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FINDINGS OF THE PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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FINDINGS OF THE PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS

WEDNESDAY, SEPTEMBER 19, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:02 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Snyder, Herseth Sandlin, Mitchell, Hall, Hare, Berkley, Salazar, Rodriguez, Donnelly, McNerney, Space, Walz, Buyer, Moran, Brown of South Carolina, Boozman, Brown-Waite, Turner, Bilbray, Lamborn, Bilirakis, Buchanan.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. This meeting of the House Committee on Veterans' Affairs is called to order and we have a distinguished panel to address us this morning.

As we all know, in March the President signed an Executive Order to establish the President's Commission on Care for America's Returning Wounded Warriors. That came in the wake of the Walter Reed scandal and I must say there were a couple of silver linings in that cloud we call Walter Reed. One was the Commission that was formed and your report, for which we are grateful. The other, of course, was, we were able to add in the various budget bills that went by over $13 billion of resources for veterans' healthcare for this year over last year, because all of America understood that we are not caring for the veterans who came back from Iraq and Afghanistan the way they thought that we were doing and we should be doing.

The Commission was charged with the task of examining the effectiveness of returning wounded servicemembers' transition from deployment in support of the Global War on Terror to returning to productive military service or civilian society, and recommend needed improvements.

That report, of course, was recently released and we will be hearing from the Co-Chairs of that Commission, Secretary Donna Shalala and Senator Bob Dole. I look forward to a frank discussion of your recommendations.

Of course, we are all focused on how to serve our troops when they transition from the Pentagon to the U.S. Department of Veterans Affairs (VA) for their healthcare. In order for our troops to

experience the seamless transition that they deserve, the bureaucratic problems that prevent many from getting the care they need must be fixed. And while both VA and the U.S. Department of Defense (DoD) have made adjustments and changes over the last few years in an attempt to address these issues, many obstacles, as you point out, still remain.

As Chairman of the Committee on Veterans' Affairs, I am sensitive to the difficulties involved in coordinating the activities of the Department of Defense and the Department of Veterans Affairs. They have different missions. But we no longer have the luxury of time and we, as a country, must act.

Right now, while we prepare to discuss this issue, our servicemembers are in harm's way. Some of these brave men and women will be killed or seriously wounded. We have talked about the necessity of providing a seamless transition for a long, long time. But now we have a test as a Nation and this is a test that, with your help, we will pass.

I want to welcome our two distinguished panelists. Donna Shalala was appointed by President Bill Clinton as Secretary of the U.S. Department of Health and Human Services (HHS) in 1993 where she served for 8 years, becoming the longest serving Secretary of HHS in our Nation's history. She directed the welfare reform process, made health insurance available to an estimated three and a half million children, raised child immunization rates to the highest levels in history, led major reforms of the Food and Drug Administration's drug approval process and food safety system, revitalized our National Institutes of Health and directed a major management and policy reform of Medicare.

You have dealt, Secretary Shalala, with large bureaucracies like the VA and DoD before this, and so we welcome your experience in implementing programs that work for people, not against people.

Senator Dole, your story is well-known. But every time I read it, I am just amazed by your strength and courage. You were twice decorated for heroism, receiving two Purple Hearts for injuries and the Bronze Star Medal with combat "V" for valor. You joined the United States Army's Enlisted Reserve Corps to fight in World War II and became a second lieutenant in the 10th Mountain Division. In April 1945, while engaged in combat in the hills of northern Italy, you were hit by German machine gun fire in the upper right back and badly injured, waiting 9 hours on the battlefield before being taken to the evacuation hospital before you began your recovery at a U.S. Army hospital in Michigan. And then, of course, a distinguished career in politics.

So thank you both for your service, not only on this Commission, but I know your commitment to implementing the recommendations. You are not letting this just become something on people's shelves. I asked both of our panelists what they were going to do and they said we are going to get this done. And so we welcome your energy, your enthusiasm, and the expertise that you brought to this adventure and we look forward to hearing from you.

I would yield to the Ranking Member, Mr. Buyer.

[The prepared statement of Chairman Filner appears on p. 32.]

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you, Mr. Filner.

Secretary Shalala and Senator Dole, we thank you for your work. Your report is before us and we appreciate your service to our country. Our country continues to call upon you, and you always step forward willingly to serve others and that is what separates you from so many. So on behalf of the country, I extend my appreciation for your contribution.

We are involved in a long war against terrorism. For this, the Nation's mothers, fathers and spouses trust their sons and daughters and spouses to the Nation's armed forces. They must be confident that they will be cared for should harm come their way. I believe that systems are still dysfunctional. The question is, are the bureaucracies, organizationally and culturally, ill-suited to make the bold changes necessary for a seamless transition?

I have my questions, because the bureaucracy will tell us that they are on top of it, that they are fixing it. The bureaucracy has had 6 years of ground combat to fix this problem. We have developed new combat systems in the last 6 years, perfected new tactics, ushered in new governments. It is time our servicemembers and veterans have seamless transition.

I personally have been fighting this battle over seamless transition since I arrived in Washington in 1992. From the year 2004, when I was a Subcommittee Chairman and a full Committee Chairman, I held 19 hearings on the issue of seamless transition. Legislation mandating the cooperation between the Pentagon and VA, Senator Dole, dates back to perhaps your memory. Nineteen eighty-two is when the mandate came from Congress and the Senate.

So it is time our servicemembers and veterans have the seamless transition. It is why I was equally enthused when I heard that President Bush hailed your work product and directed that the Administration prepare legislative proposals reflecting your recommendations. I think I can speak for all of us here that we look forward to seeing these proposals. We expect to get those proposals soon so we can act to improve the care and the seamless transition that our Nation's warriors are entitled.

We look forward to your testimony and your candor is always welcomed.

I yield back.

The CHAIRMAN. Thank you, Mr. Buyer.

You have as much time as you need and we will start with Secretary Shalala. Thank you again for your service.

STATEMENTS OF HON. DONNA E. SHALALA, CO-CHAIR, PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS (FORMER SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES); AND HON. BOB DOLE, CO-CHAIR, PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS (FORMER U.S. SENATOR FROM THE STATE OF KANSAS); ACCOMPANIED BY EDWARD A. ECKENHOFF, MEMBER, PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS, AND FOUNDER, PRESIDENT, AND CHIEF EXECUTIVE OFFICER, NATIONAL REHABILITATION HOSPITAL, AND MEMBER, BOARD OF DIRECTORS, DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION; MARIE E. MICHNICH, DR.PH., EXECUTIVE DIRECTOR, PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS, AND DIRECTOR, HEALTH POLICY EDUCATION PROGRAMS AND FELLOWSHIPS, INSTITUTE OF MEDICINE/THE NATIONAL ACADEMIES; KAREN GUICE, M.D., MSP, DEPUTY DIRECTOR, PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS, AND CLINICAL PROFESSOR OF SURGERY, MEDICAL COLLEGE OF WISCONSIN, MILWAUKEE, WI; AND SUSAN D. HOSEK, CO-DIRECTOR, RAND CENTER FOR MILITARY HEALTH POLICY RESEARCH, AND GROUP MANAGER, ECONOMICS AND STATISTICS, RAND CORPORATION

STATEMENT OF HON. DONNA E. SHALALA

Secretary SHALALA. Mr. Chairman, Mr. Buyer and sitting Members of the Committee, thank you for giving us the opportunity to testify today, and in particular with Senator Bob Dole, about the recommendations of our Commission——

The CHAIRMAN. Madam Secretary, can you pull the microphone closer to you—thank you.

Secretary SHALALA. Thank you for giving me the opportunity to testify today. It is truly a privilege to serve, to have served on the President's Commission on Care for America's Returning Wounded Warriors, especially with Senator Dole, whose shrewdness and distinction as a great public servant and whose knowledge of this subject and dedication was really an inspiration to all of us.

We worked hard, but we had an awful lot of fun and I learned a lot from him in the process. We were joined by a stellar group of Commissioners, each of whom gave their full energy and attention to the critical mission we faced. One of them, Ed Eckenhoff, who just arrived, of course, is the head of the National Rehabilitation Hospital here in Washington and one of the great experts on rehabilitation in this country and we are delighted to see Commissioner Eckenhoff here with us.

As you know, we had an extremely short timeframe to complete our mission, but we were propelled by a sense of urgency that the issues before us required. Mr. Chairman and Members of the Committee, we know you share this sense of urgency and that is why we are pleased to be with you today to discuss not only our recommendations, but the critical need to implement them.

We have been truly heartened by the response to our report that we have received from Congress, from the White House and throughout the country. This country has rallied behind the need to help those who have put their lives on the line in service to our country and we are optimistic that the Congress and the Administration will move quickly to respond to this need by enacting all of our recommendations.

We were reminded again in Saturday's *Washington Post* the problems facing our injured service men and women have not gone away. Congress and the Administration have spent a great deal of time these past few weeks discussing the future of the war in Iraq. And while this debate is one that our Nation must have, I implore you not to forget about those who have already sacrificed so much—our injured men and women. They need to be front and center in the congressional debate and within the Administration. The story of Staff Sgt. John Daniel Shannon, as told in the *Washington Post*, is a story that we heard throughout our time with the Commission, a story of numerous case managers, none of whom held responsibility for spearheading an integrated care system, a story of lost paperwork and frustration, a story of a disability system that was in desperate need of repair.

It is stories like this that sparked the creation of our Commission and stories like this that should and must drive immediate congressional and White House action. This past July, it was the Commission's honor to present to the President, to Congress and the public, six groundbreaking patient and family centered recommendations that make sweeping changes in military and veterans' healthcare and services. The recommendations include the first major overhaul of the disability system in more than 50 years.

It includes the creation of recovery plans with recovery coordinators; a new e-Benefits Web site; and guaranteeing care for post-traumatic stress disorder (PTSD) from the VA for any servicemember deployed to Iraq and Afghanistan. Our report, *Serve, Support, Simplify*, is a bold blueprint for action that will enable injured servicemembers to successfully transition, as quickly as possible, back to their military duties or to civilian life. Our report calls for, and I quote, "fundamental changes in care management and the disability system." I respectfully request that this report be submitted for the record, Mr. Chairman.

Specifically, our six recommendations will immediately create comprehensive recovery plans to provide the right care at the right time and in the right place. We recommend that we completely restructure the disability determination and compensation systems, aggressively prevent and treat post-traumatic stress disorder and traumatic brain injury (TBI), significantly strengthen support for families, rapidly transfer patient information between DoD and VA, and strongly support Walter Reed by recruiting and retaining first rate professionals through 2011.

Our 6 recommendations do not require massive new programs or a flurry of new legislation. We have identified 34 specific action steps that must be taken to implement the 6 recommendations. Only 6 of the 34 items require legislation, and that is what we will focus on today. A complete list of the action steps for the 6 recommendations is included on the last page of my testimony.

Let me summarize the first three actions that require legislation and then my colleague, Senator Dole, will cover the remaining three.

The first is to improve access to care for servicemembers with post-traumatic stress disorder. We call 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, they are more likely 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's extensive resources for diagnosis and treatment.

Next, we ask Congress to strengthen the support for our military families. In our travels across the country, it has become abundantly clear that we not only need to help the severely injured, we need to help their loved ones as well. These loved ones are often on the frontlines 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 caregiving. 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 in their homes.

We also recommended 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 the 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 their close friends stayed with them for an extended time while they were hospitalized; one in five had to give up their job to do so. That is simply unacceptable.

Getting family members to the bedside of an injured servicemember is not a 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 service-

members recover quickly and return to duty, a 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. We have tremendous experience and evidence with that Act. All of these family members have been able to care for a family member without losing their jobs.

We were pleased to see the Senate has already unanimously passed the Support for Injured Servicemembers Act which implements this particular recommendation. We hope that the House will quickly follow suit.

Mr. Chairman, having served in government for about half of my adult life, I believe that government can work to improve the lives of its citizens. But sometimes, people of good will want to solve a problem and their idea is to fix a problem by adding a program or a new regulation. What we have done in this report and the reason why it is short and very focused, is rather than simply coming to you and recommending new legislation on top of existing legislation, we have rethought existing programs.

And one of the things we have done that is never done on commissions is that we have suggested simplifying the program itself so it is very clear who is responsible for what. And Senator Dole will be speaking to the disability provision that we have recommended. So don't think of this as adding another piece of legislation that adds a program on top of programs. I spent years, as you well know, trying to sort out Medicare. Part of the problem with the most complex legislation is that it is almost impossible for an ordinary competent government worker to administer the programs, let alone the people that are supposed to get the services of that legislation to understand them, not because someone tried to create a complex bureaucracy, but because they kept trying to fix problems by adding new legislation which added to the complexity of the administration.

So read this and the word "simplify" as attempting to make clear who is responsible for what and making it much easier for the patient and their families, as well as the people that have to administer the programs, to administer those programs in a way that is very responsive and very efficient for the programs.

I believe our recommendations are doable, whether it is requiring congressional legislation or implementation by DoD or VA. We made sure what we were recommending could actually be acted on quickly. The advantage of having Senator Dole and me up here is that in many ways we are the old warriors. We know——

[Laughter.]

Me too. We have a pretty good feel for what the bureaucracy can administer and what can be implemented, because we have been through this. And I hope that you, I know that you agree with us that our seriously injured servicemembers must not be made to

wait. They deserve a healthcare system that serves, supports and simplifies.

So I would like to thank the Committee again on behalf of the Commission for the opportunity to discuss our recommendations. And because those of you who know me know I don't mince words, I leave the Committee and the Administration with three simple words. Just do it. Thank you very much.

Senator Dole.

[The prepared statement of Secretary Shalala appears on p. 34, and the Commission reports appear on p. 45 and p. 82.]

Senator DOLE. Oh, thank you.

STATEMENT OF HON. BOB DOLE

Senator DOLE. Well, first let me thank the Chairman, Steve and others for being here. I want to thank Congressman Moran, Congressman Salazar, Congresswoman Berkley and others who have already introduced a draft of the legislation which may not be totally accurate, because we drafted it as we were going through. I know the Administration is working on a draft, and I know there are others on the Committee who have joined this bipartisan effort, which leads me to the second point.

I know which political party my Co-Chair is in and she knows which party I am in. But frankly, I don't know the political affiliation of any of the other seven members. We never discussed politics. It was totally nonpartisan. We never discussed costs. My view was, if we spend billions and billions and billions of dollars of getting young women and men in harm's way, we will have to spend what it takes to get them back in as normal a life as possible, whatever it takes. And I think that is where we are coming from.

So it is going to cost a little money. And Bob, we may use some of that which you have authorized. So——

The CHAIRMAN. Are you sure you are not a Democrat?

[Laughter.]

Senator DOLE. Pardon?

The CHAIRMAN. Are you sure you are not a Democrat?

Senator DOLE. Yeah. But, you know we——

[Laughter.]

No. We went way back to the Commission headed by Omar Bradley in 1956. Now, most of you weren't around then, but I was. And there have been a lot of Commissions. This problem just didn't happen with Building 18 at Walter Reed Hospital. It has been out there for years and years and years. We have 25 million, probably 26 million, veterans now. As they get older, especially the World War II generation, more and more need hospital care and VA care. One thing we found, and we had visits all over the country, I don't remember a single complaint—there may have been one—about the acute care the soldiers received from the battlefield until the end of their acute care.

That is not the problem, as my Co-Chair Secretary Shalala pointed out, it is what happens after that. It is the bureaucracy, which is true in many civilian hospitals, too. And that is why we are so honored to have Ed Eckenhoff, Chairman of the National Rehabilitation Hospital, on our Commission. He understands the private sector. One thing we also underscored in our report is that we want

the soldier to get the best possible care. If it is not available in a DoD or a VA facility, then they are authorized to go to the best private facility that they can find. We can do no less. And Ed was very helpful, not only in that area, but many others.

We had a young man named Jose Ramos on the Commission, and he would have been here today but he has a test. He is back in school. He lost an arm in Iraq. Another young man from our Commission, Marc Giammatteo, is attending Harvard, which I won't hold against him, but—well, my wife attended Harvard. Marc has a very badly damaged leg. We had a young woman on the Commission, Tammy Edwards, whose husband had burns on 70 percent of his body. So we had a good representative Commission. We had people who really understood the problem.

And I must say, I had a Co-Chairman who must have invented the Energizer Bunny, because all we did was work, work, work and she would tell us what to do and we would all try to do it. We learned a lot from each other and we really think we have some commonsense ideas. Some have said, "Why didn't you go way back and overhaul the whole system?" Well, our charter was limited to Iraq and Afghanistan and people who may follow. Now, we hope that war ends quickly. We don't want any more injuries. One is too many. One death is too many.

But one thing we discovered in trying to get down to the brass tacks was the group, the seriously injured group, those were severe TBI or spinal cord injuries or amputees or whatever. There are about 3,000. Now, if we can't manage the care of that group in the United States of America, with all the VA facilities and all the DoD facilities we have, we are in pretty bad shape. And we can. We just need to work out some of the wrinkles and that is where we believe our Commission can be helpful.

We can't dictate anything to this Committee. I spent 35½ years in Congress and I know how the system functions. And we know it takes time. We have been pushing the Executive Branch. I was at the White House last week and I can say very honestly, I am really not surprised, but I am very pleased with the effort they are making on the executive side and they will have their legislation ready in what, another 10 days?

Secretary SHALALA. Ten days.

Senator DOLE. So the veteran groups can look at it, and certainly Members of this Committee. We also had some outstanding staff, and I would just introduce our Director, Marie Michnich, who is here and Karen Guice who worked with the Veterans Service Organizations (VSOs) and Sue Hosek of RAND Corporation who has had about 30 years experience working with these same problems. So I think we have some credibility. At my age, I don't need this job. And you know, I told that to the President. Well, I guess I didn't see him. I saw him later. But I told that to the people at the White House and we told it to Bob Gates. Donna—excuse me, Secretary Shalala, she has a lot to do. She is busy.

The University of Miami football team, they got off to kind of a bad start, but they will recover.

[Laughter.]

So, you know, we wanted to do something that might mean something to somebody. I talked to a young man from Kansas 2

days ago. I was at Fort Sam Houston. He is a triple amputee. I think there are about 10 or 11 of those. His name is Sergeant Matt Lammers and I just was in disbelief of his attitude and his spirit and what an inspiration he is. He said he can get down with one arm. He has two legs gone above the knee and one arm above the elbow missing. He has two children, one 6 and a baby about 1 year old. And how he can get down on the floor and play with his children and get back in a chair by himself without any assistance.

