rated an average of 30 percent by VA and those rated 30 percent by the Services were rated an average of 56 percent by VA. Among individuals rated by the Services as zero, 10, or 20 percent, VA rated them 30 percent or higher 61 percent of the time. This was largely because VA rated 2.4 to 3.3 more conditions than the Services. When comparing the ratings for individual diagnoses, VA ratings were statistically significantly higher than the Services for 10 of 13 frequent diagnoses analyzed.

We concluded that there should be a realignment of the process and this is essentially the same conclusion reached by the Dole-Shalala Commission, the Independent Review Group, and the Nicholson Task Force. We also believe that the Services should determine if the servicemember is fit or unfit and VA should be responsible for assigning disability ratings to all conditions found as part of a single,

comprehensive examination. The Dole-Shalala Commission made the same recommendation.

In redesigning the VA/DOD disability process and specifying the benefits available for these servicemembers, it may be appropriate to focus specifically on the severely disabled. However, we should also recognize that the overwhelming proportion of servicemembers medically discharged as unfit do not meet the several definitions of severely disabled. During the 7-year period 2000 through 2006, there were 83,008 servicemembers medically discharged as unfit. DOD rated 81 percent of these as 0 through 20 percent disabled and provided separation pay. Only 5,060 (6.1 percent) were rated by DOD as 50 percent through 100 percent and, of these, only 1,478 (1.8 percent) were rated 100 percent. The process and the benefits should be appropriate for all servicemembers found unfit, not just the severely disabled.

Our Commission did not specify which department should conduct the single examination; in fact we believe that this should be determined more by the capabilities of the two departments at the local level. Our Commission extensively reviewed the examination process used by VA with the advice of the Institute of Medicine and made recommendations relating to the use of templates, training and certification of examiners, and quality assurance. Completion of a thorough and comprehensive examination is essential for accurate ratings and these recommendations should be addressed no matter which department conducts the examinations.

CASE MANAGEMENT

All four study groups recommended developing a case management system for severely injured servicemembers and their families to ensure the right care and support at the right time and in the right place. A single case manager should have overall responsibility. The Dole-Shalala Commission also recommended comprehensive recovery plans. Improving case management is a key topic upon which there is strong agreement.

FAMILY SUPPORT

Family support is addressed by all of the study groups except the Nicholson Task Force. The families of the severely injured are assisting in the care and rehabilitation of these wounded warriors. Some are sacrificing jobs, careers, homes, and health insurance, and facing a tremendous impact on their own health in order to support their injured family members. Our Commission recommended that VA be authorized to provide similar services as currently provided by DOD to families of the severely injured. We also recommended extending ChampVA medical care to caregivers (currently this benefit is provided only to dependents of 100 percent disabled veterans, not caregivers) and providing a caregiver allowance. We also recommended eliminating any TRICARE copays and deductibles for the severely disabled because we do not believe the injured should have to pay in any way for their injuries. We feel that our recommendations would more fully meet the needs of the families and caregivers of all severely disabled. The Dole-Shalala Commission would limit TRICARE coverage to only families of those unfit due to combat-related injuries.

PTSD AND TBI

All four reports recommend improvements in awareness, research, treatment, staffing, and diagnosis/examination of Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). Our Commission focused more on compensating and rating these conditions and recommend that a "holistic" approach to PTSD be established that couples compensation, treatment, and vocational assessment. We also believe that re-evaluation should occur every 2 to 3 years to gauge treatment effectiveness and encourage wellness. Regarding TBI, we recommend including medical criteria for this diagnosis as a priority in the revision to the VA Schedule for Rating Disabilities.

ANCILLARY BENEFITS

Our Commission recommended increases to several benefits that have not kept pace with cost of living, extending eligibility in some instances to burn victims, and expanding auto and housing allowances. We also recommended eliminating the premiums for Traumatic Servicemembers' Group Life Insurance (TSGLI) as we do not believe servicemembers should have to insure themselves for Traumatic Injuries. Perhaps most importantly, our Commission recommends establishing a pre-stabilization allowance of up to 50 percent of current compensation for up to 5 years to address the real out-of-pocket expenses for the severely disabled. The Dole-

Shalala Commission recommended a transition pay of 3 months' base pay or longer-term payments if participating in rehabilitation, education, or training. This is conceptually similar to our Pre-stabilization recommendation.

QUALITY OF LIFE

Both our Commission and the Dole-Shalala Commission recommend a compensation payment for the impact of disability on quality of life. We believe the level of compensation should be based on the severity of disability and should make up for average impairments of earnings capacity and the impact of disability on functionality and quality of life. It should not be based on whether it occurred during combat or combat training; or the geographic location of injury, or whether the disability occurred during wartime or a time of peace. Current compensation payments do not provide payment above that required to offset earnings loss. Therefore, there is currently no compensation for the impact of disability on quality of life for most veterans. While permanent quality of life measures are developed and implemented, we recommend that compensation payments should be increased up to 25 percent with priority to the more seriously disabled.

VOCATIONAL REHABILITATION

All but the Independent Review Group addressed vocational rehabilitation. Both the Dole-Shalala Commission and our Commission found that the effectiveness of the program is not currently assessed and graduates are not followed except for a very brief time period. Both commissions recommend either an incentive bonus of up to 25 percent (Dole-Shalala) or exploring incentives as a way to encourage completion. The Nicholson Task Force focused on using existing programs and opportunities.

CONCURRENT RECEIPT

Regarding concurrent receipt of military retirement and VA disability payments, our Commission found these to be two different programs with entirely different missions. DOD retirement recognizes years of service and VA disability payments compensate for impairment in earnings and should compensate for impact on quality of life.

Over time, Congress should eliminate the ban on concurrent receipt for all military retirees and for all servicemembers who are separated from the military due to service-connected disabilities. Priority should be given to veterans who separate or retire with less than 20 years of service and a service-connected disability rating of 50 percent or greater or disability as a result of combat. Payment offset should also be eliminated for survivors of those who die in service or retirees who die of service-related causes so that the survivors can receive both VA Dependency and Indemnity Compensation (known as DIC) and DOD Survivors Benefit Plan (known as SBP.)

The Dole-Shalala Commission also recommends that DOD compensate for years of service while VA compensates for disability.

HAZARDS AND EXPOSURES

Our Commission and the Nicholson Task Force both addressed hazards and exposures but in different ways. The Nicholson Task Force recommended creating a center of excellence and a registry for embedded shrapnel or fragments from blast injuries. Our Commission recommended a new presumption process as proposed by the Institute of Medicine. The new process includes enhanced registries of servicemembers and veterans based on exposure, deployment, and disease histories.

IMPROVING VA AND DOD COLLABORATION

In addition to assessing areas of overlap among the four reports, you asked my views on how to improve collaboration and cooperation between VA and DOD. Our Commission made several recommendations that we believe would enhance benefits and services for servicemembers and veterans, both while they are transitioning from the military to civilian status and for many years in the future. We found many encouraging signs and also areas which need improvement.

The Joint Executive Council (JEC) established by statute has demonstrated how both departments can benefit from coordinated planning and increased cooperation. We applaud the results that are evident in specific initiatives. These include the integration of the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes (named last week for astronaut James Lovell), in the coordinated treatment of severely injured in dedicated poly trauma centers, and in shared rehabilita-

tion units. These are all indications of how joint efforts can benefit both departments and improve service to veterans and servicemembers. However, we believe that the JEC planning effort can be significantly improved by including specific milestones and designating responsible officials for each. We also suggest that transition coordination and effectiveness could be improved by including the Department of Labor and the Social Security Administration in some capacity in the JEC since these organizations have major transition roles.

Successfully transitioning servicemembers to civilian life is crucial and ensuring that servicemembers understand the benefits and services that are available to them is essential. Information is disseminated through the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP.) We believe that the TAP briefings should be mandatory for all separating servicemembers, especially the Guard and Reserves and those in medical hold status. Currently, these briefings are not mandatory in all Services. In addition, we found that funding for these briefings has been static for the last decade and we recommend that adequate funding be provided. All servicemembers should be knowledgeable about benefits prior to leaving the service.

After leaving service, many veterans find it difficult to prove that injuries and diseases that occur later in life are the result of military service. The veteran, with the assistance of VA, has to produce evidence that the condition originated in service. This is made more difficult because not all separating servicemembers receive separation examinations; only those who intend to file a claim for VA disability benefits. We believe that all separating servicemembers should receive a separation examination to establish a baseline for medical conditions. An entrance examination is required to enter active duty and a separation examination should be required to leave active duty.

Application for disability benefits is expedited through the Benefits Delivery at Discharge (BDD) process which is currently available at some 140 military facilities and these claims are processed at two VA locations. Two problems exist with the BDD process: (1) it is not available unless the individual has an established date of discharge and is within 180 days of that date; and (2) it is not available at all locations. Those on medical hold or on the temporary disability retired list are often precluded from participating in BDD and Guard and Reserves often separate at locations where BDD is not available. We believe that BDD should be available to virtually all separating servicemembers, including Guard and Reserves.

One cause for delay in claims processing even in the BDD process is availability of the DD–214 discharge document. Our Commission recommends that DOD immediately provide VA with an authenticated electronic document so that processing can begin right away.

IT COMPATIBILITY

All of the reports address the absolute necessity for VA and DOD to have compatible information systems. All recognize the importance of this capability but also recognize that this will not solve all problems.

Much has been said over the past several years about "seamless transition." This is an admirable goal but it is not a current reality. Not all of DOD's medical and personnel records are electronic and those that are electronic are not yet fully compatible between the Services, much less between VA and DOD. The AHLTA and VistA systems are not compatible. AHLTA may provide a more modern platform than VistA, but significant functions in the older VA system are not available to DOD users. For example, inpatient discharge summaries and digital images are not yet available in AHLTA. Therefore, DOD cannot easily transfer these types of information to VA upon a servicemember's discharge or transfer for medical care without paper copies first being scanned. In January 2007, VA and DOD announced an agreement to create a joint inpatient electronic record that would be instantly accessible to clinicians in both departments. As far as we know, the departments have not committed to a completion date although the Nicholson Task Force identified January 31, 2008 as the date for completion of an analysis of alternatives.

Veterans Benefits Administration continues to use paper claims folders and has no long-term plan to convert them to electronic records. Both VA and DOD will have to continue to use paper records well into the future. Plans need to be made to convert existing paper records and finally be able to exclusively use electronic records at some time in the future.

Our Commission believes that development and implementation of compatible information systems should be expedited. We also agree with the Government Accountability Office that a detailed project management plan should be developed with a lead agent designated and with specific milestones and planned completion

dates. We understand why the departments are reluctant to establish planned completion dates since they will be expected to achieve those goals. However, we believe that planned completion dates for specific actions are absolutely essential in order to estimate resource requirements and to monitor progress.

Compatible electronic systems will greatly enhance the ability of both departments to share information and work together. This critical interface will also improve claims processing and avoid some of the unfortunate cases that "slip through the cracks" during the transition from VA to DOD.

In conclusion, VA and DOD have much to gain by greater coordination and collaboration but servicemembers and veterans have even more to gain by the two departments working better together. A lot of valuable work has been done by VA and DOD and they should be commended for the progress made. However, a great deal of work remains and the only way that the goal of a reasonably seamless transition will ever be realized is if the two departments are required to develop realistic, yet challenging, goals with specific milestones. Joint ventures, sharing agreements, and integrations should be the norm rather than the exception. Congress should review the plan and oversee progress. Congress also has the responsibility to ensure that sufficient funding is provided to accomplish the goals and objectives contained in the plan.

Veterans' Disability Benefits Commission

Table 1.—Commission/Task Force Comparisons: Primary Topics and Areas of Overlap

Study Group Topic	Veterans' Disability Benefits Commission	Independent Review Group	GWOT Task Force	PCCWW
VA/DOD Disability Process.	Realign disability evaluation process—Services determine fitness for duty, VA rates disability.	DOD should overhaul the DES system by implementing a single physical exam (as described by GAO 2004). The services should consistently be determining fitness for duty & VA provides disability rating. DOD should also expand the Disability Advisory Council, Conduct quality assurance reviews on previous 0–20 percent & EPTS cases, Evaluate loss of function due to burns similar to amputation.	Joint process whereby VA/DOD cooperate in assigning a disability evaluation, determining fitness for retention, level of disability retirement & VA compensation.	Restructure disability & compensation systems—DOD/VA should create a single, comprehensive standardized medical exam that DOD administers, DOD maintains authority over fitness & pays for years of service while VA establishes rating, compensation & benefits.
Case Management	Intensive case management with an identifiable lead agent.	Create tri-Service policy & guidelines for case management services & training, Assign single primary care physician & case manager.	System of case & co-management.	Comprehensive Recovery Plans & Coordinators with HHS as lead.
Family Support	Authorize VA to provide family services, Extend health care & allowance to caregivers, Eliminate SBP–DIC offset, Eliminate TRICARE co-pays & deductibles for severely injured families.	Provide family education on benefits, Survey families on their needs, Assign family advocates.	None	Strengthen support for families through TRICARE Respite Care & Aid and Attendant Benefit,* Caregiver training, Extend FMLA for 6 months, All combat-related injured families should have full TRICARE coverage.

Veterans' Disability Benefits Commission—Continued

Table 1.—Commission/Task Force Comparisons: Primary Topics and Areas of Overlap

Study Group Topic	Veterans' Disability Benefits Commission	Independent Review Group	GWOT Task Force	PCCWW
IT Compatibility	Expedite development & implementation of compatible information systems with a detailed plan, milestones, & lead agency, Use IT to improve claims cycle time.	Streamline transition by rapidly developing a standard automated system interface for a bilateral exchange of clinical and administrative info between DOD & VA (Described in 2003 PTF).	Enhance VA computerized Patient Record System & electronic enrollment, VA needs to develop a patient tracking application compatible with DOD, Create a TBI database, Improve VA's access to military health records & create an interface with DOD, Create OIF/OEF identifiers and markers for polytrauma, Improve IT interoperability between VA & HHS Indian Health Services.	Rapidly transfer patient information, Create a MyeBenefits Web site.
PTSD	Holistic approach that couples treatment, rehabilitation, compensation & re-evaluation for wellness, Revise Rating Schedule for PTSD, Baseline level of benefits, PTSD exam process, Examiner & rater training & certification, research on Military Sexual Trauma.	Functional/cognitive measures & screenings upon entry & post-deployment, comprehensive & universal clinical practice & coding guidelines for blast injuries and TBI with PTSD overlay to include recording of exposures to blast in patient record. VA/DOD create center of excellence for TBI and PTSD treatment, research & training.	Provide Outreach & Education to Community Health Centers on VA benefits & services (to reach vets with PTSD).	VA should care for all OIF/OEF vets with PTSD & (with DOD) improve prevention, diagnosis & treatment, reduce PTSD stigma. DOD should address its mental health shortage, Disseminate clinical practice guidelines to all providers.
TBI	Update the Rating Schedule for TBI.	Functional/cognitive measures & screenings upon entry & post-deployment, comprehensive & universal clinical practice & coding guidelines for blast injuries and TBI with PTSD overlay to include recording of exposures to blast in patient record. VA/DOD create center of excellence for TBI and PTSD treatment, research & training.	Screen all GWOT veterans for TBI.	DOD/VA should prevent, diagnose, & treat TBI, Partner with the private sector on TBI care, Disseminate clinical practice guidelines to all providers.

Veterans' Disability Benefits Commission—Continued

Table 1.—Commission/Task Force Comparisons: Primary Topics and Areas of Overlap

Study Group Topic	Veterans' Disability Benefits Commission	Independent Review Group	GWOT Task Force	PCCWW
Ancillary Benefits ..	Adjust & extend A&A, Extend auto & housing allowances to veterans with severe burns, Eliminate TSGLI premiums, Improve SDVI & VMLI, Increase benefits to original intention, Adjust automatically for inflation, Provide a Stabilization Allowance, Research additional ancillary benefits.	DOD should partner with VA to provide treatment, education & research in prosthesis care, production & amputee therapy, Allow VA patients to use Military and private prosthetist.	Expedite Adapted Housing and Special Home Adaptation Grants, Expand HUD National Housing Locator, Enhance capacity to provide Dental care through VA & private sector.	Transition (3 months of base pay or long-term) payments, Earnings-loss payments, All unfit combat-related injured should receive full TRICARE coverage.
Quality of Life	Compensate for 3 consequences: work disability, loss of functionality & QOL, VA develop measures for QOL loss, but in the meantime create up to 25 percent QOL payment, Research health-related QOL & need for additional ancillary benefits, Increase SMC to address impact on QOL.	Survey patients on their needs.	None	Determine appropriate QOL payments.
Vocational Rehabilitation & Employment (VR&E).	Test VR&E incentives, Review & revise 12-year time limit, Expand VR&E to all medically separating servicemembers, & allow all service disabled veterans access to VR&E counseling, VR&E should screen all IU applicants, increase VR&E staffing, tracking, & resources.	None	Extend VR&E evaluation determination time limit, Expand eligibility for SBA Patriot Express Loans, Increase Career Fairs & integrate Hire Vets First Campaign, Provide Credentialing, Certification, Financial Aid Education Assistance, & Employment rights, Develop Wounded Warrior Intern & Wounded Veterans Readjustment Work Experience Programs.	VR&E effectiveness is not well established and should offer completion incentives of up to a 25 percent bonus.
Concurrent Receipt	Eliminate the ban	None	None	Create a DOD Annuity payment based on rank & years of service.
Hazards & Exposures.	Create a new structure for Presumption based on casual relationship using four categories.	None	Create an embedded Fragment Surveillance Center and Registry.	None.

Veterans' Disability Benefits Commission—Continued

Table 1.—Commission/Task Force Comparisons: Primary Topics and Areas of Overlap

Study Group Topic	Veterans' Disability Benefits Commission	Independent Review Group	GWOT Task Force	PCCWW
Combat/Combat-Related.	Benefits based on severity of disability, not on circumstances or location.	None	None	Benefits and process specifically for combat/combat-related injuries only.
Social Security/Disability Compensation for Earnings.	Compensation for earnings loss continues for life.			Compensation for Earnings Ends when retirement Social Security begins.
Walter Reed National Military Medical Center (WRNMMC).	None	Accelerate BRAC construction projects for WRNMMC & new complex at Belvoir, New command and control structure for WRNMMC, Apply regulatory relief to A–76 process, Survey patients & families, Staff & train Med Hold(over) personnel, reevaluate efficiency wedge, Assign a senior facility engineer to oversee non-medical maintenance, Modernize facility assessment tools & prioritize repairs.	None	Recruit & retain first-rate professionals for WRAMC through 2011 with resources and incentives to hire civilian health care professionals & admin staff.

*This refers to the Aid and Attendant benefit under TRICARE's Extended Care Health Option, and not VA's Aid and Attendance benefit.

Table 2.—Other Veterans' Commissions & Task Forces: Purposes, Findings and Recommendations

Entity	Chairperson	Charged by	Purpose	Report Date	Findings & Recommendations
IRG on Rehabilitative Care & Admin @ Walter Reed & National Naval (Bethesda).	Former VA Secretary Togo West & Former Army Secretary & Congressman John Marsh.	Secretary of Defense.	Review continuum of care, leadership & oversight issues resulting in deficiencies reported at Walter Reed Scope: Walter Reed patients & families.	4/11/07	Problems resulted from a failure of leadership, loss of resources & spending authority under BRAC, contracting out, nursing and other staff shortages, challenges of signature injuries, & failure of the Medical Holdover system. Other reports have recommended changes to the MEB/PEB process over the last 10 years, but none have been implemented, which the IRG endorsed as well as a combined DOD/VA evaluation system.

Table 2.—Other Veterans' Commissions & Task Forces: Purposes, Findings and Recommendations—Continued

Entity	Chairperson	Charged by	Purpose	Report Date	Findings & Recommendations
Task Force on Returning Global War on Terror (GWOT) Heroes.	R. James Nicholson, Secretary of Veterans Affairs.	Executive Order of the President.	Improve the delivery of Federal services and benefits to GWOT servicemembers & veterans. Scope: All GWOT servicemembers & veterans.	4/19/07	There were 25 recommendations. Action areas included health care, case management, continuity of care, TBI screening, VA Liaisons at military facilities, small business loans, education, career training, employment rights, financial aid, housing locator, electronic tracking between systems, dental, rural health, VA/DOD joint disability process & exams, VR&E extension, & home adaptation. Recommendations can be accomplished within existing authority & resources. Outreach should cover TAP/DTAP attendance, job fairs, vets preference, & a GWOT newsletter, comprehensive database of Federal services & benefits.
President's Commission on Care for America's Returning Wounded Warriors (PCCWW).	Former Senator Bob Dole & Former HHS Secretary Donna Shalala.	Executive Order of the President.	Recommend Improvements for transition, high-quality services for returning wounded troops, access to benefits & services. Scope: Wounded OIF/OEF servicemembers, veterans, families.	7/25/07	There were 6 recommendations: (1) Immediately creating a comprehensive recovery plan with a lead Recovery Coordinator; (2) Completely restructure the disability systems so DOD determines fitness and VA disability benefits; (3) Aggressively prevent & treat PTSD & TBI; (4) Significantly strengthen support for families with amendments to TRICARE & FMLA; (5) Rapidly transfer patient info, & develop a Federal benefits Web site, and; (6) Strongly support Walter Reed by recruiting & retaining 1st-rate professionals through 2011.

Table 2.—Other Veterans' Commissions & Task Forces: Purposes, Findings and Recommendations—Continued

Entity	Chairperson	Charged by	Purpose	Report Date	Findings & Recommendations
Veterans' Disability Benefits Commission.	LTG James Terry Scott (USA, Ret.).	PL 108–136 ..	Appropriateness of Benefit, level of Benefit, Determination Standards. Scope: All disabled servicemembers, veterans, families.	10/3/07	113 recommendations that focused on: compensation for quality of life & a 25 percent allowance until VA develops measures; line of duty; earnings disparity for service connected veterans with mental disorders & young entry; VA Rating Schedule revisions, especially for PTSD, TBI, & IU; A holistic approach for PTSD that couples compensation, treatment, rehabilitation, & re-evaluation; caregiver health care & an allowance; presumption standards for exposures; DOD disability evaluations and separation exams with Services determining fitness for duty & VA adjudicating a rating; concurrent receipt and survivor concurrent receipt; IT interoperability; & joint ventures, sharing agreements, & integration.

* Final report.

Table 3.—Total Recommendations

Veterans' Disability Benefits Commission	Independent Review Group	GWOT Task Force	PCCWW
113	20	25	6

* 23 action items.

Executive Summary

The Veterans' Disability Benefits Commission was established by Public Law 108–136, the National Defense Authorization Act of 2004. Between May 2005 and October 2007, the Commission conducted an in-depth analysis of the benefits and services available to veterans, servicemembers, their survivors, and their families to compensate and provide assistance for the effects of disabilities and deaths attributable to military service. The Department of Veterans Affairs (VA) expended $40.5 billion on the wide array of these benefits and services in fiscal year 2006. The Commission addressed the appropriateness and purpose of benefits, benefit levels and payment rates, and the processes and procedures used to determine eligibility. The Commission reviewed past studies on these subjects, the legislative history of the benefit programs, and related issues that have been debated repeatedly over many decades.

Congress created the Commission out of concern for a variety of issues pertinent to disabled veterans, disabled servicemembers, their survivors, and their families. Those matters included care for severely injured servicemembers, treatment and compensation for Post Traumatic Stress Disorder (PTSD), the concurrent receipt of military retired pay and disability compensation, the timeliness of processing dis-

abled veterans' claims for benefits, and the size of the backlog of those claims. Another area of concern was the program known as Individual Unemployability, which allows veterans with severe service-connected disabilities to receive benefits at the highest possible rate if their disabilities prevent them from working. The Commission gave these issues special attention.

The Commission received extensive analytical support from the CNA Corporation (CNAC), a well-known research and consulting organization. CNAC performed an in-depth economic analysis of the average impairment of earning capacity resulting from service-connected disabilities. In addition, to assess the impact of disabilities and deaths on quality of life, CNAC conducted surveys of disabled veterans and survivors. To gain insight into claims processing issues, CNAC surveyed raters from VA and representatives of veterans' service organizations who assist veterans in filing claims. CNAC also completed a literature review and a comparative analysis of disability programs similar to those provided by VA.

The Commission received expert medical advice from the Institute of Medicine (IOM) of the National Academies. Required by statute to consult with IOM, the Commission asked the institute to conduct a thorough analysis of the VA Schedule for Rating Disabilities (hereafter the Rating Schedule) and a study of the processes used to decide whether one may presume that a disability is connected to military service. In addition, the Commission examined two studies that IOM conducted for VA about the diagnosis of PTSD and compensation to veterans for that disorder. Unfortunately, a third IOM study—of the treatment of PTSD—was not completed in time to be considered by the Commission. Additionally, the Commission conducted eight field visits and held numerous public sessions.

GUIDING PRINCIPLES

The Commission wrestled with philosophical and moral questions about how a Nation cares for disabled veterans and their survivors and how it expresses its gratitude for their sacrifices. The Commission agreed that the United States has a solemn obligation, expressed so eloquently by President Lincoln, ". . . to care for him who shall have borne the battle, and for his widow, and his orphan . . ."[1]

In going about its work, the Commission has been mindful of the 1956 Bradley Commission principles, which have provided a valuable and historic baseline. This Commission's report addresses what has changed and what has endured over those five decades and throughout our Nation's wars and conflicts since the Bradley report. Many of the changes—social, technological, cultural, medical, and economic—that have taken place during that time span are significant and must be carefully considered as our Nation renews its compact with our disabled veterans and their families. This long-term context, a history of both significant change and key elements of constancy from the 1950's to the 21st century, provides the solid basis for this Commission's principles, conclusions, and recommendations.

This Commission identified eight principles that it believes should guide the development and delivery of future benefits for veterans and their families:

1. Benefits should recognize the often enormous sacrifices of military service as a continuing cost of war, and commend military service as the highest obligation of citizenship.
2. The goal of disability benefits should be rehabilitation and reintegration into civilian life to the maximum extent possible and preservation of the veterans' dignity.
3. Benefits should be uniformly based on severity of service-connected disability without regard to the circumstances of the disability (wartime v. peacetime, combat v. training, or geographical location.)
4. Benefits and services should be provided that collectively compensate for the consequence of service-connected disability on the average impairment of earnings capacity, the ability to engage in usual life activities, and quality of life.
5. Benefits and standards for determining benefits should be updated or adapted frequently based on changes in the economic and social impact of disability and impairment, advances in medical knowledge and technology, and the evolving nature of warfare and military service.
6. Benefits should include access to a full range of health care provided at no cost to service-disabled veterans. Priority for care must be based on service connection and degree of disability.

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[1] Lincoln, Abraham, Second Inaugural Address, March 4, 1865, *http://www.ourdocuments.gov/doc.php?flash=true&doc=38.*

7. Funding and resources to adequately meet the needs of service-disabled veterans and their families must be fully provided while being aware of the burden on current and future generations.

8. Benefits to our Nation's service-disabled veterans must be delivered in a consistent, fair, equitable, and timely manner.

With these principles clearly in mind, the Nation must set the firm foundation upon which to shape and evolve a system of appropriate—and generous—benefits for the disabled veterans of tomorrow.

The Commission believes that just as citizens have a duty to serve in the military, the Federal Government has a duty to preserve the well-being and dignity of disabled veterans by facilitating their rehabilitation and reintegration into civilian life. The Commission believes that compensation should be based on the nature and severity of disability, not whether the disability occurred during wartime, combat, training, or overseas. It is virtually impossible to accurately determine a disease's origin or to differentiate the value of sacrifice among veterans whose disabilities are of similar type and severity. Setting different rates of compensation for the same degree of severity would be both impractical and inequitable.

Disabled veterans require a range of services and benefits, including compensation, health care, specially adapted housing and vehicles, insurance, and other services tailored to their special needs. Compensation must help service-disabled veterans achieve parity in earnings with nonservice-disabled veterans. Compensation must also address the impact of disability on quality of life. Money alone is a poor substitute for the consequences of the injuries and disabilities faced by veterans, but it is essential to ease the burdens they experience.

It is the duty of Congress and VA to ensure that the benefits and services for disabled veterans and survivors are adequate and meet their intended outcomes. IOM concluded that the VA Rating Schedule has not been adequately revised since 1945. This situation should *not* be allowed to continue. Systematic updates to the Rating Schedule and assessments of the appropriateness of the level of benefits should be made on a frequent basis.

Excellent health care should be provided in a timely manner at no cost to veterans with service-connected disabilities (i.e., service-disabled veterans) and, in the case of severely injured veterans, to their families and caregivers.

The funding and resources necessary to fully support programs for service-disabled veterans must be sufficient while ensuring that the burden on the Nation is reasonable. Care and benefits for service-disabled veterans are a cost of maintaining a military force during peacetime and of fighting wars. Benefits and services must be provided promptly and equitably.

RESULTS OF THE COMMISSION'S ANALYSIS

The analyses conducted by the Commission with the assistance of IOM and CNAC provide a consistent and complementary picture of many aspects of veterans' disability compensation.

ENSURE HORIZONTAL AND VERTICAL EQUITY

For veterans to receive proper compensation for their service-connected disabilities, the VA Rating Schedule must be designed so that ratings result in horizontal and vertical equity in terms of compensation for average impairments of earning capacity. Horizontal equity means that persons with the same ratings percentage should have experienced the same loss of earning capacity. Vertical equity means that loss of earning capacity should increase in proportion to an increase in the degree of disability. A comparison of the earnings of disabled veterans with those of veterans who lacked service-connected disabilities revealed that the average amount of earnings lost by disabled veterans generally increased as disability ratings increased. In addition, mortality rates rose with degree of disability. Thus, vertical equity is achieved. The average earnings loss was similar across different types of disabilities except for PTSD and other mental disorders, indicating that horizontal equity also is generally being achieved at the level of body systems.

ENSURE PARITY WITH NONDISABLED VETERANS

Overall, disabled veterans who first apply to VA for compensation at age 55 (the average age) receive amounts of money that are nearly equal to their average loss of earnings as a consequence of their disabilities among the broad spectrum of physical disabilities.

The earnings of a representative sample of nondisabled veterans were compared with the sum of earnings plus compensation of disabled veterans to determine the

extent to which disability compensation helps disabled veterans achieve parity with their nondisabled counterparts. Among veterans whose primary disabilities are physical, those who are granted Individual Unemployability are substantially below parity; those who are rated 100 percent disabled and who enter the system at a younger age (45 years or less) are slightly below parity; and those who enter at age 65 or older are above parity. For those whose primary disabilities are mental, the sum of earnings plus VA compensation is generally below parity at average age of entry, substantially below parity for severely disabled individuals who enter the system at a younger age, and above parity for those who enter at age 65 or older. Also, among veterans whose primary disabilities are mental, those rated 10 percent disabled are slightly below parity. Thus, parity is generally present with respect to earnings loss except among individuals whose primary disabilities are mental, among the younger severely disabled, and among those granted Individual Unemployability.