Now, if that doesn't inspire us to do what we need to do to make certain that young man and his family and his children are taken care of. If you would just write him a blank check, it would be all right with us. But are those young people going to be able to go to college? Is he going to be able to earn enough money? He won't be able to do it with the pension he gets. So these are some of the things you may want to look at and I know some of the things have been looked at elsewhere.

I have been interested in veteran affairs—I will confess. I didn't know much about disabilities until I had one, and then you suddenly become interested. I served as a service officer of the American Legion and VFW when I was County Attorney 100 years ago in Russell, Kansas. And I worked with veterans all my life and all my years in Congress and now I am working with World War II veterans. They have what they call an Honor Flight where they bring in World War II veterans from your districts, without any cost to them. They charter them in. They go out and visit the memorials—spending most of their time at the World War II Memorial. They have a box lunch and they go back home and this makes their whole life. There will be a group in from Cleveland this afternoon. I will be down to say hello.

But the point I make is that we hope we have credibility. This is not perfect and there are changes you will want to make. And Secretary Shalala, I can't think of anybody with more experience in working with Congress than she has had and anybody more effective. So I just want to touch on three other points.

As Secretary Shalala said, there are six areas where we believe Congress needs to act, and you may think of others. And what we would like to do, but it may not be possible, is somehow get some of our suggestions into a conference report that you may be holding later this year on the Senate passed bill and your bill because these veterans can't wait much longer. And when we talk about the wait they have to get their claim settled and we know that if it doesn't make it in this year's bill, it will be next year, and that is a long time.

We think Saturday's story in the *Washington Post* would not have been there had Secretary Shalala's idea been adopted with the care coordinator. When you get out of the battlefield, and you walk or are carried into Walter Reed, you are assigned a recovery coordinator who stays with you throughout your treatment. Jose Ramos, who is on our Commission, had so many caseworkers that he couldn't remember their names. And that is what happened to this Sergeant Shannon.

So Secretary Shalala had a great idea. It is the first recommendation. And we are not talking about adding thousands or another bureaucracy. We are talking about 20, 30, 40, 50 people

who have followed the seriously injured from day one until the time they leave the hospital or go back home or back to work. Secretary Shalala has already touched on that. She outlined three major recommendations. Let me just touch on the others.

We want to get the DoD out of the disability business and we think they wouldn't mind doing that themselves. Veterans tell us that they get better ratings from the Veterans Administration, so we are trying to figure out some way—how do we work this so it is fair and we don't penalize anybody and still have the DoD with some. First they would have to get together with the VA and work out what kind of a physical it would be. And after the physical, when you are determined to be unfit for duty, then you go to the VA and they make your disability rating—not the DoD, but the Veterans Administration.

We have also added what will be called transition payment. I know from personal experience, when you first get out of the service, whether you are in the hospital or not—it doesn't make any difference—you are sort of at sea for 2 or 3 months. And so we have these transition payments. It would be your base pay for 3 months, or whatever Congress decides, while you are getting home, getting settled, getting your kids in school, getting a job, whatever.

There is another payment. It will all be in the same check—but something that has never really been considered separately and that is called quality of life. I think when you get your rating, I am certain if you are an amputee or you lost your sight, it is a consideration. But if you have lost your sight or if you are Sergeant Lammers who has lost three limbs, your quality of life has gone from a 10 to what, 1, 2 or 3? We think that should be compensable and that should be added to any other payment, whatever your rating may be, because you have lost that qualify of life forever.

It has never been specifically identified. I guess some who examine soldiers would probably say, well, they will include something. But we want to make certain that happens. Then, of course, there is the earnings loss payment which you would receive based on your disability, what your earnings loss might have been in your lifetime.

So we think, and we know there is another commission working on the disability program. I think it is fair to say that they have endorsed what we have done with two, is it two exceptions, Karen or Sue?

Ms. GUICE. They are still working on their recommendations.

Senator DOLE. In other words, we are pretty much in agreement and their report is due out, I think, sometime in the next 30 days or 45 days. But in other words, we don't want to wait and I know you don't want to wait. I think they would tell you now what they are going to do. So now there are differences in ratings depending on which military service or which regional office determines the rating. In our national survey of injured servicemembers, fewer than half understood the DoD's disability evaluation system and only 42 percent of retired or separated servicemembers who had filed a VA claim understood the process. That is about one out of two that even understood what was happening.

So, as I said, we recommend that DoD do one thing. They retain the authority to determine the fitness to serve. Out of the 28,000

wounded, 60, 70 percent are back to duty in 30 days and then there is another 10 or 12 percent that aren't hospitalized very long. But there is a group, say around 3,000, 3,200 that are very seriously injured and are going to need very special care for a long time. We believe that there should be only one physical exam, done by the DoD, and then the VA should resume all responsibility for establishing the disability and the rating.

This new structure, I think, makes it reliable and transparent and accountable. Under this action item, DoD and VA can focus on what they do best. The DoD determines fitness and the VA can determine your earnings loss and what your rating should be and the other things that my colleague has mentioned. The VA can do what they should do and I think it is a much simpler system that better supports the needs of those who transition between active duty and veteran status.

In our fifth action step, we recommend healthcare coverage for servicemembers who are found unfit because of conditions that were acquired in combat, supporting combat or preparing for combat. That includes about everybody, because once you sign up you are getting ready for combat the next day. So we think Congress should authorize comprehensive lifetime healthcare coverage and pharmacy benefits for those servicemembers and their families through DoD's TRICARE program.

Is it fair to say what the White House maybe——

Secretary SHALALA. Well——

Senator DOLE. We think the White House is going even further on this.

Secretary SHALALA. We think the White House is considering going even further to recommend that everyone who is declared unfit for service for health reasons, they will cover the individual and their family's healthcare forever. The advantage of that is, obviously, it is easier to get a job if you are disabled, even if you can work 20 hours a week, if you don't have to worry about working for benefits for your family members. I think it will help keep families together and will allow people to go to work and not have to worry about getting their healthcare covered. It is a tremendous step forward. We have limited jurisdiction and the White House may recommend going further in that regard.

Senator DOLE. So we have given a short summary here and we know there are questions and other members may want to make statements. We know everybody on this Committee wants to do what we want to do, and that is to make it work, and particularly for those who are really going to be jammed up the rest of their life. We want outcomes. We put in more money, as the Secretary indicated, for education. To keep people in the program, we raised the benefit 10 percent a year if they stayed. There is also a stipend to keep them in school. When these veterans finally leave the hospital and go to school, they are going to be better equipped to move into the mainstream of American life and have a better quality of life and a life of dignity for themselves and their family.

So you all know the figures. In Vietnam, five out of eight seriously injured survived. Now it is seven out of eight and we owe a debt to the people on the battlefield, the medics, the doctors, the nurses, therapists and all the people that take care of these men

and women who come back. Many who come back are not injured or wounded. Their illnesses, the things that happened to them are not their fault. But they are entitled to the same care. You don't have to be shot to receive benefits under our program. If it is combat-related which, as I said, covers about everybody, and if you are on the way to combat or whatever you are doing and you have an injury that is, that should be covered.

So I just say, Congressman Filner and Congressman Buyer and others, we are grateful for this opportunity. We did tell the other Commissioners that we would continue to try to help get this done. We are going to be around, Secretary Shalala will be around, for a long time. I will be around for a while at least and we are going to keep working on this. Hopefully, we are going to have your help. So thank you very much.

[The prepared statement of Senator Dole appears on p. 36.]

The CHAIRMAN. Thank you so much.

[Applause.]

Your common sense and your sense of urgency come through and provide a standard through which we have to meet. The Executive Branch will speak for itself. But we, in Congress here, have to act and act quickly. And we thank you for giving us that impetus and that charge and the background that you have here.

Secretary Shalala, you have had quite an effect on the Senator. If you had talked to him, or if he had talked like this——

Secretary SHALALA. We assure you, though, he did not become a Democrat in the process.

The CHAIRMAN. If he had learned this 10 years ago, you might not have had your last 4 years in the Cabinet, so——

Senator DOLE. I think the key, Mr. Chairman, is that I don't think we had any disagreements—I mean we may have—it doesn't mean everything was just whatever somebody wanted. But a lot of our Commission members had the ideas. On electronic transfer of records, we had this outstanding doctor from the Cleveland Clinic. He was a tremendous help to us because it is one of the problems out there. The VA has a great system. The DoD is trying to catch up. When you leave Walter Reed, you leave with a stack of paper. When you leave a VA hospital, you don't have anything. They can just punch a button and they can get your record. And there is a recommendation on information technology (IT), which we think makes a lot of sense and doesn't cost a big, big bundle of money.

The CHAIRMAN. Again, thank you so much. Your charge was the current war, but when I read your recommendations and I think about our Vietnam vets, it seems we could easily substitute Vietnam for what you said and do the same things. I think we did not treat our returning Vietnam vets with the honor, respect and care that they needed and we are paying a heavy price for it. And we still can correct some of that, but we also see what we have to do to get it right. Otherwise, we are going to be left with the kinds of homelessness and suicide rates that we saw——

Senator DOLE. I don't want to—this is the last time I will interrupt but——

The CHAIRMAN. I doubt it.

Senator DOLE. We are in the Senate. We never interrupt. But what we discussed is that it is a new kind of warfare. There are

new kinds of injuries. There is new technology. There are new opportunities. We tried to update—and I know the Chairman would have rather gone way back and kind of overhauled the whole system—but we did what our charter said. We tried to update and make some recommendations that are forward-looking.

Now, some people may resist change. I assume in the Bradley Commission report there were some who resisted change. But we have to bring the benefits and everything else up to date and we tried to do that in our report.

The CHAIRMAN. Did you at all, as we looked at the disability system and recommended a major transition, we do have a problem that exists right now, 600,000 or more backlogged claims. Some of us want to just cut through that bureaucracy right now, for example, and if a claim has been well documented and had advice of a veteran service officer, for example, to accept in the same way the Internal Revenue Service accepts your tax return and sends you a check for a refund, subject to audit, and just move out those 600,000, you know, as rapidly as we can. Did you at all think about that or take that up at all?

Secretary SHALALA. No. We actually didn't look at the backlog. As you know, this country has had considerable experience. The backlogs in Social Security were cleaned up. That requires a systems approach. That was not within our jurisdiction. We do believe, though, that our recommendations will actually help to make sure we don't create new backlogs because it will be much more straightforward as to who is responsible for what, what you are going to get and the combination of benefits, including, I should point out, an annuity even if you haven't spent 20 years in the military. All those found medically unfit to serve and leave before 20 years, will get an annuity.

I got an annuity after 14 years in the Federal service. If you are injured, you ought to be able to take that annuity with you from the DoD. So that is added to the pieces and that is pretty straightforward. I think that the combination of transition and some of these different ways of simplifying the system will help eliminate the backlog. So we didn't speak to it directly, but we just need a more modernized, straightforward system that is easier for everybody to understand.

Senator DOLE. Another thing is, I remember way back when I was at the retirement board and I had some pretty serious injuries. I couldn't use my hands and I couldn't walk at the time. But I got a disability based on the fact that I was a captain. If I were a colonel, I would have gotten a lot more money, even with lesser disabilities. That didn't make any sense to me then, and it doesn't make any sense to me now. So we think we have devised a system where you get this annuity payment, but then you also get a rating, whether you are a colonel or a private first class. We think we ought to make certain that you are being compensated for the disability.

And your rank—if you have been in the service 10 or 20 years, and many people dedicate their life to the service and we want to reward that, you will get the payment that the Secretary just pointed out, this so-called annuity, whether you have been in the service 6 years or have been in the service 25 years.

The CHAIRMAN. You all mentioned, on the basis of a medical discharge, that TRICARE should be given for life. This Committee has been concerned about the practice of using a personality disorder discharge which we think is almost a purposeful misdiagnosis of a preexisting condition, and therefore, would not obligate our government from compensating these servicemembers in the future. We think that is a big mistake and I don't know if you took that up in your report or not. But I mean we think we might have to put a temporary stop to these diagnoses because they are doing great disservice to these young men and women who are serving so faithfully. Did you look at that issue at all?

Senator DOLE. I think the Secretary is looking for the—we have the facts on it. I think the number discharged for personality disorder since 2000 has been about 6,000. I think there are some misleading figures out there; am I correct, or did you find that?

Secretary SHALALA. Right. I think—that is right. Eighty percent were never in combat.

Senator DOLE. We did check on that because you had raised the question when you testified.

Secretary SHALALA. On page 47 of our supplemental report, it is 6,000. And if I remember correctly, most of them were not in combat specifically. That obviously could use some study. But one of the things that we recommend is that the standard of care for PTSD, and a lot of the appeals are about that, must be widely disseminated. We need more research on that subject. But everyone who comes for care ought to be treated and everybody ought to be eligible to be treated, no matter when they served in combat.

And I wish I could say that the private sector had great centers of excellence. The experts in the world are in our military and in our VA, in particular. And while there are some private sector rehab hospitals that have some capabilities, most of this is in-house. We need to disseminate the standard of care. There are a number of centers and we need to make that available to everyone.

The CHAIRMAN. And thank you, Senator Dole, for praising the whole system of care, not only in the VA, but on the battlefield today. The Secretary, the VA and I and Congressman Boozman just returned from Iraq and Afghanistan and what we did was, we followed that trail of the wounded warrior from when they are wounded, to their medical evacuation, to a forward base hospital, to a regional hospital, to Landstuhl, Germany, and we followed that for very specific individuals and the incredible professionalism, expertise, dedication, morale. I mean, and these kids, I mean they are 19, 20, 21, who are doing all of this and we were just amazed at their professionalism and leading to this, you know, this incredible survival rate once you, if you survive a battlefield injury. So thank you for praising them, because they are a tremendous, tremendous asset to this Nation.

Senator DOLE. I think in our report there is a segment that tracks a veteran from injury through medical treatment.

Secretary SHALALA. We did.

Senator DOLE. We have a little chart in there.

Secretary SHALALA. We did. And the University of Miami actually trains those trauma teams. The soldiers and military personnel fly in from different parts of the country. We turn them into

a team before they go off to Iraq and Afghanistan. And the medicine today is unbelievable. The disability system is based on a 30-year-old medical system. That is the whole point here. If you saw the schedules on orthopedics in the disability system that we have in VA, it is unbelievable. It doesn't reflect modern medicine. This has to be brought up to date. It is just unacceptable the way it is currently set. And in this case, we know what to do.

Senator DOLE. The one place we need help, and Steve may have pointed this out in his hearings, is in the mental health field. There are not enough professionals available in the private sector or in VA and military hospitals. I don't know where they are going to come from, but——

The CHAIRMAN. Thank you. Thank you again. And that teamwork, by the way, was so vital, as we watched it in Iraq and Afghanistan.

Mr. Buyer, you are recognized for 5 minutes.

Mr. BUYER. Thank you.

You know, it is great to see your enthusiasm. As you know, that can move mountains. And so not only is it your credibility, but your enthusiasm that has me excited. And Mr. Dole, they kind of poked you here a little bit when you talked about spending as much money as necessary. I think you espoused exactly how you felt all the years that I have known you on these issues. When I came here in 1992, we had a VA system that was depicted in the movie "Born on the Fourth of July." And as a country we didn't do well.

And Ms. Shalala, Dr. Ken Kaiser, your good friend who was then the Under Secretary of Health during the Clinton Administration, had his ideas of moving to outpatient care and we embraced that. And we have invested well—when you look at 1995 as a benchmark, we have invested probably in excess of $300 billion.

So I embrace exactly what you said, Senator Dole, and——

Senator DOLE. Thank you.

Mr. BUYER [continuing]. A couple of things I wanted to touch on and I thank you, Secretary Shalala, for your comments. You made yourself narrow and then you went deep and that is why you have a good product. We have the Disability Commission that was out there, so you were respectful of them. Yet you touched on a few areas. So we are with great anticipation waiting on their testimony to us.

I have some questions regarding the TRICARE for Life. I created the TRICARE for Life for the military retirees when I was Chairman of the Personnel Subcommittee in our Armed Services Committee. So when you say, Senator Dole, that you would like to get DoD out of the disability business, there are a couple of things that I need to ask. In order to get DoD out of this business, we still have the medical retirees, or as your recommendation, to even do away with medical retirees. That is one question.

The other is, if we are going to say that TRICARE for Life is available to those who are found unfit because of conditions acquired in combat, supporting combat or preparing for combat, then DoD pays for the TRICARE for Life. So they are not going to be totally out of that. We are not going to be able to stovepipe that. So there are still going to be payors. And so I will be a good lis-

tener when the Disability Commission comes over and I will embrace your recommendations.

My question to you is about implementation. So if we are going to take the TRICARE for Life program and we are now going to implement that, the eligibility, are we going to restrict that eligibility to a core constituency, meaning those, as you defined here, and what is the effective date?

Senator DOLE. Why don't you go first?

Secretary SHALALA. The effective date is going to be determined by Congress and there will be legislation that will be coming up. I think——

Mr. BUYER. Do you have a recommendation?

Secretary SHALALA [continuing]. We are talking about, that will be part of, back to 2001. And you will see legislation. That, obviously, is something that can be discussed with Congress in terms of setting that, as well as who is to be covered. We are simply talking about DoD making only the fit/unfit decision and if one is not fit for health reasons and you get a medical discharge, then you ought to have the opportunity—and then you go over and get your disability out of VA. You ought to have the opportunity to have your healthcare covered.

The addition here is to cover your family as well, to encourage you to go on and get education, as well as to get ready to go to work, if you can. If you can't, obviously, there are all sorts of services that would be available for you.

Mr. BUYER. All right. With regard to the issue on VA contract care, if DoD, what you are trying to do is move these to be patient-centric, thank you very much. I wanted to jump up and hug you when I heard you talk about patient-centric.

Secretary SHALALA. Oh, that would be fun.

[Laughter.]

The CHAIRMAN. Trust me, it is not.

[Laughter.]

Mr. BUYER. Well, I am hetero, Mr. Filner.

Senator DOLE. Steve, could I ask——

Mr. BUYER. I am not sure.

[Laughter.]

Sure, Senator Dole.

Senator DOLE. You raised a point that I don't have an answer to on medical retirees.

Sue, would you, or Karen, address that? Let's say you have served 25 years and you——

Secretary SHALALA. This is Sue Hosek from the RAND Corporation.

Senator DOLE. RAND Corporation. She has had 30 years working with these issues.

How do you treat the medical retiree—I should know, but I don't.