COMPENSATE FOR LOSS OF QUALITY OF LIFE

Parity in average loss of earnings means that disability compensation does not compensate veterans for the adverse impact of their disabilities on quality of life.

Current law requires only that the VA Rating Schedule compensate service-disabled veterans for average impairment of earning capacity. However, the Commission concluded early in its deliberations that VA disability compensation should recompense veterans not only for average impairments of earning capacity, but also for their inability to participate in usual life activities and for the impact of their disabilities on quality of life. IOM reached the same conclusion; moreover, it made extensive recommendations on steps to develop and implement a methodology to evaluate the impact of disabilities on veterans' quality of life and to provide appropriate compensation.

The Commission concluded that the VA Rating Schedule should be revised to include compensation for the impact of service-connected disabilities on quality of life. For some veterans, quality of life is addressed in a limited fashion by special monthly compensation for loss of limbs or loss of use of limbs. Some ancillary benefits attempt to ameliorate the impact of disability. However, the Commission urges Congress to consider increases in some special monthly compensation awards to address the profound impact of certain disabilities on quality of life and to assess whether other ancillary benefits might be appropriate. While a recommended systematic methodology is developed for evaluating and compensating for the impact of disability on quality of life, the Commission believes that an immediate interim increase of up to 25 percent of compensation should be enacted.

A survey of a representative sample of disabled veterans and survivors was conducted to assess their quality of life and other issues. The survey found that among veterans whose primary disability is physical, their physical health is inferior to that of the general population for all levels of disability, and their physical health generally worsens as their level of disability increases. Physical disabilities did not lead to decreased mental health. For veterans whose primary disability is mental, not only were their mental health scores much lower than those of the general population, but their physical health scores were well below population norms for all levels of mental disability. Those veterans with PTSD had the lowest physical health scores.

The survey also sought to address two specific issues through indirect questions. There are concerns that service-disabled veterans tend not to follow medical treatments because they fear it might impact their disability benefits. This premise was not substantiated. Likewise, when questioned whether VA benefits created a disincentive to work, only 12 percent of respondents indicated they might work or work more if not for compensation benefits; thus, this is not a major issue.

UPDATE THE RATING SCHEDULE

The Rating Schedule consists of slightly more than 700 diagnostic codes organized under 14 body systems, such as the musculoskeletal system, organs of special sense, and mental disorders. For each code, the schedule provides criteria for assigning a percentage rating. The criteria are primarily based on loss or loss of function of a body part or system, as verified by medical evidence; however, the criteria for mental disorders are based on the individual's "social and industrial inadaptability," meaning the overall ability to function in the workplace and everyday life.

IOM concluded that it has been 62 years since the VA Rating Schedule was adequately revised and made a series of recommendations for immediately updating the Rating Schedule and requiring that it be revised on a systematic and frequent basis. The Commission generally agrees with these recommendations; however, the Com-

mission does not agree that the revision should begin with those body systems that have not been revised for the longest time period. Rather, the Commission recommends that first priority be given to revising the mental health and neurological body systems to expeditiously address PTSD, other mental disorders, and Traumatic Brain Injury. A quick review by VA of the Rating Schedule could be completed to determine the sequence in which the other body systems should be addressed, and a timeline should be developed for completing the revision.

To emphasize the importance and urgency of revising the Rating Schedule, the Commission urges Congress to require that the entire schedule be reviewed and updated as needed over the next 5 years. Congress should monitor progress carefully. Thereafter, the Rating Schedule should be reviewed and updated on a frequent basis.

INDIVIDUAL UNEMPLOYABILITY

The Individual Unemployability (IU) program enables a veteran rated 60 percent or more but less than 100 percent to receive benefits at the 100 percent rate if he or she is unable to work because of service-connected disabilities. IU has received considerable attention recently because the number of veterans granted IU increased by 90 percent. The Commission found this increase to be explained by the aging of the cohort of Vietnam veterans.

DEVELOP PTSD-SPECIFIC RATING CRITERIA AND IMPROVE PTSD TREATMENT

Concerning PTSD and other mental disorders, it is very clear that having one set of criteria for rating all mental disorders has been ineffective. IOM recommended separate criteria for PTSD. Similarly, the CNAC survey of VA raters found that raters believe separate criteria for PTSD would enable them to rate PTSD claims more effectively. In addition, the earnings analysis described above demonstrates that there is a disparity in earnings of those with PTSD and other mental disorders and that the current scheme for rating all mental disorders in five categories of severity—10, 30, 50, 70, and 100 percent—does not result in adequate compensation. It is also unclear why 31 percent of those with PTSD as their primary diagnosis are granted IU, especially since incapacity to work is part of the current criteria for granting 100 percent for PTSD and other mental disorders. It would seem that many of these veterans should be awarded 100 percent ratings without IU. The Commission agrees with the IOM recommendation that new Rating Schedule criteria specific to PTSD should be developed and implemented based on criteria from the Diagnostic and Statistical Manual of Mental Disorders.

The Commission believes that a new, holistic approach to PTSD should be considered. This approach should couple PTSD treatment, compensation, and vocational assessment. The Commission believes that PTSD is treatable, that it frequently recurs and remits, and that veterans with PTSD would be better served by a new approach to their care. There is little interaction between the Veterans Health Administration, which examines veterans for evaluation of severity of symptoms and treats veterans with PTSD, and the Veterans Benefits Administration, which assigns disability ratings and may or may not require periodic reexamination. It is evident that PTSD reexaminations have been scheduled with less frequency in recent years due to the backlog of disability claims. It is also evident that case management of PTSD patients could be improved through greater interaction between the therapy received in Vet Centers and treatment in VA medical centers. IOM concluded that the use of standardized testing and the frequency of reexaminations should be recommended by clinicians on a case-by-case basis, but did not suggest how that would be achieved. The Commission suggests that treatment should be required and its effectiveness assessed to promote wellness of the veteran. Reexaminations should be scheduled and conducted every 2 to 3 years.

IMPROVE PERFORMANCE OF VOCATIONAL REHABILITATION AND EMPLOYMENT

The Commission believes that the goal of disability benefits, as expressed in guiding principle 2, is not being met. In spite of the studies done and recommendations made in recent years, the Vocational Rehabilitation and Employment (VR&E) program is not accomplishing its primary goal. The Commission believes that recent studies have provided the necessary analyses and that VA possesses the necessary expertise to remedy this failure. Simply put, VA must develop specific plans and Congress must provide the resources to quickly elevate the performance of VR&E.

ALLOW CONCURRENT RECEIPT

The Commission carefully reviewed whether disabled veterans should be permitted to receive both military retirement benefits and VA disability compensation. The Commission also reviewed whether the survivors of veterans who die either on active duty or as a result of a service-connected disability should be allowed to receive both Department of Defense (DOD) Survivor Benefit Plan (SBP) and VA Dependency and Indemnity Compensation (DIC). Currently, military retirees with service-connected disabilities rated 50 percent or higher are authorized to receive both benefits, which are being phased in over the next few years. Survivors are not authorized to receive both benefits. The Commission is persuaded that these programs have unique intents and purposes: military retirement benefits and SBP are intended to compensate for years of service, while VA disability compensation and DIC are intended to compensate for disability or death attributable to military service. It should be permissible to receive both sets of benefits concurrently.

In addition, the Commission believes that those separated as medically unfit with less than 20 years of service should also be able to receive military retirement and VA compensation without offset. Currently, those receiving ratings of less than 30 percent from DOD receive separation pay, which must be paid back through deductions from VA compensation for the unfitting conditions before VA compensation is received. Those receiving DOD ratings of 30 percent or higher and a continuing disability retirement have their DOD payments offset by any VA compensation. Priority among medical discharges should be given to those separated or retired with less than 20 years of service and disability rating greater than 50 percent or disability as a result of combat.

ALLOW YOUNG, SEVERELY INJURED VETERANS TO RECEIVE SOCIAL SECURITY DISABILITY INSURANCE

Among the benefits available for disabled veterans, those not able to work may be eligible for Social Security Disability Insurance (SSDI). To be eligible for SSDI, an individual must have worked a minimum number of quarters, be unable to work because of medical conditions, not have income above a minimum level, and be less than 65 years of age. At 65, SSDI converts to normal Social Security at the same amount. Some very young servicemembers who are severely injured may not have sufficient quarters to qualify for SSDI. The Commission recommends eliminating the minimum quarters requirement for the severely injured. Only 61 percent of those granted IU by VA and 54 percent of those rated 100 percent by VA are receiving SSDI. Considering the very low earnings by those rated 100 percent and the exceptionally low earnings of those granted IU, it is apparent that either these veterans do not know to apply for SSDI or are being denied the insurance. Increased outreach should be made and better coordination between VA and Social Security should result in increased mutual acceptance of decisions.

REALIGN THE VA–DOD PROCESS FOR RATING DISABILITIES

The Commission also assessed the consistency of ratings by DOD and VA on individuals found unfit for military service by DOD under 10 U.S.C. chapter 61. Some 83,000 servicemembers were found unfit between 2000 and 2006. DOD rated 81 percent of those individuals as less than 30 percent and discharged them with severance pay, including over 13,000 who were found unfit by the Army and given zero percent ratings. 79% of these servicemembers later filed claims with VA and received substantially higher ratings. The reasons for the higher ratings are that VA rates about three more conditions than DOD, and at the individual diagnosis level VA assigns higher ratings than DOD.

The Commission finds that the policies and procedures used by VA and DOD are not consistent and the resulting dual systems are not in the best interest of the injured servicemembers nor the Nation. Existing practices that allow servicemembers to be found unfit for pre-existing conditions after up to 8 years of active duty and that allow DOD to rate only the conditions that DOD finds unfitting should be reexamined. Servicemembers being considered unfit should be given a single, comprehensive examination and all identified conditions should be rated and compensated.

The Commission agrees with the President's Commission on the Care of Returning Wounded Warriors that the DOD and VA disability evaluation process should be realigned so that the military determines if the servicemember is unfit for service and awards continuing payment for years of service and health care coverage for the family while VA pays disability compensation. However, in accordance with one of our key guiding principles, the Commission believes that benefits should not be

limited to combat and combat-related injuries. Nor does the Commission believe that VA disability compensation should end and be replaced with Social Security at retirement age.

LINK BENEFITS TO COST-OF-LIVING INCREASES

In its review, the Commission found that the ancillary and special-purpose benefits payments and award limits are not automatically indexed to cost of living. A few of these benefits have not been increased in many years, and as a result, some no longer meet the original intent of Congress. The Commission recommends that Congress raise ancillary and special-purpose benefits to the levels originally intended and provide for automatic annual adjustments to keep pace with the cost of living.

SIMPLIFY AND EXPEDITE THE PROCESSING OF DISABILITY CLAIMS AND APPEALS

VA disability benefits and services are not currently provided in a timely manner. Court decisions, statutory changes, and resource limitations have all contributed to this unacceptable situation. Numerous studies over the years have assessed the processing of both claims and appeals and have made numerous recommendations for change. Still, veterans seeking disability compensation face a complex process. The population of veterans is steadily decreasing with the passing of veterans of World War II and the Korean War. Yet, the aging of the Vietnam Era veterans means that they are filing original and reopened claims in large numbers. Technology offers opportunities for improvement, but it is unlikely to solve all problems. The Commission believes that increased reliance on best business practices and maximum use of information technology should be coupled with a simplified and expedited process for well-documented claims to improve timeliness and reduce the backlog. The Commission is aware that a significant increase in claims processing staff has been recently approved but is also aware that the time required for training and the slow development of job experience will limit the speed with which results can realistically occur.

The Commission believes that claimants should be allowed to state that claim information submitted is complete and waive the normal 60-day timeframe permitted for further development.

IMPROVE TRANSITION ASSISTANCE

A smooth transition from military to civilian status is crucial for veterans and their families to quickly adjust to civilian life. This goal, often expressed as "seamless transition," has yet to be fully realized, although VA and DOD have made significant improvements during the past few years. The two departments' medical and other systems are not truly compatible, and both departments will have to rely on paper records for many years. Perhaps the single most important step that can be taken to assist veterans, particularly those who are disabled and their families, and to reduce the lengthy delays plaguing claims processing would be to achieve electronic compatibility. In addition, the Commission believes that making VA benefit payments effective the day after discharge will help ease the financial aspect of transition.

IMPROVE SUPPORT FOR SEVERELY DISABLED VETERANS AND THEIR CAREGIVERS

Severely disabled servicemembers who are about to transition into civilian life need far more support and assistance than is currently provided. An effective case management program should be established with a clearly identified lead agent who has authority and responsibility to intercede on behalf of disabled individuals. The lead agent should be an advocate for servicemembers and their families. In addition, VA should be authorized to provide family assistance similar to that provided by DOD up until discharge. TRICARE deductibles and copays are costs incurred by the severely disabled; the Commission believes that these costs should be waived. In addition, consideration should be given to expanding health care and providing an allowance for caregivers of the severely disabled. Currently, health care is only provided for the dependents of severely disabled veterans but not for parents and other family members who are caregivers.

IMPLEMENT A NEW PROCESS FOR DETERMINING PRESUMPTION

Various processes have been used to create presumptions when there are uncertainties as to whether a disabling condition is caused by military service. Presumptions are established when there is evidence that a condition is experienced by a sufficient cohort of veterans and it is reasonable to presume that all veterans in that

cohort who experience the condition acquired the condition due to military service. The Commission asked IOM to review the processes used in the past to establish presumptions and to recommend a framework that would rely on more scientific principles. IOM conducted an extensive analysis and recommended a detailed and comprehensive approach that includes the creation of an advisory committee and a scientific review board, formalizing the process and making it transparent, improving research, and tracking military troop locations and environmental exposures. Perhaps most importantly, the approach includes using a causal effect standard for decisionmaking rather than a less-precise statistical association. The Commission endorses the recommendations of the IOM but expresses concern about the causal effect standard. Consideration should also be given to combining the advisory committee on presumptions with the recommended advisory committee on the Rating Schedule.

CONCLUSION

The Commission made 113 recommendations. All are important and should receive attention from Congress, DOD, and VA. The Commission suggests that the following recommendations receive immediate consideration. Congress should establish an executive oversight group to ensure timely and effective implementation of the Commission recommendations.

PRIORITY RECOMMENDATIONS

Recommendation 4.23—Chapter 4, Section I.5

VA should immediately begin to update the current Rating Schedule, beginning with those body systems addressing the evaluation and rating of Post Traumatic Stress Disorder and other mental disorders and of Traumatic Brain Injury. Then proceed through the other body systems until the Rating Schedule has been comprehensively revised. The revision process should be completed within 5 years. VA should create a system for keeping the Rating Schedule up to date, including a published schedule for revising each body system.

Recommendation 5.28—Chapter 5, Section III.3

VA should develop and implement new criteria specific to Post Traumatic Stress Disorder in the VA Schedule for Rating Disabilities. VA should base those criteria on the Diagnostic and Statistical Manual of Mental Disorders and should consider a multidimensional framework for characterizing disability due to Post Traumatic Stress Disorder.

Recommendation 5.30—Chapter 5, Section III.3

VA should establish a holistic approach that couples Post Traumatic Stress Disorder treatment, compensation, and vocational assessment. Reevaluation should occur every 2–3 years to gauge treatment effectiveness and encourage wellness.

Recommendation 6.14—Chapter 6, Section IV.2

Congress should eliminate the ban on concurrent receipt for all military retirees and for all servicemembers who separated from the military due to service-connected disabilities. In the future, priority should be given to veterans who separated or retired from the military under chapter 61 with

- fewer than 20 years service and a service-connected disability rating greater than 50 percent, or
- disability as a result of combat.

Recommendation 7.4—Chapter 7, Section II.3

Eligibility for Individual Unemployability (IU) should be consistently based on the impact of an individual's service-connected disabilities, in combination with education, employment history, and medical effects of an individual's age or potential employability. VA should implement a periodic and comprehensive evaluation of veterans eligible for IU. Authorize a gradual reduction in compensation for IU recipients who are able to return to substantially gainful employment rather than abruptly terminating disability payments at an arbitrary level of earning.

Recommendation 7.5—Chapter 7, Section II.3

Recognizing that Individual Unemployability (IU) is an attempt to accommodate individuals with multiple lesser ratings but who remain unable to work, the Commission recommends that as the VA Schedule for Rating Disabilities is revised, every effort should be made to accommodate such individuals fairly within the basic rating system without the need for an IU rating.

Recommendation 7.6—Chapter 7, Section III.2

Congress should increase the compensation rates up to 25 percent as an interim and baseline future benefit for loss of quality of life, pending development and implementation of a quality-of-life measure in the Rating Schedule. In particular, the measure should take into account the quality of life and other non-work-related effects of severe disabilities on veterans and family members.

Recommendation 7.8—Chapter 7, Section III.2

Congress should consider increasing special monthly compensation, where appropriate, to address the more profound impact on quality of life of the disabilities subject to special monthly compensation. Congress should also review ancillary benefits to determine where additional benefits could improve disabled veterans' quality of life.

Recommendation 7.12—Chapter 7, Section VI

VA and DOD should realign the disability evaluation process so that the services determine fitness for duty, and servicemembers who are found unfit are referred to VA for disability rating. All conditions that are identified as part of a single, comprehensive medical examination should be rated and compensated.

Recommendation 7.13—Chapter 7, Section V.3

Congress should enact legislation that brings ancillary and special-purpose benefits to the levels originally intended, considering the cost of living, and provides for automatic annual adjustments to keep pace with the cost of living.

Recommendation 8.2—Chapter 8, Section III.1.B

Congress should eliminate the Survivor Benefit Plan/Dependency and Indemnity Compensation offset for survivors of retirees and in-service deaths.

Recommendation 9.1—Chapter 9, Section II.5.A.b

Improve claims cycle time by

• establishing a simplified and expedited process for well-documented claims, using best business practices and maximum feasible use of information technology; and

• implementing an expedited process by which the claimant can state the claim information is complete and waive the time period (60 days) allowed for further development.

Congress should mandate and provide appropriate resources to reduce the VA claims backlog by 50 percent within 2 years.

Recommendation 10.11—Chapter 10, Section VII

VA and DOD should expedite development and implementation of compatible information systems including a detailed project management plan that includes specific milestones and lead agency assignment.

Recommendation 11.1—Chapter 11

Congress should establish an executive oversight group to ensure timely and effective implementation of the Commission's recommendations. This group should be cochaired by VA and DOD and consist of senior representatives from appropriate departments and agencies. It is further recommended that the Veterans' Affairs Committees hold hearings and require annual reports to measure and assess progress.

One commissioner submitted a statement of separate views regarding four aspects of the report. His statement is in Appendix L.

ADDITIONAL RESOURCES:

Electronic access to the complete report of the Veterans' Disability Benefits Commission is available at: *http://www.vetscommission.org*

Also available on the Commission's Web site are:

• *Bios* of the Commissioners
• *Commission Charter*
• *Commission Charter* (renewed, 2–21–2007)
• *Public Law 108–136* establishing the Commission
• *Extension* of the Commission's Charter in Public Law 109–163
• *Legislative History* of VA Disability Compensation Program, Economic Systems Inc., Dec 2004
• *Appendices* to the Legislative History (Dec 2004)
• *Literature Review* of VA Disability Compensation Program, Economic Systems Inc., Dec 2004
• *Appendices* to the Literature Review (Dec 2004)

• Commission's *Approved Research Questions*, October 14, 2005
• Institute of Medicine *(IOM) Summary of the PTSD Review* contracted by the Veterans Health Administration, Mar 2006
• *A History and Analysis of Presumptions of Service Connection (1921–1993)*
• An Updated Legal Analysis of Presumptions of Service Connection (*1993–2006*)
• Center for Naval Analyses *(CNA) Literature Review* (Final), May 2006
• *Appendix* to the CNA Literature Review (Final), May 2006
• *Veterans' Claims Adjudication Commission (VCAC)*, also known as the Melidosian Commission Report (1996)
• *Blue Ribbon Panel on Claims Processing:* Proposals to Improve Disability Claims Processing in the Veterans Benefits Administration, November 1993
• *Bradley Commission Report* 1956
• IOM Report to VA on *Post Traumatic Stress Disorder: Diagnosis and Assessment, 2006*
• *Testimony of Chairman Scott* at a Joint Hearing of the Senate Armed Services & Veterans' Affairs Committees, April 12, 2007
• CNA Report: *Findings from Raters and VSOs Surveys*, May 2007
• IOM Report to VA on *PTSD Compensation and Military Service*, 2007
• *A 21st Century System for Evaluating Veterans for Disability Benefits*, IOM Final Report, June 2007
• *Improving the Presumptive Disability Decision-Making Process for Veterans*, IOM Final Report, and *Executive Summary* August 2007
• CNA Final Report: *Final Report for the Veterans' Disability Benefits Commission: Compensation, Survey Results and Selected Topics*, August 2007

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO JAMES TERRY SCOTT, LTG, USA (RET.), CHAIRMAN, VETERANS' DISABILITY BENEFITS COMMISSION

Before addressing the specific questions asked, I would like to make it clear that my comments are my own and do not represent the views of the other members of the Commission. The Commission completed its work and submitted its report on October 3, 2007.

DIFFERENCES IN RECOMMENDATIONS

Question. Please compare your Commisson's recommendation to provide a quality of life payment as part of disability compensation with the Dole-Shalala commission's recommendation to revamp the entire disability system?

Response. First, it is important to emphasize the results of the overall analysis that the Veterans' Disability Benefits Commission conducted of the entire VA and DOD system for determining compensation for injuries, diseases, and deaths attributable to military service. Our Commission addressed the entire system, not just how the system addresses those found unfit for military duty As a result of our comprehensive analysis, we made a series of broad recommendations intended to significantly improve the existing system, including a realignment of the processes used by DOD and VA when a servicemember is found by DOD to be unfit for military duty. If implemented, our recommendations would result in important and major changes.

Our Commission's efforts relied extensively on analysis conducted for our Commission by the Institute of Medicine (IOM) of the National Academies and by the CNA Corporation (CNAC). Taken together, their work provides a picture of a disability system that needs considerable improvement but one that is generally sound. For example, IOM concluded that an effective system should ensure vertical and horizontal equity to compensate disabled veterans for average loss of earnings capacity. Horizontal equity would ensure that veterans with different types of disabilities but with similar severity of disabilities would have similar loss of earnings. Vertical equity would ensure that as rating severity increases, earnings loss would also increase. CNAC's analysis concluded that general loss would also increase. CNAC's analysis concluded that there is general parity overall with average VA compensation for all made service-disabled veterans about at parity with earnings loss and that there is not much difference among physical disorders. They did find significant exceptions with PTSD and other mental disorders and those who experience severe disabilities at a young age; these groups receive compensation that does not achieve parity with earnings loss.

IOM concluded that compensation should be provided for more than work disability or earnings loss; it would also compensate for loss of ability to engage in usual life activities and loss of quality of life. The CNAC analysis provided that cur-

rent compensation payments generally provide parity with respect to earnings loss but that there is not compensation for quality of life. In addition, the CNAC analysis provided an accurate assessment of the extent to which disability impacts on quality of life and demonstrated that health declined as degree of disability increased. CNAC also found that mental disorders impacted on physical health to an extent unanticipated. Thus, the CNAC analysis supported the independent conclusions of the IOM concerning compensation for impact of disability on quality of life. The Dole-Shalala Commission also recommended that compensation should recognized effects on quality of life.

Our Commission asked the IOM to address whether some other system of evaluating disability would be preferable to the use of the VA Rating Schedule. Specifically, IOM was asked to compare and contrast the Rating Schedule to the American Medical Association Guides to the Evaluation of Permanent Impairment. IOM found that the Guides are designed for use by physicians, measures and rates impairment and, to some extent, daily functioning, but not disability or quality of life, and does not provide mental ratings. IOM recommended updating and improving the Rating Schedule rather than adopting an impairment schedule developed for other purposes.

Concerning the recommendation by the Dole-Shalala Commission to "completely restructure" the disability and compensation system, my interpretation is that the overall focus of their report is on the processes currently used to determine whether a servicemember is fit or unfit for duty and to provide benefits and compensation for those found unfit. They recommended that the existing processes be restructured so that DOD determines fitness for duty and, for those unfit, DOD provides payment for time of service; VA rates the disability and compensates for disability. Our Commission essentially recommended the same realignment. The Dole-Shalala Commission recommended specifically that DO administer a single, comprehensive examination that could be used by both DOD and VA. Our Commission agreed that a single, comprehensive examinations be conducted but felt that either DOD or VA could administer the examination, depending on local capability of the clinical staffs. However, we extensively reviewed the examination process with the advice of the Institute of Medicine and made several recommendations to improve the examinations and ensure consistency and reliability. These recommendations include greater use of templates, improved training and certification of examiners, and enhanced quality control. These recommendations should be implemented no matter which department conducts the examinations.

DUAL RATING SCHEDULE

Question. Based on the Commission's work, do you believe that it is either necessary or appropriate to have two different disability ratings schedules, one for veterans of the current conflicts and one for veterans of earlier eras?

Response. Our Commission believes that there should be a single process used and the benefits available should be appropriate for all veterans. The processing steps may vary somewhat in the case of servicemembers found unfit for duty, but in general, all veterans' claims should be processed similarly and in a timely manner. Our Commission also believes that the payment rate of disability compensation should be based on severity of disability without regard to the circumstances of the disability. This is Principle 3 of our Commission's 8 principles. We do not believe that veterans' compensation should be different if the injury occurs during wartime or peacetime, during combat or combat-related duties, in the United States or abroad, or other distinctions. We believe that military service is a 24-hour a day responsibility as demonstrated by the fact that servicemembers are subject to the Uniformed Code of Military Justice continuously during active duty. In addition to issues of equity, such distinctions among circumstances would require subjective judgment on the part of rating officials and would serve to add further complexity into an already complex process.

All veterans should be evaluated using the same criteria, namely the VA Rating Schedule and that no attempt should be made to develop and apply different criteria or a different Rating Schedule to veterans who served during different periods of time. It is clear that VA has not been successful in keeping one rating schedule up to date. Our Commission recognized that VA had undertaken a project to revise the rating schedule as a result of a critical 1989 GAS report and had published a notice of its intent to update the entire schedule in August 1989. IOM carefully reviewed the revisions to the rating schedule and found that only 373 of 798 diagnostic codes (47 percent) had been revised since 1990. A substantial proportion (281, or 35 percent) of the schedule's diagnostic codes had not been revised at all since 1945 and 18 percent (144 codes) were revised between 1945 and 1989. Our recommendation

4.23 concerning updating the VA rating schedule said that the revision of the rating schedule should be completed within 5 years and our report (Prepublication page 80) indicated that five years is a realistic timetable. Our Commission felt that it would be important to establish a deadline that cold reasonably be met, considering VA's lack of progress in the past. We meant that deadline to be a maximum, not an estimate for how long the revision should take. In retrospect, we should have expressed this more carefully as an outside limit. We did not estimate how long a complete revision should take.

I believe that practical consideration also argue against attempting to create and maintain two separate processes and benefits. It is well known and accepted that VA has had an ongoing problem with timeliness of claims processing and with a continuing and growing backlog of claims well beyond the volume of pending claims needed to sustain efficient operations. During the period 2000-2006, VA received some 1.2 million original claims while DOD separated or retired some 83,000 servicemembers as unfit for military duty. Thus, the number of unfit separations and retirements were only 6.9 percent of all original claims.

I am also aware of proposals that would restrict benefits, particularly TRICARE family health care, to those with very strictly defined serious disabilities who are separated or retired as unfit. During the period of 2000 to 2006 reviewed by our Commission, less than two percent (1,478 of 83,008) of those separated or discharged as unfit were rated by DOD as 100 percent disabled and only six percent (5,060 of 83,008) were rated 50 percent or higher. Currently, servicemembers found unfit and rated 30 percent disabled or higher are eligible for TRICARE. The Dole-Shalala Commission recommended that all those fond unfit because of combat-related injuries should receive comprehensive health care for themselves and their families. As discussed previously, I do not believe a distinction should be made regarding combat-related injuries, but I agree with providing TRICARE to everyone found unfit.

Chairman AKAKA. Thank you very much, General.

Admiral Dunne?

STATEMENT OF REAR ADMIRAL PATRICK W. DUNNE, U.S. NAVY (RET.), ASSISTANT SECRETARY FOR POLICY AND PLANNING, U.S. DEPARTMENT OF VETERANS AFFAIRS

Admiral DUNNE. Good morning, Mr. Chairman and distinguished Members of the Committee. Thank you for the opportunity to discuss the recent activities to serve our Nation's veterans through improved processes and greater collaboration with DOD.

On April 19, the President's Task Force on Returning Global War on Terror Heroes issued its 25 recommendations to improve health care, benefits, employment, education, housing, and outreach using existing authority and resource levels. This report was unique in that it also included an ambitious schedule of action and target dates. Thanks to outstanding interagency cooperation, 56 of 58 action items have been completed or initiated.

The results of these initiatives support seamless and world class health delivery. VA and DOD drafted a joint policy document on co-management and case management of severely injured servicemembers. This will enhance individualized support for the wounded, severely injured, or ill servicemember and his or her family throughout the recovery process.

To assist OEF/OIF wounded servicemembers and their families in navigating through the transition process, VA hired 106 new Transition Patient Advocates. These men and women, often veterans themselves, work with case managers and clinicians to ensure that patients and families can focus on recovery.

VA also revised its electronic health care enrollment form to include a selection option for OEF/OIF to ensure proper priority of care.

DOD and VA work collaboratively to expand access to servicemembers' electronic health records by jointly developing the electronic capability to transfer digital radiographs from Walter Reed, Bethesda, and Brooke to VA's polytrauma centers. The capability for electronic transmission of historic health care data from DOD MTFs to VA medical centers is complete in the domains of allergies, outpatient medications, laboratory results, and radiology. Additionally, a contract was recently awarded for an independent assessment of Inpatient Electronic Health Records in VA and DOD.

In response to the report on the President's Commission on Care for America's Returning Wounded Warriors, we are preparing a statement of objectives to contract for studies of quality of life and long-term transition benefits.

An MOU was signed by DOD, HHS, and VA to define the role of the Public Health Service in the Recovery Coordinator Program. Two members of the Public Health Service Commission Corps are detailed from HHS to VA and are working with us to establish the Recovery Coordinator Program.

Rulemaking is underway to revise the ratings schedule provisions for evaluating disability due to Traumatic Brain Injury and burns.

Two weeks ago, the Veterans Disability Benefits Commission issued its report and recommendations. While some of the recommendations are similar to existing ones, others are new and we are carefully studying them.

To oversee the implementation of these recommendations, VA and DOD established the Wounded, Ill, and Injured Senior Oversight Committee on May 3. This Committee is co-chaired by the Deputy Secretary of Veterans Affairs and Deputy Secretary of Defense and meets weekly.

In a collaborative effort with DOD, VA made great strides in addressing issues surrounding PTSD and TBI across the full continuum of care. The focus has been to create a comprehensive, effective, and individual program dedicated to all aspects of care for our patients and their families. VA and DOD have partnered to develop clinical practice guidelines for PTSD, major depressive disorder, acute psychosis, and substance abuse disorders. Our Senior Oversight Committee also approved a National Center of Excellence for PTSD and TBI.

VA and DOD are also working closely to redesign and establish one Disability Evaluation System. A pilot program is being finalized to ensure no servicemember is disadvantaged by this new system and that the servicemember receives high-quality medical care and appropriate compensation and benefits. The proposed new system will be much more efficient, and I have provided additional details in my written testimony.

VA now has 153 Benefits Delivery at Discharge sites to speed up processing of applications for compensation. VA also processes the claims of OEF/OIF veterans on an expedited basis.

Collaborating with DOD, we have accomplished a great deal, but there is still much more to do. We at VA are committed to strengthening our partnership with DOD to ensure our servicemembers and veterans receive the care and benefits they have earned.

I will be happy to answer your questions.
[The prepared statement of Admiral Dunne follows:]

PREPARED STATEMENT OF HON. PATRICK W. DUNNE, REAR ADMIRAL, U.S. NAVY (RET)
ASSISTANT SECRETARY FOR POLICY AND PLANNING

Good morning, Mr. Chairman and distinguished Members of the Committee. Thank you for holding this hearing and providing the opportunity to discuss the recent activities of the Department of Veterans Affairs (VA) to improve benefits and services to our Nation's veterans through improved processes and greater collaboration with the Department of Defense (DOD).

The level of attention currently focused on our wounded servicemembers and their families is unprecedented—and rightly so. Over the past 7 months, I have had the privilege of being engaged in many activities dedicated to ensuring our returning heroes from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) receive the best available care and services. I join my colleagues from VA in striving to provide a lifetime of world-class care and support for all our veterans and their families.

On March 6, 2007, by Executive Order, the President established the interagency Task Force on Returning Global War on Terror Heroes. VA Secretary Nicholson was appointed to Chair the Task Force and I was proud to support him as the Executive Secretary. On April 19, 2007, the Task Force issued its report to the President. The Task Force made 25 recommendations to improve the delivery of Federal services and benefits to returning servicemembers. The Report contained recommendations in the areas of health care, benefits, employment, education, housing and outreach that could be achieved with existing authority and resource levels. The report was unique in that it also included an ambitious schedule of milestones and actions necessary to implement its recommendations. We continue to monitor implementation and I am pleased to inform you that, thanks to outstanding interagency cooperation, as of August 28, 56 of 58 action items have been completed or initiated.

The results of actions taken in response to recommendations in the Task Force Report are having a positive impact on the lives of servicemembers, veterans, and their families. I would like to highlight some of the progress achieved.

In response to a Task Force recommendation, the Small Business Administration launched the Patriot Express Loan Initiative. This program provides a full range of lending, business counseling, and procurement programs to separating servicemembers, veterans, spouses, survivors, and eligible dependents. This program has already approved more than $23 million in loans since it began in mid-June.

Several initiatives have and will continue to support seamless and world-class health care delivery. VA and DOD have drafted a joint policy document on co-management and case management of severely injured servicemembers. The goal is to provide individualized, integrated, interagency and intergovernmental support for the wounded, severely injured or ill servicemember and his/her family throughout the process of treatment, rehabilitation, and renewal. VA and DOD will work together to minimize fragmentation of Federal clinical and non-clinical services, improve the coordination of medical and rehabilitative care, and ensure access to all needed resources.

To assist OEF/OIF wounded servicemembers and their families in navigating through the transition process, VA hired 100 new Transition Patient Advocates (TPA). These men and women, often veterans themselves, recognize the difficulty in understanding the many different programs and processes which come into play. VA TPAs work with case managers and clinicians to ensure that patients and families can focus on recovery.

VA also revised its electronic health care enrollment form to include a selection option for OEF/OIF to ensure proper priority of care.

Many advances are the result of improved records management and greater sharing and Information Technology (IT) interoperability with DOD. In response to Task Force recommendations, DOD and VA worked collaboratively to expand access to servicemembers' electronic health records by jointly developing the electronic capability to transfer digital radiographs from Military Treatment Facilities (MTFs) at Walter Reed, Bethesda, and Brooke to VA Polytrauma Rehabilitation Centers. The capability for electronic transmission of historical health care data from DOD MTFs to VA Medical Centers is complete in the domains of allergies, outpatient medications, laboratory results, and radiology. Additionally, a contract was recently awarded for an independent assessment of inpatient electronic health records in the Departments of Veterans Affairs and Defense. The contract will provide recommendations for the scope and elements of a joint electronic inpatient medical record.

In July of this year, the Report of the President's Commission on Care for America's Returning Wounded Warriors was issued. This Commission had a greater scope than the Task Force and was not constrained by existing authority and resources. We are preparing the statement of objectives to contract for studies of Quality of Life and long-term transition benefits. An MOU was signed by DOD, HHS and VA to define the role of the Public Health Service in the Recovery Coordinator program. Two members of the Public Health Service commissioned corps are detailed from HHS to VA and are working with VA and DOD to establish the Recovery Coordinator program. Rulemaking is underway to revise the Rating Schedule provisions for evaluating disability due to Traumatic Brain Injury and scars.

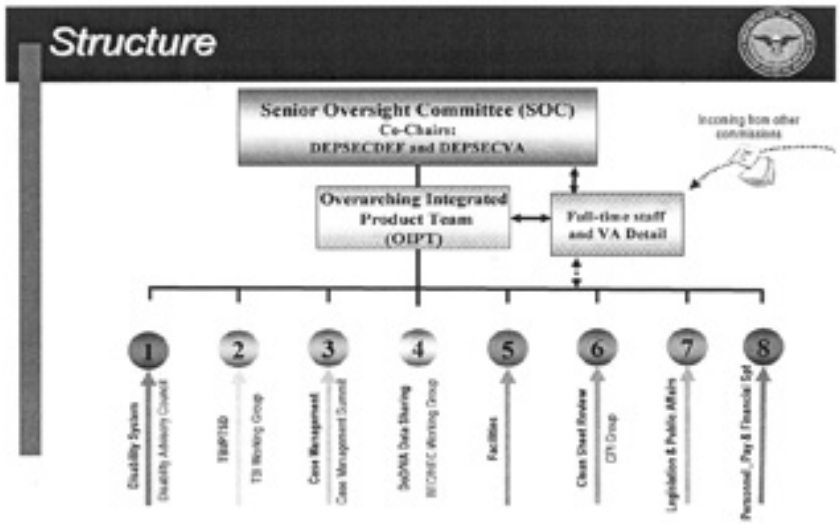
Two weeks ago, the Veterans Disability Benefits Commission issued its report and recommendations. While some of the recommendations are similar to existing ones, others are new, and we are reviewing them carefully.

To ensure a seamless continuum of benefits and health care services to wounded, ill, and injured servicemembers, the Departments of Veterans Affairs and Defense began an integrative effort, and established the Wounded, Ill, and Injured Senior Oversight Committee (SOC) on May 3, 2007. The SOC, composed of senior military and civilian officials from both Departments, was established for a 12-month time period, and was tasked to ensure the recommendations of the task forces and committees were properly reviewed, coordinated, implemented, and resourced. The Committee is co-chaired by the Deputy Secretary of Veterans Affairs and Deputy Secretary of Defense, and meets weekly to streamline processes, mitigate potential conflicts, and expedite the two Departments' efforts to improve support of injured servicemembers' recovery, rehabilitation, and reintegration.

Senior Veterans Affairs and Defense officials serve on the SOC. This includes the Service Secretaries, the Chairman of the Joint Chiefs of Staff, the Service Chiefs, and VA's Under Secretary for Health, Under Secretary for Benefits, Assistant Secretary for Policy and Planning, and Deputy Assistant Secretary for Information and Technology. The driving principle guiding the SOC's efforts is the establishment of a seamless continuum that is efficient and effective in meeting the needs of our wounded, ill, and injured servicemembers/veterans and their families.

Supporting the SOC decisionmaking process is an Overarching Integrated Product Team (OIPT), composed of the Under Secretary of Benefits, Assistant Secretary of Policy and Planning, and other senior officials from VA and DOD. The OIPT reports to the SOC and coordinates, integrates, and synchronizes the work of eight Lines of Action and recommends sourcing solutions for resource needs.

The diagram below depicts the structure supporting the SOC. The Lines of Action, which have Senior Executive Service Co-Leads from both Departments, establish plans, set and track milestones, and identify and enact early, short-term solutions.



The Lines of Action (LOA) and their goals are:

- LoA #1: Redesign the Disability Evaluation System

Goal: To develop a single, supportive, and transparent disability evaluation system.

• LoA #2: Address Traumatic Brain Injury/Psychological Health

Goal: To provide servicemembers with lifelong standardized and comprehensive screening, diagnosis, and care for all levels of Traumatic Brain Injury and Post Traumatic Stress Disorder, in conjunction with education for patients and family members.

• LoA #3: Fix Case Management

Goal: To coordinate health care, rehabilitation, and benefits, delivery of services and support that will effectively guide and facilitate servicemembers and their families through necessary processes.

• LoA #4: Expedite Data Sharing

Goal: To ensure appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information management systems.

• LoA #5: Facilities

Goal: To provide servicemembers and families with the best possible facilities for care and recovery.

• LoA #6: "Clean Sheet" End-to-End Review

Goal: To honor our servicemembers by providing wounded, ill, and injured personnel and their families the best quality care and a compassionate, fair, timely, and non-adversarial disability adjudication process—enabling servicemembers to return to the fullest, most productive and complete quality of life possible.

• LoA #7: Comprehensive Legislation and Public Affairs

Goal: To coordinate the development of comprehensive legislation that will provide the best possible care and treatment for injured servicemembers and families. Additionally, to keep the public informed of significant accomplishments and events.

• LoA #8: Personnel, Pay, and Financial Benefits

Goal: To provide compassionate, timely, accurate and standardized personnel, pay, and financial support practices for Wounded, Injured and Ill to ensure appropriate data sharing, quality control, and support benefits.

In a collaborative effort with DOD, VA has made great strides in addressing issues surrounding Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) across the full continuum of care. 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 military members, veterans, and families who deal with these important health conditions.

Since June 2007, a collaborative team of VA and DOD experts known as the "Red Cell" has worked to: (1) create an integrated, comprehensive Department of Veterans Affairs/Defense program to identify, treat, document, and follow-up those who experience TBI or PTSD conditions while either deployed or in garrison; and (2) determine how to build resilience, both in people and in organizations, to prevent issues from developing and to reduce their impact if they do occur.

VA and DOD have partnered to develop clinical practice guidelines (CPG) for PTSD, Major Depressive Disorder, Acute Psychosis, and Substance Use Disorders. These guidelines help practitioners determine the best available and most appropriate care.

Our Senior Oversight Committee also has approved a National Center of Excellence for PTSD and TBI. It will include liaisons from both VA and DHHS, 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. This center will facilitate coordination and collaboration between VA and the Military Services, promoting and informing best practice development, research, education and training.

As of the first half of fiscal year 2007, approximately 263,900 returning veterans have sought care from VA medical centers and clinics. Of these, about 38 percent have received at least a preliminary diagnosis of a mental health condition, and 18 percent have received a preliminary diagnosis of PTSD, making it the most common, but by no means the only mental health condition related to the stress of deployment. Professionals with special expertise in PTSD are available in all medical centers to serve veterans with PTSD. Most are best served in outpatient programs, but for those with more severe symptoms, VA has inpatient and residential rehabilitation options across the country.

VA has taken several actions at multiple levels to promote the recruitment and retention of mental health professionals in the Veterans Health Administration (VHA). In February 2007, both an Education Debt Reduction Program and an Employee Incentive Referral Initiative began. The new mental health Education Debt Reduction Program currently provides up to $38,000 of education loan repayment

for qualified student debt. The Employee Incentive Referral program provides a bonus to VA employees who refer mental health providers who are hired into VA positions. These initiatives have already generated significant interest.

At the local level, opportunities have been developed for VA facilities to engage in local advertising and recruitment activities and to cover interview-related costs, relocation expenses, and provide limited hiring bonuses for exceptional applicants. VA has also established opportunities for supporting individual training and education activities for mental health employees, demonstrating an investment in staff can also have a positive impact on retention.

Rates of hiring have increased significantly in recent months, suggesting that the enhanced recruitment efforts are having a positive impact. Since fiscal year 2005, VA has authorized 4,367 new Mental Health Enhancement positions. As of August 31, 2007, 81 percent of these positions have been filled.

In terms of treating TBI, VA offers comprehensive primary and specialty health care to our veterans, and is an acknowledged national leader in providing specialty care in the treatment and rehabilitation of TBI and polytrauma. Since 1992, VA has maintained four specialized TBI Centers. In 2005, VA established the Polytrauma System of Care, leveraging and enhancing the existing Brain Injury Polytrauma expertise existing at these TBI centers to meet the needs of seriously injured veterans and active duty servicemembers from operations in Iraq, Afghanistan, and elsewhere. The Secretary of Veterans Affairs recently announced the decision to locate a fifth Polytrauma Center in San Antonio TX.

The Departments of Veterans Affairs and Defense are also working closely to redesign and establish one Disability Evaluation System (DES) for use by servicemembers. A pilot program is being explored via tabletop exercise to ensure that no servicemember is disadvantaged by this new system, and that the servicemember receives the high quality medical care and appropriate compensation and benefits for the residuals of his or her disabilities incurred or aggravated by military service. An operational pilot program should be completed in the second quarter of 2008. If it is as successful as we plan, this pilot program will be expanded beyond the Washington Capital Region to become the DES system, worldwide.

The proposed new system will be much more efficient. It will produce more consistent outcomes and, with VA and DOD working together as a team, the new system will be a seamless, single process for users. We envision it cutting in half the time it takes for a servicemember to go through the DES, from the time the member is referred to a Medical Evaluation Board (MEB) to the time the member is discharged from active military service and receives his or her first payment from VA.

An important improvement in this proposed system is that the servicemember will only be required to have one medical examination or series of medical examinations, depending on the severity of the potentially disqualifying conditions to meet the requirements of both DOD and VA. Currently, a service-specific medical examination is required for the purpose of determining a servicemember's ability to continue on active military service based on the residual unfitting disability and the servicemember's, rank, rating, or military occupational skills, and a VA medical examination is also required for the purpose of evaluating the residual of the disability under VA's Schedule for Rating Disability and assigning a percentage evaluation to the disability. Under the current system, if servicemembers are found unfit and are separated or retired, they must complete the second VA exam to determine whether the claimed medical conditions are service-connected and represent impediments to full employment capability.

Under the proposed new DES system, the one-medical-examination process collects information required by both Departments. Under this system, when the servicemember transitions to civilian life, VA will already have the information needed to immediately start paying the veteran the appropriate amount of compensation for the residuals of his or her disability incurred or aggravated by military service.

Over the last 5 years, the Veterans Benefits Administration (VBA) service coordinators conducted more than 38,000 briefings attended by more than 1.5 million active duty and reserve personnel and their family members. Additionally, through the Benefits Delivery at Discharge program, servicemembers at 153 military bases in the United States, Germany, and Korea are assisted in filing for disability benefits prior to separation. This fosters continuity of care between the military and VA systems and speeds up VA's processing of their application for compensation. Claims decisions can be completed prior to separation, and veterans can begin receiving VA compensation payments, without delay, upon separation from the military. VBA also processes the claims of OEF/OIF veterans who apply for VA disability compensation or pension on an expedited basis.

Thank you for providing me this opportunity to share with you recent activities in the Department of Veterans Affairs. I will be happy to answer any questions you may have.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY REAR ADMIRAL PATRICK W. DUNNE, U.S. NAVY (RET.), ASSISTANT SECRETARY FOR POLICY AND PLANNIING, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. According to recent testimony by Mr. Dominguez, DOD's Principal Under Secretary of Defense for Personnel and Readiness, DOD and VA are working closely to redesign and establish one disability evaluation system for use by servicemembers. I understand that this redesign was done without the benefit of knowing the recommendations of the Veterans Disability Benefits Commission. How is the redesign being carried out, what information was considered, and what are the expected outcomes? Does the redesign of the Disability Evaluation System include improved processes for all separating servicemembers or just those separating as a result of being found unfit or continued service?

Response. The Department of Veterans Affairs (VA)/Department of Defense (DOD) Disability Evaluation System (DES) pilot program will begin on November 26, 2007. The intent of the DES pilot is to evaluate a stream-lined process designed to improve the timeliness and effectiveness of the DES program. This pilot program integrates VA and DOD processes thereby maximizing resources, eliminating duplication, and improving case management practices. The pilot will operate within the parameters of titles 10 and 38, United States Code and will be used for personnel who are separating through the medical evaluation board (MEB)/physical evaluation board (PEB) process.

VA and DOD designed a program that would remove current burdens on servicemembers by simplifying the process and producing a single disability rating. A key feature of the DES pilot is the use of one comprehensive medical examination, using VA-based protocols, that is administered by DOD. This single medical exam will meet the needs of the PEB in determining a servicemember's fitness for duty and the needs of VA for determining a total service-connected disability rating.

To ensure a seamless transition of our wounded, ill, or injured servicemembers from DOD care, benefits, and services to the VA system, the DES pilot will test enhanced case management methods; identify opportunities to improve the flow of information; and identify additional resources, which may be necessary to facilitate successful transitions for servicemembers and families.

Chairman AKAKA. Thank you very much, Secretary Dunne. Secretary West?

STATEMENT OF TOGO D. WEST, JR., CO-CHAIR, INDEPENDENT REVIEW GROUP, REPORT ON REHABILITATIVE CARE AND ADMINISTRATIVE PROCESSES AT WALTER REED ARMY MEDICAL CENTER AND NATIONAL NAVAL MEDICAL CENTER

Mr. WEST. Mr. Chairman, Ranking Member Senator Burr of my home State of North Carolina, Senator Murray, and Members of the Committee, thank you for including the Independent Review Group in your hearing today. I am aware—we are aware—that you are focusing on disability issues, but you asked us to speak to questions of overlap or cooperation between DOD and the Department of Veterans Affairs that are touched on by our report and that would assist in providing the best of care to returning servicemembers and veterans.

I will do that quickly. You have my statement. I won't take the time to go through it. I want to make two points about two issues that we touch on that certainly have to do with cooperation between DOD and VA.

First of all, let me say this issue of how the two departments, the two largest in terms of personnel in our government, can cooperate to support servicemembers and veterans is not a new one, of course. We were talking about it when I was the Secretary of

Veterans Affairs, also when I was Secretary of the Army, and that is now turning out to be a while back. Indeed, it was before me.

Something that was said here today, I think, is well worth saying. Let me speak specifically to the issue of electronic records. VA has certainly outdistanced the Department of Defense on that score. The fact is that the transition to an essentially paperless health records system is in many ways a marvel. DOD is not there, and although I have heard some encouraging statements both today and in past weeks, it is not clear to me how quickly they will get there.

As General Scott pointed out—and I know you noticed his comment, it is not just that DOD as a whole is not where VA is in getting its medical records online, as it were; it is that the individual services are not there. They can't even talk with each other within the Department of Defense. Indeed, the Army has three systems that can't talk to each other.

And so, when we talk about the objective of getting some kind of useful collaboration between the two departments on something that is as essential as the ability to put health care records in an electronic means and make them available so that they can go where a servicemember or former servicemember or veteran needs them to go within the two systems, we are talking about something that is not yet upon us, and I am concerned we will have difficulty getting to. I understand that the DOD part of it is a concern of another committee, but it is the concern of the entire Senate, as well.

The Secretary of Defense and his people have made it clear that they understand our recommendations and the recommendations of the other commissions. But, I say to you, that is an area that is going to take a lot of pressure. Perhaps I will leave it at that and you can ask me questions about it later.

Secondly, we had some strong language in the Independent Review Group's report, as everyone else has had, concerning the disability review process. We said then, and in our testimony several subsequent times, that it makes no sense not to have one system. It is no surprise, as I say in my comments, that a department of government, several departments of government, can offer good rationales for having the complicated systems they have. Three levels of review—for example, in the Army before you get a decision, before you even get to VA, if you are a servicemember who is eventually discharged and needs to continue in the VA system. Their reasons are good: that the local commanders can make a better decision as to who is fit to return, yet you need a level further after that to decide, and so on.

But, the servicemembers and their families—as you have heard from Senator Dole and Secretary Shalala, for example—to servicemembers and their families, it looks like an incomprehensible nightmare. We, as a government, should be able to resolve that.

I am encouraged by what we are hearing in terms of moving forward with a plan to proceed. Indeed, the members of the Independent Review Group are meeting tomorrow with Assistant Secretary Cassell to talk further about DOD's efforts to resolve its internal process. But that again is an area that will require continued oversight and urging, because we have talked about and considered improving the disability review process, as it involves both

DOD and VA for a number of years there, as well. It is not a new issue this year.

Finally, the Independent Review Group was the first body called into action when the national scandal known as the Walter Reed situation broke. Shortly after Secretary Gates took over, he asked our group, which I have to say, in contrast to what Senator Dole and Secretary Shalala were able to say about their group, ours was the normal suspects—a couple of formers: former Secretaries of the Army; some former military doctors too; one a former Surgeon General of the Air Force; and the other former Congressman Schwartz, who is also a doctor who served as a military doctor; but also a former Navy nurse, Rear Admiral Kathy Martin, who was a Deputy Surgeon General; and a former Commander of Bethesda National Naval Medical Center; as well as a former command sergeant, and two other private citizens.

I mention that to say that our focus as we met and did our deliberations, despite what the formal letters of reference may have said in terms of what we were called on to do, were to essentially find out what happened, find out why it happened, and find out what needed to be done to fix both that problem and its implications in other active duty facilities, as well. We were not asked to look at VA, and indeed in an early draft of our terms of reference there is a specific line that told us to stay away from looking at the Department of Veterans Affairs. At the suggestion of several of us, including me, that was taken out. We understood what our area was, but, of course it would make sense for us to look at the overlap at the place of transition.

And so, our report heavily focuses on DOD and the many things that need to be done there. But, I have to conclude by saying with respect to that effort, that we found that where DOD and VA have been making efforts to cooperate and to collaborate, and there have been a number of them, the Department of Veterans Affairs has been better able to move ahead. You haven't asked me for a comparison and I am not really offering one, but I am pointing out that the difficult challenge continues to lie in pushing that large department, which has so many different actors who have to participate, to bring their activities to the point where they can work together and mesh together with VA.

So, I thank you for this hearing. I thank you for including us in it. I know you have had hearings like this before—I have heard them referred to—and so have others. But wherever the Senate or House of Representatives gathers in a Committee or in full session to consider these problems of our servicemembers and our veterans, there on that day is another opportunity for the improvement of what we can do for them. Thank you.

[The prepared statement of Mr. West follows:]

PREPARED STATEMENT OF HON. TOGO D. WEST, JR., CO-CHAIR, INDEPENDENT REVIEW GROUP

The report by the Independent Review Group is replete with findings and recommendations covering a wide range of issues and circumstances which have come to our attention. They converge around four core concerns. Let me pose them as questions.

Firstly, who are we—as a country, as an Army, as a health care center—here at Walter Reed? Unfortunately, if one considers reports we have heard from servicemembers and their families about the lapses in support to them during their reha-

bilitation phase of care, we would conclude that we may be answering that question in ways that are not attractive to us as an Army or as a Nation. We say so much about ourselves by the attitudes we display toward those who look to the Nation for support during the most vulnerable times of their lives. We have included a number of findings and recommendations involving the assignment and training of caseworkers, increases in the numbers of caseworkers and adjustment of the caseworker to patient ratio, assignments of primary care physicians, and attention to the nursing shortages.

Secondly, who and what are we to become? The Base Realignment and Consolidation (BRAC) process and the A–76 process have caused incalculable dislocation in Walter Reed operations and threaten the future of both installations.

Thirdly, how are our servicemembers doing? At every turn, the IRG has encountered servicemembers, their families, health care professionals, and thoughtful observers who point out how challenging the traumas associated with TBI (Traumatic Brain Injury), and PTSD (Post Traumatic Stress Disorder) have become; and how challenging they have been in terms of both DOD and Department of Veterans Affairs diagnosis, evaluation, and treatment. We believe there is a need for greater and better coordinated research in this area. We have made a detailed recommendation with respect to a center of excellence and increased attention to cooperative efforts by both the Department of Defense and the Department of Veterans Affairs.

Fourth, how long? The IRG has operated with what is, for me, a rare sense of unity and consensus in our effort. If there is one issue, on which we are even more unified than all others, it is that the horrors that are inflicted on our wounded servicemembers and their families in the name of the physical disability review process, known in the Department of Defense as the MEB/PEB process, simply must be stopped.

It is no surprise to you on the Committee, or to us on the IRG, that each part of the governmental process can make sound arguments to defend and explain why three, and in the case of the Army four, separate Board proceedings—with associated paperwork demands on the wounded servicemember and family, accompanied by delays and economic dislocation for assisting family members, and characterized prominently by inexplicable differences in standards and results—are justified. We, however, are a Nation which values the every day good sense of the common man or woman—that is why we call it common sense. And common sense says that from our servicemembers' and families' point of view this must seem a wildly, incomprehensible way to settle for servicemembers and families the question of whether the member must leave the service and, if so, under what conditions. We recommend one combined physical disability review process for both DOD and VA. (See Attachment for specific areas that require collaboration between the DOD and VA.)

Virtually every finding and recommendation we make, then can be traced to these four concerns: (1) leadership and attitude; (2) the transition from Walter Reed Army Medical Center to Walter Reed National Medical Center; (3) the extraordinary use of IED (improvised explosive devices) in the current wars and their impacts on the brains and psyches of our servicemembers; and (4) the long-standing and seemingly intractable problem of reforming the disability review process.

It is important to note that at the conclusion of the IRG investigation, Army officials said the service has resolved, or is in the process of resolving, 24 of the 26 findings listed in the report.

To be sure, it was the degradation in facilities that first caught the eye of media reporters. Important as that is, however, we believe that there is far more to be dealt with here than applying paint to rooms or even in crawling around basements to deal finally with electrical problems. We had experts of every sort assigned to us, and talented and experienced health professionals as part of the Independent Review Group itself.

None of these concerns, however, is our bottom line: not BRAC, not facilities, not even the search for failures, breakdowns, or culprits. Rather our bottom line is this:

(1) We are the United States of America.

(2) These are our sons and daughters, brothers and sisters, uncles and aunts, even a grandparent or two who lie and sit wounded.

(3) Their families are our families, we are their neighbors, and we, their fellow citizens and residents.

(4) Their anguish is our anguish.

(5) We can and must do better.

ATTACHMENT

Finding:

There are inconsistencies within the Department of Defense and the Department of Veterans Affairs regulatory systems which deal with the functional loss of limb due to Traumatic Injury and burn. Currently, the disability system does not adequately compensate for the functional and physiological loss of limb in burn patients.

Discussion:

The Code of Federal Regulations, Title 38, Part IV (Veterans Affairs Schedule for Ratings and Disabilities) does not address specific disability ratings for burn injuries. It does thoroughly cover amputations. It also addresses many skin injuries such as scarring, disfigurement and dermatitis. There exists a gap for addressing issues specific to burn injuries. Burned skin needs extra protection from the sun and elements; it does not sweat normally and needs extra precautions (for example: ultraviolet protective clothing and salves) for warm/hot environments. Because there are not specific disability ratings for burn patients, they do not qualify for home or vehicle modification as an amputee patient would.

Recommendations:

1. The Secretary of Defense should request the Secretary of Veterans Affairs to update the Code of Federal Regulations, Title 38, Part IV to account for the unique disabilities and needs of traumatic amputees and burn victims, focused on a loss of function and post-service needs. This would require an expedited process for publishing the change.
2. The Secretary of Defense should review the Physical Evaluation Board determinations of all burn cases, dating back to 2001, within 1 year after the update to United States Code 38.

Finding:

When an amputee leaves the Department of Defense medical system, the follow-on care, the amputee receives, may not be as technologically advanced outside the military medical system.

Discussion:

The Department of Defense, from clinical necessity, has been on the cutting edge of prosthetic replacement for traumatic amputation. The Department of Veterans Affairs has largely been focused on patients who lost a limb (or limbs) through disease or accident instead of combat. In addition, many amputees in the Veterans Affairs system are much older than those who have suffered an amputation due to combat.

The Sun-Times News Group recently reported, MAJ (RET) Tammy Duckworth, currently the Director of the Illinois Department of Veterans Affairs, testified before the U.S. Senate Committee for Veterans Affairs on March 27, 2007 and stated, "The U.S. Department of Veterans Affairs is absolutely not ready to treat amputee patients at the high tech levels set at Walter Reed. Much of the technology is expensive and most of the Veterans Affairs personnel are not trained on equipment that has been on the market for several years, let alone the state-of-the-art innovations that occur almost monthly in this field. I recommend that the VA expand its existing SHARE program that allows patients to access private prosthetic practitioners. There is simply not enough time for U.S. Department of Veterans Affairs to catch up in the field in time to adequately serve the new amputees from Operations Iraqi and Enduring Freedom during these critical first 2 years following amputation. Perhaps after the end of current wars in Iraq and Afghanistan, the VA will have time to advance its prosthetics program." Travel for prosthetic care also includes Department of Defense beneficiaries follow up post amputation patients often requires travel to medical centers with competent prosthetics departments. Often a patient does not live in a geographic area where TRICARE Prime is offered. The TRICARE Prime travel benefit covers per diem and travel if a patient is referred to care more than 100 miles away from their home. TRICARE Standard does not offer a travel benefit.

Recommendations:

1. The Secretary of Defense should pursue partnerships with the Secretary of Veterans Affairs to provide treatment; promote education and research in prosthesis care, production, and amputee therapy.
2. The Secretary of Defense should pursue a partnership with the Secretary of Veterans Affairs to expand the Department of Veterans Affairs' existing program to

allow patients to access the military health system and private prosthetic practitioners.

3. Review TRICARE regulations (CFR 199.17) and update specifically to change them so that the geographic home of the patient does not limit access to benefits for prosthetic care and treatment.

Finding:

There are serious difficulties in administering the Physical Disability Evaluation System due to a significant variance in policy and guidelines within the military health system.

Discussion:

There is much disparity among the Services in the application of the Physical Disability Evaluation System that stems from ambiguous interpretation and implementation of a Byzantine and complex disability process. It is almost as if a peacetime, draft-era program is being applied to an all-volunteer force engaged in war.