Ms. HOSEK. If you are declared unfit, you get your discharge for medical reasons. And, obviously, if you have served 20 years, you are still going to get your retirement. What our proposal does is to provide essentially a partial retirement benefit in the form of an annuity payment for those who don't reach the 20 years. Right now they walk away with nothing. And so we don't want the person

who has, you know, say, 15 years of military service to walk off without that. And so that is an important change that we——

Senator DOLE. But then you get your earnings loss from the VA.

Ms. HOSEK. Yes. Then the VA takes care of the disability benefits that you would be entitled to, yeah.

Mr. BUYER. Thank you.

Senator DOLE. Well, they are a little different, Steve. I wanted to say just one word about Walter Reed. I think the initial *Washington Post* story was kind of a wake up call for all of us and everybody began to focus on a lot of things that should have been focused on before. But, again, having been treated there for a lot of—I had several operations there. It is a great hospital.

Our last recommendation is that until the other place is totally ready, we have to keep Walter Reed in A–1 condition before they turn off the lights, because we hope this conflict is going to end soon. For about 26 percent of the patients, their first stop is Walter Reed Hospital. So we have to keep that, if we have to, and we suggest providing incentives, because a lot of people don't want to stay in a place that is about to sink. You know, you want to get overboard, get in a life raft or something or find another job.

So we would recommend some incentives for the civilians who may be contracting there or even the military personnel—some kind of a bonus for staying on the job at Walter Reed, because this is where at least one-fourth of our casualties go. So we don't want anything but first-rate service there until somebody finally says, okay, we can turn off the lights.

Mr. BUYER. Thank you for your contribution and viewing this through the eyes of a soldier.

The CHAIRMAN. Thank you. Dr. Snyder is next. I just want to thank him for focusing on an issue that I know may be not as part of your charge, but, you know, half of our fighting forces are the Guard and Reserve units who we think have got to have access to the same benefits. And Dr. Snyder has led the way and we thank him. You are recognized.

Dr. SNYDER. Thank you, Mr. Chairman. Thank you all for being here today. We held a hearing yesterday on the Subcommittee on Oversight and Investigations on the Armed Services Committee on Military——

Senator DOLE. I have a little, I have a little trouble——

Dr. SNYDER. I am sorry. We held a hearing yesterday on our Subcommittee on Oversight on the Armed Services Committee on DoD civilian personnel and their medical care and benefits and incentives serving in a war zone. And I will tell you what, I presented a scenario to the Department of Labor guy. If I was a DoD civilian that worked 18 hours a day at the Baghdad airport and had 6 hours off and was playing basketball on the court for my recreation time and a mortar came in and I got injured, would I be covered by worker's comp?

And we could not get a definitive answer, that for sure, even though it was a clear-cut combat-related injury, that a DoD civilian would be covered by worker's comp. My guess is they will come back and say well, yeah, we thought about it and we think we can definitely say that. But I will tell you what, if you were a civilian

government worker working in Iraq right now, that kind of answer would create some uncertainty for you.

The Disability Commission, I am told, report will be briefed to the Armed Services Committee staff on October 2nd and that their report will be made public October 3rd, which should be out in plenty of time, I think, to inform these decisions as we go forward in conference and hopefully there will be things that we can react to this year.

I wanted to ask a couple of specific questions. In your report, you mention—well, I will just read the two sentences. "To make the system work, recovery coordinators need considerable authority and to be paid accordingly. Recruitment, training and oversight by a new unit of the U.S. Public Health Service serves as commission corps and the Department of Health and Human Services should be strongly considered." That makes some of us apprehensive when we consider the years that we have tried to bring the VA system and the DoD system together and we are going to throw up our hands and say well, the way to get it is bring in a third huge system that everybody in this room has had problems with also in other areas.

Is that really something we need to do in terms of bringing in HHS, or is there not another way to get at that?

Secretary SHALALA. There are other ways, obviously. And our feeling was that the Commission corps ought to be involved certainly in the training and that is being considered by the White House in the legislation they are going to send forward. The most important thing is a degree of independence, that this recovery coordinator has to be able to cut across whatever benefits are available and have some authority and be there for the full period of time when the soldier, from the time they are injured until they either go back to civilian life or complete their disability and rehab period.

If a police officer goes down in my community of Miami, an officer is assigned to that person from the time they are injured, right through their hospital stay, right through their rehabilitation. The problem now, as the Senator pointed out, is that there are so many care coordinators. These soldiers and their families can't remember all their names. So that for the most severely injured people, we need a highly trained professional. And we are not talking about that many people. But a number of agencies have to participate in the outline in that training. Where they are located, who pays their salary, we were, we strongly recommended that it be independent of the VA and the DoD. But the most important thing to us is the level of their training, the fact that they are going to stick with that soldier and their family right through the process and that they don't change, for particularly these very complex cases.

Dr. SNYDER. I agree with all——

Secretary SHALALA. We are not talking about a large number of people. Does that answer your question well enough?

Dr. SNYDER. It does. I think it is the function that is key.

Senator DOLE. I would just add that there has been some concern with that provision by the veterans groups, another layer of bureaucracy. Well, we are not trying to do that. We are talking about a very small number of people. And if it is not the Public Health

Service, the Secretary has had a lot of experience with them because HHS is sort of the umbrella group.

But she stated it very clearly. We want somebody with authority to get an appointment.

Dr. SNYDER. No. I want to ask one——

Senator DOLE. It might speed up the process and——

Dr. SNYDER. I want to ask one final question before my time runs out. And you talked about it, Senator Dole, when you talked about the combat-related injury related to training hazardous duty. I think we have always had a pretty strong feeling in the Congress that we want to treat all our veterans, military people, in similar situations the same. And so, I can come up with scenarios, you know, Little Rock Air Force Base is in my district. A guy is working on a water tower in the military, falls off the tower or gets blown off by the wind or crosses the street and gets hit by a car, has a terrible spinal cord injury, that we would, I would think that would not fit under the language of Ms. Berkley's bill or the kind of language that you outline there and we are going to treat that person differently and their family medical leave qualification differently than a person who may have landed on a carrier in the Gulf and had a similar kind of injury.

I understand the importance of focusing on combat-related, but on the other hand, we are going to have two classes of people in our military. I am not sure that we want to go down that road. What do you think?

Senator DOLE. Right. We had a lot of discussion. We talked about line of duty, combat-related, other ways we can define it. I think what we, in essence, finally concluded was that unless it is some reprehensible conduct—you are drunk, disorderly and you are injured or something—but if you are on a tower and you are in the line of duty and the wind blows you off, in my view, you are covered.

Dr. SNYDER. Well, take the one you are crossing the street to the PX and you are hit in the parking lot, that would not be considered hazardous duty, right?

Senator DOLE. Yes.

Dr. SNYDER. We could have families living next door that are treated differently with similar injuries.

Senator DOLE. I am not sure we would cover everybody crossing the street, but our intent was to make it broad——

Dr. SNYDER. Right, I see.

Senator DOLE [continuing]. Not to limit it. You know, you don't have to be shot to be——

Dr. SNYDER. Severely hurt.

Senator DOLE [continuing]. To be injured in the line of duty serving your country, and you ought to have the same benefit.

Dr. SNYDER. Right. Thank you. Thank you for your service.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Moran.

Mr. MORAN. Mr. Chairman, thank you. Thank you to you and Mr. Buyer for holding this hearing today and it is a real privilege to be here with Secretary Shalala and Senator Dole and I want to

thank them for their distinguished service to our country and especially in this latest effort in regard to their Commission's work.

Senator Dole, of course, needs to make no statements to prove his credibility on the topic that is before us. Senator Dole, I was at the Dole Institute of Public Policy on Monday before returning to Washington, DC, where I welcomed 100 new U.S. citizens to our country and used you as the role model, the example of what one can attain in their life. With the recognition that in many ways, I suppose, you grew up an ordinary Kansan, but accomplished extraordinary things.

And Kansans hold you in high regard, as do Americans, for your public service here in our Nation's capital. But I really do think it is your service to our country in the military, the injuries that you incurred and your recovery that is the remarkable part of your life. And I appreciate the effort that you make on a daily basis to care for those who have been injured in service to their country.

You tell in your book *One Soldier's Story* that none of us who travel the valleys of life ever walk alone. And your personal story is one that is a reminder to all of us about how we do rely upon others. Your mother, Bina, and her day-to-day efforts in your recovery——

Senator DOLE. She was my coordinator, my mother, yeah. She was there every day. She even held my cigarette. She hated people who smoked, but it was a little habit I picked up because in World War II they gave you a little pack with four cigarettes in it for your dessert, so we all started smoking. But one of them dropped down my cast one day and we had to pour water down there and all that stuff, but—but again, you go out to Walter Reed and if you see a single soldier, I will bet you 10 to 1, in nearly every case, the mother is going to be standing right there, or the father or some family member. And that is another area that the Secretary and I want to address.

Mr. MORAN. Well, your mother and your family, as well as the folks of Kansas, particularly your hometown of Russell, the cigar box story is one that is an inspiration, I think, to all of us. The community of Russell, which is a typical Kansas community, put the cigar box in the drug store and collected money for Senator Dole's rehabilitation and today there are those in Russell who remember their efforts on behalf of the Senator and how well he is——

Senator DOLE. Well, if I could add, it was only $1,800 and I was wounded late in the war and all the good doctors, of course, wanted to go home, because the war was—I was wounded in April and it ended in Europe in May. In fact, I was wounded a hill apart and a week apart from where Senator Inouye was wounded and we ended up in the same hospital together and then later ended up in the Senate.

But that is an indication—and I wish the Committee could give me some guidance on, there are all these wonderful groups out there trying to raise money to help veterans. I don't know whether, Mr. Chairman, have you ever checked to be sure they are all bona fide? The volunteer groups are doing a great deal. In those days, in our little town of Russell, $1,800 was a big amount. In 1947, that was kind of a recession era. I remember one man, Mr. Wegley,

brought a duck. He didn't have any money, but he brought a duck, which we couldn't put in the bank, but we ate it.

So just the generosity of the people and it is still out there and we want to tap into that, too.

Secretary SHALALA. And I think that is also the point, Senator. We met a mother who is from Ohio whose community is paying her mortgage while she is down in San Antonio at Brooke coordinating the care. Three decades later, we are still doing the same thing and there are other ways to do this that are more supportive of family. Women are working now. They weren't in an earlier generation and the whole family is working.

Mr. MORAN. Well, I think you both have great credibility in bringing to us this idea of a support system for those who are leaving the military. I have one question, although I would like to tell you, Senator Dole, but for you, I have never seen any place outside Kansas. I grew up in a family where vacations were a very rare thing. We only went to Iowa on an almost annual basis on your behalf. Every time you ran for President we got to see the rest of the country.

Senator DOLE. Yeah, well, it still——

Mr. MORAN. It didn't work.

Senator DOLE. It is still a possibility for 2008, but I don't think, I don't think so.

[Laughter.]

Mr. MORAN. Let me ask you——

The CHAIRMAN. We have an exclusive.

Mr. MORAN. Let me ask you, Senator Dole, about contract care. One of the things that I worry a lot about on behalf of rural America, rural Kansans in particular, is the ability for us to have a continuum of care that exceeds just the boundaries of our cities. The VA traditionally has been bricks and mortar in large communities. I represent a congressional district, your congressional district. There is no VA hospital and we continue to push the VA to provide greater contract care where the veteran can access through his own, his or her own physician, local hospital, other providers. And I wonder if your Commission has looked at what we do to expand the opportunities across America, not just in the traditional places at the VA or a military hospital which can provide assistance.

Senator DOLE. Right. You know, I wonder if I could just ask Ed Eckenhoff, a member of the Commission, to respond to that, because one thing we emphasize in our report, if you live in Las Vegas, you know, you have a big, wonderful VA hospital there. But in some of these rural areas, you have got to drive 300 or 400 miles to get access to good medical care if you are going to go to a DoD or VA facility.

So we urge—well, we want Congress to make it possible to underscore that you can go to the private sector to get good care.

And Ed, can we hear you? You have a good voice.

Mr. ECKENHOFF. Well, if you can hear me, I will just stay right here.

Senator DOLE. Yeah, Ed Eckenhoff.

Mr. ECKENHOFF. We have talked a great deal about that and came to the conclusion that while you are absolutely right that 170 plus Veterans Administration hospitals, 60 plus DoD hospitals, we

have 5,200 civilian hospitals, many of them practicing good acute rehabilitation. Now, within that population of civilian hospitals, we have roughly 1,100 that have acute rehabilitation units, anywhere from 10 to 50 beds. We have roughly 250 freestanding civilian rehabilitation hospitals, all of these very well-staffed, even though we do have our vacancy problems, understand rehabilitation extraordinarily well, particularly the traumatic brain injury, as we have discovered, is our signature injury within these two wars.

Secretary SHALALA. Our first recommendation was for a recovery plan and with the recovery coordinator. The point of that plan is that with an interdisciplinary team, you can figure out and make adjustments to it when someone can go home, what care is available where, and particularly for these young men and women that want to go home, getting access to that care would be part of the recovery plan. So plotting it out so that someone could go home as soon as possible, get access to care, even the use of telemedicine. We have had a lot of experiences in this country now with rural healthcare. My family, part of it lives in North Dakota and there are a lot of soldiers in that place. And making sure people can get home and get care, the quality of care that they need, using local physicians, local rehab hospitals, traveling when they need to, ought to be part of that plan and the recovery coordinator ought to be able to get them to the right place at the right time.

Senator DOLE. That is a good question. It is a big issue.

Mr. MORAN. Mr. Chairman, thank you. I appreciate the gentlemen from Colorado, Mr. Salazar. He and I have joined together and have introduced as legislation the recommendations of the Commission. We now know that the Administration also has a plan to do something similar, but we would welcome any of our colleagues to join us. Thank you, Mr. Chairman.

Senator DOLE. That may be, you know, it is subject to change, obviously. You may want to change it. I know the White House is working on a draft. They are actually liberalizing some of the areas. I think it is good to send a message, you know. We appreciate your introducing what could be modified later.

The CHAIRMAN. Thank you. I now recognize Mr. Michaud, who chairs our Subcommittee on Health.

Mr. MICHAUD. Thank you very much, Mr. Chairman, Mr. Ranking Member, for having this hearing and I really want to thank both Senator Dole and Secretary Shalala for all your work, not only on this, but your continued service to our country. Providing the best possible care for our men and women who risk their lives for our country should be, and is, one of our highest priorities.

I believe that in general we do a good job, but there are also, as you realize, significant gaps in services that our men and women receive. I not only thank both of you, but also your staff for all their hard work in putting this report together. I really appreciate it. I believe that your recommendations as they relate to PTSD and TBI, as well as those regarding assisting families, are very good and we will continue to hopefully move those ideas forward and I look forward to working with you as we do move this bill forward.

My question is, I appreciate recommendation number two to simplify the disability and compensation system, but I want to make sure that we do not create an unintended negative system at the

same time. This would essentially create a rating system for current veterans and new veterans that will be coming into the system. My concern is that dual type system, but also, how does your, how do you envision this disability, how does that take into account veterans who, as you know, will manifest service-connected disabilities much later in life in some cases? How does this new disability system affect that?

Senator DOLE. I am going to let you, but I——

Secretary SHALALA. Go ahead.

Senator DOLE. One thing we do, and we do it in a positive way. Now, some may not like it. For the veterans with disabilities, we have a review every 3 years which will take care of anything that may arise in that 3-year period if there is a sickness or illness or something they discover. We think it is a very positive step. Particularly men don't go to doctors like they should and there are all kinds of studies on that issue. I think we really tried to simplify the system. And I think in every case that we tried to look at, the veteran is better off under our system dollar-wise.

Even more importantly, we had our eye on what we call outcome. What is the outcome? What condition will this person be in when they are finally free of all the hospitalization and education? Where are they going to fit in society? We think in both cases we did the best we could and I think Secretary Shalala has an added comment, with some help. Go ahead.

Secretary SHALALA. The disability system will establish, the new system will establish a really good baseline. So if someone gets something else a little later, it will be easy to make that adjustment. The most important thing for people that have already gotten their disability determination is they will have a choice. They can keep the current determination or they can look at the new system and then make a choice of what is better for them. We believe that in the new system, people will be much better off. All of our recommendations, it will simplify it. If you combine the annuity, the extended disability payment that covers quality of life, as well as modernizes that actual decision, people will just be better off.

If they were injured in an accident and there was liability and they were represented by a lawyer, they would get all these other payments. They would get the earnings stuff. They get the quality of life payment. Why is it that these young soldiers don't get that? Because we have a very old fashioned system. And yet if they got a similar kind of injury in the private sector, all of those other things would be taken into account as part of the payment.

Mr. MICHAUD. Okay. My next question, actually, Senator Dole, you had mentioned that, I believe it was in action plan, your fifth action plan, that the White House is coming up with actually a more liberal proposal and I couldn't really figure out the distinction between the report versus what the White House might be coming up with.

Senator DOLE. Well, I can't tell you specifically. I do know in the TRICARE area they are going to extend it to more people and families. So that is a big, big step. It is probably a big cost. But that is already in the mix. As I said, I was there last week. The Secretary was there yesterday. She may have some later information.

I was very pleased because we have been pushing the people in the White House and, obviously, haven't been pushing Members of Congress, but we have been letting Members of Congress know we were available. We wanted to follow up. We wanted something to happen. I don't know whether they spell out any other areas. But they like our report. I think they really think we did a pretty good job in the time we had.

We were together with the President at the local VA hospital where he, in effect, endorsed the report. We know there is another one coming out on benefits, but again, I think with minor differences.

Did the White House add anything else you learned yesterday?

Secretary SHALALA. No. This Presidential Commission made six recommendations that require congressional action. The White House is preparing draft legislation and has indicated absolute willingness to work with the Congress. From what we heard, and I was there yesterday, they are considering broadening both the definition of who is covered, extending the TRICARE benefit to those that are discharged for medical reasons and to their families further than we did.

So I think that you will be very pleased with their proposal. And that, of course, is draft legislation to give you another touchstone to work from. So because it was a Presidential Commission, they will do the drafting of those six. All of the other recommendations are now being implemented by the Administration and they are marching through each one with, from what I could tell, because I have talked to the two secretaries as well as to the White House, pretty firm commitments. I can usually tell, since I have been there before, whether they are really doing it. They have pretty firm commitments from the agencies that need to do the implementation, with the expected push back and I think you can hear our enthusiasm because we think this is going to get done.

I actually don't believe in long commissions. I think you ought to be able to go in, see where you ought to intervene to make it better, identify pieces of legislation that need to be passed and just get it done.