The Governing Statute, implementing publications and regulatory guidelines: Code of Federal Regulation: Title 10, USC chapter 61, provides the Secretaries of the Military Departments with the authority to retire or separate members for physical disability. Code of Fed reg Title 38, provides the authority for the VA. DOD Directive 1332.18, Separation or Retirement for Physical Disability; DOD Instruction 1332.38, Physical Disability Evaluation; DOD Instruction 1332.39, Application of Veterans Affairs Schedule for Rating Disabilities, and applicable service specific regulations or instructions set forth the polices and procedures implementing the statute. For each respective service, the governing service specific guidelines include: Department of the Air Force, AFI 36–3212, Physical Evaluation for Retention, Retirement, and Separation; Department of the Army, AR 635–40, Physical Evaluation for Retention, Retirement, or Separation; Department of the Navy, SECNAV Instruction 1850.4E and Department of the Navy Disability Evaluation Manual. A Government Accounting Office (GAO) Report (2006), acknowledged the differences among the services and recommended improved oversight of the physical disability evaluation system, to which the Department of Defense agreed and indicated an intent to implement.

"The Government Accountability Office noted that eligibility criteria for disability programs need to be brought into line with the current state of science, medicine, technology and labor market conditions."

During the course of its review, the Independent Review Group identified no less than five Government Accountability Office reports and one Presidential Task Force report that noted deficiencies and made recommendations to improve the physical disability evaluation system. These reports include:

- November 2004 Government Accountability Office Report: VA and DOD Health Care: Efforts to coordinate a single physical exam process for servicemembers leaving the military
- September 2005 Veterans Affairs and Department of Defense Health Care: VA has policies and outreach efforts to smooth transition from DOD Health Care, but sharing of Health Information remains limited.
- June 2006 Government Accountability Office Report: VA and DOD Health Care: Efforts to provide seamless transition of care for OEF and OIF servicemembers and veteran's.
- March 2006 Military Disability System: Improved oversight needed to ensure consistent and timely outcomes for reserve and active duty servicemembers.
- March 2007 Government Accountability Office Report: DOD and VA Health Care: Challenges encountered by injured servicemembers during their recovery process.
- 2003 President's Task Force to Improve Health Care Delivery for Our Nation's Veterans.

Despite the comprehensive findings and recommendations in these reports, the Group found little evidence of action on the recommendations.

Recommendations:

1. The Secretary of Defense should provide recommendations to Congress to amend Title 10 United States Code, Chapter 61, and Title 38 United States Code, to allow the "fitness for duty" determination to be adjudicated by the Department of Defense and the disability rating be adjudicated by the Department of Veterans Affairs.

2. Following the changes to the United States Code, the Secretary of Defense, should quickly promulgate regulatory guidelines and policy to the Service Secretaries.

Finding:

The current Medical Evaluation Board/Physical Evaluation Board process is extremely cumbersome, inconsistent, and confusing to providers, patients, and families.

Discussion:

The physical disability evaluation system is the means by which servicemembers are retired or separated due to physical disability in accordance with the aforementioned references. The Department of Defense Directive (DODD) 1332.18, Section 3.2 outlines four elements of the physical evaluation disability system: the physical evaluation; appellate review; counseling; and final disposition. According to the Department of Defense regulations, the physical evaluation process consists of the Medical Evaluation Board and the Physical Evaluation Board. The Department of Defense and the Department of Veterans Affairs use the Veterans Administration Schedule for Rating Disabilities.

The Veterans Administration Schedule for Rating Disabilities (VASRD) is primarily used as a guide for evaluating disabilities resulting from all types of diseases and injuries encountered as a result of, or incident to, military service.

Not all the general policy provisions set forth in the rating schedule apply to the military. Consequently, disability ratings consistently vary between the Department of Defense and Department of Veterans Affairs. The Services rate only conditions determined to be physically "unfitting," compensating for loss of a military career. The Department of Veterans Affairs may rate any service-connected impairment, thus compensating for loss of civilian employability. Additionally, the term of rating is different among the Department of Defense and the Department of Veterans Affairs. The Services' ratings are permanent upon final disposition. The Department of Veterans Affairs ratings may fluctuate with time, depending upon the progression of the condition. Further, the Services' disability compensation is determined by years of service and basic pay; while Veterans Affairs compensation is a flat amount based upon the percentage rating received.

Recommendations:

1. The Under Secretary of Defense (Personnel & Readiness) should completely overhaul the physical disability evaluation system to implement one Department of Defense level Physical Evaluation Board/Appeals Review Commission with equitable Service representation and expand what is currently the Disability Advisory Council.

• According to a Government Accountability Office report, a problem with the current organization is that the Council only "aims" to meet quarterly, but did not meet for a full year, to discuss issues raised by the Services. This recommended concept would have consolidated operational oversight and responsibility of the Physical Evaluation Board process, including the current Service level Physical Evaluation Board and Appeals Review levels of jurisdiction. This action allows for streamlining of personnel and resources, and eliminates the intra and inter-Service disparities of the disability ratings and provides a forum for implementing immediate corrective action. This recommended concept incorporates Veterans Affairs representation and ensures a seamless transition from the Department of Defense into the Department of Veterans Affairs health system.

2. The Under Secretary of Defense (Personnel & Readiness) should conduct a quality assurance review all (Army, Navy/Marine Corps, and Air Force) Disability Evaluation System decisions of 0, 10, or 20 percent disability and Existed Prior to Service (EPTS) cases since 2001 to ensure consistency, fairness, and compliance with applicable regulations.

3. The Secretary of Defense and the Secretary of Veterans Affairs should establish one solution. Develop and utilize one disability rating guideline that remains flexible to evolve and be updated as the trends in injuries and supporting medical documentation/treatment necessitate. Revise the current process of updating the disability ratings system to include an operation update that pushes changes to the field on a weekly, or as needed basis.

Finding:

A common automated interface does not exist between the clinical and administrative systems within the Department of Defense and among the Services, causing a systemic breakdown of a seamless and smooth transition from Department of Defense to the Department of Veterans Affairs.

Discussion:

Servicemembers should not be burdened with the arduous navigation requirements of our current system. The complexity of the physical disability evaluation

system is further perpetuated as the servicemembers transition into the Veterans Affairs system. Currently there is not a seamless transition.

A "seamless transition" from military service to veteran status is especially critical in the context of health care, where readily available, accurate, and current medical information must be accessible to health care providers.

For the administrative aspects of this process, no one system currently exists. The Department of Defense does not have an integrated automated system that supports the standardization of the clinical and administrative requirements of the physical disability evaluation system. Absent a corporate solution, the Services have created individual systems to track the servicemembers within the physical disability evaluation system. This exacerbates the process variation.

The Air Force currently does not have an automated system. The Army currently uses the Medical Evaluation Board Internal Tracking Tool (MEBITT). The Navy uses the Medical Board On Line Tri-Service Tracking System (MedBOLTT). Each system serves its Service independently for Medical Evaluation Board processing; yet do not interface with the next step of the Physical Evaluation Disability System, or Physical Evaluation Board.

The Army Physical Evaluation Board uses the Physical Disability Case Processing System (PDCAPS) to track Army cases once they enter the Physical Evaluation Board stage of the process. Using the Army as an example of the lack of interface between systems, during the Medical Evaluation Board phase of the process, the Medical Evaluation Board Internal Tracking Tool is used. During the Physical Evaluation Board phase, the Physical Disability Case Processing System is used. These two systems, unique to one Service, result in numerous disparities within the Army since the systems do not interface. From a clinical perspective, all medical documentation should be available to the servicemembers' providers throughout the entire process. This includes the transition into the Veterans Affairs system where there is no continuity other than what records the servicemember carries to the Veterans Affairs. This issue has been continually addressed without resolution.

"The Department of Veterans Affairs and the Department of Defense should develop and deploy, by fiscal year 2005, electronic medical records that are interoperable, bidirectional and standards-based". [Refer to Recommendation 3:1 of President's Task Force. (2003) Final report to improve health caredelivery for our Nation's veterans. Washington, DC.] The same report recommends a single separation physical and electronic transmittal of the Department of Defense Form 214 (DD214) to the Department of Veterans Affairs. These recommendations have yet to come to fruition and as a result, there is a significant amount of redundancy still required at this point starting at the physical examination.

Recommendation:

The Secretary of Defense, in conjunction with the Secretary of Veterans Affairs, should direct the transition process be streamlined for the servicemember separating from the Department of Defense and entering the Department of Veterans Affairs.

• As already identified in the Government Accountability Office report (2004), implement the single physical exam. Review the 1998 Department of Defense memorandum of understanding (MOU) between the Department of Defense and Department of Veterans Affairs, implement a common physical for use by the Services and the Department of Veterans Affairs for those servicemembers in the physical disability evaluation system, and allow flexibility in the timelines test or procedures that would eliminate redundant efforts.

Rapidly develop a standard automated systems interface for both clinical and administrative systems that allows bilateral electronic exchange of information. Review and implement the recommendations of the 2003 President's Task Force.

Chairman AKAKA. Thank you very much, Secretary West.

We have some questions for you. General Scott, we have seen proposed legislation that would require the Secretary of Veterans Affairs to conduct a 6-month study relating to disability benefits, and after providing Congress with the results of the study, to write regulations to implement the study's findings so as to create a total change to the VA disability system. Based on your Commission's review of VA's disability process, do you believe that a total system reform can be carried out in 6 months and be done on an administrative basis with no Congressional hearings or legislative action?

General SCOTT. Mr. Chairman, you are going to have to find a whole lot faster moving commissioners than the group that I represented was if you can get that done in 6 months.

I am not sure how long it would take to do the study that you mentioned. There was a question before about whether a study be completed in a brief period of time to take a look at quality of life. Quite frankly, one of the reasons that our Commission recommended an immediate interim fix to quality of life, which is upping the payment based on level of disability, was that we didn't have a lot of confidence that a quick study could be done that would address it and it might drag on and on and on. We recognize, as did Dole-Shalala, that some of these people need some more immediate help than might occur a few years down the line.

In regards to a complete study of the Veterans' Disability Rating System, we offered in our Commission report some priorities. One of them was to sort out the TBI, PTSD, and other contributing mental ailments, so that it was clearer as to how diagnosis and evaluation might occur in that. And then we offered some other priorities, such as those parts of the schedule that had not been touched in many years might need some attention.

But our estimate was that a system as complex as the schedule of disabilities was going to take a significant amount of time to—I don't know whether the term is, "redo it," "change it," whatever; but I think we all recognize there is a significant challenge involved.

So, in my personal view, sir, it probably couldn't be done very well in 6 months. We recommended that the Congress put a time line on the VA that the entire schedule of disabilities be redone within a 5-year period. That was our guess as to how long it might take to do the entire thing. But again, sir, we offered some priorities where one might start and we would hope that those would be done in a more expeditious fashion.

Chairman AKAKA. Part of my question was whether it can be done on an administrative basis without Congressional hearings or legislative action.

General SCOTT. Sir, I think that from my own experience as a military officer over the years and my experience since that time, it would be that it was going to take all branches of Government working together to make this thing work. So, it appears to me, my personal opinion, that Congress has an important role in overseeing this rewrite, not micromanaging, but overseeing. I believe it is the responsibility of this Committee and the like Committee in the House to do just that, sir.

Chairman AKAKA. Thank you. Secretary West, the Independent Review Group endorsed the consolidation of the DOD and VA disability systems so as to create a single comprehensive medical exam resulting in a single disability rating. However, the Independent Review Group did not recommend reforms to DOD disability retirement pay. What are your views on the Dole-Shalala recommendation that DOD disability retirement pay be based solely on rank and years of service and not on the degree of disability?

Mr. WEST. Mr. Chairman, I looked at those recommendations. I speak for myself. The IRG has not taken a position on it. But they are reasonable. The division of labor is reasonable. And so, I don't

have a problem with it. I think that makes sense. I understand that this Committee is trying to work through competing, or not necessarily competing, but several different recommendations in that area. I think for us, what is important is that we move as quickly as possible to get the clearest possible resolution for retiring and for veterans.

I have some other views about some other parts of that, but let me just confine my answer to what you asked me.

Chairman AKAKA. Thank you very much.

Admiral Dunne, in my opening remarks, I stated how pleased I was that the Under Secretaries of VA and DOD were meeting weekly to address many of the issues we are discussing today. Would you please comment on all the things that SOC has done and is planning to do to address the recommendations of the Dole-Shalala Commission, the Independent Review Group, and the VA Task Force?

Admiral DUNNE. Mr. Chairman, the Senior Oversight Committee, in order to deal with the recommendations, has created eight different groups and assigned them their recommendations based on those responsibilities.

The first work group is the Disability Evaluation System. In response to the recommendations on a single comprehensive physical—at yesterday's weekly meeting we actually came to a final decision on that single comprehensive physical and that will be used in the pilot for the DES system, which we will commence during the month of November.

Another work group is looking at TBI and psychological health. The Senior Oversight Committee has been briefed on and approved the National Center of Excellence for TBI and Psychological Health and the intent is to have the ribbon-cutting for that at the end of November.

We have also overseen the development of clinical practice guidelines for PTSD, for major depressive disorder, and for substance abuse disorders, and also the Senior Oversight Committee has reviewed programming of some $900 million to support TBI and psychological health prevention, treatment, and continued research.

Another work group is looking at case management. They are working now on the development of the Recovery Coordinator Program, working together with HHS as well as DOD and VA. The Memorandum of Understanding between the three agencies is already in existence and has been approved. The memorandum establishing the program will be approved this month. And we are also in the process of developing what we are calling a Federal Individual Recovery Plan, which will take the servicemember or veteran from their first point of entry back into the United States where they start their care and recovery, all the way through their reintegration into the community or their return to duty, if they are able to recover sufficiently to return to duty.

The fourth work group is looking at data sharing between VA and DOD, and the Senior Oversight Committee is monitoring all the actions that are in place right now to have all essential health and administrative data viewable between our two agencies by October 31, 2008, which would meet the criteria that was mentioned earlier this morning of getting it done within a year's time.

We also have a contract in place to develop an analysis of alternatives for an Electronic Inpatient Health Record, and we are looking to the possibility of having some head start opportunities coming out of that contract in advance of the final deliverable, where we could do just that—get a head start on complete interoperability—so that, instead of just having viewable records, we have computable records between the two agencies.

The data sharing group is also developing a plan for a single web portal that the Dole-Shalala Commission recommended so that veterans could go online and see all the benefits that are available to them, and track their own progress.

And we are also developing an IT plan to support the Federal Recovery Plan, which the case management group is putting into place. This IT plan would be within the Web site that is being created so that those personnel who need to track an individual soldier or sailor could go online and review that and keep up to date with the progress.

The facilities work group has approved the DOD housing inspection standards for medical hold and holdover personnel, and they are also in the process of preparing the inspection report on all medical hold and holdover facilities, which will be submitted to Congress later this year.

A sixth work group is looking at a complete clean sheet review of the entire process: disability process; benefits process; et cetera; to say, what if there wasn't anything in place right now? What if there weren't any laws? What would you see as the ideal organization's benefits package to put in place?

Another work group is working on legislation, and you have the immediate product of their work now—creating the legislation to implement the Dole-Shalala recommendations.

And an eighth work group is looking at personnel pay and financial benefits. Some examples there are: DOD and VA are now sharing information—patient administrative data—when an active duty servicemember comes to a VA facility. We have seen problems in the past where, administratively, pay purposes, et cetera, have been complicated, because they somehow seem to fall through the cracks. We believe that we have taken care of that now.

We are also looking at implementing what we have learned to be the best practices for operating the TSGLI insurance system for the benefit of the severely injured veterans.

Chairman AKAKA. Thank you very much.

Senator Burr?

Senator BURR. Thank you, Mr. Chairman.

General, Admiral, Mr. Secretary, welcome. We can't thank you all enough and your Commission members that are here and those that aren't here for their time and commitment.

I want to take an opportunity to voice a personal frustration. This is the most powerful country in the world. Between our military and our veterans, we have some of the brightest people that exist on the planet. We are going to be tasked with helping to do the hard part—that 10 percent that I think everybody agrees legislatively has to be done, whether you just can't get there, you can't get the critical mass administratively—somehow the authority of Congress says, OK, we are going to do this.

The sad part is that I don't get a sense even if we did the legislation, that it happens tomorrow—I would only share with you my frustration. What takes so damn long? As powerful, as bright as we are, we are still talking about the DOD technologically getting up to where a community hospital is today. We have got community hospitals across the country that do remote monitoring of congestive heart patients that save money, increase the quality of life, yet we can't track somebody in the system and hand it off electronically to another system, and both have existed for decades.

I share that with you only because it is a frustration, I think, of all of us, as I know it is with you. I feel like we put you in an untenable position to sit in front of the table knowing that your reluctance is—well, history tells us, you can't do it that quick.

My only suggestion to all of us in the room and to those that read the testimony from this hearing is: we don't have any choice. We have to do it and we have to do it quick. If we don't, then we are the ones that have caused a quality of life issue with the veterans that are in the system. We have to fix it and we have to fix it now.

Now let me move to some very quick questions, if I can. General, the Commission recommends that all applicants for individual unemployment benefits first be screened by vocational rehabilitation and employment counselors. In support of this recommendation, the Commission cited a 2005 GAO report that found only 495 of 219,000 veterans in receipt of individual unemployment benefits had been evaluated by vocational counselors. My specific question is, what happens if, after being screened, the VA determines that employment is feasible, but only if a veteran receives vocational rehabilitation services?

General SCOTT. Well, in our report, we made a number of recommendations to how we could enhance the VR&E services to disabled veterans. Our thinking on the screening process is that, basically, before we award individual unemployability to a veteran, that the person should be screened to see if he or she is employable. In other words, we should——

Senator BURR. I guess my question, going right to the heart is, if the determination is that they are employable, but they choose not to do the vocational rehabilitation proposals that have been laid out for them to become employable, then what do we do?

General SCOTT. Well, we talked about that in a different context. When we talked about PTSD, we said that treatment, compensation, evaluation and VR&E should all occur, and they should be linked. So, I would say that if the problem happened to be recalcitrance, in many cases, I think we should link treatment with compensation. Now, I have no information that leads me to believe that recalcitrance is a problem, but if it is, that is a way that it might be addressed.

Senator BURR. Most of, I think, the recommendations of the Commission have overwhelming support. I want to go to one where Commissioner Brady had a different view and it dealt with different compensation levels being appropriate for some veterans based upon the circumstances of their injury. For example, Commissioner Brady wrote the sacrifice made by soldiers entered in combat is greater than the sacrifice made by servicemembers in-

jured in an off-duty motorcycle accident. Can you enlighten us on why the Commission did not recommend that compensation rates take into account the veteran's injury or the circumstances of the veteran's injury?

General SCOTT. Senator Burr, I will be happy to. First of all, let me say that all the Commissioners made major contributions to the final document. I can also say—and I think the Commissioners that are present will back me up—that we did not all agree on every aspect of every issue. We were able to achieve a consensus, which is found in the report. There are a few things in there that I can assure you that almost all the Commissioners would have worded a different way.

So, having said that, the Commission as a group views service kind of like this: we are in a 24-hour a day, 7-day a week service environment. I will use myself as an example. During the 32 years that I was on active duty, I was subject to the Uniform Code of Military Justice: 24/7; on leave; on duty; in the U.S.; out of the U.S. If we are going to continue to require our servicemembers to work to a 24/7 standard, then we have to look after them in that way—24/7. That is the consensus of the Commission.

Not to get too far afield here, but, we could be like the Dutch army, where everybody is a union member. They all work from eight to four and get a couple of hours off for lunch. If we went to a standard like that instead of the 24/7, I think there would be a case for looking at some sort of differentiation. But, if you are on duty 24 hours a day, then you should be protected 24 hours a day, and so——

Senator BURR. Rest assured, I am not a proponent of the Dutch system, nor am I questioning the recommendation and the fact that you didn't draw that distinction. I am trying to short-cut the process we will go through, because I am sure an issue will arise dealing with, "is there an off-duty difference versus combat." Understanding where the Commission was, as a whole, is extremely important.

Admiral, very quickly, a common theme among the Commissions that testified today and mentioned in your report is the need for a formal system of case management or a central individual to coordinate all the servicemembers' needs as they transition from DOD to VA. Real specifically, from what you have seen on the task force, do you feel that VA's recent move to create Recovery Coordinators, and I think you mentioned Federal Recovery Plans, as well—is that a silver bullet, or, is this just another piece of the process that we have got to get right?

Admiral DUNNE. Well, I think it is an essential part of the process, Senator. We have already moved out, and put on the VA side, Transition Patient Advocates in place. 106 of them have been hired so far, and I think they are essential to helping the family focus on recovery, and let the Transition Patient Advocates worry about those administrative things that have to happen in order for the recovery to take place properly. But, that is at the scene.

We also need the Recovery Coordinators who are going to be the next level up, Federal Recovery Coordinators who will start at day one with that servicemember and track them through all the way to the end. And they will be overseeing and monitoring the efforts

of the Transition Patient Advocates or the Army Triad, et cetera, who also have key and essential jobs to make sure that our veterans and servicemembers are taken care of. So, they are going to have to be working together.

Senator BURR. Admiral, as you are well aware, the VA-assigned case managers to our service personnel when they came in. I think Senator Dole was the one that said one of his Commission members who went through the process had so many case managers they couldn't remember the last one's name, so they wouldn't have known who to call. I only point that out to you to say we have been here before. We have had the right focus. For whatever reason, I think the administrative side of it didn't recognize the need for that personal bond, much the same as a patient-doctor relationship. Somebody without a medical home has a very difficult time accessing preventative care. Somebody who doesn't have an entryway into the VA today has a very difficult time, and we know that to be the fact. It is another challenge that we have got to address in a different forum.

Mr. Secretary, I am delighted to be reminded that you remember your home of North Carolina. I am sure your mother would be proud to know that.

I am going to give you an opportunity to expand on your answer to the Chairman. You had possibly some additional observations about the Dole-Shalala legislation. You limited your answer to just the specific area. If there are other areas you would like to address, I would like to give you that opportunity.

Mr. WEST. Thank you, Senator. I didn't mean to sort of appear to promise some areas of disagreement. I don't have any, just some reactions. But I am reminded, before I do, of something you said about your frustration with hearing that whatever we say has to be done, it seems to take forever to do it in a Nation like this.

When we try to change these huge institutions like VA and DOD, you have heard the analogy before, I am reminded with the Admiral sitting here, about trying to turn a huge ship and it looks like it never happens. It doesn't mean that we take our hands off the wheel. It doesn't mean that we lessen our efforts to turn, because we know eventually we get it turned.

And so frustrating as it may be when I recite how far DOD has in some respects against it, at the same time, when I listen to these task forces that are meeting, there are two, it seems to me, big areas of optimism. One is the fact that the two Gordons continue to meet on this. Gordon England has a reputation as a problem solver and a doer at DOD. He has certainly got the confidence of the President, who has had him in two different departments and in two different parts of the Department of Defense, Navy, DOD, Homeland Security, and the like, and we all know Gordon Mansfield and his record of achievement at VA. That is not the point, though. The point is the power of their offices. They run those departments for their principals who are trying to do other things, and as long as they are engaged, we will make progress on these things.

The other is, there are no good things about what happened at Walter Reed except that it caused us as a Nation to focus on the problems you are discussing. I was just listening to the caseworker

discussion. We found at Walter Reed that part of the problem that was discussed in the press about soldiers who were expected to keep their appointments when they were in rehabilitation and they had had the kind of surgery that made it very difficult for them to know who was their doctor that they had to go see and what their appointments were and who was going to help them to do it and how unfair it is to the families is that you needed someone who was following that whole thing throughout. The solution, of course, could be if it were the same person who could follow the servicemember and family all the way through. That is why this focus on caseworkers is a continuing thing that we need to try to do and to get right.

In terms of the various recommendations by the Dole-Shalala report, they had the opportunity to hear from us. We completed our work as they were starting. That was the time line that had been given us and the idea was that our stuff should—it is going to be available to inform them, and we are very happy with their elements. I did not mean to suggest anything. I think it was the particular topic that was being addressed at the time, responsibilities between DOD and VA as we looked at the joint scheme.

One reaction I had was the discussion between who should do the physical examination. This effort is combined into one thing. I am reminded that one of the things we found as we talked to servicemembers at Walter Reed, also at Bethesda and elsewhere, was their mistrust of the system, of the doctors in the system, that the doctors somehow were biased against them—certainly the Army doctors, in some way, that perhaps their notes weren't reflecting everything that they should reflect. An important part of the treatment and the determinations is what is in the notes of the attending physicians as they look at them along the way. It has a big impact on decisions that later get made by reviewing authorities.

It may be well that servicemembers would be more inclined to see VA doctors doing that one single examination. I think the better answer is the one I heard given here, which is that even more, it may be even best if we look to see what the abilities are in a given area where the examination is to be given between the two services. It may not be so good as to make it an iron-clad process where it is a DOD physician every time that does it. I think there is a little area there we want to be careful about. I am sorry I took so much time.

Senator BURR. No, and I didn't mean to infer that you had disagreements with Dole-Shalala. I thought you had some additional things you wanted to say. You are in a unique situation, having served as Secretary of the Army and the Secretary of the Veterans Administration, but all of you are in a unique situations from the standpoint of the studies you have just done and the service that you have given.

Mr. Chairman, I hope that they will continue to make themselves available to the Committee relative to questions that we might have that help us to sort through this at a faster pace than what Senate historical standards are, as well. I thank the Chair.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Murray?

Senator MURRAY. Yes. Mr. Chairman, thank you very much. I think none of us want to have the sound and fury of the Walter Reed scandal to be the sound and fury of this year, then 2 years come back here and we have done nothing. So, I think we all want to see progress made, and to that point, General Scott, you, in your recommendations with your Commission, seek to establish an oversight group to make sure that the Commission recommendations are followed on. That is not part of what we heard from the Dole-Shalala Commission. Can you tell us why you believe an oversight commission is important?

General SCOTT. This goes back, Senator, to an earlier comment about how long is it going to take to get some of these things done. It seemed to our Commission that oversight at a couple of levels was critical. One of them: is we thoroughly endorse the SOC with Deputy Secretary England and Deputy Secretary Mansfield. But, we also believe that there are some specific areas where additional oversight may be needed and we suggested that the Congress may wish to establish an oversight group or committee to keep up with these many, many recommendations from all these groups, to make sure that none of the important ones fall in the cracks. We don't want to find ourselves all back here in 2 years saying, well, gee, we talked about this before but nothing ever happened.

So, taking nothing away from the two departments and taking nothing away from the Senior Oversight Council, it seems to us that in some of these areas, oversight—you can call it independent oversight or you could call it another level of oversight—might be valuable to make sure that some of these things don't just go away. That was the intent of the recommendation, ma'am.

Senator MURRAY. OK. Thank you very much for that.

Secretary Dunne, the Senate has acted on legislation. We came together—the VA and the DOD Committee. We put together the Dignified Treatment of Wounded Warriors Act. It has passed out of the Senate. Has the administration taken a position on that legislation?

Admiral DUNNE. Senator, I think the best way I can describe reaction to the legislation is based on my experience of the past 7 months and looking at the comprehensive plan that the Senior Oversight Committee is putting in place right now to address such activities as the TBI, PTSD, case management, et cetera, and creating a Center of Excellence—putting that into action already on PTSD and TBI.

My best understanding is with the legislation which I participated in drafting, which was sent over here yesterday, to reflect the recommendations of the Dole-Shalala Commission, and what I have learned as a member of the Senior Oversight Committee. I think that I would say, that is the best legislative approach to take.

Senator MURRAY. So, they are not commenting, or they are commenting in opposition to it?

Admiral DUNNE. I don't believe that we have an administrative position right now.

Senator MURRAY. OK. One other quick question. All of the other task forces emphasized and talked about family support except for the President's Task Force. I understand you were limited in your scope. The President said he didn't want to spend any new money,

so you were not looking to expand anything. I know that put a big damper on it. But, can you tell me what the VA's recommendations are on family support programs?

Admiral DUNNE. Well, one of our key assets is using the Vet Centers, which we have over 200 of them throughout the country, and they are available, legislatively have been made available to families and dependents, as well as servicemembers, for counseling; dealing with the challenges of deployments; et cetera; and also, where necessary, bereavement counseling for the families.

Senator MURRAY. I am sure you have seen the other reports. They focus a lot on what the real stresses for families today in the current military are and how families are the support groups, and all the issues from health care to being there for someone who is critically ill for a long period of time. Did your task force not look at all at some of this extra support, additional support, needed support, for those families?

Admiral DUNNE. The task force responded to the request that we received from the different information sources we sought, including our Web site, e-mails coming in, et cetera, and——

Senator MURRAY. That sounds so bureaucratic. I am just asking you, don't you think that there are a lot of families out there who, in today's world, really need additional services?

Admiral DUNNE. I absolutely do, and one of the ways we are dealing with that is with the Transition Patient Advocates, who have the ability to communicate with the family and determine where there is a need, where there is a special circumstance, et cetera, and for them to find an answer to that special circumstance anywhere within VA—that they need to go to get the answer.

Senator MURRAY. Well, don't you think a lot of them are getting lost today because they don't know where to go?

Admiral DUNNE. I am confident that my fellow workers at VA are doing their utmost to make sure that nobody falls through the cracks.

Senator MURRAY. And you wouldn't think that the VA needs today to look differently at veterans' families than they have in the past?

Admiral DUNNE. We need to continue to emphasize that the family is a very essential element to the recovery of our veterans and active duty personnel and we need to work with them to make sure that they can focus on recovery and not on administrative procedures.

Senator MURRAY. Mr. Chairman, my time has expired, but I do think in today's world, with what we are asking of our men and women who serve us and the fact that many of them have families today, they end up being the caregivers. That is something we have to really focus on. Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Murray.

I want to thank this panel very much for your testimony, your responses, as well as your recommendations. It will be helpful to our Committee as we proceed here. In case we receive any further questions, we will be submitting them to you for the record. So, thank you again, and thank you to the rest of the Commissioners who are here for your service to our country.

I now welcome our third and final panel and want to extend our welcome to each of you.

I extend a welcome and aloha to Ms. Ariana Del Negro, the wife of an Army Ranger who suffered a Traumatic Brain Injury while serving in Iraq in 2006. Ms. Del Negro traveled all the way from my home State of Hawaii to testify before the Committee today. Ms. Del Negro also testified at a field hearing I held this August in Honolulu where she shared the challenges that she and her husband have faced in obtaining proper medical care for his injuries. I thank Ms. Del Negro for traveling a great distance to share her and her husband's experience with us and for the record.

Also testifying on the third panel are Colonel Peter Duffy, who is the Deputy Director of Legislative Programs for the National Guard Association of the United States; Gerald Manar, the Deputy Director of VFW's National Veterans Service, who is representing the views of the Independent Budget; Meredith Beck, National Policy Director of the Wounded Warrior Project; and Colonel Steve Strobridge, Director of Government Relations for the Military Officers Association of America.

I thank all of you for being here today and look forward to hearing your perspectives on the proposals and recommendations put forth in the reports of those who appeared on today's earlier panels. Of course, your full statements will appear in the record of the hearing.

May I ask Ms. Del Negro to begin with your statement.

STATEMENT OF ARIANA DEL NEGRO,
WIFE OF 1LT CHARLES GATLIN

Ms. DEL NEGRO. Thank you very much. As you mentioned, my name is Ariana Del Negro and I am here representing most of the families who are entering the awkward transition stage between active duty and veteran status.

As Chairman Akaka mentioned, my husband, Charles Gatlin, a First Lieutenant and scout platoon leader of his infantry battalion, was wounded September 28, 2006, after a vehicle-born improvised explosive device detonated less than 20 yards from where he was standing. My husband is a very accomplished soldier. His prior service was in the Old Guard. He deserved better care when he came home.

He was subsequently returned to Hawaii approximately 4 weeks after his injury. It was immediately frustrating. At our first doctor's appointment they didn't know what a VB–IED was; they also took no initiative to get him the care he needed. My husband, an Army Ranger, a 200-pound man who was responsible for collecting intelligence to ensure the safety of his fellow soldiers, admitted he was having anxiety at his first neurologist appointment. The response from the neurologist, "See me in 2 weeks," was inappropriate—absolutely inappropriate.

My husband could not drive when he came home. He had severe vertigo. He leaned to the left. He had hand and facial tics and he couldn't keep eye contact when speaking. My husband used to work in the Pentagon in the public tour program. There was no room for error with speech. He developed a stutter and it significantly compromised his communication abilities. I had to act on his behalf as

his agent. He was unable to follow conversations. He did not receive any education about his injury.

I work in the health care field and made sure to familiarize myself with the complexities of the injury and the required standard of care that should be delivered. Throughout this process, initially at Tripler Army Medical Center, that standard of care was not administered. There was no coordination of care. There was no communication between providers. And the providers we were able to see, and only able to see after we demanded that those appointments be made, did not have any consensus between them.

Subsequently—this was January of 2007—we finally had a meeting with my husband's providers. They still did not have a coordinated care plan established, and it was at that time that we continued with our insistence that he be referred to the Defense and Veterans Brain Injury Center in San Diego for treatment. Our request for referral was finally granted January 31, 2007, 5 days before the Washington Post articles were released.

Our experience represents exactly what those articles captured. It was humbling to see that we were not an exception but more the rule, and it was very sad. I am from Bethesda, Maryland. I work in the health care industry for a very large online health care resource. We have no children and I telecommute to New York for work. The responsibilities that me and my husband were asked of were not fair. If they were not fair for us, who were more independent and capable, what does that mean for these other families, for those whose husbands return far worse off than my husband, for those with children who have to work to supplement the family's income and who don't know that the care they are receiving is not what they need?

I urge you to continue to support these families, specifically by extending resources to them. I would not have known about the Defense and Veterans Brain Injury Center had I not done extensive research and actively reached out to those providers.

I must mention that we received care at the Sharp Rehabilitation Program, which coordinated with Balboa Naval Medical Center. The treatment at Sharp was impeccable. It represented the complete antithesis of the treatment we received at Tripler and my husband came home a husband. I am no longer a caregiver, I am a wife. Because of Sharp, which was a civilian program—because they had 20 years of experience, we managed to survive as a family. That is the bottom line. That is the most important message. We can sit here all day and discuss the importance of policy, but unless some of these things are implemented immediately, we will continue to fall through the cracks.

Thank you.

[The prepared statement of Ms. Del Negro follows:]

PREPARED STATEMENT OF ARIANA DEL NEGRO, WIFE OF 1LT CHARLES GATLIN

Mr. Chairman, Committee Members, thank you for allowing me the opportunity to participate in this vital forum on the issue of providing coordinated care to servicemembers, veterans, and their families. My name is Ariana Del Negro and I represent one of the many families with a loved one injured in Iraq or Afghanistan who are now entering the awkward and unfamiliar transition phase between active duty and veteran status. I am here today not only to tell you about the numerous obstacles my husband and I faced when he first returned home from Iraq, but also to describe the excellent care he ultimately received for his Traumatic Brain Injury

(TBI). My husband and I believe that there is much work to be done and hope that sharing our experiences will help create a model of care for servicemembers and veterans with TBI and their families that establishes: (1) strong support networks and access to information; (2) timely, comprehensive, and coordinated care; and (3) appropriate funding for the continued research and training required to provide a high standard of long-term care to the ever-increasing numbers of warriors suffering from TBI.

The wounds suffered from these injuries extend beyond the soldier; the frustrations with gaps in care and lack of support also wound the families fighting for their loved ones. These servicemembers, veterans, and families need our help, and the responsibility to provide them with that help falls on the Nation for whom these warriors bravely fought.

OUR STORY

My husband, 1LT Charles Gatlin was the Scout/Sniper Platoon Leader of his Infantry Battalion. He was honored to hold this highly coveted position, one which was reserved for the "best" lieutenant in the Battalion. He took pride in having the degree of skill and professionalism required for the position, particularly because his work gathering intelligence helped both to ensure the safety of his fellow soldiers and to meet the larger objective of unifying a politically and religiously diverse area. My husband commands deep respect from his soldiers and continues to perform his job (albeit in a different capacity) with the highest degree of excellence and professionalism.

On September 28, 2006 in Kirkuk, Iraq, my husband suffered a closed-head TBI after a very large vehicular-borne improvised explosive device (VBIED) detonated less than 20 yards from where he was standing. He was exposed to three concussive forces: first, the explosion; then the engine block from the vehicle which struck him on the back of the head as he was thrown into the air; and finally when he hit his head again after falling to the ground on his back, where he remained unconscious for at least 10 minutes.

The screening and care my husband received in the battlefield and in the theater was excellent, proficient, and per protocol. Within 1 hour of his injury, my husband was medevaced to Balad Medical Hospital where he was admitted in serious condition. After 3 days in the intensive care ward, he was eventually discharged from the hospital and returned to his base in Kirkuk in hopes that his initial TBI symptoms would subside enough that he could return to the field of combat within a few weeks. I believe that my husband was returned to his base in Kirkuk instead of being medevaced to Landstuhl Regional Medical Center in Germany because of his insistence that he be back with his men in the field. During the 4 weeks my husband spent back in Kirkuk, he had to depend on his medic and roommate, CPL Joshua Harmon. CPL Harmon tended to him, helped him dress, assisted him when moving from room to room, and checked his pupils each night. (Sadly, on August 22, 2007, CPL Harmon and nine of his fellow Scout platoon members died in a helicopter crash outside of Kirkuk, Iraq. To CPL Harmon and his family, and to the families of his fallen comrades, thank you.)

After spending approximately 4 weeks in Kirkuk without resolution of his symptoms, my husband was returned back to his home base in Hawaii. He could barely keep his balance, let alone figure out where he was supposed to go and whom he was supposed to see for his medical care. Unfortunately, the system he reported to, Tripler Army Medical Center, did not know either.

My husband had sustained what is now known as the "signature wound" of the Global War on Terror. However, he was injured before this phrase was coined and before the full implications of the injury were recognized. The general lack of awareness of TBI at the time of his injury, coupled with its "silent" symptoms, were significant barriers when my husband first sought medical treatment upon his return from Iraq.

A closed-head TBI is literally a hidden injury; an injury with the potential for subtle yet devastating symptoms that go unnoticed by those who are unfamiliar with the individual's functioning prior to his or her injury. Health care professionals are used to having physical evidence of an injury, but mild, closed-head TBIs typically do not show up on brain scans and referrals for treatment must be made on the basis of neurological exams, self- and family-reported symptoms, and the results of neuropsychological testing.

When he first returned home from Iraq, my husband complained of debilitating headaches, chronic vertigo, memory lapses, anxiety, and hearing loss. He leaned to the left, developed hand and facial tics, and could not maintain eye contact when speaking. Two weeks later, as some symptoms worsened, new symptoms emerged.

He developed a significant stutter, had difficulty recalling words, and frequently dropped objects. Unable to drive, this fiercely independent man lost his autonomy and was forced to depend upon others for his basic needs. It was also at this time that he began to withdraw socially, avoiding public and busy areas. His time was mostly spent sitting, staring blankly. Watching my husband, an exceptionally accomplished and strong man, struggle with such simple tasks was very difficult.

EARLY DISAPPOINTMENTS

The phrase "twice wounded," often used to describe the struggles wounded warriors face when seeking care in the military health care system may seem clichéd, but it is exactly what my husband experienced after he returned from Iraq. He describes the struggles we encountered at Tripler as being as painful as sustaining the injury itself.

Treating TBI requires a multidisciplinary approach from as many as nine specialists. However, the single most important component of treatment is effective communication and coordination among these providers. Although Tripler had the resources required to effectively treat TBI, they lacked that crucial coordination. Coupled with Tripler's lack of experience managing TBI and post-concussive syndrome (a diagnosis made when a patient continues to exhibit symptoms from TBI beyond 1 month), this lack of coordination compromised and slowed my husband's recovery. Despite his worsening symptoms, we had to fight for every referral he needed—audiology, vestibular testing, ophthalmology, speech therapy, etc. And, even after we were referred to and met with these specialists, no two specialists agreed about what my husband needed; we spent our days shuttling from one appointment to the next, only to discover that the recommendations made by one provider were deemed unnecessary by another.

Many of the providers we saw had little or no experience with blast-related TBI. When my husband told the doctors treating him at Tripler that his injury was caused by a VBIED, they asked him what a VBIED was. Likewise, when my husband—the brave infantryman who had insisted on remaining in Kirkuk after his injury—actually summoned up the courage to acknowledge to his neurologist that he was experiencing anxiety, his neurologist simply responded: "See me in 2 weeks." Had this neurologist instead taken the time to find out what my husband's responsibilities were in Iraq and what he witnessed, he would perhaps have realized that exposure to these stressors meant my husband was at increased risk for depression, anxiety, and other psychological issues. In my husband's case, these risks were exponentially compounded by the fact that several symptoms associated with post-concussive syndrome secondary to TBI are psychological in nature. Whether due to a lack of combat experience, poor training, or overwhelming caseloads, these doctors simply did not have the knowledge or skills to treat my husband's injuries.

Similarly, because doctors cannot see physical evidence of TBI, they sometimes wrongly conclude that servicemembers suffering from TBI are malingering and trying to shirk their duties and avoid returning to Iraq or Afghanistan. One of the physicians treating my husband in Hawaii made exactly this kind of accusation against my husband, which added salt to an already open wound.

My husband was unable to drive, which placed responsibility for taking him to each and every one of his appointments and to and from work on me, his lone caregiver. Because of the adverse cognitive and communication effects of his injury, I also had to act as his representative, speaking and processing information on his behalf. But the system at Tripler was far from encouraging and supportive of my efforts. Many of the people we encountered seemed to be less than pleased with a wife who was outspoken, informed, and persistent. One physician even went so far as to suggest that my husband was receiving poor care because of my outspokenness.

Finally, after 14 long and frustrating weeks of struggling with the system to get my husband the care he needed, our request for referral to the Defense and Veterans Brain Injury Center (DVBIC) at Balboa Naval Medical Center in San Diego, CA, for thorough evaluation and comprehensive treatment was granted. After waiting another 6 weeks for the paperwork to be finalized, we finally arrived in San Diego. All told, it took us more than 5 months to get access to this excellent level of specialized health care. These were five valuable months lost in the crucially important acute rehabilitation stage of TBI.

FINE EXAMPLE OF EXCELLENT CARE AND INVALUABLE EDUCATION

The care in San Diego represented the complete antithesis of what we received in Hawaii. The DVBIC at Balboa coordinates its care with the Community Re-Entry Program at Sharp Rehabilitation Center, a center with more than 20 years of expe-

rience in rehabilitative care. The providers at Sharp and at Balboa addressed all of my husband's needs (physical, occupational, and speech therapy), integrated our requests into their rehab program, and provided amazing support to both of us. My husband finally received the care he should have received all along. He underwent intensive rehabilitation 7 hours a day, 4 days a week. We had biweekly coordination meetings with all of my husband's providers who met with us to discuss his progress, make suggestions, and ask for feedback.

The care my husband received in San Diego represented what we should have been receiving all along. I use the term "we" because the caregiver and family unit are integral to a successful rehabilitative process. In stark contrast to the care in Hawaii, where my involvement was discouraged, the program in San Diego integrated the caregiver into the rehabilitative process.

And, importantly, they educated us. We learned that our situation was not unique and that many closed-head TBI patients face similar obstacles and frustrations that compound their symptoms. Shortly after coming home from Iraq, for example, my husband commented that because he was not missing a limb and/or did not have scars on his head or body, he questioned whether he was as seriously wounded as those with visible injuries; a question reinforced by his experiences with some of the doctors he encountered at Tripler. The education we received at the DVBIC and Sharp provided affirmation to my husband that he was seriously injured and deserved the best care possible. They explained that the adverse effects of his injury would have resolved faster had some of the frustration with his medical care been avoided. They also explained that my husband probably would have made greater progress during rehabilitation had he been referred earlier in the treatment process. Although he likely would have recovered to the same degree, he would have done so at a much faster rate. Importantly, they also explained that there may be some symptoms that will never resolve and that the success of his rehabilitative therapy depends on our ability to set reasonable goals and maintain realistic expectations.

My husband left San Diego a changed man. He regained his ability to accomplish complex tasks, his speech was fluid, he was able to run, and he passed a driving evaluation. He was able to regain his autonomy, enabling me to (semi-) retire from my roles of caregiver and chauffeur. Now I can be a wife and he can be a husband. He has since returned to duty in an administrative capacity as his Battalion's Rear-Detachment Executive Officer in Hawaii. Although he still suffers from intermittent headaches, vertigo, fine motor skill deficits, and some memory problems, they are less intense than when he first came home. He has applied the lessons we learned in San Diego and is learning to accept and compensate for his limitations.

Throughout this process, my husband and I have done our best to keep a sense of perspective, returning time and time again to our sense that we are one of the lucky families. My husband and I are both well-educated and make a good living. Working in the health care industry, I have been able to rely upon my medical background to find appropriate resources. My husband was also fortunate to receive remarkable support from his Command. His Commander, MAJ William J. O'Brien, in the spirit of a true Infantryman, dedicated a significant amount of time and effort to ensure that my husband received the care he rightly deserved. Without MAJ O'Brien's support, and the support of the 25th Infantry Division, it's likely that I would be sharing a different story with you today.

However, if it has been this difficult for my husband and me, we cannot imagine what it must be like for the other families—those with warriors who return far worse off than my husband; families with children; families with mothers who have to work outside the home to help support their families; and those who do not know that the care they are receiving is far inferior to what they need and, importantly, deserve.

SUPPORT FOR FAMILIES AT ALL STAGES IN THE RECOVERY PROCESS

The success we had at Sharp Rehabilitation demonstrated that in addition to providing adequate funding and training, it is important that systems be created to provide support for servicemembers, veterans, and their families. Our frustrations with my husband's initial care alienated us; we had nothing to compare our own experience with, and had no communication with other families in similar situations. Less than 1 week after our request for referral to the DVBIC was honored, The Washington Post published the first in its series of articles on Walter Reed, chronicling the frustrations wounded servicemembers, and their families faced trying to navigate through a complicated and bureaucratic system. The Washington Post articles were bittersweet: the sweet of knowing we were not alone coupled with the bitter of knowing we were not an exception. These articles also validated my belief that it is not just the individual servicemember who bears the brunt of injury.

The unrealistic expectations that the system places on the caregiver add further burden to an already stressful and taxing situation.

It is critically important that servicemembers and their families are proactively made aware of the resources that are available to them; they should not have to seek them out. I would not have known about the DVBIC unless I had actively sought out information and made contact with both Walter Reed and San Diego. I would not have known that my husband was not getting the appropriate standard of care if I did not have a medical background and if I hadn't done extensive research to educate myself on TBI. I made sure that I was armed with knowledge for each doctor's appointment and I did the best I could to educate my husband. What is clear from our own experience is that there are many families in need. These families need immediate access to resources, they need advocates, and they need support. It is one thing to develop resources but it is another to actually utilize them. If the families do not know that these resources exist, they are unlikely to ever be able to reap benefits from those programs.

I am pleased that the reports from The President's Commission on Care for America's Returning Wounded Warriors (commonly referred to as the Dole-Shalala Commission), as well as the Veterans Disability Benefits Commission, recognize the pivotal role of family in the treatment process and I strongly advocate for an amendment to the Family Medical Leave Act, extending unpaid leave from 12 weeks to 6 months for caregivers tending to the needs of a servicemember. I believe, however, that the legislation should go one step further to include those tending to the needs of wounded veterans, particularly since many of the diagnoses for TBI and PTSD are made after servicemembers are separated from active duty.

THE IMPORTANCE OF TIMELY AND COORDINATED CARE

Our success with Sharp's Community Re-entry Program was the result of receiving excellent individualized care and education from a multidisciplinary group of providers who worked well together and integrated the family unit into the decision-making process; in essence, they practiced "relationship-based health care". This medical model is outlined in pending legislation, such as the Veterans Traumatic Brain Injury Rehabilitation Act of 2007 (S. 1233).

My husband was very high-functioning after his injury and was not an injured servicemember for whom the military typically considered intensive rehabilitation necessary. However, the increasing awareness of the deleterious and long-term consequences of TBI—namely through the adoption of the DVBICs across the country—my husband was finally properly identified as someone who could benefit from such care.

Our experience at the Sharp Rehabilitation Center also demonstrates the importance of extending civilian health care services to servicemembers and veterans. Programs such as the one at Sharp have experience with these types of injuries, have an effective program in place, and clearly yield excellent results. More initiatives need to be taken to institute similar programs partnering military, veteran, and civilian health care services. In addition, consideration must be given to properly pairing the offerings of a rehabilitation center with the specific needs of a servicemember/veteran with TBI. Employing the valuable resources of these non-Department facilities could help reduce the heavy burden on the Department of Veterans' Affairs (VA)—a burden likely to grow in parallel with the number of wounded.

STAFFING SHORTAGES AND LACK OF TRAINING COMPROMISE CARE

As noted in Dole-Shalala Commission Report, the chances of recovery from TBI are greatest when prompt and correct care is administered. Communicating this message to health care providers is pivotal to ensure that all servicemembers and veterans have immediate access to care. Meeting this objective, however, is contingent on providing appropriate, timely, and comprehensive training to health care professionals, with an emphasis on the signs and symptoms of TBI and PTSD. It is also dependent upon adequate long-term funding.

This also speaks to the staffing shortages of health care providers in the military and VA systems. Tripler Army Medical Center is the largest military medical treatment facility in the entire Pacific Basin, covering an eligible population of 400,000 servicemembers, veterans, and their families. Yet, when my husband first arrived at Tripler for care, there were only three neurologists in the entire hospital. Furthermore, there was only one full-time neuropsychologist, a provider described in a Veterans Health Initiative as "the key player in diagnosing cognitive impairments" in patients with post-concussive syndrome. Neuropsychological testing is a labor-intensive process and the results of the testing require careful and detailed analysis

to ensure a fair assessment. Given the recent findings of the Neurocognition Deployment Health Study that deployment to Iraq increases the risk of neurological compromise, the caseload for these neuropsychologists will undoubtedly increase.

MORE RESEARCH IS NEEDED!

There is little doubt that more research on blast-related TBI is needed, particularly as it relates to the effects of exposure to multiple primary blasts and long-term outcomes. TBI in a combat environment is a complex injury. A thorough understanding of the nuances of the injury, whether physically evident or otherwise, is absolutely essential to identify effective therapies and maximize outcomes. Currently, much of the evidence on blast-related TBIs is derived from animal studies, which have helped researchers understand the pathophysiologic effects of the injury; however, the implications of these findings in the clinical setting have not been well studied. As the number of closed-head TBI wounds increase, so too does the need for allocated funding to support clinical research and new practice guidelines.

For example, much of the data on TBI are largely based on older studies, evaluating outcomes of patients who sustained a TBI in an automobile accident, a fall, or a sports injury. These studies do not take into consideration that a blast-related TBI may injure cells at a more severe, microscopic, sub-cellular level. Injury to this fine of a degree may influence outcomes and possibly require longer periods for maximum recovery than TBIs suffered in a non-combat setting.

Although much has been learned about the recovery and treatment process for TBI, much remains unknown, particularly about the long-term effects of these injuries. For example, how long should care be administered? When is a patient considered fully recovered? What will the long-term consequences of closed-head TBI be—epilepsy? Parkinson's? Alzheimer's? Answers to these questions remain ambiguous at best. Applying the tragic lessons learned from exposure to Agent Orange, we should prepare for the likelihood of long-term adverse effects from this conflict as well.

TRANSITIONING FROM ACTIVE DUTY TO VETERAN STATUS—ACTION IS NEEDED

Although my husband is still on active duty, our experience represents what many young veterans suffering TBI have had to face before being discharged from the service. We fear that without major reform, the obstacles and frustrations we faced within the Army's medical system will not be significantly different from those we may encounter when we enter the VA health care system. Although the VA and Department of Defense (DOD) systems are separate entities, the two departments share similar bureaucratic problems. We need to learn from the experiences of servicemembers and families such as ours in order to avoid similar obstacles within the VA system. The continuum of care must begin on the battlefield, move to the military health care system, and continue through the VA.

We are encouraged by recent initiatives proposed by Congress, the DOD and the VA to improve the care and support for servicemembers, veterans, and their families, particularly as it relates to developing a strong collaboration between the two departments to streamline the transition process. There is little doubt that the systems to accomplish these goals are in place; however, they are still in the early stages of implementation and, as with any natural process, it will take time for them to mature to the degree desired. While the development of these initiatives are imperative for the future, we must not lose focus and overlook the fact that today's servicemembers and veterans continue to face a number of obstacles and hardships. Unless immediate action is taken, these individuals will continue to fall through the large cracks borne of years of neglect and empty promises.

CONCLUSION

Although The Washington Post articles in February 2007 have turned much-needed public attention to the hardships that both servicemembers and veterans face, they were hardly the first warnings about these problems. For years, the Government Accountablity Office has issued reports documenting the significant backlog in the VA disability system, the outdated nature of the VA Schedule for Rating Disabilities, and the incompatibility of electronic health records between the VA and DOD systems. Concerns regarding blast-related TBIs were also addressed prior to The Washington Post articles. On August 11, 2006, the Armed Forces Epidemiology Board presented its findings on the acute and long-term health implications of TBI in military servicemembers to the Assistant Secretary of Defense for Health Affairs. The Board's recommendations closely mirror those made in the Dole-Shalala Commission Report.

I ask of you: why did it take a series of articles in The Washington Post for these concerns to suddenly be regarded as serious? And, if only little progress has been made in response to reports over the course of the past few years, why should we believe that recommendations in the new reports will suddenly transform the status quo? Reform has been needed for years and some of the recommendations made in these reports will take still more years to implement. Where does that leave today's and tomorrow's generation of veterans?

I am aware that this continues to be an ongoing learning process, but I also believe that measures need to be put in place to ensure that these changes are made, to assess the efficacy of these programs, and to set specific benchmarks. Thus far, we have a wealth of data and an abundance of recommendations. However, until these recommendations are actually integrated into the existing system and successfully applied, they will remain nothing more than notes on a page.

In the end, my husband and I hope that you and your colleagues will work to make other returning servicemembers and veterans just as fortunate by implementing systems that: (1) provide family members with support and assistance navigating the system; (2) that facilitate coordinated care; and (3) that fund further long-term research of the devastating injuries of TBI and PTSD. It is time that the excellence that these servicemembers and veterans dedicated and displayed in the field of combat be matched by the system for which they sacrificed.

Chairman AKAKA. Thank you very much, Ms. Del Negro.

Colonel Duffy?

STATEMENT OF COL. PETER J. DUFFY, USAR (RET.), DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NATIONAL GUARD ASSOCIATION OF THE UNITED STATES

Colonel DUFFY. Chairman Akaka, Ranking Member Burr, and Members of the Committee, it is my distinct pleasure to appear before you on behalf of the National Guard Association of the United States (NGAUS), to address certain recommendations of particular concern to the welfare and benefit of our wounded National Guard members and their families, as set forth in the report of the President's Commission on Care for America's Returning Wounded Warriors, hereinafter referred to as the report.

This brief submission will address four recommendations of the report relative to improving care for our wounded members. NGAUS supports all recommendations of the report with additional recommendations of its own to improve the subject care. NGAUS urges this Committee to continue to differentiate between the medical needs of our active duty members and our veterans, particularly with respect to geographical barriers.

It is important to note that National Guard members returning from deployment can be extended on active duty for treatment by military treatment facilities before being discharged. In most cases, our members, upon returning from deployment, are quickly discharged from active duty and then eligible as veterans for care at the Department of Veterans Affairs health facilities. Once discharged, most of our members continue in the Selected Reserve and, as such, are eligible to enroll in TRICARE Reserve Select beyond the six-month Transitional Assistance Management Program. However, once discharged, our members are no longer eligible for treatment at military treatment facilities.

Report recommendation one.—Immediately create comprehensive recovery plans to provide the right care and support at the right time in the right place. The needs of our wounded National Guard members and their families are geographically spread across the full area of our country, its Commonwealths and Territories. Once released from medical hold, our wounded members return to their

civilian communities, not to military installations. These communities are often in areas isolated from a Department of Veterans Affairs treatment facility. Obtaining continuing treatment at a DVA facility for many of our veterans will mean having to travel significant distances. This travel may require the veteran and possibly an accompanying family member to take time off from work, thereby further straining an employer-employee relationship already stressed by previous deployments.

Although perhaps most often associated with States west of the Mississippi, geographical barriers to treatment can occur in States as small as Rhode Island and as far East as Maine. Maine Representative Michael Michaud, Chairman of the Health Subcommittee of the House Veterans Affairs Committee, indicated this session at a hearing of his Subcommittee that some of his veterans in the State of Maine must travel 9 hours to be treated at facilities in Boston. In recommending the creation of Comprehensive Recovery Plans to provide the right care and support at the right time, in the right place, the report speaks to the need to expand DVA treatment for our National Guard members in their communities. If necessary, this may mean authorizing DVA to contract with civilian health care providers and other facilities to remove the geographical barriers peculiar to the National Guard veterans. Our members and their families deserve no less.

Report recommendation three.—Aggressively prevent and treat Post Traumatic Stress Disorder and Traumatic Brain Injury. Without a shifting of care to the communities, the geographical barriers to treatment may be insurmountable for the psychologically wounded and for those suffering from Traumatic Brain Injuries (TBI). Experts have written that individuals experiencing moderate to severe brain injuries require a continuum of care that, at some point, will involve community-integrated rehabilitation that will include neurobehavioral programs, residential programs, and home-based programs.

For those requiring behavioral readjustment or treatment for Post Traumatic Stress Disorder and willing to seek the same, eliminating time and distance factors will intuitively expedite and ease the transition from non-recognition to treatment. Physicians say that the sooner these behavioral conditions can be recognized and treated, the more successful and mitigating the treatment will be. DVA needs to have access to all available behavioral health care resources in communities throughout the country to provide the care our National Guard veterans and their families are requiring in a convenient location.

In addition to removing geographical barriers for psychological health, it is essential that mandatory cognitive screening both pre- and post-deployment be implemented to establish a baseline against which any delta in cognitive functioning occurring during deployment can be determined for purposes of expeditiously diagnosing and treating TBI and possibly PTSD conditions. The screening technology exists and needs to be implemented immediately.

Report recommendation four.—Significantly strengthen support for families. NGAUS strongly supports amending the Family and Medical Care Leave Act as recommended in the report to authorize family caregivers for our wounded members to take leave from em-

ployment for up to 6 months. A visit to Walter Reed will quickly show that our seriously wounded National Guard members are actively attended by family members for extended periods. These family members should not be penalized with the loss of employment for attending to the needs of our heroes with their care and support.

Under current law, an employee would only be allowed a total of 12 weeks during a 12-month period to provide such care. In too many cases, the serious injuries suffered in the Global War on Terror are requiring far more than 12 weeks of treatment. As our members convalesce in military treatment facilities or in their communities over these extended periods, the care of their loved ones is an irreplaceable comfort to them and an immeasurable aid in the recovery process. Extending the 12-week period to 26 weeks under the FMLA would provide the caring family members with the assurance that he or she will not be terminated from reemployment during that extended period of care should it be needed.

Report recommendation five.—Rapidly transfer patient information between DOD and VA. The recommendation that DOD and the VA must move quickly to transfer clinical and benefit data to users will require interoperability of the AHLTA and VISTA electronic recordkeeping systems used by DOD and DVA, respectively. Although this moment of interoperability is reported by DOD's contractors to be close at hand, the medical needs of our National Guard members have been overlooked with this effort that does not require the records of civilian health care providers treating our members to be entered into the DOD AHLTA database.

Currently, although the technology exists, there is no mandate from DOD to scan or otherwise enter hard copies of our National Guard members' medical records from their civilian health care providers into the DOD AHLTA database. Please keep in mind that our National Guard members in a non-deployed status do not receive their medical care from military treatment facilities but from civilian physicians.

Failure to scan National Guard members' civilian treatment records into the AHLTA database will continue to keep military physicians in the dark when treating our members relative to preexisting conditions and medication histories found in their civilian medical records. Lack of ready access to this information in emergency treatment situations during deployments puts the National Guard patient at risk while being treated by military physicians.

The recommendation of the report needs to go further to include the mandatory transfer of all MTF treatment records for National Guard members into the DOD and DVA electronic records system. If these records were required to be entered into the AHLTA system, then they would also be accessible to the DVA once interoperability of the DOD and DVA systems is attained.

In conclusion, we at NGAUS hope that we have both reinforced and amplified, where needed, the recommendations of the report of the President's Commission on Care for America's Returning Wounded Warriors relative to the needs of the National Guard.

Thank you again for this opportunity to address this Committee and for all that you do for our Nation's veterans. Thank you.

[The prepared statement of Col. Duffy follows:]

PREPARED STATEMENT OF COL. PETER J. DUFFY, USAR (RET), DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NATIONAL GUARD ASSOCIATION OF THE UNITED STATES

Chairman Akaka, Ranking Member Craig, and Members of the Committee, it is my distinct pleasure to appear before you on behalf of the National Guard Association of the United States (NGAUS) to address certain recommendations of particular concern to the welfare and benefit of our wounded National Guard members and their families as set forth in the Report of the President's Commission on the Care for America's Returning Wounded Warriors (hereinafter referred to as the Report). This brief submission will address four recommendations of the Report relative to improving care for our wounded members. NGAUS supports all recommendations of the Report with additional recommendations of its own to improve the subject care. NGAUS urges this Committee to continue to differentiate between the medical needs of our active duty members and our veterans particularly with respect to geographical barriers.