Senator DOLE. We have already had a report, and I assume that—if you don't have it, we will send it up. But what is happening so far with DoD and VA and their joint meetings and the areas of our recommendations they have focused on is that they are starting to implement. So there is positive movement, so——

Mr. MICHAUD. Good. I thank you both very much.

The CHAIRMAN. Thank you. Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman.

I want to thank you all for your work. I think you are a great example of how you can take individuals that are very well respected on both sides of the aisle and really accomplish a great deal. I think that you are a great example for all of us.

In dealing with the 3,200, that group that is severely injured, I think the recovery coordinator is an excellent idea. All of us though, having been around the bureaucracy and things, and there is nothing inherently wrong. It is just the system. I would really encourage that hopefully those people, those recovery coordinators, will have a general officer, somebody with some clout that when

they run into a roadblock, they have somebody that can cut through the system that says hey, these 3,200 are individuals that were totally committed and have unique situations, many times, that can cut through the red tape. And I hope somehow we can integrate that into the thing.

Secretary SHALALA. I think that is exactly right for accountability. I think of them as torpedoes which literally cut through with the authority to order appointments, to get agencies and services to work together, but more importantly, to make sure that individuals with very complex problems and their families get every benefit they are eligible for and get it on time.

Senator DOLE. Our hope is, when they have that meeting when the patient arrives at Walter Reed and the doctors are hovering around there, one member of that team will be the recovery coordinator and he will be there from, or she or he will be there from whatever point. I really give full credit for that to Secretary Shalala, and I think it is a great idea and it is not a big, big layer. We are talking about 40 or 50 specialists, right?

Secretary SHALALA. Yeah, not that many, you know, it is just a handful of people given the number of people that are involved. And I think the most important thing is they don't get deployed. What happens now with the care coordinators is they are there for a year and then they get deployed. And so they keep changing and you have one for each kind of service. You just can't do that when you have a complex situation.

Mr. BOOZMAN. Right. Let me ask you another thing, too, or maybe you can comment. I have run into another situation. I am an optometrist and was asked to—I have been to Walter Reed several times. I went over to Walter Reed, was asked by the ophthalmologist and optometrist there, they have a situation where, with traumatic brain injury and they don't really understand why, but many of these people have symptoms of not being able to read, you know, like they used to, comprehend. And so we are trying, we introduced a bill to provide them some money to go forward with that study.

As you all know, it is very difficult and hopefully we can get that blended into this legislation or some other. But there ought to be a pool of money that as these things come up, you know, a small pool of money was something where they don't have to have an act of Congress to go forward with these little, very, very important things. Does that make sense? You all are very familiar with this issue.

Secretary SHALALA. You know, DoD has a lot of research money for health research, as does the National Institutes of Health (NIH) and there is no reason why a first class application for research money for a period of time on something specific like that ought not to be funded.

Mr. BOOZMAN. And, again, I think you can help by cutting the——

Secretary SHALALA. But it is not that the resources aren't available. We have just got to make sure that when those applications go in, that they have the priority they deserve.

Mr. BOOZMAN. Exactly.

Secretary SHALALA. And there is an increasing interest. I am happy to talk to the Director of the NIH and to the DoD health research people. But you have put a lot of money in DoD research, as well as in NIH research. I come from a place that has the number one ranked eye hospital, Baskin-Palmer, and I know that our scientists are very interested in these kinds of questions.

Mr. BOOZMAN. Well, again, that would be helpful, like I say, in getting some priority.

Secretary SHALALA. I would be happy to have those conversations.

Mr. BOOZMAN. The last thing, you mentioned unfit for service. And what does that, what does that entail as far as disability? That doesn't mean 100 percent, does it, or does that mean the whole gambit or——

Senator DOLE. Well, DoD wants to keep as many people as they can. So you could have some problems, some health problems, some disabilities, but still be fit for service. And it doesn't mean you are in perfect health and everything is fine.

Mr. BOOZMAN. Sure.

Senator DOLE. But there are certain, some things you can do in the service that if you are 100 percent you couldn't do. So that is why we want to make certain that they make that finding and the VA does the rest.

Secretary SHALALA. You know, the two young soldiers that were members of our panel, both of them could have stayed in the military, that is, in desk jobs. They chose not to. So they took their discharge and got on with their education. But it was basically their choice. And the military is trying to keep some people—first of all, they are great role models and there obviously are stories of people jumping out of airplanes, you know, who have a prosthetic limb. But I think they know pretty well who is fit to serve, but their incentive is to try to keep people.

Mr. BOOZMAN. Thank you all very much. Senator, you mentioned the program, the vets coming up, you know, the World War II guys.

Senator DOLE. Honored Flight.

Mr. BOOZMAN. We had a group from Arkansas that you met and that was such a special thing. So we appreciate those little things that make such a big difference. Thank you very much.

Senator DOLE. Yeah. Well, not many World War II veterans around are all that active. But I am sort of the official greeter. I try to go out there whenever I can and greet these World War II veterans. And if they are not doing it in your district, you ought to check into it, because it is just a great thing to do. It may change the life of some of these 80-year-olds, 85. I met one guy who was 92. He wanted to get a picture. He was in a wheelchair. I said you stay right there. He said no, no, I am going to stand up and he stood up straight and strong, but you can see the tears in their eyes and they probably reflected when they were young and what they were doing. It is a great program. You just raise the money locally. It is called Honor Flight. You can get information on their Web site. Some fellow that is not a big CEO, but some young businessman in Hendersonville, North Carolina, named Jeff Miller came up with the idea and it is really great. Every Saturday you can almost count on—last Saturday there were 600 from all over

the country. And I did have a good chance to meet, I met two Kansans in that group from Arkansas, so——

The CHAIRMAN. Thank you. Mr. Walz.

Mr. WALZ. Well, thank you, Mr. Chairman and Ranking Member, and of course, a thank you to our guests, Senator Dole and Secretary Shalala.

Senator Dole, you were out in Rochester, Minnesota, to our soldier's field which we are very proud of our memorial out there and my friend, Wayne Steelman, and many of our veterans out there recall that day with intimate detail about your taking time to tour the memorial and it truly does matter.

As a veteran, when I saw that the two of you were appointed to this, I couldn't have been happier and the report you produced is one that I was hoping we would get. It is absolutely what we need. It comes from two distinguished voices on this and my regret is today that this hearing is not being covered with the same, the same gusto as was last week's hearing, because listening to Senator Dole's words, the two are intertwined.

I see members out here of our veteran service organizations, veterans themselves, people who have worked on this issue for decades and we know you can't separate the two and I think it is very important for this Nation to understand that this treatment is truly critical. And I think it is important when we talk about the VA to recognize the amount of great work that happens there. I have in Minnesota, at the VA medical center in Minneapolis, the polytrauma center there. The work that they are doing—when I hear mothers with severely injured sons and they say the only thing getting them through the day are those saints that are there on that floor, those nurses, those doctors, that is heartwarming.

But the Senator made the point that all of us make on this. This is a zero sum proposition. One Sergeant Shannon is one too many. And that is what we have to get to. And I think in all of these areas, we are trying to figure out what are the systemic issues here and some of us are trying to understand the cultural inertia that happens in this. One area that I am interested in, and I am glad to hear it got reported on, is this issue of exchanging medical records from DoD to VA. I represent the City of Rochester, which includes the Mayo Clinic. And this is an area that has been working, an institution that has been working on this for years. This is a very complex issue. It doesn't involve just getting a standardized database. It involves many things that go into what is on that record.

And when I talk to the people at the Mayo who have been looking at this, they are convinced that the VA has the best in the world. They said this is the best system in the world. And their suggestion was, and this was made not, you know, this was a little more anecdotally when I was talking to them about it with their very intimate knowledge of this, that DoD needs to maybe adjust to that.

Now, I had the opportunity after talking with the Mayo people in looking at this to mention this to some, a person in DoD on the Army side that would have the ability to influence these types of decisions. And they simply wanted to hear nothing about it. They didn't want to hear about it. It wasn't the right way to go.

My question to both of you with vast experience in the bureaucracy, talking about the torpedo, Secretary, of cutting through, how do we get to this issue? How do we move these electronic medical records, this record sharing? It is so important for the care of our soldiers, for the efficiency and for everything else. And I guess I am asking you maybe to answer a really, really difficult question here. But it is one that I think—this has been around for many of these Members' entire tenure here and we still can't get it fixed and it is a critical part of that seamless transition, so, please.

Secretary SHALALA. Actually, I don't think it is that complex, not if you look at it from the point of view of the patient. I was Secretary of HHS while the VA record system was being put in place. That technology certainly will need modernization and some investments in the years ahead. It seems so simple, why doesn't the military just adopt it and be done with it. It is in part not the answer because the VA and DoD are doing different things. That is number one.

But what we focused on is the soldiers now, and what can you do to get the interoperability of the two systems. We suggested, under the leadership of a member of our Commission who does this for the Cleveland Clinic and is an international expert on the subject, that there are a series of steps that will get us more rapidly to interoperability, which are now taking place. They have to do it as fast as they can to make sure that you have access to information necessary for both care and services.

That is more important at this point in time than for us to suggest that you spend billions trying to get one new system built from the bottom up. And you can tell our pragmatism here, that first of all, those of us that have experienced the bottom up systems are a little nervous about starting that while the technology is changing. It is not that we would ever say we are opposed to it, but at the moment, what you want to do is serve these soldiers now and also the ones that come behind them. There are ways to do that.

We have suggested a series of steps. You don't have to pass any legislation on it. The government can do it. The two agencies can do it. They are in the process of doing it. And we have suggested action steps that can be measured and what the goals are of those steps so that we can actually hold the DoD and the VA accountable for making sure those systems work together. And they are in the process of doing that. That is the good news here.

The bad news is that we actually did not take a vote or look at, you know, adopting one system versus another, because they actually do have different purposes and need different kinds of interactions, nor did we make a recommendation on a bottoms up, multi-billion dollar review. We looked at the practical ways to get the system to work for these soldiers now so it is not necessary to carry paper records across the street.

The CHAIRMAN. Madam Secretary, we are going to have to adjourn very soon. But we have time for—I apologize to the Members. But if Mr. McNerney, Mr. Hare and Ms. Herseth each have one question before we adjourn——

Secretary SHALALA. Okay. We will try to answer it quickly then.

The CHAIRMAN. Do you have a question before we adjourn?

Mr. MCNERNEY. Thank you, Mr. Chairman. I really wanted to compliment you all on your can-do attitude, which is inspiring, and on the simplicity of the approach. Sitting here on the Veterans' Affairs Committee, we see problems that seem overwhelming and you have taken them by the horns and you have produced a report that makes it look like we can actually make significant progress. So I applaud you on that.

One thing that was interesting was the proposal to ask for reevaluation on a continuing basis. And my concern is, wouldn't that seem like it would make the backlog even more for evaluation of veterans?

Senator DOLE. Well, that is one of the practical questions that we looked at and I don't—it would seem to me, after maybe a couple evaluations it would stop. You don't do this for the rest of your life because you are going to know, unless somebody has a deteriorating condition that you want to continue to check on. But we are just going to have to find the people. It is pretty much like the passport problem when we had this big backlog. Maybe we are going to have to bring in some of these people who have left and bring them back on a temporary basis and let them help us get rid of these backlogs. That could be a problem.

The CHAIRMAN. Mr. McNerney, thank you. I——

Secretary SHALALA. But we do want to give the opportunity to upgrade someone's benefits, so there is a positive and a negative here. But people ought to be able to look at someone's file and make a pretty quick decision on whether you need to move forward on that evaluation, because in the vast majority of the cases it makes no sense. But we want to make sure that we can upgrade benefits if that is necessary.

The CHAIRMAN. Thank you. Mr. Hare.

Mr. HARE. Mine is just real quick. Thank you very much for what you both have done. The other day, the Secretary was here just yesterday talking about 177 days for a person as an average on a claim. And it seems to me, why, and I wanted to get your thoughts. Why can't we err on the side of the veteran? In other words, start the process of the claim immediately the same way you do when somebody files their taxes and the claim begins.

If we want to audit this claim and we think that there is a problem with it, fine. But it would seem to me, and the Secretary said he supported a pilot program, but their goal is to get it down from 177 to 145 days and for that veteran, I don't think that is, I don't think that is acceptable. So I wonder what your thoughts are on being able to err on the side of the veteran and at the VA here on disability claims.

Secretary SHALALA. You know, I think we are always in favor of erring on the side of the patient, that this has to be patient-centered. We did not look at how to eliminate the backlog. I have had some experience in looking at that kind of thing, but our Commission did not actually review that specific issue. So I am reluctant to even comment on it, because there are different ways to approach it. But our point is that you get a patient-centered system that doesn't delay people's ability to get the help they need and doesn't delay their ability to get educational benefits and get those investments on the front end as quickly as possible.

The CHAIRMAN. Thank——

Senator DOLE. And some people have a right to appeal and, of course, the appeal takes a long time and I think, yeah, what is it, 12 months or something——

Secretary SHALALA. Yeah.

Senator DOLE [continuing]. Can delay it. So there are other things that maybe we need to look at. We think with our new system we are going to streamline the process so you won't have that big backlog. And you also, obviously, you get paid even though you will have to wait for a time, but you will get paid when it is finally adjudicated.

The CHAIRMAN. Thank you. Ms. Herseth.

Ms. HERSETH SANDLIN. Thank you, Mr. Chairman, and thanks to both of you. I commend you for your great work and the recommendations. I, too, like many others here, appreciate and would support the creation of someone who would coordinate recovery for servicemembers. I have had a number of constituents who I feel have been kind of caught between DoD and VA, one in particular who suffered a devastating traumatic brain injury. His family did not feel that he was getting the quality of care at a polytrauma center and, after some intervention, had him transferred to a private rehabilitative facility in California.

And so I guess just two very quick questions. One, do you envision the recovery coordinator serving as the advocate for the patient?

Secretary SHALALA. Yes.

Ms. HERSETH SANDLIN. Okay. And then the other, in all of the interviews and surveys that you did over the past 4 months, did you find anything that would suggest that we prematurely moved traumatically brain injured soldiers to long-term care who did not receive aggressive ongoing therapy and rehab and, if they did, would be much better off today than if they were prematurely transferred to a long-term care facility?

Secretary SHALALA. Our survey did not provide answers at that level of detail, nor did we have a health services research capacity to be able to answer that question. But it certainly is a question that ought to be looked at.

Ms. HERSETH SANDLIN. And one final thought——

Senator DOLE. I would just add that Mr. Eckenhoff, who is a member of our Commission and the National Rehab Hospital Director—they have a number of, or have had a number of active duty people where they couldn't get the best care. They can get the best care at his facility and we encourage that.

Ms. HERSETH SANDLIN. Okay. Thank you. That answered the——

The CHAIRMAN. Thank you, Madam Secretary and Senator Dole. This has been one of the most productive and helpful sessions we have ever had here. It reflects your personalities, your enthusiasm, your commitment and we thank you so much and we intend to meet your challenge of speed and urgency and being patient-centered. And we thank you so much. We are going to have the—next week the Disability Commission will be in to testify and—I am sorry, the 10th of October. And we look forward to working with you on behalf of our combat veterans. Thank you so much.

This meeting is adjourned.

[Whereupon, at 11:44 a.m., the Committee was adjourned.]

APPENDIX

Prepared Statement of Hon. Bob Filner, Chairman, Full Committee on Veterans' Affairs

On March 6, 2007, the President signed an Executive Order to establish the President's Commission on Care for America's Returning Wounded Warriors.

The Commission was charged with the task of examining the effectiveness of returning wounded servicemembers' transition from deployment in support of the Global War on Terror to returning to productive military service or civilian society, and recommend needed improvements.

The Report of the Commission was recently released and today the Committee will be hearing from the Co-Chairs of that Commission—Secretary Donna Shalala and Senator Bob Dole. I look forward to a frank and open discussion of the recommendations made by the Commission.

According to the report, there have been 1.5 million servicemembers deployed to Iraq and Afghanistan. Twenty-eight thousand have been wounded in action, with 3,082 of those seriously injured. The nature of the injuries sustained on today's battlefield is very complex and resource-intensive. Because of the advancements in battlefield medicine, protective gear and technology, the rate of survival is much greater than that of past wars.

My concerns are focused on how we serve our troops when they turn from the Pentagon to the VA for their healthcare. In order for our troops to experience the seamless transition they deserve, the bureaucratic problems that prevent many from getting the care they need must be fixed.

While VA and DoD have made adjustments and changes over the last few years in an attempt to address the issues surrounding the treatment of these injuries, as well as the transitioning of severely wounded servicemembers, many obstacles remain.

As Chairman of the Committee on Veterans' Affairs, I am sensitive to the difficulties involved in coordinating the activities of the Department of Defense and the Department of Veterans Affairs. These Departments do indeed have different missions.

That being said, we no longer have the luxury of time, and we, as a country, must act.

Right now, while we prepare to discuss this issue, our servicemembers are in harm's way. Some of these brave men and women will be killed or wounded. We have talked about the necessity of providing a seamless transition for many years. This is our test as a Nation. And this is a test we simply must pass.

I would like to welcome our two distinguished panelists this morning.

In 1993, President Bill Clinton appointed Donna Shalala as the Secretary of Health and Human Services (HHS) where she served for eight years, becoming the longest serving HHS Secretary in our history. As HHS Secretary, she directed the welfare reform process, made health insurance available to an estimated 3.3 million children, raised child immunization rates to the highest levels in history, led major reforms of the FDA's drug approval process and food safety system, revitalized the National Institutes of Health, and directed a major management and policy reform of Medicare.

Secretary Shalala has dealt with large bureaucracies like the VA and DoD before and she is experienced in implementing programs that work for the people . . . not against the people.

Senator Dole knows all too well the problems that our brave men and women face as they deal with the painful injuries of war. Senator Dole was twice decorated for heroism, receiving two Purple Hearts for his injuries, and the Bronze Star Medal with combat "V" for valor. In 1942, he joined the United States Army's Enlisted Reserve Corps to fight in World War II and became a second lieutenant in the Army's 10th Mountain Division. In April 1945, while engaged in combat in the hills of northern Italy, he was hit by German machine gun fire in his upper right back and badly injured. He had to wait nine hours on the battlefield before being taken to

the 15th Evacuation Hospital before he began his recovery at a U.S. Army hospital in Michigan.

I want to take this opportunity to thank you both for your service to our country and your dedication to our Nation's veterans. We are all grateful for the work that you do.

Prepared Statement of Hon. Harry E. Mitchell,
a Representative in Congress from the State of Arizona

Thank you, Mr. Chairman.