It is important to note that National Guard members returning from deployment can be extended on active duty for treatment at Military Treatment Facilities before being discharged. In most cases our members upon returning from deployment are quickly discharged from active duty and then eligible as veterans for care at the Department of Veterans' Affairs health facilities. Once discharged, most of our members continue in the Selected Reserve and as such are eligible to enroll in TRICARE Reserve Select beyond the 6 month Transitional Assistance Management Program (TAMP). However, once discharged, our members are no longer eligible for treatment at Military Treatment Facilities

REPORT RECOMMENDATION 1—IMMEDIATELY CREATE COMPREHENSIVE RECOVERY PLANS TO PROVIDE THE RIGHT CARE AND SUPPORT AT THE RIGHT TIME IN THE RIGHT PLACE

The needs of our wounded National Guard members and their families are geographically spread across the full area of our country, its Commonwealths and territories. Once released from medical hold, our wounded members return to their civilian communities not to military installations. These communities are often in areas isolated from a Department of Veterans Affairs (DVA) treatment facility. Obtaining continuing treatment at a DVA facility for many of our veterans will mean having to travel significant distances. This travel may require the veteran and possibly an accompanying family member to take time off from work thereby further straining an employer/employee relationship already stressed by previous deployments.

Although perhaps most often associated with states west of the Mississippi, geographical barriers to treatment can occur in states as small as Rhode Island and as far east as Maine. Maine Representative Michael Michaud, Chairman of the Health Subcommittee of the House Veterans' Affairs Committee, indicated this session at a hearing of his Subcommittee that some of his veterans in the state of Maine must travel 9 hours to be treated at facilities in Boston.

In recommending the creation of comprehensive recovery plans to provide the right care and support at the right time in the right place, the Report speaks to the need to expand DVA treatment for our National Guard members in their communities. If necessary, this may mean authorizing VA to contract with civilian heath care providers and other facilities to remove the geographical barriers peculiar to the National Guard veteran. Our members and their families deserve no less.

REPORT RECOMMENDATION 3—AGGRESSIVELY PREVENT AND TREAT POST TRAUMATIC STRESS DISORDER AND TRAUMATIC BRAIN INJURY

Without a shifting of care to the communities, the geographical barriers to treatment may be insurmountable for the psychologically wounded and for those suffering from Traumatic Brain Injuries (TBI).

Experts have written that individuals experiencing moderate to severe brain injuries require a continuum of care that at some point will involve community integrated rehabilitation that will include neurobehavioral programs, residential programs, residential programs and home based programs.

For those requiring behavioral readjustment or treatment for Post Traumatic Stress Disorder and willing to seek the same, eliminating time and distance factors will intuitively only expedite and ease the transition from non recognition to treatment. Physicians say that the sooner these behavioral conditions can be recognized and treated, the more successful and mitigating the treatment will be. DVA needs to have access to all available behavioral health care resources in communities throughout the country to provide the care our National Guard veterans and their families are requiring in a convenient location.

In addition to removing geographical barriers for psychological health care, it is essential that mandatory cognitive screening both pre and post deployment be implemented to establish a baseline against which any delta in cognitive functioning occurring during deployment can be determined for purposes of expeditiously diagnosing and treating TBI and possibly PTSD conditions. The screening technology exists and needs to be implemented immediately.

REPORT RECOMMENDATION 4—SIGNIFICANTLY STRENGTHEN SUPPORT FOR FAMILIES

NGAUS strongly supports amending the Family and Medical Leave Act (FMLA) as recommended in the Report to authorize family care givers for our wounded members to take leave from employment for up to 6 months. A visit to Walter Reed will quickly show that our seriously wounded National Guard members are actively attended by family members for extended periods. These family members should not be penalized with the loss of employment or attending to the needs of our heroes with their care and support.

Under current law an employee would only be allowed a total of 12 weeks during a 12 month period to provide such care. In too many cases the serious injuries suffered in the Global War on Terror are requiring far more than 12 weeks of treatment. As our members convalesce in military treatment facilities or in their communities over these extended periods, the care of their loved ones is an irreplaceable comfort to them and an immeasurable aid in the recovery process. Extending the 12 week period to 26 weeks under the FMLA would provide the caring family member with the assurance that he or she will not be terminated from reemployment during that extended period of care should it be needed.

REPORT RECOMMENDATION 5—RAPIDLY TRANSFER PATIENT INFORMATION BETWEEN DOD AND VA.

The recommendation that DOD and the VA must move quickly to transfer clinical and benefit data to users will require interoperability of the AHLTA and VISTA electronic recordkeeping systems used by DOD and DVA respectively. Although this moment of interoperability is reported by DOD's contractors to be close at hand, the medical needs of our National Guard members have been overlooked with this effort that does not require the records of civilian health care providers treating our members to be entered into the DOD AHLTA database.

Currently, although the technology exists, there is no mandate from DOD to scan or otherwise enter hard copies of our National Guard members' medical records from their civilian health care providers into the DOD AHLTA database. Please keep in mind that National Guard members in a non deployed status do not receive their medical care from Military Treatment Facilities (MTF) but from civilian physicians. Failure to scan National Guard members' civilian treatment records into the AHLTA database will continue to keep military physicians in the dark when treating our members relative to pre existing conditions and medication histories found in their civilian medical records. Lack of ready access to this information in emergency treatment situations during deployments puts the National Guard patient at risk while being treated by military physicians.

This recommendation of the Report needs to go further to include the mandatory transfer of all non MTF treatment records of our National Guard members into the DOD and DVA electronic record systems. If these records were required to be entered into the AHLTA system, then they would also be accessible to the DVA once interoperability of the DOD and DVA systems is attained.

In conclusion, we at NGAUS hope that we have both reinforced and amplified, where needed, the recommendations of the Report of the President's Commissions on Care for America's Returning Wounded Warriors relative to the needs of the National Guard.

Thank you again for the opportunity to address this Committee and for all that you do for our Nation's veterans.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO COL. PETER J. DUFFY, USAR (RET.), DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NATIONAL GUARD ASSOCIATION OF THE UNITED STATES

Dear Chairman Akaka, Ranking Member Burr and Members of the Committee, thank you for the opportunity to respond to the following question:

MENTAL HEALTH CONTRACTING

Question. The Dole-Shalala report very broadly notes that "Congress should enable all veterans deployed in Afghanistan and Iraq who need PTSD care to receive it from VA." While the Dole-Shalala report did not include specifics on this recommendation, your organization believes this should take the form of contracting with outside providers. In your view, are there other options, such as bringing on more mental health providers and positioning them in communities that would address this concern?

Response. PTSD among our Reserve Component veteran population has reached alarming levels. A JAMA article released November 14, 2007 entitled, "Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War" identified 42 percent of Reserve component veterans of Operation Iraqi Freedom (OIF) and 20.3 percent of active duty personnel as requiring mental health treatment based upon their responses to the Post Deployment Health Re-Assessment completed 3–6 months after return from deployment.

The medical community says that PTSD is treatable but stresses that early recognition and treatment offer the best opportunities for success. Although veterans suffering from PTSD can receive 2 years of care from the VA, many face geographical barriers in rural areas that delay and even frustrate their efforts to obtain the same. In serious cases of PTSD, this delay can prove fatal. The most desirable option for successfully treating veterans suffering from PTSD is the supplemental mental health contracting afforded by S. 38 that would allow veterans under the auspices of the VA to be treated conveniently and expeditiously in or near their communities by qualified mental health care providers within and without the VA.

According to a roster compiled by the VHA Office of Public Health and Environmental Hazards, 751,273 Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans with out-of-theater dates through May 2007, have left active duty and have become eligible for VA health care. According to the subject roster, 389,036 of these new veterans (52 percent) are from the ranks of our Reserves and National Guard while 362,237 (48 percent) are from the ranks of our active forces.

Applying the percentages from the JAMA study, 42 percent of the population of 389,036 OIF and OEF Reserve Component veterans (163,395) and 20.3 percent of the population of 362,237 OIF and OEF active duty veterans (73,737) are arguably requiring or have required mental health treatment from the VA through May 2007. The treatment needs of this growing new veteran group and the mental health care needs of the pre-2002 veteran population have overwhelmed mental health care facilities of the VA. They will continue to do so unless all mental health care providers in the country can be engaged in treating our veteran population.

The need for the rapid delivery of mental health care in the widely scattered communities of our surging veteran population is urgent. Unfortunately, the VA does not and will not have that capability without mobilizing all mental health providers in every community with a nearby veteran population. Because it is impractical for the VA to hire all mental health providers or to build clinics in every community, the solution must lie in authorizing the VA to contract, when necessary, with mental health care providers in remote areas having a veteran population in need of mental health care. This is what S. 38 would provide for veterans and their families.

S. 38 is modeled after similar programs operating in Montana, Washington and South Dakota where the VA has been contracting successfully with Community Mental Health Centers in delivering behavioral health care to our members in those expanded geographically areas. Because the mental health contracting program has been proven effective, it should be made available to all areas of the country where it is needed. The pilot program proposed by S. 2162 is appreciated but it will only serve to delay nationwide implementation of a necessary program that has already been successfully piloted.

Please note that S. 38 already builds into its matrix the features of the proposed pilot program of S. 2162. If the civilian provider effectively addresses the needs of our members, the VA will continue to use that provider, but only as long as the need persists. Any decision to contract with outside mental health care providers would be driven by need recognized by the VA. Each regional VA facility would be able to evaluate the effectiveness of any contracted behavioral care provider. The VA would retain oversight and control of the process.

Five years into this war, the geographically dispersed behavioral needs of our members and families are not being met by the VA. Those needs cannot endure another pilot program in ten regions. Veterans in rural areas outside the pilot areas would still be neglected. Denying those veterans and their families outside of the

ten pilot regions the same treatment options as those within the ten regions is neglectful and unfair. Moreover, without participation across the country, information on the availability of the pilot programs will be difficult to disseminate. For the VA to claim that it alone can address these needs in house is admirable, but ultimately neglectful of our veterans' mental health needs.

The question may arise within the Committee that if the contracting programs in Montana, Washington and South Dakota have worked work so well, why have they been they limited to those states? The answer to that question lies in the reluctance of the VA to contract with local care providers, not in the lack of quality care available in the civilian community. The Committee should recall the testimony of Tammy Duckworth on this point.

This Committee heard testimony from witnesses on November 6 about the difficulty the VA has had in finding qualified physicians in the remote area of Marion, Illinois. Ms. Duckworth, Director of the Illinois Department of Veterans' Affairs, testified about a lack of health care consistency across the VA especially in rural communities. She criticized the reluctance of the VA to access local physicians despite having the authority to do so. S. 38 would send a clear message that it may be necessary for the VA to care for the behavioral needs of our veterans by contracting with mental health care providers in the civilian community.

Contracting with local health care providers will not toll the death knell for the VA. S. 38 does not seek to tear down the brick and mortar of the VA but to offer an affordable and viable alternative in addressing the historical surge of PTSD cases in our veteran population. Using civilian providers in remote areas when necessary will save the VA the costs of hiring staff and acquiring space in remote areas not otherwise having a large veteran population.

Using local civilian providers when necessary would also give the veteran consumer a closer and more immediate choice once he or she overcomes the reluctance to recognize the need for treatment. That reluctance, once overcome, could return to the detriment of the veteran if time and distance barriers delay treatment. A distant VA facility might also require the veteran and family members to take time off from work which would only further stress an employment relationship already stressed by a previous deployment. Local treatment would avoid leaving the veteran and family member the choice of distant treatment for a poorly understood illness or continued employment. It is in the best interest of the veteran to remove the time and distance barriers to make mental health treatment as convenient as possible.

It is important to reemphasize that S. 38 does not require the DVA to contract with civilian providers. It only authorizes the VA to do so with the force of a statute that breaks internal and perhaps regional adhesions that are blocking innovation and response in this crisis.

The downside risk posed by S. 38 is minimal. PTSD is not unique to the military. Licensed civilian psychiatrists are fully capable of recognizing and treating PTSD without having to enter an employment relationship with the VA to do so. To require them to be employed with the VA as a condition to treat our veterans at government expense would waste a needed capability.

There is a sense that the VA and some veteran support organizations are pushing back against this legislation out of fear that it would diminish the VA when the contrary would be true. S. 38 would expand the outreach of the VA throughout a state in a qualitative and cost-effective manner that would inure to the benefit of our veterans and their families. Insistence on the VA's paternal model of delivering health care, although very effective in most cases, should yield, in this instance, to the behavioral health care needs of our veterans and families who need the geographical outreach in mental health treatment that S. 38 would provide.

NGAUS is and will remain a staunch supporter of the Department of Veterans Affairs (DVA). The DVA is and will remain the backbone of service and benefits to our veterans. NGAUS is committed to a robust DVA that would only be made more robust by authorizing it to engage all available behavioral health care providers within and without DVA to enable it to provide the necessary surge capacity in meeting the burgeoning behavioral health care needs of our veterans and their families.

Chairman AKAKA. Thank you very much, Colonel Duffy.

Mr. Manar?

STATEMENT OF GERALD T. MANAR, DEPUTY DIRECTOR, NATIONAL VETERANS SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES, ON BEHALF OF THE MEMBERS OF THE INDEPENDENT BUDGET

Mr. MANAR. Mr. Chairman and Members of the Committee, thank you for the opportunity to speak with you about transition issues affecting the men and women who serve our Nation with perseverance, courage, and honor.

For more than 20 years, the members of the Independent Budget—AMVETS, Paralyzed Veterans of America, the Disabled American Veterans, and the Veterans of Foreign Wars—have annually assessed the state of the VA and made recommendations to Congress, which would, if adopted, better help the Department of Veterans Affairs help veterans. Interestingly, in recent years, many of our recommendations on the VA budget, health care, construction, and other issues have been closer to VA's actual needs than were reflected in the budgets submitted to Congress. We are not new to this work. Our organizations have been working with and serving America's veterans for more than 100 years.

With this as background, I would like to take a few minutes to discuss the recommendations of the President's Commission on Care for America's Returning Wounded Warriors, and in contrast, the recommendations of the Veterans Disability Benefits Commission.

The President's Commission was created in March 2007 and ended its work in July 2007. They did a significant amount of work in a little over 4 months. Where they were strongest was in those areas of their principal interest—care for injured servicemembers at the end of their military service and their transition from active duty to civilian life. Where they were weakest, in our view, is in the area of reforming the VA compensation program.

Our written testimony outlines in great detail those transition recommendations we believe are most effective, and most likely to help disabled servicemembers. We would like to use our short time this morning discussing some of the problems we note with the President's Commission and the alternatives provided by the Disability Commission.

The President's Commission recommends creation of a two-tiered system of benefits, one for combat veterans and one for all other veterans. We find this an unacceptable distinction, one which is not supported in history, law, or the veteran community.

We are all veterans equally. This is not a new concept. The Bradley Commission adopted a guiding principle in April 1956, which said, in part, that providing compensation on a uniform basis to people with equal handicaps is the best possible way to discharge our obligation to them. Fair and equal treatment of all veterans, disabled and non-disabled, according to their service-connected needs should be the guiding principle in all our programs.

The Veterans Disability Benefits Commission, in their Guiding Principle Three, stated that compensation must be based on severity of disability and not where or how it was incurred, and Congress, no less, supports this principle since it eliminated separate compensation for disabilities incurred in combat with legislation in 1972.

This does not mean that distinctions cannot be made among veterans. In fact, the opposite is true, and this is a theme that runs through the Disability Commission report—that the more seriously disabled a veteran is, the more treatment, support, and benefits he or she should receive.

The President's Commission recommends the creation of transition payments, and with this we concur—not necessarily in the form that they propose, but rather as a separate benefit, totally unrelated to compensation. All of us in this room who are veterans have had the opportunity to be released from active duty, and after the first joy of the moment has passed, we wonder what we are going to do. Now, some of us have planned ahead and we have lined up jobs, but many veterans come home, they take a break, and then they start looking for work.

There is every reason to support a recommendation that Congress create a specific transition benefit, unrelated to compensation. The idea that was proposed by the President's Commission to have a transition benefit for 3 months in lieu of compensation from VA for service-connected disabilities is unacceptable to us; but a transition benefit focused on helping bridge the few months following service is certainly within the realm of our support.

In addition, the President's Commission, their proposals, if adopted, would require a new rating schedule—a new rating schedule which, in their view, could be done in 6 months. I submit to you that I could sit down and in a matter of a week or two come up with a new rating schedule. That doesn't necessarily mean that it is better, it would simply be different.

The Veterans Disability Benefits Commission, on the other hand, has provided in their report an ordered and deliberate process for evolving and reforming the ratings schedule that the VA currently uses, and we commend their recommendations for your consideration.

In addition, the President's Commission would, under their new separate program for compensating our future veterans, create a new rate schedule. It is totally devoid of any suggestion of what this rate schedule would look like or how it would be made up.

Finally, there are so many other things that the VA does, and should be looked at from time to time, that the President's Commission has not even addressed. For instance, the Veterans Disability Benefits Commission, with the help of the Institute of Medicine, has come up with a plan, a scheme, for regularizing, if you will, the designation of disabilities that are presumptively related to service. Although we don't agree with the entire proposal, the point is that they come up with a process for reform, for evolving into something which is better than what currently exists, and that is what we support.

If we adopt—if you adopt—the President's Commission's recommendation to create a second separate disability compensation program, what you are forcing the VA to do is to run two disability compensation programs for at least the next 70 years. Imagine that, two separate programs with a workforce either required on an individual basis to master both programs or to separate the workforce to deal with both. This is an unnecessary imposition on the VA and on America's veterans.

I would like to leave you with this thought. The President's Commission served 4½ months to arrive at their recommendations. In our view, nearly all of the recommendations dealing with VA compensation are mere bullets. They are hollow. They lack substance and definition. If their program is simple, it is because the things that make a compensation program work have not been added to it yet.

On the other hand, the Veterans Commission served, studied, argued, and decided everything in public for 30 months. They did the heavy lifting necessary to support their recommendations with substance and process. Its report has been described today as 600 pages of band-aids. Well, this 544-page document lays a solid foundation and a clear path forward for reform of the VA compensation program. We do not agree with all the recommendations, but we can say, conclusively, that we agree with the framework that they have laid down to effect change in an ordered, evolutionary way.

Thank you for your time this afternoon and I will take questions when you have them.

[The prepared statement of Mr. Manar follows:]

PREPARED STATEMENT OF GERALD T. MANAR, DEPUTY DIRECTOR, NATIONAL VETERANS SERVICE, VETERANS OF FOREIGN WARS OF THE U.S.

Thank you for this opportunity to provide the views of the members of the Independent Budget—AMVETS, Disabled American Veterans, Paralyzed Veterans of America and the Veterans of Foreign Wars of the United States—on VA and DOD collaboration, the Report of the President's Commission on Care For America's Returning Wounded Warriors, the Report of the Veterans Disability Benefit Commission and other related reports.

It seems that every few years another study is commissioned to examine some of the problems involving benefits and delivery of benefits available to service disabled veterans. With the Veterans Disability Benefits Commission (VDBC), a pattern has emerged that our Nation requires a more comprehensive review every 50 years or so to help us all refocus on the entire system of benefits, note the things that are working well and devise solutions to those that no longer fully address the needs of the men and women who stood ready in both peace and war to defend our Nation, even at the possible cost to themselves of disability or death.

Six years after terrorists attacked us on American soil, we remain deeply embroiled in armed conflict in both Iraq and Afghanistan. Over 3,800 men and women have been killed and nearly 28,000 wounded. Another 29,000 were treated for diseases and injuries not arising from combat, disabilities so debilitating that they required air transport from the region in order to receive appropriate medical treatment.[1] There is no accounting for the thousands of other service men and women who were treated and returned to duty in that troubled region of the world.

Thousands of soldiers, Marines, sailors and airmen have returned home with catastrophic injuries. It was their difficulty in obtaining treatment, proper housing, adequate benefits and services, as well as basic help in the transition from military service to civilian life that caught our attention earlier this year. What was most disturbing was that the problems coming to light in 2007, while perhaps exacerbated by the current conflict, have existed to some extent for decades. The Presidents Commission on Care for America's Returning Wounded Warriors (PCCWW), created in March 2007 and reporting 4 months later, examined how the Armed Services treat those with serious injuries and help them through discharge from service and transfer to the Department of Veterans Affairs.

While this testimony will focus primarily on the recommendations of the PCCWW and VDBC on transition issues, we will also address the recommendations of both commissions on benefits provided by the Department of Veterans Affairs for disabilities arising while performing military service.

You have before you enough ideas, suggestions and recommendations to create another title in the U.S. Code and keep regulation writers at both the Department of Defense and the Department of Veterans Affairs busy for the next 10 years. It is

[1] *http://icasualties.org/oif/;* October 12, 2007.

little wonder that you have asked those of us at this table to help you parse the cornucopia of proposals and make coherent the competing voices.

There are many good things presented in these reports: some are simple, others complex beyond imagination. Some will help DOD and VA help service men, women and veterans while others would create more problems. Some are inexpensive while others will place additional burdens on the Treasury.

We offer you our views, not to make your task easier, but rather, to help make the correct path more visible.

THEY ARE ALL VETERANS EQUALLY

One of the Guiding Principals adopted by the VDBC was that benefits should be awarded based on the severity of the service-connected disability and not on the circumstance under which it was acquired. This principle is not new. At one time VA paid higher benefits to veterans with service connected disabilities incurred in combat. However, Congress recognized the inequity of paying veterans with identical disabilities different amounts of compensation solely because one received his injury in combat and the other did not; as a consequence, Congress equalized the rates for all veterans in 1972.

The Veteran Service Organizations we represent today endorse the current government policy and completely reject the notion that injuries acquired in combat are any more disabling, any more worthy of compensation, than those incurred elsewhere in service to our country. We agree with the VDBC that benefits should be based only on the severity of disability.

TRANSITION

Care for seriously disabled servicemembers.—We support the PCCWW recommendations which would:

- Develop integrated care teams
- Create individualized recovery plans
- Develop and assign Recovery Coordinators
- However, we oppose the idea that Recovery Coordinators should be Public Health Service employees. We believe that properly trained VA employees, with substantial support from both DOD and VA, can be effective in supporting seriously disabled servicemembers and veterans.

We believe that these services should be provided to all seriously disabled servicemembers regardless of where their disabilities were acquired. A soldier paralyzed from the neck down from an accident in Germany or Korea is no less deserving of these services than is someone who was paralyzed by an IED in Iraq.

Transfer of patient information across systems.—We support the PCCWW recommendations that would:

- Make patient information available to all personnel who need it
- Continue efforts for a fully interoperable information system between DOD and VA
- Provide internet access to personal treatment records and health care information through secure Web sites for servicemembers and veterans.

Strengthen support for families of seriously disabled servicemembers and veterans.—We support the PCCWW recommendations that would:

- Expand eligibility for TRICARE respite care and aid and attendance
- Expand caregiver training for families
- Cover family members under the Family Medical Leave Act (FMLA)
- However, TRICARE, caregiver training and expanded coverage under the FMLA should be available to all seriously disabled servicemembers and not just OIF/OEF servicemembers.

Improve care for servicemembers with Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI).—We support the PCCWW recommendations that would:

- Address the shortage of mental health professionals in both DOD and VA
- Establish and expand networks of experts in PTSD and TBI
- Improve dissemination of clinical practice guidelines
- Increase availability of treatment for PTSD for Iraq and Afghanistan veterans from the VA
- While we support increased availability of mental health providers through the VA for veterans suffering from PTSD, the PCCWW recommendation that "all Iraqi and Afghanistan veterans who need PTSD care [should] receive it from VA" is problematic. First, all veterans who are discharged today may receive free treatment for

virtually any problem within 2 years of discharge. In addition, this recommendation would allow any new veteran, regardless of the source of PTSD (e.g. pre-service car wreck) to move ahead of veterans with service related PTSD. Further, we are already receiving complaints from older veterans who believe that they are being forced to wait longer for appointments because of priorities given to newer veterans.

We believe the better approach would be to vastly increase the numbers of mental health professionals at VA to provide better and timelier service to all veterans with PTSD. While increasing mental health staff, VA should use its fee-basis authority whenever old or young veterans must receive care immediately.

Finally, VA should improve its ability to triage veterans with mental health symptoms to ensure that those who might be a danger to themselves or others are seen immediately and by an appropriate professional.

Again, we believe that every disabled servicemember should be eligible for every benefit and service required by the severity of the disability they have and not by the place or circumstance under which it was incurred.

Enhance the Joint Executive Council (JEC).—We support the recommendation of the VDBC to:

- Develop a strategic plan with specific milestones
- Designate lead officials responsible for each milestone
- Include DOL and SSA in the JEC

VA and DOD should develop a joint intensive case management program for severely disabled veterans with an identifiable lead agent.—We support the recommendation of the VDBC.

Congress should adequately fund and mandate the Transition Assistance program DOD-wide.—We support the recommendation of the VDBC.

Benefits Delivery at Discharge (BDD) should be available to all disabled servicemembers including Guard, Reserve and medical hold patients.—We support the recommendation of the VDBC.

DOD should mandate separation examinations for all servicemembers; the examination should conform with VA protocols and directives.—We support the recommendations of the VDBC.

DOD should provide TRICARE free of charge for severely injured servicemembers and their families.—We support the recommendation of the VDBC.

We commend the other recommendations from the VDBC dealing with transition issues to you for consideration.

POST SERVICE TRANSITION

Both the PCCWW and the VDBC understand the need to ensure that services and benefits do not stop as disabled servicemembers make the transition to civilian life. Too often, the only "transition" disabled servicemembers received was a Transition Assistance Program briefing or a bit of counseling from the VA or a veteran service officer at a BDD site. The recommendations discussed earlier, if adopted, should make the transition process much better for disabled servicemembers.

However, most veterans are not seriously disabled at discharge and are not processed through the Disability Evaluation System. While they know what their education benefit eligibility might be, they have little knowledge of vocational rehabilitation, home loan guarantees and the like from VA.

Vocational rehabilitation.—Both the PCCWW and the VDBC recommended changes in vocational rehabilitation which, in our view, should be seriously considered for implementation.

- Veterans with service connected disabilities causing employment handicaps should be encouraged to undertake and complete training that will help them find not just gainful employment but a career for life.
- Further, vocational rehabilitation should not be a one-time benefit. Disabilities often worsen throughout life and some veterans may need vocational rehabilitation services a second time. Helping a disabled veteran remain productively employed should be a goal of VA. We believe that a disabled veteran should be able to utilize vocational rehabilitation more than once.
- Vocational rehabilitation subsistence allowance rates are inadequate to support veterans as they obtain the training needed to help them adjust to the employment handicap caused by their service-connected disabilities. We support increases in subsistence allowance rates.

Transition payments.—As the claims backlogs have increased at the VA, it seems that a growing number of people, including some Members of Congress, have voiced the opinion that these veterans should not be made to wait for VA to decide their claims for benefits. Their greatest concern has been for the recently discharged vet-

eran who often has little income, perhaps some disability and no job. In the last year, some have even suggested that VA should simply pay the veteran whatever it is they claim.

We oppose the use of the disability compensation program to pay what amounts to a transition benefit or bonus. We do, however, support the idea of a transition payment independent of VA compensation. We urge Congress to consider creating such a payment, a form of deferred compensation, independent and separate from VA compensation, to help men and women during the initial few months following their discharge from service.

REENGINEERING VA DISABILITY COMPENSATION—REVOLUTION OR EVOLUTION?

In 2004 the Congress enacted legislation creating the Veterans Disability Benefits Commission:

> "The purpose of the Veterans' Disability Benefits Commission is to carry out a study of the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service, and to produce a report on the study." [2]

The first few meetings of the Veterans Disability Benefits Commission (VDBC) (starting in May 2005) were met with skepticism and wariness by some of us in the veteran community. We were well aware of the forces which led to the creation of that commission and were deeply concerned that at least some Commissioners harbored secret agendas which, if adopted, would lead to the dismantling of programs designed to help treat and compensate veterans for the residuals of disabilities incurred or aggravated while in service to our country.

During the 28 public sessions spanning 55 days of public hearings, it became apparent that Commissioners were willing to work hard to learn about compensation benefits: what they are; how the program evolved to where it is today; and what problems exist. Further, we were gratified to note that Commissioners were willing to reconsider their opinions as facts were brought to light by the Center for Naval Analyses and the Institute of Medicine. We watched extensive fact gathering and more extensive debates on issues that were critical to the establishment of a foundation for later decisions.

While we have disagreed with some decisions made by the commission we could tell the veterans we represent that the commission was well on the way to producing a thoughtful and constructive report which addressed many problems without harming veterans.

A few weeks ago the VDBC released its final report. Of the commission's 114 recommendations, fully 83 percent deal with compensation benefits or factors related to compensation benefits. Even when the commission drifted a little afield and made recommendations dealing with transition issues, it is clear that most deal with ensuring that VA has the information it needs as soon as possible to process claims from veterans.

The President's Commission on Care for America's Returning Wounded Warriors, on the other hand, was created in March 2007 and delivered its report less than four and a half months later. It produced 24 recommendations; 8 of the 24 recommendations were focused on discarding the current compensation program and substituting a new program requiring a new rating schedule, new rates for disability benefits, new theories of what could be service connected, how long compensation payments would continue and so on.

While there are a few ideas presented by the PCCWW that may have merit, the discussion, below, describes those that are most objectionable.

• Two-tiered system.—The PCCWW recommends the creation of a two-tiered system of compensation for service connected disabilities, one for combat injured veterans and one for all others. Under their proposal, combat injured veterans would be eligible for quality of life payments while those not injured in combat would be denied. This means the paralyzed veterans mentioned earlier in this paper would receive substantially disparate compensation even though their quality of life would be the same.

• Delay of compensation.—The PCCWW would delay compensation benefits for a minimum of 3 months and possibly for years while the veteran receives "transition" payments. In our view, it is for Congress to decide whether newly discharged veterans should be granted a transition benefit for a short period following service.

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[2] Public Law 108–136, Section 1502. See also, *http://www.vetscommission.org/index.asp.* Charter.

Since the transition benefit is not based on disability but would be, in fact, available to all new veterans, it should not replace compensation paid for disability incurred or aggravated while in military service. If Congress agrees that vocational rehabilitation rates are too low and do not encourage veterans to remain in vocational rehabilitation, then it should raise those rates to appropriate levels.

• Average impairment of earnings capacity.—In its report, the PCCWW says that:

> "Congress has directed that the VA disability compensation system should replace lost civilian earnings." [3]

What the law actually says is:

> "The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations." [4]

The seemingly subtle difference between "earnings" and "average impairment of earning capacity" is significant. We commend to you the discussion in the VDBC report on this topic. We can say, however, that this focus on earnings rather than average impairment of earning capacity opens the door for some of the draconian recommendations by the PCCWW discussed below. What the commission recommends is nothing short of throwing out a compensation program, designed, refined and tested over 70 years to pay disabled veterans based on the average impairment of earnings capacity to one based solely on loss of earnings. This, in turn, opens the door for means testing, taxing and curtailing compensation.

• Means testing compensation.—The PCCWW would substitute a payment scheme that is means tested in place of the current compensation program (". . . the amount would be recalculated periodically as veterans' condition or earnings change." Figure 11) (". . . once transition payments end, disabled veterans should receive earnings-loss payments—to make up for any lower earning capacity remaining after training." Draft, page 6). This means that veterans with identical disabilities would receive different benefits or, in some cases, no compensation at all. The commission suggests that the DOD disability annuity payment, as well as the quality of life payment, would continue for life. However, only about 10 percent of all veterans (those discharged through the DES) would receive the annuity. While not all veterans have service-connected disabilities for which they receive compensation, a significant percentage of those receiving compensation today would not be eligible for the annuity.

Further, since the PCCWW proposes that only combat injured veterans would be potentially eligible for quality of life payments, those non-combat injured veterans no longer eligible for compensation because of means testing would receive nothing at all.

• Taxing compensation.—The PCCWW would tax disability compensation payments to veterans. In a word, we find this proposal to be outrageous. We are speaking of men and women who sacrificed not only their time and energy in defense of our Nation but who continue to suffer from the residuals of injury or disease incurred during that service. Under this proposal, veterans would be taxed to marginally mitigate a reduction of their benefits when they can no longer work. Outrageous.

• Termination at retirement.—The PCCWW proposes the termination of compensation benefits at "retirement" to be followed by Social Security. A recent article in the Washington Post showed that more people work past "retirement" than ever before; and the trend is increasing. Further, a Center for Naval Analysis study conducted for the VDBC shows that current compensation rates generally replace lost earnings if paid over a veteran's lifetime. If the PCCWW recommendation is adopted, veterans will not have earnings replaced by compensation prior to "retirement" unless compensation rates are substantially increased.

• Abuse of reexamination process.—The PCCWW recommends that veterans be recalled for examination every 3 years throughout their lifetime to determine whether their disability has worsened or improved. VA already has the authority to reexamine veterans whose disabilities could improve. This authority has existed for many decades. If it is not often used now it is more a function of VA trying to manage its workload by reducing review examinations in the face of extremely high backlogs than it is anything else.

Further, this proposal is a transparent attempt to not just identify those individuals whose disabilities may improve over time but to harass those veterans whose disabilities are static. And since failure to report for an examination is a basis for

[3] PCCWW Report, pg. 109.
[4] 38 U.S.C. 1155.

terminating compensation, this practice would, if adopted, result in the termination of benefits to many veterans whose disabilities are either static or worsened primarily because they do not always notify the VA when they move.

For these reasons, and others, we strenuously object to the proposals by the PCCWW to throw out the current compensation program and put in its place a program which will be harmful to the vast number of men and women who have volunteered to serve our Nation, and who are fighting even now in Iraq and Afghanistan.

The Veterans Disability Benefits Commission has exhaustively examined the current compensation program, affirmed its strengths and pushed forward many thoughtful and constructive recommendations for evolving it into a mechanism to better serve America's new generations of veterans. Their approach is to retain the best parts of the disability compensation program and create a process for measured and deliberate reform and improvement. We urge you to carefully consider their recommendations.

We trust that this is the first of several hearings on these reports and other proposals affecting the transition of servicemembers from warrior to respected veteran. We appreciate the opportunity you have afforded us today.

I will be happy to answer any questions you may have for me.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO GERALD T. MANAR, DEPUTY DIRECTOR, NATIONAL VETERANS SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES, ON BEHALF OF THE MEMBERS OF THE INDEPENDENT BUDGET

EASY ACCESS TO CARE

Question. The Dole-Shalala Commission recommends that veterans with PTSD have immediate access to VA evaluations and treatment. You noted in your testimony that such an opportunity does, in fact, exist now in the two year window of easy access to VA care and treatment following release from active duty. In your view, how well is this two-year authority working?

Response. According to VA, by the end of FY 2007 nearly 800,000 OIF and OEF veterans left active duty and became eligible for VA health care since FY 2002. Nearly 300,000 (37 percent) of those veterans obtained VA health care since their discharge. Further, slightly more than 120,000 veterans (40.1 percent of those seeking treatment) were seen for complaints of a mental disorder. Finally, half of those seen for mental health issues were diagnosed with PTSD.

Clearly, OIF and OEF veterans know that health care is readily available from VA as demonstrated by the 37 percent who obtain it. Further, they know that they can receive free health care for virtually any condition without the need to demonstrate a connection with their military service.

While some observers may be concerned that more OIF/OEF veterans have not sought treatment from VA, we must be mindful of the fact that most of these men and women are in the prime of their lives when it is significantly less likely that they will have medical or psychological conditions requiring treatment.

We believe that the current law opening up VA health care to all OIF/OEF veterans for 5 years following discharge is working and no additional legislation will likely result in greater participation by these men and women.

If Congress is concerned that this group of veterans is underutilizing VA health care opportunities, it could provide an increase in funds for advertising and outreach.

Chairman AKAKA. Thank you very much, Mr. Manar.

Ms. Beck?

STATEMENT OF MEREDITH BECK, NATIONAL POLICY DIRECTOR, WOUNDED WARRIOR PROJECT (WWP)

Ms. BECK. Thank you, sir. Mr. Chairman, thank you for the opportunity to testify today regarding the various reports, commissions, and task forces completed to date addressing the needs of our Nation's wounded servicemembers. The Wounded Warrior Project has direct daily contact with these wounded warriors and we have a unique perspective on their needs and the obstacles they face as they attempt to reintegrate into their communities. With re-

spect to the reform of the Disability Evaluation System, the Wounded Warrior Project strongly supports the spirit and intent for which the Dole-Shalala and the Veterans Disability Benefits Commissions were established. WWP agrees with the finding of both reports that the current benefits system places too little emphasis on veterans' recovery, rehabilitation, and reintegration into the community. For those who are able, incentives to participate in vocational rehabilitation programs, educational opportunities, and reintegration to the workforce could lead to a better, healthier life. In addition, under the current system, individual unemployability ratings are necessary for some, but others are often burdened at a young age to choose between potentially beneficial vocational experience and needed compensation.

Periodic evaluation, gradual reduction in compensation rather than abrupt termination, and improvements in the compensation structure for warriors with PTSD or TBI would result in a more effective system that enables wounded warriors to successfully reintegrate to civilian life. WWP believes these principles must be taken into consideration during discussions on modernizing the current disability compensation system and any significant changes should require ultimate Congressional approval.

WWP also strongly supports removing the Department of Defense from the disability ratings process. DOD and the VA ratings systems are currently confusing and overly-burdensome. Currently, DOD assesses the veteran's fitness for duty. Following this determination, the VA performs yet another physical to rate the veteran for all service-connected injuries. Unfortunately, these ratings are not assigned in a vacuum. Lost records, lack of resources, ineffective training, and inconsistencies in the interpretation of regulations by both agencies are often cited as reasons for the extended period of time required to assign a disability rating. A system such as that proposed by the Commissions would encourage a more efficient and fair evaluation and remove one of the most frustrating aspects of an already difficult process.

WWP agrees that comprehensive changes are needed within the compensation and benefits delivery system. However, we are deeply concerned that the inclusion of provisions to overhaul the existing veterans disability compensation system in the same package as health and transition-related recommendations would be a distraction from these important health proposals. Any legislation implementing compensation-related recommendations must be carefully crafted through a thoughtful and deliberate process to ensure the most beneficial outcome for those who have sacrificed in service to this country.

However, as many of us recognize, the current disability ratings system suffers from significant shortcomings which have become more apparent with the passage of time. We must use our passion to encourage honest discussion to resolve these issues.

WWP is very pleased that the Dole-Shalala panel recognized the need for education and training of family members. Specifically for the family members of those with severe TBI, who often have to leave their jobs. WWP also supports payments to caregivers similar to those already in place in the San Diego VA Medical Center for Spinal Cord Injury patients. This program offers training and

makes eligible for payment those family members who have become certified as personal care attendants. This often removes at least part of the financial burden incurred by those with severe injuries.

WWP also strongly supports the Dole-Shalala recommendation to implement a recovery plan that promotes prompt care in, quote, "the most appropriate facility." With respect to Traumatic Brain Injury, legislation currently exists to facilitate such a recommendation. Section 203 of the Senate version of H.R. 1538, the Dignified Treatment of Wounded Warriors Act, would allow the Secretary of the VA to refer patients to non-department facilities if the Secretary is unable to provide the required treatment or, even more importantly, when the Secretary determines that such a referral is optimal for recovery and rehabilitation. In order to comply with our obligation to offer these wounded warriors the best care possible for their respective injuries, these facilities must be readily available as an option for their care.

With respect to DOD–VA collaboration, there are still many issues to address, but WWP has been very impressed with the level of involvement of the leadership of both DOD and VA in the Senior Oversight Committee formed to address these issues. As recommended by the Dole-Shalala Commission, the SOC is in the process of improving the case management process through the creation of a Recovery Coordinator. However, the Recovery Coordinator can only be successful if he or she has the authority to break through the current barriers within both agencies.

Part of that authority would have to include the overlap of benefits and services about which WWP and other organizations have previously testified and which is included in the Senate version of H.R. 1538, as well. An overlap would allow the Recovery Coordinator to access DOD and VA systems necessary to ensure the proper care and rehabilitation of severely injured servicemembers. Each agency has its own strengths. Why would we base their access to care on the status of the servicemember as active duty or retired, rather than on his medical condition?

The skills and previous experience of the Recovery Coordinator are extremely important to their success. In the past, both agencies have based their hiring criteria for similar positions solely on education level. WWP is concerned that the agencies will once again rely on education level alone and exclude eminently qualified candidates with good problem-solving skills and institutional knowledge.

It is not only DOD and VA who need to cooperate more fully or collaborate more fully. Others, such as the Social Security Administration, Medicare, and the Department of Labor and private entities need to be included more fully in these discussions. For example, an injured servicemember recently contacted WWP because he was understandably confused. He had been rated as unemployable by the VA, but was told he did not qualify for Social Security disability benefits because he was able to work. Additionally, the Social Security Administration has had a difficult time accessing DOD records necessary to evaluate his claim. These agencies must work together to resolve inconsistencies in their policies, or the often-stated goal of seamless transition will never be achieved.

Finally, it is imperative that a joint permanent structure be in place to evaluate changes, monitor systems, and make further recommendations for process improvement. This office must be structured to minimize bureaucracy and must have a clearly defined mission with the appropriate authority to make necessary changes or recommendations as warranted. With the passage of time, as veterans' issues fade from the national spotlight, it will be necessary to have that joint structure in place to ensure the future agency coordination.

Thank you, and I look forward to your questions.

[The prepared statement of Ms. Beck follows:]

PREPARED STATEMENT OF MEREDITH BECK, NATIONAL POLICY DIRECTOR, THE WOUNDED WARRIOR PROJECT (WWP)

Mr. Chairman, Senator Burr, Members of the Committee, thank you for the opportunity to testify today regarding the various reports, commissions, and task forces completed to date addressing the needs of our Nation's wounded servicemembers. My name is Meredith Beck, and I am the National Policy Director for the Wounded Warrior Project (WWP), a non-profit, non-partisan organization dedicated to assisting the men and women of the U.S. Armed Forces who have been injured during the current conflicts around the world. As a result of our direct, daily contact with these wounded warriors, we have a unique perspective on their needs and the obstacles they face as they attempt to reintegrate into communities across America.

Due to the broad range of topics covered by this hearing, I would like to limit my comments to those that WWP finds most pressing.

COMMISSION REPORTS:

With respect to the reform of the disability evaluation system, the Wounded Warrior Project strongly supports the spirit and intent for which the Dole-Shalala and Veterans Disability Benefits Commissions were established. WWP agrees with the finding of both reports that the current benefits system places too little emphasis on veterans' recovery, rehabilitation, and reintegration into the community. For those who are able, incentives to participate in Vocational Rehabilitation programs, educational opportunities, and reintegration into the workforce could lead to a better, healthier life. In addition, under the current system, Individual Unemployability ratings are necessary for some, but others are often burdened at a young age to choose between a potentially beneficial vocational experience and needed compensation. Periodic evaluation; gradual reduction in compensation rather than abrupt termination; and improvements in the compensation structure for warriors with Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI) would result in a more effective system that enables wounded warriors to successfully reintegrate to civilian life. WWP believes these principles must be taken into consideration during discussions on modernizing the current disability compensation system. Any significant changes should require ultimate Congressional approval.

WWP also strongly supports removing the Department of Defense (DOD) from the disability rating process. DOD and the Department of Veterans Affairs rating systems are currently confusing and overly burdensome. Currently, the Department of Defense assesses a servicemember's fitness for duty and then assigns a rating based on the injury that made him/her unfit. Following this determination, the Department of Veterans Affairs performs yet another physical examination to rate the veteran for all service-connected injuries, and, depending on the rating level, the veteran could then become eligible for a myriad of benefits. Unfortunately, ratings are not assigned in a vacuum—lost records, lack of resources, ineffective training, and inconsistencies in the interpretation of regulations by both agencies are often cited as reasons for the extended period of time required to assign a disability rating. A system such as the ones proposed by the Commissions would encourage a more efficient and fair evaluation and remove one of the most frustrating aspects of an already difficult process.

WWP would like to make another recommendation. A servicemember should not be retired until he or she has a VA rating in place. This would prevent severely injured servicemembers from experiencing a long gap between their military retirement and eventual receipt of VA compensation. Additionally, as DOD would be responsible for paying servicemembers until their retirement, DOD would be encouraged to quickly share medical records to expedite the process.

WWP believes that a comprehensive review of the disability compensation and benefits delivery system is needed. However, we are deeply concerned that the inclusion of provisions to overhaul the existing veterans' disability compensation system in the same package as health and transition-related recommendations is an unnecessary distraction from these important health and transition proposals. Any legislation implementing compensation-related recommendations must be carefully crafted to ensure the most beneficial outcome for those who have sacrificed in service to this country. However, as many of us recognize that the current disability ratings system suffers from significant shortcomings, which have become more apparent with the passage of time, we must use our passion to encourage honest discussion to resolve these issues. Veterans deserve a thoughtful and deliberate process for reform of the disability compensation system, with appropriate Congressional oversight.

WWP is very pleased that the Dole-Shalala panel recognized the need for education and training of the family members. Specifically for the family members of those with severe TBI who often have to leave their jobs. WWP also supports payments to caregivers similar to those already in place at the San Diego VA Medical Center for Spinal Cord Injury patients. This program offers training and makes eligible for payment those family members who become certified as personal care attendants. This often removes at least part of the financial burden incurred by those with severe injuries.

WWP also strongly supports the Dole-Shalala recommendation to implement a recovery plan that promotes "prompt" care in "the most appropriate facility." With respect to Traumatic Brain Injury, legislation currently exists to facilitate such a recommendation. Section 203 of the Senate version of HR. 1538 would allow the Secretary of the VA to refer patients to non-department facilities if the Secretary is unable to provide the required treatment, OR, even more importantly, for whom the Secretary determines that such a referral is optimal for their recovery and rehabilitation. In order to comply with our obligation to offer these wounded warriors the best care possible for their respective injuries, these facilities must be readily available as an option for their care.

DOD/VA COLLABORATION

With respect to DOD/VA collaboration, while there are still many issues to address, WWP has been very impressed with the level of involvement of the leadership of both DOD and the VA in the Senior Oversight Committee (SOC), formed to address these issues. As recommended by the Dole-Shalala Commission, the SOC is in the process of improving the case management process through the creation of a recovery coordinator. However, the recovery coordinator can only be successful if he/she has the authority to break through the current barriers within both agencies. Part of that authority would have to include the overlap of benefits and services about which WWP has previously testified, and which is included in the Senate version of H.R. 1538, The Dignified Treatment of Wounded Warriors Act. An overlap would allow the recovery coordinator to access DOD and VA systems necessary to ensure the proper care and rehabilitation of severely injured servicemembers. Each agency has its own strengths. Why base access to care on the status of a servicemember as active duty or retired, rather than on the medical condition?

The skills and previous experience of the Recovery Coordinator are extremely important to their success. In the past, both agencies have based their hiring criteria for similar positions solely on education level. WWP is concerned that the agencies will, once again, rely on education level alone and exclude eminently qualified candidates with good problem solving skills and institutional knowledge.

It is not only DOD and VA who need to collaborate more fully. Others such as the Social Security Administration, Medicare, the Department of Labor, and private entities need to be included in these discussions. For example, an injured servicemember recently contacted WWP because he was understandably confused. He had been rated as unemployable by the VA, but was told he did not qualify for Social Security Disability benefits because he was able to work. Additionally, the Social Security Administration had a difficult time accessing DOD records necessary to evaluate his claim. These agencies must work together to resolve inconsistencies in their policies or the often stated goal of "seamless transition" will never be achieved.

Finally, it is imperative that a joint, permanent structure be in place to evaluate changes, monitor systems, and make further recommendations for process improvement. This office must be structured to minimize bureaucracy and must have a clearly defined mission with the appropriate authority to make necessary changes or recommendations as warranted. With the passage of time, as veterans issues fade from the national spotlight, it will be necessary to have a joint structure in place to ensure future agency coordination.

Mr. Chairman, thank you again for the opportunity to testify before you today, and I look forward to answering your questions.

Chairman AKAKA. Thank you very much, Ms. Beck.

Now we will hear from Colonel Strobridge. Colonel?

STATEMENT OF COL. STEVEN P. STROBRIDGE, USAF (RET.), DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

Colonel STROBRIDGE. Thank you, Mr. Chairman, Ranking Member Burr, and distinguished Members of the Committee. Thank you for this opportunity to present the Military Officers Association's views on the needs of America's returning warriors.

I would start by recognizing the tremendous efforts by this Committee and by the Armed Services Committee, as well, to ensure that we do the right thing by these veterans. Senior DOD and VA leaders also deserve great credit for their unprecedented cooperation in working to address the many serious problems encountered by these members and their families.

As you know, most of the problems aren't new. They have been identified in multiple previous studies. What is different now is the degree of leadership involvement and commitment to finding fixes. That kind of top-down leadership is the only way to break down the barriers of departmental parochialism, and it is gratifying to us to see it happening.

But, we are concerned about ensuring continuity of those efforts into next year and beyond, when most of the leaders who have been driving those efforts will be departing. Often, a new administration faces a lag in installing new leaders and many new appointees face a significant learning curve. That raises the potential for the change process to lose momentum during the transition. For that reason, the continuing leadership and oversight of this Committee will be crucial to sustaining long-term success.

The Committee has seen the findings of all the various study groups on the wounded warrior issues and MOAA thinks they have been pretty much on target with most of their recommendations. We strongly endorse the use of a single DOD and VA separation physical and reform of the Military Disability Retirement System as recommended by the Veterans Disability Benefits Commission. In that regard, we very much support the pilot program now being implemented by DOD and VA under which the services determine fitness for continued service, the VA is the single agency assigning disability ratings, and DOD must accept those ratings for military disability retirement purposes.

We strongly agree with the findings of all the panels on case management needs, the importance of TBI and PTSD screening assessments, care and rehabilitation, and updating the VA ratings system to more appropriately reflect those conditions' effect on veterans and their families.

We are concerned that there are a number of gaps, as Meredith mentioned, in coverage between DOD active duty retired and VA health programs. Some of the examples are: cognitive therapy; and per diem for caregivers, which ceases when a member is retired and is not available from the VA. Those significantly detract from disabled veterans' continuity of care. Rather than trying to chase

down all the individual shortfalls, we think it is essential to authorize temporary overlap of both coverages. To us, that means continuing active duty-level TRICARE coverage for at least 3 years for all service-disabled personnel and their families and also authorizing VA care for active duty wounded warriors.

As the Committee considers possible benefit adjustments or recommends against creating a differential benefit system for members who are disabled in combat versus other service-connected causes, I think you have heard the different panel members. I think we have all kind of said the same things—that there is a little bit of confusion, I think, in terms of what some people mean when they say, "combat disabled." When we have asked people, everybody has pretty much said, anything that is service-connected should be compensated. If a member becomes a quadriplegic in service, the effect on the member's life is the same whether that was caused by a bullet or a military vehicle or a slip on an icy street. Similarly, we should sustain the longstanding principle that military service is 24/7 duty that we discussed earlier for the purposes of determining service connection in disabilities.

Like Meredith said, we believe it will be particularly important to establish a Joint Seamless Transition Office, permanently staffed with full-time personnel from both DOD and VA to oversee development, fielding, and sustainment of initiatives such as the Electronic Medical Record and the Electronic Separation Document. It is ironic that when I worked in DOD in 1988, I was initiating action for a joint DD Form 214. I got promoted and left the office a year later, called back and said, what is the status, and the answer was, "huh?" That is the problem that you have. We have to build a structure of responsibility that won't evaporate with the departure of the incumbent or the departure of the incumbent's boss.

Finally, we urge the leaders of the Veterans Affairs Committees and Armed Services Committees to continue that example of top-down leadership collaboration in addition to the recent efforts in the Executive Branch. We know all of the committees and staffs are working hard to do the right thing, but we also know that frustration with past joint efforts and some of their lack of success can foster skepticism about the future, and that is a big concern. A renewed commitment by committee leaders to bipartisan, bicameral collaboration would establish an important guideline for the difficult road ahead.

We appreciate this opportunity to offer our comments and pledge our continued support on all of these issues to ensure the Nation completes its obligations to our wounded warriors and their families. Thank you.

[The prepared statement of Col. Strobridge follows:]

PREPARED STATEMENT OF COL. STEVEN P. STROBRIDGE, USAF (RET.), DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

Mr. Chairman and distinguished Members of the Committee, I am honored to appear before you today on behalf of the Military Officers Association of America (MOAA), to present our views on various Commission recommendations on the wounded warrior care, transition support, the disability evaluation process and related matters.

MOAA does not receive any grants or contracts from the Federal Government.

EXECUTIVE SUMMARY

Urgency of Joint Congressional Action and Oversight.—Military and VA systems have been caught unprepared for the large wave of wounded and traumatized veterans returning from Iraq and Afghanistan, and these veterans' needs will only grow in the future. Sustained bipartisan, bicameral congressional leadership focus and cooperation will be vital to successfully address continuing problems, especially with a change of leadership coming soon in the Executive Branch, and attendant introduction of new DOD and VA leaders who will be far less sensitized to the urgency of leadership-driven changes currently underway or contemplated.

VA–DOD Disability Evaluation Reform.—MOAA strongly endorses the recommendation of the Veterans' Disability Benefits Commission (VDBC) that DOD and VA should realign the disability evaluation process so that the Services determine fitness for duty, and servicemembers who are found unfit are referred to VA for the disability rating.

All conditions that are identified as part of a single, comprehensive medical exam should be rated and compensated. In revamping the DES, the Services must include all unfitting conditions as rated by the VA in assessing whether the servicemember is to be medically retired or separated. (See Items 6, 12 and 46 in the attached matrix.)

MOAA does not support elimination of the military disability retired pay system, as some would interpret the Dole-Shalala recommendations as implying. Rather, we support DOD's acceptance of VA-determined disability percentages in calculating military disability retired pay.

Traumatic Brain Injury/PTSD Care, Treatment and Service Connection.—MOAA strongly supports the recommendations of the Dole-Shalala Commission and other panels on TBI/PTSD care, coordination and rehabilitation. (See Items 3, 4, 15, 22, 23, 33, 37 and 38 in the matrix.)

Establish Joint Seamless Transition Agency/Office.—MOAA strongly supports establishment of a separate, joint DOD–VA Seamless Transition Agency staffed with full-time DOD and VA professionals to oversee the development, fielding, completion and assessment of seamless transition imperatives. (See Item 50 in the matrix.)

Overlap in Active Duty and VA Health Coverage.—MOAA strongly recommends authorization of at least 3 years of eligibility for active duty TRICARE benefits for wounded warriors after leaving service. This will protect them from loss of urgently needed services—such as cognitive therapy and caregiver per diem—that now terminate when they leave active duty. (See Item 34 in the matrix.)

Caregiver Support and Case Management.—MOAA strongly endorses the recommendations of the commissions and task forces on caregiver support/assistance and case management for wounded warriors. (See Items 2, 10, 13, 21, 29, and 34 in the matrix.)

Reaffirmation of the "24–7" Principle in Assessing Service-Connection of Disabilities.—MOAA strongly recommends the Committee reaffirm its longstanding commitment to the principle that all service men and women who are disabled in the line of duty—the "24/7" rule—are entitled to service-connected compensation, or if eligible, military retirement, if the disability did not result from misconduct.

Collaboration and Oversight of Congressional Committees.—MOAA notes that parochial departmental concerns in the past have extended beyond the executive branch, and strongly recommends that leaders of the Committees on Veterans Affairs and Armed Services make a concerted effort with their House counterparts to develop a more collaborative framework to assess, oversee, prioritize, and fund cross-jurisdictional issues affecting wounded warriors and their families who are having such unacceptable difficulties getting fair and effective outcomes from DOD and VA bureaucracies.

INTRODUCTION

Last February, a series of articles in the Washington Post titled "The Other Walter Reed" profiled shocking cases of wounded servicemembers who became lost in military health care and administrative systems upon being transferred to outpatient rehabilitative care.

Subsequently, the national media were flooded with stories of seriously wounded troops warehoused in substandard quarters, waiting weeks and months for medical appointments and evaluation board results, confused by a maze of benefit and disability rules, and lowballed into disability separations rather than being awarded the higher benefits of military disability retirement.

There were interviews with family members—spouses, children, and parents—who quit their jobs and virtually lived at military hospitals to become caregivers to seriously wounded troops. Left with diminishing resources and unfamiliar with mili-

tary benefit and disability rules, they were severely disadvantaged in trying to represent the interests of their wounded spouses and children who couldn't stand up for themselves.

These issues drew the attention of the President and Congress, leading to the appointment of special commissions and task forces charged with investigating the problems and identifying needed solutions. The details of sorting out the multiple overlapping proposals to fix the bureaucratic snafus among multiple Federal departments can be mind-numbing, whether you're a legislator, a lobbyist, a Federal administrator, or an average citizen.

The key to success will be to stay focused on the top priorities, and recognize that the government must bear responsibility for these long-term costs of war.

MOAA is very grateful for the work of the Dole-Shalala Commission, the Veterans Disability Benefits Commission, the Marsh-West Independent Review Group, VA Interagency Task Force on Returning Veterans, and the Mental Health Task Force. Attached to this statement is a summary of the major recommendations of these panels and MOAA's positions and recommendations on them. We are very pleased to say that with relatively few exceptions, as noted, MOAA endorses the vast majority of these groups' recommendations.

URGENCY OF JOINT CONGRESSIONAL ACTION AND OVERSIGHT

Military and VA systems have been caught unprepared for the large wave of wounded and traumatized veterans returning from Iraq and Afghanistan, and these veterans' needs will only grow in the future.

Sustained bipartisan, bicameral congressional leadership focus and cooperation will be vital to successfully address continuing intra- and inter-agency problems. With a change of leadership coming soon in the Executive Branch, and attendant introduction of new DOD and VA leaders who have not been a party to developing urgent leadership-driven changes currently underway or contemplated, the importance of congressional oversight cannot be overstated.

DISABILITY EVALUATION SYSTEM (DES) REFORM

Current gross disability rating disparities between the services and between DOD and the VA must be resolved. The Independent Review Group appointed by the Secretary of Defense found huge disparities between the disability retirement (vs. separation) statistics between the services for returning veterans. The percentage of returning veterans who received military disability ratings of 30 percent or higher (and thus qualified for lifetime retirement benefits) was far lower among the Army and Marine Corps, who had the greatest exposure to combat injuries. The disability retirement rate for the Navy was nearly three times higher than the Army's, feeding perceptions that seriously combat-wounded soldiers were being "low-balled" to save the government money, as shown on the following chart.

DISABILITY RETIREMENT DISPARITY

Percent of disabled members awarded disability retirement (30+ percent DOD disability rating)

Army 13%
Navy 36%
USMC 18%
USAF 27%

MOAA believes strongly that members with significant, lifelong, service-caused disabilities should be retired rather than separated with no military benefits. There must be a common rating standard that accounts for all service-connected disabilities and provides fair compensation and benefit packages commensurate with the level of disability. Wounded members should be retained on active duty until the disabling condition is stabilized, rather than expediting separation and shifting care responsibility to the VA.

Further, the process of assigning fair and consistent disability ratings is too important to be left to five independent agencies (four services and the VA). While the services need to be the arbiters of what conditions render a soldier, sailor, airman or Marine unfit for continued service, the percentage disability rating should be determined by the VA, and the VA system must be made as uniform as possible across the country. (In this regard, MOAA is concerned at studies that have shown large disparities in disability ratings by VA offices in different states/regions.)

MOAA strongly endorses the recommendation of the Veterans' Disability Benefits Commission (VDBC): that DOD and VA should realign the disability evaluation

process so that the Services determine fitness for duty; and servicemembers who are found unfit are referred to VA for the disability rating.

All conditions that are identified as part of a single, comprehensive medical exam should be rated and compensated. MOAA strongly recommends that in revamping the DES, the Services must include *all* unfitting conditions as rated by the VA in assessing whether the servicemember is to be medically retired or separated. (See Items 6, 12 and 46 in the attached matrix.)

MOAA does *not* support elimination of the military disability retired pay system, as some would interpret the Dole-Shalala recommendations as implying. Rather, we support DOD's acceptance of VA-determined disability percentages in calculating military disability retired pay.

WOUNDED WARRIOR CARE AND TREATMENT: FOCUS ON TRAUMATIC BRAIN INJURY (TBI) AND POST TRAUMATIC STRESS DISORDER (PTSD)

TBI and PTSD affect 25% to 50% of returning veterans, according to a number of government and other studies. And the percentage rises with prolonged and repeated exposure through multiple and extended deployments. But reluctance to disclose mental health conditions deters many members and families from testing and treatment.

Traditional military "can-do" and "tough-it-out" attitudes that are the pride of the warrior ethos actually work against the future well-being of the warrior who doesn't understand the potential long-term consequences of failing to at least find someone to talk to. Officers and senior NCOs who fear that acknowledgement of such conditions may affect their security clearances or future leadership opportunities are particularly vulnerable through such reluctance.

Even less visible and likely to go unidentified are the secondary effects on family members who also suffer the long-term effects of living with victims of war-related stress.

We must get a better handle on cause and effect, starting with crash efforts to destigmatize mental health conditions and publicize opportunities for confidential discussions.

We also must dramatically improve diagnosis and treatment capacity and methodology. One key is to dramatically improve testing for the effects of Traumatic Brain Injury, including routine baseline pre- and post-deployment neurocognitive assessments; and testing as soon as possible after any exposure to high-risk blast or concussive events.