First and foremost I want to thank Senator Dole and Secretary Shalala for their efforts.

These distinguished Co-Chairs have not only provided us critical information . . . they have provided us a model of bipartisanship on an issue of great importance.

They know that the best way for us to help our Nation's veterans is for all of us to work together.

And as their report has demonstrated, we have our work cut out for us.

We need to improve information-sharing between the Department of Defense and the Veterans Administration. This is not only inefficient, it poses a risk to the quality of care our veterans receive.

We need to reduce the long wait times veterans are enduring at the VA, and ensure that the VA has the resources it needs to serve veterans in a timely manner.

We need to do more to help the families of veterans who, in many cases, are forced to shoulder the burden of advocating for healthcare services.

The President's Commission outlined six specific changes to the current veteran care organization that can be made through Congress, which would improve the services that our Nation's veterans receive.

Some of these recommendations will be easy fixes requiring little negotiation or further investigation.

Others, like the restructuring of disability and compensation systems, will require us to put our partisan differences aside and work creatively to arrive at the best outcome.

The wars in Afghanistan and Iraq pose different challenges for our VA than previous conflicts. Many of our returning heroes are bringing back new and different kinds of injuries which need new and different kinds of treatments.

Our challenges are great, but working together, I know we can meet them.

Our veterans have served us, and they have a right to expect us to serve them. And that is exactly what we are going to do.

I look forward to today's discussion, and I yield back.

Prepared Statement of Hon. Jerry Moran,
a Representative in Congress from the State of Kansas

I want to first welcome our distinguished guests with us today. Senator Dole and Secretary Shalala have both experienced long and successful careers in public service. Today, we appreciate their willingness to use their time and talents for a most worthy goal: to ensure our country is providing the best care and services to our military men and women and veterans, especially for those wounded in service to our country.

A couple years back, Senator Dole published a moving memoir titled "One Soldier's Story." In this book he chronicles his powerful story of growing up in Russell, Kansas, going off to war, being wounded on a battlefield in Italy, and his struggle to overcome the odds to recover and rebuild his life. What I found remarkable about the Senator's recovery period was not only his personal courage, but also the help that he received from those around him. Senator Dole wrote, "None of us who travels the valleys of life ever walks alone." From his mother who was by his bedside night and day, to the gifted Army doctors, to the Russell community who collected donations in a cigar box to pay for his surgeries, the system of support for wounded servicemembers matters.

Our military members and veterans today deserve a strong support system, one that matches the times. The Wounded Warrior Commission—after several months of visits to DoD and VA facilities, public meetings, and patient surveys and interviews—recommends that improvements can and should be made. Change is needed to modernize the current system to adjust to the realities of today's wars and improve the quality of life of soldiers and their families. The Commission has put forth a set of action items to do this.

It is now Congress's turn to take a serious look at these recommendations. To move things along, Congressman Salazar and I have introduced the Wounded Warriors Commission Implementation Act, H.R. 3502, to enact the recommendations of the Commission requiring congressional action. Before the Commission's report was released, both the House and Senate acted to pass legislation addressing some of the concerns later identified by the Commission. This was a good first step to improving care and services, but clearly more comprehensive action is needed. I encourage my colleagues to move quickly to make the changes necessary to support those who have sacrificed so much for our country.

Prepared Statement of Hon. Ginny Brown-Waite, a Representative in Congress from the State of Florida

Thank you, Mr. Chairman.

Senator Dole and Secretary Shalala, I want to thank you for testifying before this Committee today. I would like to commend you for your work on the President's Commission on Care for America's Returning Wounded Warriors. When we send the brave men and women of our armed forces into battle, we better make sure they have everything they need when they come home.

Your recommendations suggest the need in some instances to make sweeping changes to the way the Department of Veterans Affairs conducts its business. I will be interested in hearing exactly how you think these recommendations can be implemented

I was pleased to see the recognition you gave to the importance of addressing post-traumatic stress disorder and traumatic brain injuries in our returning soldiers. This along with strengthening the support for their families, will go a long way to help soldiers transition back to life as a civilian.

Once again, I welcome you to the hearing and look forward to hearing your thoughts on the issue before us today.

Prepared Statement of Hon. Donna E. Shalala, Co-Chair, President's Commission on Care for America's Returning Wounded Warriors (Former Secretary of the U.S. Department of Health and Human Services)

Good morning, Chairman Filner, Congressman Buyer, and distinguished Members of the Committee. Thank you for giving me the opportunity to testify today, along with my fellow Co-Chair, Senator Bob Dole, about the recommendations our Commission presented to the President 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 and dedication was an inspiration to us all. We were joined by a stellar group of Commissioners, each of whom gave their full energy and attention to the critical mission we faced.

As you know, we had an extremely short timeframe to complete our mission—but we were propelled by a sense of urgency that the issues before us required. Mr. Chairman and Members of the Committee, we know you share this sense of urgency and that's why we are so pleased to be with you today to discuss not only our recommendations, but the critical need to implement them.

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—and we are optimistic that Congress and the Administration will move quickly to respond to this need by enacting our recommendations.

As we were reminded again by the article in Saturday's *Washington Post*, the problems facing our injured service men and women have not gone away. Congress and the Administration have spent a great deal of time the past few weeks discussing the future of the war in Iraq. And while this is a debate that our Nation must have, I implore you not to forget about those who have already sacrificed so much—our injured men and women. They need to be front and center in congressional debate and within the Administration.

The story of Staff Sgt. John Daniel Shannon, as told in the *Washington Post*, is a story that we heard throughout our time with the Commission—a story of numerous case managers, none of whom held sole responsibility for spearheading an integrated care system—a story of lost paperwork and frustration—and a story of a disability system that was in desperate need of repair.

It's stories like this that sparked the creation of our Commission—and stories like this that should and must drive immediate congressional and White House action.

This past July, it was the Commission's honor to present to the President, Congress and the public, six groundbreaking patient and family centered recommendations that make sweeping changes in military and veterans' healthcare and services. The recommendations include the first major overhaul of the disability system in more than 50 years; creation of recovery plans with recovery coordinators; a new e-Benefits Web site; and guaranteeing care for post-traumatic stress disorder from the VA for any servicemember deployed to Iraq and Afghanistan. Our report—*Serve, Support, Simplify*—is a bold blueprint for action that will enable injured servicemembers to successfully transition, as quickly as possible, back to their military duties or civilian life. Our report calls for (and I quote) "fundamental changes in care management and the disability system." I respectfully request that this report be submitted for the record.

Specifically, our six recommendations will:

- **Immediately Create Comprehensive Recovery Plans to Provide the Right Care and Support at the Right Time in the Right Place**
- **Completely Restructure the Disability Determination and Compensation Systems**
- **Aggressively Prevent and Treat Post-Traumatic Stress Disorder and Traumatic Brain Injury**
- **Significantly Strengthen Support for Families**
- **Rapidly Transfer Patient Information Between DoD and VA**
- **Strongly Support Walter Reed By Recruiting and Retaining First Rate Professionals Through 2011**

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 we will focus on today. A complete list of the action steps for the six recommendations is included on the last page of my testimony.

I will summarize the first three actions that require legislation, and, then, Senator Dole will cover the remaining three.

The first is to improve access to care for servicemembers with Post-Traumatic Stress Disorder.

We call 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's extensive resources for diagnosis and treatment.

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

In our travels across the country, it became 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 frontlines 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 caregiving. 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 six 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 were pleased to see that the Senate has already unanimously passed the ***Support for Injured Servicemembers Act*** which implements this recommendation. We hope the House of Representatives will quickly follow suit.

Mr. Chairman, having served in government a good deal of my life, I believe that government can work to improve the lives of its citizens. But sometimes, people of good will want to solve a problem and their idea of a fix is to add a program or a new regulation. What we've done 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.

Above all, our recommendations are doable. Whether requiring congressional legislation or implementation by DoD or VA, we made sure that what we were recommending could be acted upon quickly. Our seriously injured servicemembers must not be made to wait. They deserve a healthcare system that truly serves, supports and simplifies.

On behalf of the Commission, I want to thank the Committee again for the opportunity to discuss our recommendations. And because those of you who know me know I don't mince words, I leave the Committee—and the Administration—with these three simple words—Just do it! And, Mr. Chairman and Members of this distinguished Committee, I know that through your leadership, our recommendations WILL become a reality for our servicemembers and their families.

Thank you and I look forward to joining Senator Dole in answering your questions.

Prepared Statement of Hon. Bob Dole, Co-Chair,
President's Commission on Care for America's Returning Wounded Warriors
(Former United States Senator from the State of Kansas)

- 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 to support this Nation's goal of assuring that our service men and women 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 healthcare 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 our recommendations and some of the action steps to be taken by Congress. I will now review the remaining three action steps that require legislation and are part of our call for a complete restructuring of the disability and compensation systems.
- In our next action step, we call on Congress to revise the DoD and VA disability systems. Right now each of these Departments assesses each injured servicemember's disability level, based on different objectives. Each assessment leads to a rating of the amount of disability. The two systems often disagree, they take way too long, and the process is way too confusing.

- There are differences in ratings depending on which military service determines the DoD rating and which VA regional office determines the VA rating. 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.
- We recommend that DoD retain authority to determine fitness to serve. Servicemembers whose health makes them unfit for duty would be separated from the military. DoD would provide them a lifetime annuity payment based on their rank and years of military service.
- 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*.
- This new structure makes timely, reliable, transparent, and accountable changes in both systems.
- Under this action item, DoD and VA can focus on what they do best—determining fitness standards and the health and readiness of the military workforce. The VA can focus on providing care and support for injured veterans, including providing education and training early in the rehabilitation process. It is a much simpler system that better supports the needs of those transitioning between active duty and veteran status.
- In our fifth action step, we recommend healthcare 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 healthcare 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 fits their needs without worrying whether the job provides adequate family healthcare coverage.
- **And, in our final 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 three months of base pay, if they are returning to their community and not participating in further rehabilitation; or an amount to cover living expenses for up to four years while they are participating in education or work training programs.
- **"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.
- **And "Quality of Life Payments,"** which should be 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.
- The disability status of veterans should be reevaluated every three years and compensation adjusted, as necessary.
- By overhauling the DoD and VA disability systems, Congress will make the systems less confusing, eliminate payment inequalities, and provide a solid base and incentives for injured veterans to return to productive life.
- I really believe, and I can say this having voted on a lot of military and veterans bills, having met on other commissions, having been a service officer in my younger years, and having worked hard to help veterans in the Legion and the VFW, that these are really bold action steps. They will do justice for our brave servicemembers fighting in Iraq and Afghanistan. I also believe these actions, which support our six recommendations, will benefit past and future generations of American servicemembers.
- You know, in Vietnam 5/8 seriously injured servicemembers survived; today 7/8 survive—many with injuries that in World War II would have been fatal. Over 1.5 million servicemembers have been deployed in the Global War on Terror. At the time of our report, 37,851 had been evacuated from Iraq or Afghanistan for illness or injury—23,270 of these individuals were treated and returned

to duty within 72 hours. We believe that the number of seriously injured is small—on the order of 3,000, based on the number who have received Traumatic Servicemembers' Group Life Insurance (TSGLI).

- Both of us are grateful that Congress is determined to improve the system of care for America's injured servicemembers and their families. We call upon you to move quickly and implement the actions we have discussed today. To make the significant improvements we recommend requires a *sense of urgency and strong leadership*.
- Congress plays a critical role in helping to change the way our military and veterans healthcare systems work. Together, we are truly creating a system that serves our bravest men and women who have made the ultimate sacrifice for our Nation.
- In closing, Mr. Chairman, let me emphasize again that *our report is doable and necessary. We ask that you draft legislation to implement the six action items that Secretary Shalala and I have just discussed*.

Thank you.

Statement of Joseph A. Violante,
National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Committee:

The Disabled American Veterans (DAV), a national veterans service organization, was founded in 1920 and chartered by Congress in 1932 to represent this Nation's war-disabled veterans. DAV is dedicated to a single purpose: building better lives for our Nation's disabled veterans and their families. While representing the interests of all service-disabled veterans, DAV counts among its membership 1.3 million war veterans who were injured in service to the Nation. On behalf of DAV, I appreciate the opportunity to submit testimony to the Committee on the matter before you today.

The *President's Commission on Care for America's Returning Wounded Warriors* (hereinafter, "Dole-Shalala") was ordered by President Bush following the public outcry earlier this year on discovery of substandard living conditions and confusing bureaucracy affecting hundreds of wounded soldiers at Walter Reed Army Medical Center. All of us were justifiably outraged that our Nation's newest wounded and disabled military servicemembers were being forced to live in deplorable conditions and experienced frustrating delays to get their disabilities adjudicated by the military service departments. But even today, Mr. Chairman, injured and ill veterans continue to be denied benefits to which they are rightfully entitled, and I will explain our stance on this issue further in this testimony.

In general the report issued July 25, 2007 by Dole-Shalala strikes a positive chord in advocating improved support to the immediate families of the wounded; calling for better coordination between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) across a number of separate, but overlapping responsibilities; and, establishing within both VA and DoD better guidance and more informed assistance for wounded servicemembers, veterans and their families. These are very good ideas and should be implemented rapidly. We support them and commend the Commission for making these recommendations. In fact DAV, in our *Stand Up For Veterans* initiative (www.standup4vets.org), is developing our own legislative recommendations, for consideration by Congress, covering areas very similar to the Dole-Shalala recommendations of better supporting family caregivers and improving coordination of care. We hope to have our recommendations from that initiative, formulated by consultants now working with DAV after completing significant careers in the VA healthcare system, in legislative form to you by the end of this session of Congress, and for further consideration by the Committee early next year.

Over the years DAV and other veterans service organizations have testified before this Committee and others on numerous occasions to identify many existing gaps in health and benefits systems, and to urge they be filled by actions within either VA or DoD, or both, or by Congress. Congress has responded to many of these initiatives, and we appreciate that assistance. Nevertheless, we believe a few of the Dole-Shalala recommendations that seek the same goals are in fact misguided or fail to recognize a degree of effectiveness that we at DAV understand and appreciate from decades of direct experience working in this very field, helping veterans obtain their rightful government benefits.

Recalling the explosion of media reports earlier this year to document the Walter Reed Army Medical Center scandal, it is ironic that the recommendations from a well-conceived, 2-year study by the President's Task Force to Improve Healthcare

Delivery for Our Nation's Veterans issued in 2003, with broad support from the entire veterans community, have gone nowhere. Yet the Dole-Shalala recommendations—some of which could do harm to the very system now in place and intended to help veterans—are apparently being put on a fast track to implementation. DAV was invited with others to a White House briefing only a few days ago to be informed that the Administration is in the final stages of developing proposed legislation to carry out the Dole-Shalala recommendations, less than two months following the report of the Commission. We at DAV hope this Committee—one that will have the major responsibility to consider the Administration's proposal—will very carefully evaluate the potential consequences of this bill. Its untoward affects in some areas that seem to help one group of disabled veterans may well damage the best interests of another group. DAV's policy is to protect the interests of *all* service-disabled veterans, not one group to the detriment of another.

In respect to protecting the interests of all disabled veterans, a major strategic goal of DAV, we appreciate the Committee's interest in scheduling a hearing next month on the need for reform of funding of VA's healthcare system—a key issue ignored by the Dole-Shalala Commission's report. The Senate Committee on Veterans' Affairs held such a hearing on July 25, 2007, the same date that the Dole-Shalala Commission issued its report. The President's earlier Task Force in 2003 specifically pointed out the obvious mismatch between funding made available through the discretionary appropriations process now in use, versus meeting the true financial needs of VA healthcare. This President's Task Force hypothesis was validated in 2005 and 2006 by very public and embarrassing developments in VA healthcare when, during both periods, the VA Secretary reluctantly admitted to Congress that VA needed major emergency supplemental funding to keep the system financially solvent. Congress eventually provided that needed extra funding, but we continue to believe that significant reform is necessary. DAV strongly supports conversion of VA healthcare funding to a mandatory status as our top legislative goal, and we look forward to further discussions of this issue at your upcoming hearing.

Mr. Chairman, most of the six Dole-Shalala recommendations are already being addressed in the Department of Veterans Affairs. For example, early on in these wars VA established polytrauma rehabilitation centers to treat traumatic brain injuries and other polytrauma cases from the wars in Iraq and Afghanistan, and VA has been the pioneering force and recognized expert in the treatment and research on post-traumatic stress disorder (PTSD). So, in many ways, VA is far and away ahead of the Dole-Shalala recommendations.

The VA has an established nationwide healthcare system that is a recognized leader in specialized treatment (including long-term medical and vocational rehabilitation) of the kinds of injuries and psychological wounds occurring in the wars in Iraq and Afghanistan. Yet, initially Dole-Shalala has recommended that DoD take *the lead role* in coordinating long-term care for men and women with traumatic brain injury and post-traumatic stress disorder after they've been released from the military medical system. The report recommends these individuals, as veterans, retain lifetime access to DoD healthcare through its TRICARE program, rather than make a smooth transition to VA care as the primary locus of their long-term rehabilitation. While we do not object on its face to continued TRICARE eligibility for this newest generation of veterans, no former injured veteran group has ever been given this government benefit (even following the Persian Gulf War, when casualties were light). This proposal, if approved by Congress, would set a precedent to continue for veterans of any future U.S. conflict. After several decades of growing reliance on DoD, rather than VA, by service-disabled veterans, we question whether the VA healthcare system we know today would be able to retain its viability if wounded war veterans were still attached on a long-term basis primarily to military medicine. The military's top mission in healthcare is the maintenance of readiness. Giving the military a new mission to provide lifelong care to severely disabled veterans will sap resources and challenge the military services' ability to sustain a strong readiness posture.

Mr. Chairman, we are most troubled by an ill-advised Dole-Shalala recommendation for a seemingly wholesale and radical overhaul of the disability evaluation and compensation systems in use today in DoD and VA. Dole-Shalala would establish a complicated and *different* system of compensation payments for our newest injured military members while failing to address the accuracy and timeliness problems that have plagued both the VA and DoD for many years. Dole-Shalala would have the government adjudicate disability for new and future injuries based on two primary factors—loss of earnings and diminished quality of life—instead of retaining and fixing the highly structured disability compensation system now in use that collectively considers both factors. Even more troubling is the Dole-Shalala recommendation to drastically reduce the level of government disability compensation

when a veteran stops working or gains eligibility for receipt of Social Security benefits.