MOAA strongly endorses the recommendations of the commissions/task forces on Traumatic Brain Injury and PTSD care and rehabilitation. (See Items 3, 4, 15, 22, 23, 33, 37 and 38 in the matrix.)

JOINT SEAMLESS TRANSITION AGENCY NEEDED

Widely reported breakdowns in the management of care at Walter Reed Army Medical Center reflect the fact that policies and administrative procedures for the care, rehabilitation, outprocessing and transitioning of our wounded warriors are not working "seamlessly" for them and their families.

DOD and VA have critical, complementary roles in the transition process. The pace of the two departments' collaborative and cooperative efforts continues to be hampered by bureaucratic and parochial barriers.

The key, we believe, is a coordinated top-down strategy which engages both departments' leadership from a single point of attack. Recent leadership initiatives generated at the secretarial level have had galvanizing effects on the two agencies' staffs, and there has been unprecedented cooperation and progress in recent months.

However, MOAA is very concerned for the viability of these newly energized efforts beyond the next 15 months, given the inevitable leadership turnover that will attend any new administration.

The JEC does not appear to have the authority to direct change in both departments, only to forge broad agreements and report to Congress. We are into the fifth year of the war on terror, and the hand-off between the departments for those who are in the greatest need is far from seamless, despite recent, more strenuous leadership efforts.

This effort is too important to be someone else's part-time job. MOAA believes strongly that there is an overriding need to establish a permanent joint office, with permanently assigned staff from both departments, whose full-time mission is to devise, implement, oversee and sustain the joint mission of serving our warriors rather than serving their respective departments' bureaucratic prerogatives.

Acting Secretary of Veterans Affairs, Gordon Mansfield, a distinguished disabled Vietnam veteran, endorsed a joint transition agency in testimony before the House Veterans' Affairs Committee on 28 September 2006.

Some elements of seamless transition oversight and implementation that should come under this office include:

- Bi-Directional Electronic Medical Records
- A Single Separation Physical and Electronic Separation Document (DD–214)
- Coordination of Policy/Procedures for Special Needs Health Care, including implementation of a case management system and patient-centered recovery plan program
- Coordination of multiple agency inititiatives on Traumatic Brain Injury (TBI) and PTSD diagnosis, treatment and Rehabilitation
- Expansion of Joint DOD–VA Research
- Improvement and Expansion of the Benefits Delivery at Discharge program.

Joint Bi-Directional Electronic Health Record

MOAA and our colleagues in The Military Coalition recently were briefed on efforts underway to improve the transfer of medical records between DOD and the VA. There are significant signs of progress, in our view, on this complex issue. However, we are concerned that full electronic record "jointness" won't be completed until 2012 at best. That is just too long to wait. MOAA strongly endorses accelerated completion of this critical seamless transition function.

Joint DOD–VA Physical

A "one stop" separation physical supported by an electronic separation document (DD–214) is a cost-saving initiative that is an essential component of the seamless transition model. Although prototypes exist in some facilities, one has yet to be accepted as a standard throughout the two departments. It must become the "gold standard" of effective and efficient transitions.

Polytrauma Centers and Traumatic Brain Injury

TBI is the signature injury of OIF/OEF—its impact on combat veterans ranges from mild to severe. Developing best practices for identification and treatment is essential, including research on the long-term consequences of mild TBI. The goal of achieving optimal function of each individual TBI patient requires improved interagency coordination between VA and DOD.

MOAA is pleased to note that the VA is establishing a fifth Level One polytrauma center. The new center and the four existing VA Polytrauma Rehabilitation Centers require special attention in order to ensure the needed resources are available, to include specialized staff, technical equipment and adequate bed space in order to ensure top-quality care for severely injured servicemembers and veterans.

MOAA strongly supports establishment of a separate, joint DOD–VA Seamless Transition Agency to oversee the development, fielding, completion and assessment of seamless transition imperatives. (See Item 50 in the matrix.)

ASSISTANCE FOR FAMILY CAREGIVERS

The unprecedented quality and rapid delivery of battlefield health care, along with widespread use of body armor and other protective equipment, means that unprecedented numbers of warriors who would have died of their wounds in previous wars are surviving to return to their families. Unfortunately, many of these heroes face long and arduous recovery periods, and many require significant levels of care for months or years, and some, for the rest of their lives.

In this tragic situation, many spouses, parents, siblings, and other family members find themselves having to take on roles as full-time caregivers and representatives of severely injured/disabled personnel who are unable to navigate military and VA personnel and compensation bureaucracies on their own. Many give up their jobs and careers to care for a loved one, in come cases having to rely on the goodwill of charities and communities to meet various necessities of their loved ones' new lives.

MOAA believes strongly that the government has an obligation to change this situation and develop new programs to meet the extreme needs of these special cases. There must be institutionalized outreach programs to provide information and navigation assistance on administrative proceedings, appeal options, and benefit programs. In the more severe cases, compensation is appropriate and essential to recognize family members' sacrifice of their own incomes and careers to care for service-disabled members.

For the longer term, the VA needs to establish fair compensation for caregivers forced into hardship situations. For the short term, MOAA strongly recommends au-

thorization of at least 3 years of eligibility for active duty TRICARE benefits for wounded warriors after leaving service. This will protect them from loss of urgently needed services—such as cognitive therapy and caregiver per diem—that now terminate when they leave active duty. (See Item 34 in the matrix.)

MOAA strongly endorses the recommendations of the commissions and task forces on caregiver support/assistance and case management for wounded warriors. (See Items 2, 10, 13, 21, 29, and 34 in the matrix.)

RETROACTIVE CASE REVIEW

In addition to making more sensitive decisions in the future, equity demands a review of discharge and retirement cases already completed for warriors wounded or otherwise disabled in Iraq or Afghanistan, while their case histories are still fresh. Multiple examples of severely disabled soldiers whose separation with zero disability ratings created the pressure for change, but that change can't just be prospective. It must include retroactive review and re-adjudication for those whose examples brought the inequities to public attention.

In the same vein, an even more sensitive situation is coming to light. There are numerous cases of exemplary soldiers and marines who, after multiple tours in Iraq or Afghanistan, became "changed men"—disciplinary cases who experienced demotion, incarceration, and adverse separation characterizations that now bar them from eligibility for VA treatment, compensation and rehabilitation for conditions many would not have incurred if not for their wartime service.

LENGTHY CLAIMS PROCESSING DELAYS ARE INTOLERABLE AND MUST BE FIXED

The workload and complexity of VA disability claims continues to increase. As of mid-February 2007, there was a backlog of 626,429 claims. VA projects that by the close of this year there will be at least 800,000 claims in the system. Moreover, disability claims processing time rose to nearly 6 months (177 days) on pending claims in 2006 against an original performance goal of 100 days. It's our understanding that VA has moved the goalposts and its new performance goal for completing initial claims is 125 days.

MOAA endorses the VDBC's recommendation on improving the VA claims processing system. (See Item 48.) MOAA recommends that the Committee work with its Armed Services Committee counterparts to ensure this review is completed as soon as possible. (See Item 8 in the matrix.)

MOAA CONCERNS

MOAA applauds the work of the commissions and task forces that have examined wounded warrior care, treatment, transition, and services. As indicated elsewhere in this statement, MOAA endorses most of the major recommendations of these panels. We do, however, have some concerns about certain recommendations, while recognizing that in some cases a commission's recommendation was limited by its charter and time.

MILITARY SERVICE IS A "24/7" ENTERPRISE, AND IS SUBSTANTIVELY DIFFERENT FROM CIVILIAN EMPLOYMENT

Under current law, the term "service-connected" means generally, "with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in the line of duty in the active military, naval, or air service." (38 U.S.C. § 101(16)) An injury or disease incurred "during" military service "will be deemed to have been incurred in the line of duty" unless the disability was caused by the veteran's own misconduct or abuse of alcohol or drugs, or was incurred while absent without permission or while confined by military or civilian authorities for serious crimes." (38 U.S.C. § 105)

This statutory framework has withstood the test of time and thorough past reviews. MOAA is confident that the statutes reflect the will of Congress and the American people regarding the unique nature and the inherent sacrifices involved in military service.

Disability and survivor benefits should continue to reflect the unique nature of that service in defense of the Nation.

MOAA understands that the Dole-Shalala Commission was empowered to examine only wounded warrior issues. However, we cannot support establishment of separate disability evaluation processes and benefit differentials for combat or operations-related disabilities vs. other service-connected disabilities. (See Items 6, 30 and 46 in the matrix.)

MOAA strongly recommends that the Committee reaffirm its longstanding commitment to the principle that all service men and women who are disabled in the line of duty—the "24/7" rule—are entitled to service connected compensation, or, if eligible, military retirement, unless the disability was a result of misconduct.

COLLABORATIVE CONGRESSIONAL LEADERSHIP NEEDED

MOAA was pleased to note that a rare joint hearing was held earlier this year between the Senate Veterans Affairs and the Armed Services Committees to receive the views and preliminary recommendations of the Veterans Disability Benefits Commission. In the House, there have been joint hearings on educational benefits under the Montgomery GI Bill.

But it's no secret that on some issues, jurisdictional firewalls in the Legislative Branch as well as the Executive Branch inhibit effective collaboration on some of the core issues affecting VA and DOD interaction. In this regard, we have been dismayed on many occasions at the continuing skepticism of Veterans Affairs and Armed Services Committee staffs in both chambers about the extent of joint cooperation between the committees that's likely or feasible on various topics of common interest.

We recognize the enormous challenges involved in crafting and revising public laws that cross jurisdictional lines. We also can appreciate the budgetary and political histories that have arisen from difficult interactions over multiple past congresses.

But MOAA believes strongly that there is bipartisan, bicameral agreement among all of the committees on the need for far greater communication and collaboration between DOD and VA to achieve positive outcomes for wounded veterans in such great need.

We've been extremely encouraged by the personal efforts of the Secretaries of Veterans Affairs and Defense, demonstrating that determined leadership initiative can, in fact, cut through longstanding parochial red tape and generate a genuine cooperative effort among staffs whose main experience has been colored by "stove-piped" perspectives.

But those efforts can be undermined in the longer term if there is not decisive, determined, top-down congressional leadership direction to develop joint congressional staff consensus on priorities, policy direction, and funding responsibilities on these vital matters.

MOAA strongly recommends that leaders of the Senate Committees on Veterans Affairs and Armed Services make a concerted effort with their House counterparts to develop a more collaborative framework to assess, oversee, prioritize, and fund cross-jurisdictional issues affecting wounded warriors and their families who are having such unacceptable difficulties getting fair and effective outcomes from DOD and VA bureaucracies.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO COLONEL STEVEN P. STROBRIDGE, USAF (RET.), DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

RETROACTIVE REVIEW OF DOD RATINGS

Question. The Disability Benefits Commission report suggests that many servicemembers may have been given low ratings by the DOD Physical Disability Evaluation System to save DOD from having to pay them medical retirement benefits. Your testimony supports retroactive case review for certain veterans who are dissatisfied with the rating assigned them by DOD. What criteria would you suggest be used to determine who is eligible for a reevaluation?

Response. At a minimum, we believe there should be a retroactive review of all medical separations since Oct. 7, 2001—that is, servicemembers who had service-caused or service-aggravated medical conditions that precluded further service and whose disabilities were rated by the service as less than 30 percent disabling. This would catch the most egregious situations in which a member was wrongly denied a medical retirement and the attendant annuity, health coverage and other benefits associated with military retirement.

Other members who were medically retired with less than 20 years of service should be notified of their right to appeal to their service Board for Correction of Military Records if they believe the physical disability evaluation by their parent service inappropriately denied consideration of any service-caused condition(s) that also would have precluded their continued service in uniform.

Chairman AKAKA. Thank you very much, Colonel.

I have a question for all of our panelists. If the VA disability system is revised from the current form, should different consideration be given to those veterans whose disability was incurred in a combat zone versus those who were disabled elsewhere? Let me start with Ms. Del Negro.

Ms. DEL NEGRO. I have conflicting feelings about that. During the initiation of the MEB process for my husband, we were in a room. Actually, the first time he showed up for Part I of his physical, the soldiers were sitting on the floor. They didn't even take them into the back. Some of them were combat-wounded soliders. It was very appalling to my husband to see these gentlemen sitting on the floor.

At the same time, however, while I would like to think that combat-related injuries would receive greater compensation, I think that creating a second line of differentiation between veterans will create even more bureaucratic obstacles, slowing down the process. By virtue of that, I would say that I would discourage the making differences between combat and non-combat injuries. Perhaps a caveat to that would be that if one is a Purple Heart recipient, that there would be some sort of additional severance associated with it, but that it would not influence health care benefits.

Chairman AKAKA. Thank you. Colonel Duffy?

Colonel DUFFY. Yes, sir. I agree with Ariana. I thought that was very well said. In creating another category that the veteran has to prove, you are creating more work for the veteran, more work for the administration in judging a claim. A servicemember is under the care and custody of the military 24/7. Any injury that occurs during that period should be compensated.

In the civilian world, if an employee is hurt at work, there is a Workers' Compensation system that covers that employee as a work-related injury. Anything that happens during the day is work-related for a servicemember and should be compensated.

Chairman AKAKA. Thank you. Mr. Manar?

Mr. MANAR. Simply said, ditto. I have talked about this. We have all, I think, arrived at the same conclusion—that the distinction here should be based on the severity of disability, the level of disability, not where or how it was incurred. If someone spends a year in Iraq and comes back with Post Traumatic Stress, are they any more or less deserving of treatment than the female soldier who was raped in Germany or Japan? If someone steps on an IED and has a leg amputated below the knee in Falujah, are they any more or less worthy of compensation and benefits and care than someone who has their leg amputated because of diabetes in the U.S. or because of an automobile accident while they were serving in Japan?

So, our view is that there is no distinction. The distinction is on the level of severity. With greater severity of disabilities, then they should receive greater compensation, greater care, of course, for their service-connected disabilities.

Chairman AKAKA. Thank you, Mr. Manar.

Ms. Beck?

Ms. BECK. My brother is a Marine Corps helicopter pilot, and whether he is deployed or at home with his children, they still share the same fear and anxiety of when he would be deployed or

a possible accident whether he is deployed or not in combat. As a result, as General Scott said, if you are covered by the UCMJ, you should be covered by the good things, too.

Chairman AKAKA. Colonel Strobridge?

Colonel STROBRIDGE. Sir, we very strongly believe there should be a single system. Let me give you one example of a real case of a person to show how good intentions can go awry. This individual was disabled preparing for a combat mission out on the wing of an airplane doing pre-flight, slipped off the wing, fell on a piece of equipment, broke his back, became a paraplegic. When he applied for combat-related special compensation under this new program, it was denied. Even though he was preparing for a combat mission, the determination was the reason he broke his back was the ice, so it was weather, not combat, that caused the disability.

I don't think that was ever envisioned when Congress established combat-related special compensation, but that is what can happen to these kinds of determinations. And to us, it is to avoid that kind of hair-splitting that it is very important to say it is the disability, not how you got it. As long as it was service-connected: if it was service-connected, you deserve the same compensation.

Chairman AKAKA. Ms. Del Negro, are there any issues that were not addressed by today's other witnesses that you think merit attention?

Ms. DEL NEGRO. Do you have a few minutes? No, I am just kidding. [Laughter.]

There are a number of issues, and I will do my best to keep this brief. As I said, my husband and I endured this process before the *Washington Post* articles came out, which seemed to bring the onslaught of all these reports and recommendations, even though the same reports and the same recommendations had been around for a decade.

However, when my husband is released from active duty, the recommendations that are made in this report—given the amount of time they will take to implement—will not be available to my husband because he will have already been separated from active duty. So, I would like to see that some of these changes be made retroactive to affect and benefit some of those recently separated.

In addition, the Recovery Coordinator plan proposed by the Dole-Shalala Commission report is difficult because you are already dealing with staffing shortages, as documented by a GAO report dated September 27, showing that over 50 percent of the Warrior Transition Units that are being employed by the Army have less than—or are missing—two or one of the critical triad positions, including case managers. So, if you can't even fill slots of case managers, how are you proposing to fill slots of Recovery Coordinators that are also going to require training?

Furthermore, I would like to reiterate previous comments regarding the Family Medical Leave Act. I think it is absolutely imperative that it be extended. I had the opportunity to meet with President Bush, my husband and I both, in Hawaii; and he was generous enough to ask how he could help, and my response was that he could sign that amendment when it graced his desk. I emphasized that that was one way he could help servicemembers and their families. However, I also think it will benefit the veterans

and their families in the long-term. We do not know the long-term implications of the injuries sustained in this conflict.

Traumatic Brain Injury, the focus today primarily mentions moderate to severe brain injury. We don't know the implications of mild Traumatic Brain Injury, particularly as it is related to blast injuries. The basis of conclusions so far on mild Traumatic Brain Injury are based on pre-clinical studies evaluating rats. We need more data before we can conclude that those individuals are not going to require long-term care.

In addition, there is no definition of severely injured. What is severely injured? If you are admitted to a military hospital or classified as SI, does that mean that you will get all these benefits? I think that that really places us in a precarious situation, to define what severely injured is.

Lastly, the integration of the data between the DOD and VA systems, no one mentioned today the security of the data. In the last few years, there have been reports about problems with the VA and release of data, and while developing an e-benefits page and whatnot may help, it does not address the security issues. Thank you.

Chairman AKAKA. Thank you very much.

I am going to now call on Senator Burr. I may have a second round, but Senator Burr?

Senator BURR. Thank you, Mr. Chairman. We may both have second rounds, but I know we have kept our witnesses here too long and let me thank all of you.

Ms. Del Negro, thank you for your family's sacrifice, your husband's service to the country. How is he doing?

Ms. DEL NEGRO. He is doing fantastic.

Senator BURR. Great.

Ms. DEL NEGRO. Absolutely great.

Senator BURR. I apologize that you have had to weave your way through and navigate through a system that took some time getting the right degree of benefit. I can only say that we are learning. The Committee is well aware of the progress that needs to be made and we are committed to work with the Veterans Administration. Armed Services is committed to work with the Department of Defense, which seems to be the area that your husband was in through his transition.

To try to understand that it is a little different today and that we are dealing with different injuries; that we have got to have the right responses; let me ask you just to expand on one thing that I didn't quite understand—the distinction of seriously injured. When we have an injured veteran, there is no difference in the treatment, the health care that is delivered to them. What was the purpose of highlighting seriously injured?

Ms. DEL NEGRO. I believe the Veterans Commission report identified that basis of service, as Mr. Manar addressed, should not be based on whether or not the injury was combat or not combat-related, but it should be related to——

Senator BURR. OK. I just wanted to make sure I hadn't missed something relative to——

Ms. DEL NEGRO. Sorry.

Senator BURR. Colonel Duffy, thank you for being here. Your testimony regarding unique issues surrounding the seamless transfer

of medical records for Guard and Reserves has intrigued me. I went to your testimony and I will read from it, "Although this moment of interoperability is reported by DOD contractors to be close at hand, the medical needs of our Guard members have been overlooked with this effort that does not require the records of civilian health care providers treating our members to be entered into the DOD AHLTA database." Is that a HIPAA problem that we have? Is there a privacy health insurance, health privacy issue?

Colonel DUFFY. There is potentially a HIPAA problem with any medical record, but to overcome a HIPAA problem, the patient only needs to consent—and the military could certainly require that consent—for a soldier to be deployable.

Senator BURR. So could this——

Colonel DUFFY. They would need to know all the medical information on that servicemember.

Senator BURR [continuing]. Could this be as simple as we are not asking Guard and Reserves to sign a release on their health care privacy, or is it—go ahead.

Colonel DUFFY. It is at least a two-fold issue. Yes, any HIPAA issue would have to be overcome with an authorization, which could be voluntarily given, or, in the case of a servicemember, I suppose involuntarily, required to be given.

But, there is also the technology. The contractor who runs the AHLTA program, Northrop Grumman, has informed us the technology is there. They have just not been asked to do it. Civilian medical records—and there is some concern that any treatment within the Guard is not being scanned into the DOD AHLTA system—not just civilian medical records, but should any treatment be given at a Guard medical installation. The technology is there. They are just lacking the mandate. Tell us to do it and we will do it.

Senator BURR. You have triggered the right degree of fault. So, let us take it from here and see what we can do to try to find a solution to something that I would think would be extremely helpful, not only to Guard and Reservists, but on the back end of the system—to have within DOD, within VA, the complete records of individuals that will end up back in the system.

Colonel DUFFY. Absolutely. And sir, may I say just one thing. I think at a hearing earlier this year, you had patients at Walter Reed come, one of whom testified that when he was sent from Iraq to Walter Reed, his medical records were placed on his stomach. I think we all heard that. And then they were not there when he returned Stateside—a big concern if he is later filing a disability claim with the Veterans Administration and doesn't have those records.

Senator BURR. We share your concern.

Mr. Manar, let me say from the start, I have looked at all these proposals on disability changes and I am, hopefully like the Chairman, I am in neutral. I am in the middle somewhere still trying to assess them. But, you made a statement that I have just got to ask you some questions on. If the President's Commission recommendations were adopted, the VA would have to run a dual system for 70 years, and you alluded to the fact that they couldn't do that. Did I——

Mr. MANAR. They are having difficulty running the current program.

Senator BURR [continuing]. Let me just say this. If a dual system is better for future veterans, which has not been determined yet, but were it, would you object to a dual system? If you were convinced that it would benefit the next generation?

Mr. MANAR. First, let me answer that by saying I will be speaking for myself here. If it could be shown to me, proven, if you will, that a new system is better for future veterans, then I wouldn't oppose it. But, I would also ask, why not make it available to all veterans?

Senator BURR. That is certainly something the Dole-Shalala Commission threw out within the organizations and felt that there was enough push-back, according to Senator Dole, that they would make it available to the future generations and an option to the past. I agree with you. If it is better, then everybody ought to be offered it.

But let me just share with you, 13 years ago when I got to Washington, we have this—government employees all have an opportunity for their retirement funds in the TSP, whatever that stands for, and it had three options as far as I can invest in. I remember the first day I asked, why are there not more options, and they said, well, that is what there has always been. [Laughter.]

And they made a change in the head of the TSP and we now have, Colonel, nine or something different options—international funds and all this—and now Federal employees are actually in better shape about their retirement funding because of the additional options that were added to the Thrift Savings Plan.

I only point that out to you because what we have is a unique opportunity, a unique opportunity to look at the population that is the most affected right now and figure out how do we integrate them through the system? How do we deliver the best quality of care and learn what we have been doing wrong and transition it for the ones that are still in the system? How do we look at the disability process and try to figure out, is there a better way to do it? Is there a way that is fairer? Is there a way that is more efficient? And that we take the opportunity to make that transition.

I wish I could tell you how many man hours my office spends with veterans on disability claims because nobody understands how the process happens. And its usually on the close calls, which requires a call from me, or a call from the Senator from Hawaii, and if I fail, I am going to get the Senator from Hawaii to call on my behalf.

But it shouldn't happen like that. It is pretty clear cut. Clearly, when you have got two different entities making disability determinations, one has to look at it and say, how can two different entities come up with two different conclusions? Because they are judging two different things. We understand that now. Is that right? Probably not for the future. Colonel, I was glad to hear you say, one is great.

Ms. Beck, let me ask you, you support the idea of Recovery Coordinators. As you know, these coordinators hopefully would overcome the barriers of DOD and VA. The Commission's recommendation is that these coordinators be employees of an independent Pub-

lic Health Service, but the decision has now been made that the coordinators are to actually be VA employees.

One, what do you feel about Recovery Coordinators? Two, what do you feel about them as a VA employee versus an independent entity, and would they be able to exert a sufficient amount of authority over DOD employees if they are VA employees?

Ms. BECK. Regarding the Public Health Service question—in an ideal world, that might work; but in the real world, having a Marine going to a Public Health servant before he can go to another Marine—it is not going to happen. So, the idea of having them be a VA employee and their authority would actually probably rely on, one, as I mentioned, that overlap of benefits to be able to legally access both sides. We can talk about it all day, but if they have legal obstacles to doing that, then they are not going to be able to do it.

The other issue is, that Steve and I have discussed, is the option to allow to have that oversight structure in place—to ensure that they have the ability to maneuver within the Department of Defense and within the VA; and honestly, within the Social Security Administration, Medicare, and the Department of Labor. So, you are going to have to have those entities in place because these problems are going to happen. We all know they are going to happen. And, without some sort of ability to address those problems in the future, we are going to find ourself in the same place 5 years from now.

So yes, we do support the idea of a Recovery Coordinator. You are going to have to find someone who has the ability and the initiative and problem solving skills to do this because it is not easy. Sarah, as you mentioned, she is her husband's recovery coordinator and that is not fair. She is his wife and she should be. So, that would be our one concern—that they not be able to have that buy-in from the other agencies.

Senator BURR. I thank you for that. I also thank you for the fact that it was clear from your testimony, you are focused on outcome and not process. I am not sure that we can say that enough up here, because this is about outcome. It is not about whether we follow what the process is. It is about what comes out on the other end. And I think there is a tendency that we look at things from the wrong end. Maybe it is time we work backwards a little bit and say, what is the optimum outcome that we want and how do we get it?

I actually think we are going through that process on a lot of things right now. It is difficult to absorb it all. I know it is for all of us who are asked to play a part in it. So, I implore all of you to stick with it, because anything short of attempting to do this, somebody will lose.

Colonel, let me ask you one last thing. You raised, I think, a very important issue and that is without some type of permanent transitioning structure, how can any of us leave the jobs we are in and believe that: (1) a task will be completed, or (2) it will continue to evolve into what it should over time. Let me ask it from another side. Do you have any worry that creating a new bureaucracy within this difficult hand-off between DOD and VA will impede our ability to actually make this transition?

Colonel STROBRIDGE. Well, sir, I guess the only thing you can go by is based on experience, and not having one doesn't work. So, having been in OSD and looking at the structures now and talking with the folks there, you have some folks for whom this is a part-time job—they have other things to do, and you never know when something else is going to crop up that pulls them away from this. Right now, there is a lot of leadership emphasis on making sure this gets done.

Senator BURR. How quick would this have to happen from your standpoint? What is the time line that it would have to happen where you would say, you know what? It has happened. We don't need another bureaucracy.

Colonel STROBRIDGE. Well, there is a provision in the Senate version of the defense authorization bill that would establish a joint office specifically to oversee the Joint Medical Record, which we certainly think is a good start. There would be some other things that probably ought to come under that, not the least of which is the Transition Coordinators.

One of the issues that you have right now, you can have the greatest person in DOD who is assisting these folks through the DOD system; then, they hand them over to the VA and they are done; and now somebody picks them up at the VA who doesn't have the background. So, to us, part of that office's responsibility should be saying, what do we need to do to get them through—not just to the point of VA—but until they are stable in the VA system.

Senator BURR. Well, as somebody said, we are hopeful that Gordon and Gordon are actually mapping out all the transitional things that need to exist, and then it is an implementation and an oversight function.

Colonel STROBRIDGE. And a maintenance, yes, sir.

Ms. BECK. Sir, can I make one point on that? It would be imperative that if you create such a structure, and to avoid the bureaucracy that you are talking about, that you actually absorb the functions of all the little offices that have popped up throughout the Department of Defense and the VA. Because right now, the VA doesn't normally know where to go when they have a problem within the Department of Defense, because there are so many different areas where they could try to resolve their problems.

Senator BURR. Nor do we sometimes. Thank you.

Chairman AKAKA. Thank you very much, Senator Burr.

I have more questions, but at this point, I just looked at the time and I want to praise all of you for your patience today. In a few minutes, it will be 4 hours that we have been here, and thanks so much for all of that. I am going to submit my questions for the record.

Again, thank you so much for your time, for traveling this far. All of your testimonies and your responses will be helpful to this Committee and what we will be doing in the future and I thank you very much. I thank all the witnesses today. It is not every hearing that we get to hear from so many distinguished guests like you.

I want you to know that we really appreciate you taking the time to give us a better understanding of the recommendations of the various groups so that we have a clearer sense of what is needed

to move closer to making the transition back to civilian life as seamless as possible. You have been a big help in doing this.

With all of that and just about 4 hours, this hearing is now adjourned.

[Whereupon, at 1:25 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. BARACK OBAMA, U.S. SENATOR FROM ILLINOIS

Mr. Chairman, I want to thank you as well as Ranking Member Burr for holding this important hearing today. I also want to welcome and thank distinguished Members of the various commissions as well as our partners and friends in the VSO community.

While there are different views in Congress about the war in Iraq, there should be no disagreement about the tremendous sacrifice being made by the men and women who are serving in Iraq and Afghanistan. They have performed valiantly under exceedingly difficult circumstances. They have done everything that we have asked of them. And when they come home, they should be able to expect the care and benefits they so richly deserve. Our military families and recovering servicemembers should not have to wage a second war at home to get that next doctor's appointment or receive that first disability check.

Like most Americans, I was outraged to learn of the disgraceful conditions and obstacles confronting those who have served us with honor. That is why I am proud to have introduced bipartisan legislation, the Dignity for Wounded Warriors Act of 2007 (S.713), to address both the immediate and systematic problems uncovered in a recent Washington Post series about Walter Reed Army Medical Center.

This comprehensive legislation addresses problems not only at Walter Reed but throughout the military medical system. The bill sets new standards for all outpatient medical facilities—including a "zero tolerance" policy for pest infestations and overdue work orders; streamlines the paperwork and red tape currently imposed on servicemembers and their families—especially with regard to the disability review process; increases caseworker ratios to provide extra support to servicemembers and their families; increases access to mental health services, including a new 24-hour hotline; and provides important new protections for family members, including health care and mental health services while on invitational job orders—as well as Federal employment protections for their jobs. In my view, a mother should never have to choose between caring for an injured son and keeping her job.

I am proud that many of these provisions passed the Senate recently in a larger package focused on helping our wounded warriors, and I hope the House and Senate will complete its conference soon and submit this legislation for the President's signature. But more action is needed. The pace of change is too slow within the Pentagon and VA, and we have to consider other fundamental reforms that will help ensure our wounded warriors and our veterans are getting the care and benefits they deserve.

I look forward to hearing from the panelists, especially the recommendations from the President's Commission on Care For America's Returning Wounded Warriors and the Veterans Disability Benefit Commission. I think we can all agree on the need to pursue some of these recommendations, such as the Dole-Shalala commission's call for better prevention and treatment of PTSD and TBI; and for providing much more robust support for our recovering warriors as they transition from the military to the VA. But Congress must also avoid ceding its important role in revising other complicated policies, such as the current disability rating system within the military and the VA. I share the Chairman's concerns, for example, over any proposal that would effectively cut Congress out of this important work.

Mr. Chairman, we owe it to our returning servicemembers and veterans to get this right. I look forward to working with you and our panelists to consider the range of options and find the best approach to giving these heroes what they deserve.

Thank you.

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