Based on DAV's eight decades of contact with, and work in, the VA and DoD disability adjudication systems, DAV testified before the Dole-Shalala Commission and called for adequate staffing, structured training programs, and strict accountability for claims processing in VA. Unfortunately, the Commission ignored our recommendations. Our testimony to the Commission is attached to this testimony to provide the Committee an opportunity to fully consider our views as provided previously to the Dole-Shalala Commission. Dole-Shalala had the opportunity to push the VA to take the first genuine steps toward effectively reducing to a minimum the present massive claims backlog. Sadly, it chose not to do so by failing to address the staffing, accuracy and timeliness problems that have plagued both VA and DoD and instead proposed a program exclusively attuned to new combat-wounded veterans. Without that important and vital mandate as suggested by DAV, the VA may never be fully responsive to the needs of disabled veterans already in its claims adjudication queue. We question where this leaves the 600,000 veterans of earlier military service now awaiting resolution of their VA claims. Implementing this Dole-Shalala recommendation would set a dual standard for disabled veterans—one that DAV could not support.

Mr. Chairman, it may be good to remind the Committee that this is not our first, nor probably our last, war. Currently, like many other veterans organizations, members of DAV are largely drawn from the Vietnam War generation. We at DAV are wartime veterans and have suffered many of the same kinds of injuries that are being suffered now in Baghdad or Kabul in our latest wars. Had it not been for the existence of a caring, attentive VA system almost 40 years ago, including its health and compensation programs that sustained us and our families through the long-term rehabilitation process, and the VA's Vocational Rehabilitation Program (under title 38, United States Code, Chapter 31), that enabled us to embark on many rewarding careers, as disabled veterans we simply could not know where our lives might have taken us. The VA healthcare system has been an intimate part of our lives for decades since those traumatic "Alive Day" events in the early lives of DAV members. The quality of care and dedication to purpose and commitment of VA employees would be difficult to match elsewhere, in public or private systems.

We believe VA has a system that has worked well for years, is time tested and proven, but is now under fire because of the process, as opposed to the fundamentals. We believe the fundamentals are sound at VA and should be preserved. To provide VA what it needs in financial resources to employ and train sufficient staff, and to hold them accountable for the work they are supposed to do, would go a long way to keeping the system solvent well into the future to meet the needs of older veterans, the newest generation of wounded combat veterans, and future generations to come. Said another way, we at DAV do not see the need for wholesale changes and the development of an entirely new compensation and benefit system at VA to replace, for new veterans what has worked successfully to assist veterans over many decades.

In 2004, in section 1501 of Public Law 108–136, the National Defense Authorization Act for FY 2004, Congress authorized a Veterans Disability Benefits Commission to examine VA's disability compensation system, and to make a report with recommendations for any needed reforms. The report of that Commission is due for release next month. We hope this Committee will examine that report at least as closely as you examine this one from Dole-Shalala, to determine a proper and equitable disability compensation policy for war-wounded veterans, whether new or old.

Mr. Chairman, in summary DAV is concerned about the Dole-Shalala Commission report, especially in the areas indicated. When the Administration's legislative proposal is released to implement the intent of the Commission's recommendations, we are hopeful DAV will have an opportunity to review it and provide the Committee further commentary before you act on that proposal.

Mr. Chairman, this concludes DAV's statement. Again, on behalf of DAV, thank you for the opportunity to provide this testimony.

Statement of Hon. Jeff Miller,
a Representative in Congress from the State of Florida

Thank you, Mr. Chairman.

Providing top-notch medical care and a seamless transition for separating servicemembers between the Department of Veterans Affairs (VA) and the Department of

Defense (DoD) is a priority. This is especially important when we address care provided by VA to the severely wounded warriors from the Global War on Terror.

Serving on both the Committee on Veterans' Affairs and the Committee on Armed Services, I take great interest in the medical care and services available to our Nation's veterans, and the men and women serving in uniform.

Today we will review the recommendations to improve the care and services for our wounded warriors and veterans from the President's Commission on Care for America's Returning Wounded Warriors, co-chaired by Senator Bob Dole and Secretary Donna Shalala.

The Dole-Shalala Commission based its recommendations on three goals to prioritize patients and families, so that we *simplify* the complicated systems that are in place while *serving and supporting* our wounded warriors from the Global War on Terror. These are important goals as we address the needs of our veterans and wounded warriors. The Commission framed its recommendations by these goals.

Among the specific recommendations reported by the Dole-Shalala Commission we find the immediate creation of comprehensive recovery plans to provide the right care and support at the right time and place to help establish a continuity of care. Providing a plan would fulfill the goals to serve, simplify, and support. These concepts will be valuable to review as the Committee moves forward this Congress.

Continued support for the severely wounded is imperative. We must ensure that we are able to provide care and services for our wounded, and I look forward to the discussion today.

Senator Dole and Secretary Shalala, I appreciate your service to America and its veterans. Your contribution is appreciated.

Thank you, Mr. Chairman. I yield back the balance of my time.

POST-HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC
October 18, 2007

The Honorable Donna E. Shalala
President
University of Miami
P.O. Box 248006
Coral Gables, FL 33124–4600

The Honorable Bob Dole
Alston & Bird, LLP
950 F Street, NW
Washington, DC 20004

Dear Ms. Shalala and Senator Dole:

In reference to our Full Committee hearing "Findings of the President's Commission on Care for America's Returning Wounded Warriors" on September 19, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on November 16, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Response to Questions from the Honorable Bob Filner, Chairman, Committee on Veterans' Affairs, to Hon. Donna E. Shalala, Co-Chair, President's Commission on Care for America's Returning Wounded Warriors, and President, University of Miami, and Hon. Bob Dole, President's Commission on Care for America's Returning Wounded Warriors

Recommendation #2

Completely Restructure the Disability and Compensation System

The report recommends that the VA update its current disability rating system to reflect current injuries and modern concepts of the impact of disabilities on quality of life.

Q. What kinds of problems did you see with the current disability rating schedule?

Response: The current system is not contemporary and reflects neither quality of life nor earnings loss adequately. For example, results from the Center for Naval Analysis study provided to the Veteran's Disability Benefits Commission identify the inadequate treatment of Post-Traumatic Stress Disorder in the rating schedule. We heard from several of the Nation's leading disability experts that the system is in need of fundamental change, a finding that has been confirmed by two recent reports from the Institute of Medicine, and by the Veteran's Disability Benefits Commission.

Q. What would you like to see modified or added to the current system?

Response: We have called for the addition of Quality of Life payments and a top to bottom revision of the disability system. We have also recommended routine and regular evaluation and updating of the system going forward.

The report recommends that all disability-related payments and benefits for veterans would be obtained through VA. There are listed three types of payments: transition payments, the earnings-loss payments and the quality-of-life payments. It is not clear in the report how these payments affect other government payments. The earnings-loss payments, similar to compensation payments of today, are to make up for any reduced earning capacity. Right now, a disability compensation payment is not taxed.

Q. Under the proposed changes, would this payment be taxed?

Response: The Commission did not take a position on taxation of disability-related payments.

Q. What happens to this payment once a veteran is eligible to receive Social Security? Does the payment stop?

Response: Under the proposed new system for payments to disabled veterans, the annuity payment and quality-of-life payments would continue throughout retirement while earnings loss would convert to Social Security payments after retirement.

The streamlined disability compensation system calls for periodic reassessments of veterans' disability ratings.

Q. Where did the Commission get the 3-year timeframe from?

Response: The Commission considered the frequency of recommended health evaluations for many stable medical evaluations, ranging from annual exams for breast cancer screening to every five years for colon cancer screening. We selected every three years as an average. We believe that annual evaluations would present a burden to the system and to the veteran. However, given the nature of some problems, like Post-Traumatic Stress Disorder, we believed that 5 years would be too long.

Q. Is that the average length of time under the current system that veterans generally apply for an increase in a service-connected disability?

Response: Not that we are aware of.

Q. Will this reassessment take the place of the veteran's current ability to apply for increases in service connection disability ratings if and when the disability becomes more debilitating?

Response: No.

Q. Is it the Commission's intention to limit those types of claims so VBA can cut down on their workload?

Response: No. Resources should be provided to be sure that veterans are taken care of in a timely manner.

Q. Is it the Commission's intention for the streamlined system in the report to apply to all veterans or just those that are severely injured?

Response: All veterans.

Recommendation #5

Rapidly Transfer Patient Information Between DoD and VA

Recommendation 5, Rapidly Transfer Patient Information Between DoD and VA, lists three caveats with it. One of the caveats is: underlying organizational problems must be fixed first, or information technology merely perpetuates them. VA and DoD have struggled for years to find a fix.

Q. Could you elaborate on what some of the organizational problems are?

Response: None of the services have systems that easily "talk to each other." We provide a number of specific examples in the Commission's Subcommittee Report on Information Systems (page 115 in the Subcommittee report). Each service has a separate personnel system that feeds only some information to a central DoD data archive. The Army computer systems and the Air Force computer systems are not fully compatible, and we found that electronic medical records for Air Force servicemembers may not be available to the Army physicians who may treat them. Most

information systems have been developed to support specific functions and were not originally designed to be integrated. This information exchange is further compounded by the need to share information between the VA and the DoD. Even the VA's path-breaking Vista medical record system today consists of 128 different systems at individual medical facilities and it does not achieve full interoperability. Thus inter- and intra-departmental issues abound.

Q. What does the Commission recommend as a "fix" to the underlying organizational problems?

Response: It is necessary to focus on the outcome—information availability—not the computer systems themselves. The first step is to assure that all information that supports the development and implementation of the patient's recovery plan and is needed to provide healthcare and benefits is viewable by relevant DoD and VA staff within the next year. That means that clinicians, administrators, and benefit administrators must be able to see the relevant information in electronic form so that appropriate decisions may be made and patient progress may be monitored. We have supplied in our Subcommittee report on page 131 a template for a Scorecard for Information Exchanges that can be used as an aid to track the progress for sharing specified categories of essential data.

Response to Questions from the Honorable Joe Donnelly, Member, Committee on Veterans' Affairs, to Hon. Donna E. Shalala, Co-Chair, President's Commission on Care for America's Returning Wounded Warriors, and President, University of Miami, and Hon. Bob Dole, President's Commission on Care for America's Returning Wounded Warriors

Q.(1). Would you support a shift away from the current claims process to approving veterans' disability claims based on a presumption of service connectedness?

Response: The scope of the Commission's recommendations did not include the topic of presumption of service connectedness for the purpose of VA claims filing. We did, however, look at the Benefits Delivery at Discharge system, which has been successful in expediting VA disability evaluation for servicemembers before they leave military service with a medical separation or retirement. That program would presumably mitigate the need for presumption at the time of hospitalization with a known outcome of military discharge.

Q.(2). To what extent would such a change be applied? Would you only apply the presumption process to new claims of recent veterans, or for new claims by all veterans?

Response: Again, we did not explore the presumption concept and, therefore, cannot comment.

As questions 3–5 also pertain to presumption and were not a focus of the Commission, we are unable to provide comment.

Serve, Support, Simplify

Report of the President's Commission on Care
for America's Returning Wounded Warriors
July 2007

LETTER OF TRANSMITTAL

July 30, 2007

Dear President Bush:

We are pleased to transmit the final report of the President's Commission on Care for America's Returning Wounded Warriors, created March 6, 2007. To arrive at our recommendations, the Commission has visited a number of DOD facilities, VA hospitals, and other care sites across the country. We have listened to injured service members, their families, professionals who provide medical and rehabilitative services, program administrators and many, many others.

Our recommendations are few, but they are actionable. They are based on the priorities of patients and families. Essentially, our recommendations hope to accomplish three goals:

- To **serve** those injured in the line of duty while defending their nation
- To **support** their recovery and successful rehabilitation and
- To **simplify** the sometimes overly complex systems that frustrate some injured service members and their families and impede efficient care.

Our charge was to address the needs of the current generation of "wounded warriors," but if implemented, they will help other deserving veterans as well.

The dedicated personnel working in our nation's military and veterans' medical care, disability, and rehabilitation systems are working very hard. They are making substantial technical and administrative improvements. But America can do better. We are all concerned about the care provided to those most seriously injured in Iraq and Afghanistan. The number sustaining serious injuries is not overwhelming, so it is a problem that can be addressed quickly.

It has been a privilege to serve on this Commission and to provide you with an agenda for moving forward.

Bob Dole, Co-Chair

Donna Shalala, Co-Chair

COMMISSIONERS

Commissioner Edward A. Eckenhoff

Commissioner Tammy Edwards

Commissioner Kenneth Fisher

Commissioner Marc Giammatteo

Commissioner C. Martin Harris, MD

Commissioner Jose Ramos

Commissioner Gail Wilensky, PhD

CHARGE TO THE COMMISSION

THE WHITE HOUSE

March 6, 2007

Executive Order: Establishing a Commission on Care for America's Returning Wounded Warriors

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to provide a comprehensive review of the care provided to America's returning Global War on Terror service men and women from the time they leave the battlefield through their return to civilian life, it is hereby ordered as follows:

The mission of the Commission shall be to:

(a) examine the effectiveness of returning wounded service members' transition from deployment in support of the Global War on Terror to successful return to productive military service or civilian society, and recommend needed improvements;

(b) evaluate the coordination, management, and adequacy of the delivery of health care, disability, traumatic injury, education, employment, and other benefits and services to returning wounded Global War on Terror service members by Federal agencies as well as by the private sector, and recommend ways to ensure that programs provide high-quality services;

(c) (i) analyze the effectiveness of existing outreach to service members regarding such benefits and services, and service members' level of awareness of and ability to access these benefits and services, and (ii) identify ways to reduce barriers to and gaps in these benefits and services; and

(d) consult with foundations, veterans service organizations, non-profit groups, faith-based organizations, and others as appropriate, in performing the Commission's functions under subsections (a) through (c) of this section.

THE PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS

Final Report – July 2007

"It is almost cliché now to find examples of a wounded Marine having initially been treated by a Navy Corpsman find himself medevac'ed by an Army helicopter to undergo emergency surgery at an Air Force Theater Hospital."[1]

LtCol Moore's testimony demonstrates how the skills and resources of the U.S. military can be brought together to aid an injured service member—without regard for traditional bureaucracies and hierarchies. Under the best circumstances, the entire system smoothly joins forces to provide exactly what is needed, precisely when it is needed. His example embodies the kind of efficient care, centered on the needs of the patient, that we envision for our injured service members throughout the process of treatment, rehabilitation, and return to their military unit or home community.

In our few months of operation, we nine Commissioners—health care, disability, and housing experts, injured service members, and family—have visited 23 Department of Defense (DoD), Department of Veterans Affairs (VA), and private-sector treatment facilities. We have heard first-hand from injured service members and their families, from health care professionals, and from the people who manage military and veterans' programs. More than 1,700 injured service members responded to a national survey we conducted,[2] and we received more than 1,250 letters and emails from service members, veterans, family members, and health care personnel. We have analyzed the recommendations of past commissions and task forces, including several issued earlier in 2007.[3] And, we have drawn on the extensive knowledge of our fellow Commissioners.

SOME DEFINITIONS

Serious injury
A physiological condition affecting one or more body systems that has lasted or is expected to last at least 12 contiguous months and that precludes unaided performance of at least one major life activity (breathing, cognition, hearing, seeing, ability to bathe, dress, eat, groom, speak, use stairs or toilet, transfer, walk).[4]

Disability
A physical or mental impairment that substantially limits one or more major life activities.[5]

Combat-related
Injuries and illnesses attributable to the special dangers associated with armed conflict or the preparation or training for armed conflict.[6]

1 Testimony of Air Force LtCol Andrew E. Moore, MD, at the Commission's public hearing in San Antonio, Texas, May 4, 2007.
2 Our survey was conducted from June 7 to June 19, 2007. A random sample of 5,995 active duty, reserve component, and retired, medically retired, or separated service members and veterans treated for wounds sustained in Iraq and Afghanistan that led to evacuation to the United States. The survey received responses from 1,730 individuals—a 30 percent response rate.
3 These are listed in an Appendix at the end of this report.
4 32 CFR Sec 199.2
5 Americans with Disabilities Act, 1990.
6 DoDD 1241.01, February 28, 2004, Section E3.P5.2.2.

We want to emphasize that we've heard time and again about the overall high quality of our military's battlefield medicine and the care delivered by the staffs in our nation's military medical facilities and the VA health system. These clinical professionals' skill and intense commitment to the wounded is palpable. In the Vietnam era, five out of every eight seriously injured service members survived; today, seven out of eight survive, many with injuries that in previous wars would have been fatal. This is a remarkable record. The number of "seriously injured" service members on whom much of this report focuses is, without doubt, eminently manageable.

The following chart compiles recent data from several sources, which don't all use the same definitions and include some double-counting (some individuals have both traumatic brain injuries and amputations, for example). The data nevertheless provide a sense of the scale of the problem of seriously injured service members and the kinds of injuries being addressed in this report.

Number of deployments	2,200,000
Number of service members deployed	1,500,000
Air evacuated for illness or injuries	37,851
Wounded in action	28,000
Treated and returned to duty within 72 hours	23,270
Seriously injured (TSGLI recipients)[7]	3,082
Traumatic Brain Injuries	2,726
Amputations	644
Serious burns	598
Polytrauma	391
Spinal cord injuries	94
Blind	48

Despite accomplishments in clinical care, problems do occur—particularly in handoffs between inpatient and outpatient care and between the two separate DoD and VA health care and disability systems. To resolve these problems, we have concentrated on ways to better:

- **Serve** the multiple needs of injured service members and their families
- **Support** them in their recovery and return to military duty or to their communities and
- **Simplify** the delivery of medical care and disability programs.

7 TSGLI (Traumatic Servicemembers' Group Life Insurance) helps severely injured service members with a one-time payment, depending on their injury.

We believe our recommendations will produce a patient-centered system that fosters high-quality care, increases access to needed care and programs, promotes efficiency, supports families, and facilitates the work of the thousands of dedicated individuals who provide a gamut of health care and disability programs to injured service members and veterans. Our nation needs a system of care that enables injured service members to maximize their recovery and their opportunity to return to the mainstream of American life. Such a system not only should treat all service members—whether active duty or reserve component (that is, the National Guard and reserve)—even-handedly, but it also must be perceived as doing so.

Our Commission was established at a time of great change in U.S. health care. Many of the statements—good and bad—that we have heard about care in the DoD and VA systems could apply to the nation's health care delivery system as a whole. While numerous aspects of U.S. medical care are excellent, problems in coordination and continuity of care are common; our nation's hospitals and health systems are struggling to develop effective information technology systems; the stigma associated with seeking mental health care is slowly diminishing, but far from gone; our overall health system is oriented to acute care, not long-term rehabilitation; and shortages in critical staff categories are felt nationwide.

In the past few months, the health care and disability systems for our service members and veterans have been under a media microscope and the subject of several reports cited earlier. Public concern arises because Americans recognize and respect the sacrifices of our young men and women fighting in Iraq and Afghanistan and the great debt we owe those injured and killed.[8] Many of the concerns already are being addressed by Congress and in the two Departments.

The reports published earlier this year provided invaluable background information and analyses for our work. Because they are so recent, we did not need to reiterate their findings. Rather, we focused on ways to move forward. One other difference between our Commission and previous ones is that, while they addressed discrete pieces of the DoD and VA medical care and disability systems, President Bush charged us with looking at the whole continuum of care and programs for wounded service members, as well as what is needed to assure their successful return to military duty or civilian life.

We don't recommend merely patching the system, as has been done in the past. Instead, the experiences of these young men and women have highlighted the need for *fundamental changes* in care management and the disability system. Our recommendations address these fundamental changes. We believe they will help military service members and veterans of today and of tomorrow, as well.

8 In Operation Iraqi Freedom and Operation Enduring Freedom, the latter of which is focused primarily in Afghanistan, but has involved smaller operations in other geographic areas, as well.

Making the significant improvements we recommend requires *a sense of urgency* and *strong leadership*. The tendency to make systems too complex and rule-bound must be countered by a new perspective, grounded in an understanding of the importance of *patient-centeredness*. From the time injured service members are evacuated from the battlefield to the time they go back to active duty or are discharged home to complete their education, go to work, and be active family and community members, their needs and aspirations should inform the medical care and disability systems.

RECOMMENDATIONS

Our recommendations will serve, support, and simplify health care and rehabilitation for injured service men and women, and return them as quickly as possible to their military duties or to civilian life. To make these recommendations a reality, the President, Congress, and Departments of Defense (DoD) and Veterans Affairs (VA) should initiate the steps described in this report.

1 Immediately Create Comprehensive Recovery Plans to Provide the Right Care and Support at the Right Time in the Right Place

Recommendation: Create a patient-centered Recovery Plan for every seriously injured service member that provides the right care and support at the right time in the right place. A corps of well-trained, highly-skilled Recovery Coordinators must be swiftly developed to ensure prompt development and execution of the Recovery Plan.

Goals: Ensure an efficient, effective and smooth rehabilitation and transition back to military duty or civilian life; establish a single point of contact for patients and families; and eliminate delays and gaps in treatment and services.

What it is:
The Recovery Plan should smoothly and seamlessly guide and support service members through medical care, rehabilitation, and disability programs.

The Recovery Plan will help service members obtain services *promptly* and *in the most appropriate care facilities*—whether DoD, VA, or civilian.

The Recovery Coordinator is the patient and family's single point of contact, who makes sure each service member receives the care specified for them in the plan when they need it, and that no one gets "lost in the system."

The Recovery Coordinator moves injured service members through the system in a timely way, because experience shows that people recover better when treatment and services are provided promptly.

Who oversees it:
A Recovery Coordinator would oversee implementation of the Recovery Plan. Recovery Coordinators would have the authority to coordinate medical care, rehabilitation, education, and employment-related programs, as well as disability benefits. This is a difficult and complex job, and both Departments must be committed to making it work.

Recovery Coordinators would ensure that patients and families understand the likely trajectory of the service member's recovery, the types of care and services that will be needed, and how much time recovery may take.

Action Steps

DoD and VA should develop integrated care teams (physicians, nurses, allied health professionals from relevant specialties, social workers, and vocational rehabilitation staff). These teams would create injured service members' initial Recovery Plans, which should start with a comprehensive clinical evaluation.

• • •

DoD and VA should direct that Recovery Plans be created for all service members seriously injured since the beginning of the Afghanistan and Iraq conflicts who still would benefit from them.

• • •

DoD & VA must work with the Commissioned Corps of the Public Health Service, Department of Health and Human Services, to develop a cadre of well-trained, highly skilled Recovery Coordinators.

2 Completely Restructure the Disability and Compensation Systems

Recommendation: DoD maintains authority to determine fitness to serve. For those found not fit for duty, DoD shall provide payment for years served. VA then establishes the disability rating, compensation and benefits.

Goals: Update and simplify the disability determination and compensation system; eliminate parallel activities; reduce inequities; and provide a solid base for the return of injured veterans to productive lives.

The following data from our survey illustrate why we believe an overhaul is needed (Throughout this report, our survey results appear in blue):

- 38 percent of active duty, 34 percent of reserve component, and 38 percent of retired/separated service members are "very" or "somewhat" satisfied with the disability evaluation system.
- 46 percent of active duty, 36 percent of reserve component, and 40 percent of retired/separated service members say they "completely" or "mostly" understand the military's disability evaluation process.
- 42 percent of retired/separated service members who filed a VA claim report that they "completely" or "mostly" understand the VA claims process.

Department of Defense Responsibilities

Each branch of the armed services would retain authority for determining whether a service member is fit for continued military service.

If not medically fit, the service member should receive DoD annuity payments, the dollar value of which would be *based solely on rank and length of service.*

Department of Veterans Affairs Responsibilities

The VA should assume all responsibility for establishing disability ratings and for all disability compensation and benefits programs.

The VA should initiate its education, training, and work-related benefits *early in the rehabilitation period.*

The Department's education, training, and employment programs should include incentives to encourage veterans to participate and stay enrolled. (Our survey found that 21 percent of demobilized reservists and 31 percent of retired/separated service members are enrolled in an educational program leading to a degree.)

Periodic Review

The disability status of veterans should be reevaluated every three years and compensation adjusted, if their condition has worsened or improved.

Vocational Rehabilitation & Education Program (VRE)

The effectiveness of various vocational rehabilitation programs is not well established, and the VA should undertake an effort to determine which have the greatest long-term success.

VA policies should encourage completion of effective programs by increasing the flexibility of scheduling for those whose disability does not permit taking a full course load. This can be done without increasing the dollar amount of the benefit.

Also, the VA should develop financial incentives that would encourage completion.

Action Steps

Congress should clarify the objectives for DoD and VA disability systems, in line with this recommendation.

• • •

DoD and VA should create a single, comprehensive, standardized medical examination that DoD administers. It would serve DoD's purpose of determining fitness and VA's of determining initial disability level.

• • •

Service members found unfit because of their combat-related injuries should receive comprehensive health care coverage and pharmacy benefits for themselves and their dependents through DoD's TRICARE program.[9]

• • •

Congress should restructure VA disability payments to include:

1. *"transition payments"*—to cover living expenses for disabled veterans and their families. They should receive *either*
   - 3 months of base pay, if they are returning to their community and *not* participating in further rehabilitation

continued

9 TRICARE is the Department of Defense's health care program for members of the military, their families, and survivors and serves more than 9.1 million beneficiaries worldwide.

Action Steps
continued

OR
- longer-term payments to cover family living expenses, if they are participating in further rehabilitation or education and training programs

2. once transition payments end, disabled veterans should receive *earnings-loss payments*—to make up for any lower earning capacity remaining after training
3. *quality-of-life payments*—to compensate for non-work-related effects of permanent physical and mental combat-related injuries

• • •

The VA should commission a six-month study to determine the appropriate level and duration of longer-term transition payments.

• • •

The VA should move swiftly to update (and thereafter keep current) its disability rating schedule to reflect current injuries and modern concepts of the impact of disability on quality of life.

• • •

To improve completion rates in its VRE program, VA should:
- allow veterans to suspend training for a time or attend part-time (for up to 72 months), with approval of their Recovery Coordinator and vocational counselor
- pay a bonus (10 percent of annual transition pay) for completing the first and second years of VRE training and 5 percent for completing the third year

3 Aggressively Prevent and Treat Post-Traumatic Stress Disorder and Traumatic Brain Injury

Recommendation: VA should provide care for any veteran of the Afghanistan and Iraq conflicts who has post-traumatic stress disorder (PTSD). DoD and VA must rapidly improve prevention, diagnosis, and treatment of both PTSD and traumatic brain injury (TBI). At the same time, both Departments must work aggressively to reduce the stigma of PTSD.

Goals: Improve care of two common conditions of the current conflicts and reduce the stigma of PTSD; mentally and physically fit service members will strengthen our military into the future.

- In our survey, around 70 percent of active duty, reserve component, and retired/separated service members report they had been asked whether they were exposed to an event or blast that caused a jolt or blow to the head.
- 59 percent of active duty and 52 percent of reserve component and 65 percent of retired/separated service members had been exposed to such an event.

Workforce Strategies

We recognize that augmenting DoD's mental health workforce will not be easy, because of national shortages in mental health professionals. DoD personnel requirements

must take into account the expanding need for such personnel, due to the military's expanded prevention and education missions in behavioral health; and, both Departments should prepare for the expected long-term demand that may arise from chronic or delayed-onset symptoms of PTSD.

Reduce Stigma

DoD should intensify its efforts to reduce the stigma associated with PTSD.

Action Steps

Congress should enable all veterans who have been deployed in Afghanistan and Iraq who need PTSD care to receive it from the VA.

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DoD should aggressively address its acute shortage of mental health clinicians.

• • •

DoD should establish a network of public and private-sector expertise in TBI and partner with the VA on an expanded network for PTSD, so that prevention, diagnosis, and treatment of these two conditions stay current with the changing science base. Specifically, it should:

- conduct comprehensive training programs in PTSD and TBI for military leaders, VA and DoD medical personnel, family members, and caregivers
- disseminate existing TBI and PTSD clinical practice guidelines to all involved providers; where no guidelines exist, DoD and VA should work with other national experts to develop them.

4 Significantly Strengthen Support for Families

Recommendation: Strengthen family support programs including expanding DoD respite care and extending the Family and Medical Leave Act for up to six months for spouses and parents of the seriously injured.

Goals: Strengthen family support systems and improve the quality of life for families.

- In our survey, 33 percent of active duty, 22 percent of reserve component, and 37 percent of retired/separated service members report that a family member or close friend relocated for extended periods of time to be with them while they were in the hospital.
- 21 percent of active duty, 15 percent of reserve component, and 24 percent of retired/separated service members say friends or family gave up a job to be with them or act as their caregiver.

Many of the recommendations in this report serve and support families and simplify their lives. Prime examples are the Recovery Coordinator and increased availability of online resources that will be helpful to family caregivers.

DoD and VA should explore the applicability for service members and their families of innovative private-sector initiatives that have been developed and tested in the past few years.

DoD should establish a standby plan for family support of injured service members, drawing on the experiences and model programs developed during this conflict, to enable a quicker program ramp-up in any future large deployments.

Action Steps

Congress should make combat-injured service members eligible for the TRICARE respite care and aide and personal attendant benefits currently provided in the Extended Care Health Option program.

• • •

DoD and VA should provide families of service members who require long-term personal care with appropriate training and counseling to support them in their new caregiving roles.

• • •

Congress should amend the Family Medical Leave Act to allow up to six months' leave for a family member of a service member who has a combat-related injury and meets the other eligibility requirements in the law.

5 Rapidly Transfer Patient Information Between DoD and VA

Recommendation: DoD and VA must move quickly to get clinical and benefit data to users. In addition, DoD and VA should jointly develop an interactive "My eBenefits" website that provides a single information source for service members.

Goals: Support a patient-centered system of care and efficient practices.

Three Strong Caveats:

- Congress and the Departments should recognize that information technology is not the "silver bullet" that will solve various quality, coordination, and efficiency problems within the Departments' medical and benefits systems.
- Underlying organizational problems must be fixed first, or information technology merely perpetuates them.
- Every effort must be made not to make systems unnecessarily complex, difficult to use, or redundant.

DoD and VA should make information about benefits and services available online, via a password-protected site (which we call "My eBenefits), in which service members and veterans can securely enter personal information. Based on this profile, they would receive tailored information about relevant programs and benefits in both the public and private sectors.

Action Steps

Within 12 months, in order to implement our Recovery Plan recommendation, DoD and VA must make patient data much more accessible—to begin with, in viewable form. All essential health, administrative, and benefits data must be immediately viewable by any clinician, allied health professional, or program administrator who needs it.

• • •

DoD and VA should continue the work under way at present to create a fully interoperable information system that will meet the long-term administrative and clinical needs of all military personnel over time.

• • •

DoD and VA must develop a plan for a user-friendly, tailored, and specific services and benefits portal for service members, veterans, and family members.

6 Strongly Support Walter Reed By Recruiting and Retaining First-Rate Professionals Through 2011

Recommendation: Until the day it closes, Walter Reed must have the authority and responsibility to recruit and retain first-rate professionals to deliver first-rate care. Walter Reed Army Medical Center has a distinguished history and, with one in five injured service members going directly to Walter Reed, continues to play a unique and vital role in providing care for America's military.

Goals: Assure that this major military medical center has professional and administrative staff necessary for state-of-the art medical care and scientific research through 2011.

Approximately one in five injured service members go directly to Walter Reed, and more than 700 outpatients remain on the campus.

Not only is it active today, but Walter Reed is scheduled to continue operation for at least four more years and must have the resources—professional and otherwise—to continue its historic role as a vital tertiary care and research center until the day it actually ceases operation.[10]

10 The decision to close Walter Reed came from the Department of Defense's Base Realignment and Closure Commission (BRAC).

Action Steps

DoD must assure that Walter Reed has the resources it needs to maintain a standard of excellence in both inpatient and outpatient care.

• • •

DoD must implement tailored incentive packages to encourage civilian health care and administrative professionals to continue working there and to enable recruitment of new professionals, as needed.

A SYSTEM THAT SERVES

America has recognized the nation's responsibility to care for injured soldiers ever since the early days of the War of Independence. More than 80 years later, near the end of the Civil War, Abraham Lincoln reaffirmed that responsibility, admonishing the country to strive "to care for him who shall have borne the battle . . ." And, today, a huge and generally well regarded infrastructure has developed to sustain this commitment to our service members, veterans, and their families:

- 68 military treatment facilities
- 154 military outpatient clinics
- 153 VA medical centers and
- 875 VA outpatient clinics.

"The rehabilitation of disabled veterans and their reintegration into useful economic and social life should be our primary objective."
–The Bradley Commission, 1956

The nation also has developed non-medical programs for those injured during military service—not just disability compensation, but a wide array of supporting programs and benefits to help veterans and their families with recovery, transition to civilian life, education, and employment. Federal and state government programs are augmented by more than a thousand private-sector, community, volunteer, and faith-based initiatives that help injured service members and their families meet housing, transportation, and short-term financial needs.

In 1956, the President's Commission on Veterans' Pensions, chaired by General of the Army (Ret.) Omar N. Bradley, concluded that there was "*no clear national philosophy of veterans' benefits.*" That Commission developed a philosophy and guiding principles that remain relevant today. Not only did it assert a national responsibility "to do justice by those who were injured or disabled as a consequence of their military service," but it also laid out a rationale for disability programs. Despite the Bradley Commission's urging, neither Congress nor the Executive Branch has established clear overall objectives, such as those we recommend, for the constellation of veterans' benefits the government offers. To this day, lack of a specific objective hinders the design, coordination, and evaluation of both individual veterans' programs and the disability system as a whole. We recommend that these objectives should include recognition of the degree of disability, effects on quality of life, and earnings loss, and should facilitate participation in education, training, and employment programs to maximize life recovery.

A Continuum of Care

The acute medical care that injured service members receive in the field and in military hospitals back home is consistently and demonstrably of high quality. Clearly, today's skilled medical corps and our military surgeons, physicians, and critical care teams save many lives. But DoD never intended to provide the long-term, rehabilitative programming now understood as necessary to optimal recovery. Rehabilitation and long-term care were a VA specialty. What is needed now is to improve the continuity and integration of medical and rehabilitation programming across the two Departments.

The majority (68 to 80 percent) of individuals in our survey are "very" or "somewhat" satisfied with inpatient care.

Our Vision:
A care system that continually strives to offer injured service members the highest standard of quality.

Injured service members receive clinical care in many settings. It may be provided in military hospital inpatient units and outpatient departments, in the private practices of physicians and mental health care professionals, and in various physical rehabilitation programs connected with the hospital, the nearby community, the VA, or back home in their own communities. They also are eligible for numerous education, training, and employment programs that, although not clinical, depend for their effectiveness on service members' level of physical and mental functioning.

We recommend that DoD and VA medical care, support programs, vocational rehabilitation programs, and disability benefits for seriously injured service members be integrated under a *comprehensive, patient-centered Recovery Plan* that sets goals for recovery and facilitates transitions across settings and programs. Development of the plan should begin as soon as possible during the acute care phase of a service member's recovery.

The initial plan should include *a complete clinical evaluation* by a team that includes physicians, nurses, mental health and allied health professionals, rehabilitation and vocational rehabilitation specialists, and social workers, as appropriate. The plan should take into account the *goals of the patient* with respect to future activities—including return to military duty, community, education, or employment—and it should be adjusted periodically, as appropriate. Because families are so important to the recovery of individuals with serious injuries, Recovery Plans should, insofar as possible, address family needs, too. In short, the Recovery Plan should be designed to move seriously injured service members efficiently through treatment and rehabilitation.

A Patient-Centered Recovery Plan Should:

- Identify patient goals for: post-acute, outpatient, and rehabilitation care; and return to military duty, home community, or into education, training, and employment programs
- Specify all resources–clinical and other–needed to meet these goals
- Specify milestones and estimates of time for recovery phases
- Assess where these clinical and rehabilitative needs can be most appropriately addressed
- Evaluate and provide for family needs
- Monitor for timeliness of receipt of care and patient progress

Well-trained and highly skilled Recovery Coordinators should oversee the implementation of service members' Recovery Plans. Recovery Coordinators would work with existing case managers involved in discrete aspects of care, engage family members, arrange for support programs, make sure care is timely, and advocate for service members across systems. Working across departments, benefits programs, and both public and private sectors is enormously difficult and will require energy and tenacity.

"We are now training our seventh case manager."
—family member, Washington, DC

Our Vision:
A system in which families of seriously injured service members would have a primary point of contact to coordinate their care.

To make this system work, Recovery Coordinators need considerable authority and to be paid accordingly. Recruitment, training, and oversight by a new unit of the U.S. Public Health Service's Commissioned Corps, in the Department of Health and Human Services, should be strongly considered.

Recovery Coordinators would manage many more issues than case managers currently do in the DoD and VA systems. Now, patients typically have several case managers, each concerned with a different component of their care. We heard reports of high turnover among case managers and that some are not adequately trained. (In particular, some families of patients with traumatic brain injury and post-traumatic stress disorder believed that case managers did not well understand these conditions, the issues they present, and how they should be managed.)

The Recovery Plan concept also requires cross-Departmental health information exchange that does not exist at present. Every health care and rehabilitation professional working with injured service members, as well as the administrative personnel involved with various benefits programs, would need access to relevant information regarding those individuals—not just "read-only" access, but also the ability to add information to the record.

Serious Injuries of the Afghanistan and Iraq Conflicts

"We're thinking about what this person will be like five or ten years from now."
—Chief, Brooke Army Medical Center Burn Center

Our Vision:
A patient-centered, integrated care model that addresses the needs of the "whole patient."

Tremendous strides in military medicine have led to markedly reduced mortality rates among U.S. service members—many of whom require lengthy hospital stays and extensive rehabilitation. Those with serious burns, for example, need several years of treatment in order to reach their maximum functioning. State-of-the-art burn care, such as that provided at Brooke Army Medical Center in San Antonio, often requires a year in the hospital, multiple rounds of surgical reconstruction, and two to four years of rehabilitation. Likewise, amputees require numerous fittings and trials of different artificial limbs. Some of the world's most advanced prosthetic technologies are available at Walter Reed Army Medical Center. It also has the highly trained staff needed to fit prostheses properly and help service members learn how to use them. For service members with these types of injuries, military treatment facilities are often their best choice.

Our military personnel in Iraq and Afghanistan are constantly at risk for car bombs, suicide bombers, and improvised explosive devices. They face difficult military operations, largely carried out in crowded urban environments, where civilians are active players and anyone—young or old—might be a suicide bomber. The stress is enormous. These battlefield conditions have highlighted two particularly challenging consequences of combat:

- post-traumatic stress disorder (PTSD)—an anxiety disorder that develops in reaction to traumatic events—and

- traumatic brain injury (TBI)—a physical injury to the brain, often caused by exposure to one or more explosions, or other blows to the head. Injuries can be penetrating or closed, and the latter can be mild, moderate, or severe.

A sizeable fraction of service members returning from Iraq and Afghanistan suffer from PTSD. Best estimates are that PTSD of varying degrees of severity affects 12 to 20 percent of returnees from Iraq and 6 to 11 percent of returnees from Afghanistan. To date, 52,375 returnees have been seen in the VA for PTSD symptoms. Severe and penetrating head injuries are readily identified, but cases of mild-to-moderate TBI can be more difficult to identify and their incidence harder to determine. A recent report indicated that when some 35,000 returnees believed to be healthy received a screening test, ten to 20 percent had apparently experienced a mild TBI during deployment. Many have both PTSD and TBI. Multiple deployments increase the risk.

56 percent of active duty, 60 percent of reserve component, and 76 percent of retired/separated service members say they have reported mental health symptoms to a health care provider.

"The biggest thing you could do is to beat down the stigma of being treated."
—PTSD patient, Brooke Army Medical Center

Our Vision:
A military that focuses on strengthening warrior resilience and preventing PTSD, TBI, and their consequences and gives mental health and physical health the same importance.

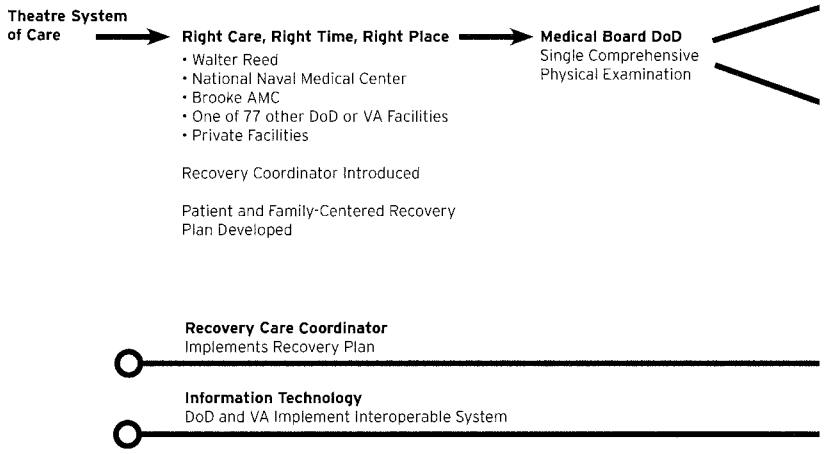
In an attempt to increase resilience and prevent PTSD, the military has developed new ways of training service members, and it has deployed mental health personnel with battle units in order to de-stigmatize mental health issues and facilitate early identification of individuals with problems. Post-deployment, the military services try to identify individuals with PTSD and mitigate its effects. For example, post-deployment health assessments include mental health screening questions, and a reassessment process has been added, in order to identify cases that develop over time. However, we heard many reports that service members, believing that revealing psychological symptoms will delay their return home or jeopardize their careers, do not report them. By contrast, some service members will report PTSD symptoms to "game the system," in order to avoid deployment or to receive disability benefits.

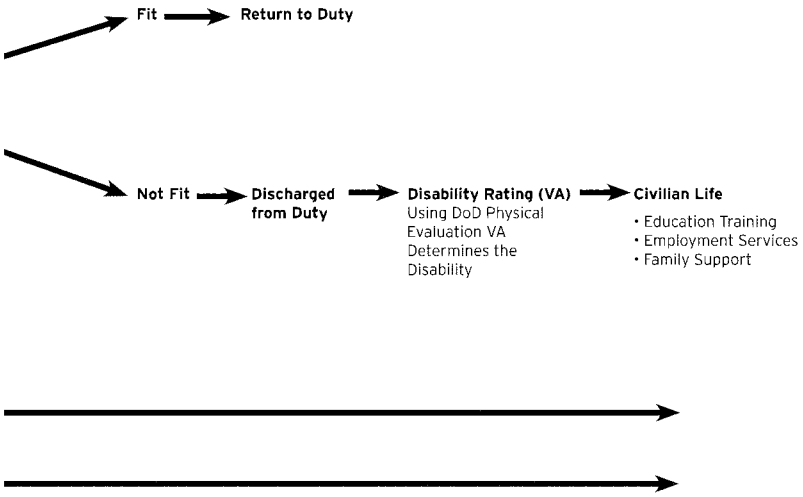
For both PTSD and TBI, prompt, correct treatment improves the chances for recovery. DoD is working to increase its medical professionals' expertise in treating TBI, although clinical guidelines are needed for rehabilitation. Because the VA recognized that injury to the brain often occurs at the same time as other, more visible injuries and should be treated as aggressively, it designated four Polytrauma Rehabilitation Centers[11] to tackle such multidimensional care. These Centers, although within the VA system, accept patients from the active-duty military.

The VA has a long history of treating combat-related PTSD. Yet, clinicians are not necessarily informed about state-of-the-art treatment or available resources, public and private. Other mental health-related problems, including substance abuse, depression, suicide, and family disruption, often co-occur with PTSD and likewise merit attention. The VA recently announced a major expansion of mental health services, to increase their availability system-wide.

11 These Centers are at the James A. Haley Veterans Affairs Medical Center, Tampa, Fla.; Minneapolis Veterans Affairs Medical Center; Veterans Affairs Palo Alto Health Care System, Calif.; and Hunter Holmes McGuire Veterans Affairs Medical Center, Richmond, Va.

Simplifying the Path to Recovery




Fit
Return to Duty
Not Fit
Discharged from Duty
Disability Rating (VA)
Using DoD Physical Evaluation VA Determines the Disability
Civilian Life
• Education Training
• Employment Services
• Family Support

The military's laudable efforts to prevent mental health problems and identify symptoms more quickly have severely stretched its already thin mental health program staff. Multiple deployments of uniformed mental health professionals have increased the rate at which they are leaving military service. Hospitals located in geographically isolated or less "desirable" areas report great difficulty recruiting civilian staff.

However, for PTSD, the larger problem may be cultural, not clinical. Many service members believe it unmilitary or a sign of weakness to hetray the symptoms of psychological distress. As recently as last month, a DoD Mental Health Task Force concluded that the stigma attached to mental health problems remains pervasive.

67 to 70 percent of active duty and reserve component members are "very" or "somewhat" satisfied with rehabilitative care, as are 60 percent of those retired or separated.

Our Vision:
A system that lets injured service members and their families concentrate on healing, not dealing with bureaucracy.

Concentrating specialized care—like burn and amputee care—at specific centers makes sense not only for reasons of economy, but, more important, for quality of care. A hospital needs enough patients in a specific category in order to attract specialized staff, keep their skills sharp, and maximize patient outcomes. By contrast, service members with relatively common conditions, like mild traumatic brain injury and post-traumatic stress disorder, should find high-quality care *regardless of where they are treated.*

Medical Rehabilitation

Rehabilitation of injured service members is geared to restoring patients to their highest possible level of functioning. It takes place in a wide variety of inpatient and outpatient facilities, in DoD, VA, and community settings, and is provided by an array of health care specialties, depending on the nature of an individual's injuries. As noted, DoD's specialized centers provide initial care for the most seriously injured. This approach enables DoD to offer the most expert care, but it can conflict with the desires of service members—especially those from the reserve components—to be cared for closer to home and to reduce the burden on their families.

We observed that the supply and demand for medical rehabilitation care are not well balanced. Some facilities—like the VA's Polytrauma Rehabilitation Centers—are not being optimally used, whereas others—like Walter Reed's outpatient units—are over capacity. An overall, coordinated plan for use of existing DoD and VA facilities is needed, with attention to where private sector facilities may fill gaps. Because seriously injured service members' rehabilitation needs can be very long-term, their individual Recovery Plans should consider whether these needs can be met close to home.

A SYSTEM THAT SUPPORTS

More than 3,000 service members have been seriously injured during operations in Iraq and Afghanistan. In virtually every case, a wife, husband, parent, brother, or sister

has received the heart-stopping telephone call telling them that their loved one is sick or injured, halfway around the world. While recovery from most injuries is relatively quick, and service members soon return to their units, one telephone call has changed the lives of many service members' families forever.

The most seriously injured service members and their families are embarking on a long journey together, one that may require family to temporarily relocate to a different part of the country to be near the facility where their loved one is being treated. Relocation may require them to give up the lives they know—jobs, school, homes—and live for an uncertain period far from their existing network of friends and family.

Family support is critical to patients' successful rehabilitation. Especially in a prolonged recovery, it is family members who make therapy appointments and ensure they are kept, drive the service member to these appointments, pick up medications and make sure they are taken, provide a wide range of personal care, become the impassioned advocates, take care of the kids, pay the bills and negotiate with the benefits offices, find suitable housing for a family that includes a person with a disability, provide emotional support, and, in short, find they have a full-time job—or more—for which they never prepared. When family members give up jobs to become caregivers, income can drop precipitously.

Military families are changing. The majority of spouses work. The Iraq and Afghanistan conflicts rely more heavily than in the past on the reserve components. The husbands, wives, and parents of these troops are distributed across many communities, not concentrated in and around the large installations where military treatment facilities and family support programs are located.

Family or close friends stayed to assist recovery of almost 66 percent of active duty and 54 percent of reserve component service members.

"Even though things went relatively smooth for us, it's a lot. We basically do not have a life any more."
–father of a severely wounded soldier

Our Vision:
A restructured, more flexible system of benefits for addressing the multiple needs of families–especially those who must take on a major, long-term caregiving role.

Temporary Housing

When family members receive the call telling them that their service member has been injured, their first thought is "How fast can I get there?" Only after they arrive at the medical treatment facility do they begin to think through all of the day-to-day logistics of being at their loved one's bedside.

One of the first issues to resolve is housing. Every major military medical center and a number of VA medical centers have Fisher Houses on their grounds—residential facilities built with private money, then donated to and operated by the government. Fisher Houses are available free of charge to family members of hospitalized service members and those receiving intensive outpatient care. The nation's 38 Fisher Houses serve approximately 8,500 families a year, with more houses slated for construction.

When the number of injured service members with long recuperation times has occasionally stretched the capacity of temporary lodging facilities at some military installations, additional housing is arranged on base or in the community.

50 percent of active duty, 24 percent of reserve component, and 26 percent of retired/separated service members say their family members staying with them were provided with comfortable, convenient housing.

Our Vision:
A system better integrated with private-sector care facilities for service members who want care closer to home.

Support Programs

"Returnees tell me 'It's like drinking out of a fire hose' when all these programs are described to them."
—transition coordinator, Ft. Bragg

Our Vision:
Simple, user-friendly ways for service members and families to learn about benefits, when and where they are needed.

Support programs for injured service members and their families help in meeting a wide variety of needs: temporary housing, transportation, financial assistance, meals, counseling, and information about benefits.

Family Service Centers exist on every military installation. These Centers provide referrals to a wide range of programs—from child care to employment assistance. In partnership with community-based organizations, the Centers provide families a "safety net" during long hospital stays. Ironically, the sheer number of overlapping support programs, public and private, and their varying requirements and benefits can at times be overwhelming.

Having a coordinated Recovery Plan and the Recovery Coordinator as a single point of contact may make it easier for families to figure out which programs are most appropriate for them, at what point during recovery. DoD, VA, and private entities have made an effort to put information about their resources online.[12] Families comfortable with accessing and acting upon Web-based information may find these compendiums a promising start. In the long run, online resources will be of greatest help if they can provide information specific to service members' home communities and tailored to their specific questions and needs.

Employment, Education, and Training

21 percent of demobilized reserve component and 31 percent of retired/separated service members are enrolled in an educational program leading to a degree.

33 and 36 percent of these groups are "very" or "somewhat" satisfied with VA employment services.

73 and 44 percent of these groups are working at a paid job.

Employment is the dominant concern of most service members reentering civilian life. VA vocational rehabilitation programs—such as vocational assessment, education, retraining, development of alternative employment plans, identification of assistive technologies, and assistance with job-seeking skills—focus on helping veterans with disabilities enter a different job or career. For severely disabled veterans for whom paid employment is not an option, these programs focus on enhancing the ability to live more independently in their homes and communities. Further, an array of federal, state, and private-sector programs and employer incentives promotes employment opportunities for veterans in general and disabled veterans in particular. Education and training assistance also is widely available.

Participation in vocational rehabilitation programs can significantly increase employment and quality of life for people with disabilities. Unfortunately, the VA does not—and should—routinely track vocational rehabilitation participants over time to evaluate program outcomes and identify factors associated with success. As a result, it is impossible to determine which programs work best. Research does show that

12 For example, the military's online resource and telephone hotline, Military OneSource; the DoD's "America Supports You," which compiles information on many charitable organizations; and an Army website currently under development, MyArmyBenefits.mil.

vocational rehabilitation and employment programs should be provided as early as possible after the onset of the disability, in order to have the greatest impact on the service member's likelihood of returning to work; likewise, the sooner an injured person can return to regular activities, the more successful the transition is.

Veterans who qualify for and complete VA's Vocational Rehabilitation and Employment program achieve good results in the short run. However, of the 65,000 veterans who apply for the program each year, only half qualify for it; of these, less than 40 percent complete either the education or independent living tracks. Including a vocational rehabilitation component in the Recovery Plan should increase the number of participants and program completion rates. Financial incentives also could increase program retention.

A SIMPLER SYSTEM

Many aspects of the DoD and VA medical care, support program, and disability systems have become tremendously complex over the years. As various needs have arisen, the Departments have undertaken initiatives to augment or clarify existing policy and programs. Often these initiatives are—or were—good solutions for limited problems, but ripple through the entire system in undesirable ways. Unplanned and uncoordinated programmatic evolution creates redundancies, while gaps are unfilled. It adds layers of complicated policies and rules. Then, because different individuals, offices, and military service branches interpret rules differently, the result can be real or perceived inequities.

The patchwork of programs, rules, and regulations affecting injured service members is mirrored in the complicated, uncoordinated information technology systems that support these activities. Efforts to streamline IT have to be built on a more coherent underlying structure. As stated earlier in this report, altbough IT systems are important, they cannot by themselves solve all the information flow and quality problems the Departments face. They are a means to an end, not the end itself.

"We cannot begin piecing our lives back together or caring for ourselves until our loved ones are cared for first."

–wife of a severely injured soldier

Our Vision:
An easier return to normal life for service members and families.

Consequences for Families of a Complex System

Families thrust into stressful new situations by a loved one's serious injury understandably are confused and anxious. They cannot be expected to know about care or benefits available, and they may feel incapable of determining the best course. Our recommendation for a Recovery Coordinator should ease this burden.

Complexity in Disability Determination & Compensation Systems

Less than half of service members understand the DoD's disability evaluation process.

Just 42 percent of retired/separated service members who had filed VA claims understand that process.

The DoD's disability determination system focuses on whether service members are fit or unfit to perform their primary military duties. DoD's disability ratings determine how much service members will receive in military disability compensation and whether this compensation is lifelong or one-time-only. It determines whether they and their families receive lifetime TRICARE medical benefits or coverage for only 180 days after discharge. Similarly, the VA's disability ratings determine the amount of VA compensation veterans receive and their eligibility for an array of vocational rehabilitation and other benefits that help them recover.

The DoD and VA each have their own complicated disability rating processes that take several months to complete. If a service member appeals the rating decision, the case may not be resolved for several years (for the VA, an *average* of 657 days). A positive step is a joint VA/DoD initiative—the Benefits Delivery at Discharge Program—intended to provide medically separating or retiring service members a smoother transition into the VA health care system and prompt receipt of VA disability compensation.

Research confirms that there are indeed differences in ratings, depending on which military service determines the DoD rating and which regional office determines the VA rating. Disability ratings assigned by DoD are scored differently and are usually lower than those assigned by the VA.

Despite their disability systems' different intents, processes, and outcomes, DoD and VA use the same outdated rating schedule to establish a service member's percent disability.[13] The rating schedule has not been completely revised since 1945, although portions have been updated over the past 20 years. The schedule is problematic for service members injured in Iraq and Afghanistan, because of:

- the number of injuries that are new or for which diagnostic criteria are changing rapidly, such as traumatic brain injury
- a new appreciation of the disabling impact of other conditions, such as post-traumatic stress disorder and
- advances in medical care and rehabilitation that change the prognosis for certain conditions, such as serious burns and amputations.

Future conflicts may produce their own "signature conditions," and at the same time clinical treatment continues to advance. This dynamic situation requires that the VA review and adjust the disability rating system *at frequent and regular intervals.*

13 Institute of Medicine. *A 21st Century System for Evaluating Veterans for Disability Benefits.* Washington, DC: National Academies Press, 2007.

As long as injured service members remain in the military, they receive their military pay. Once their disability rating is established and they leave the military, they receive disability compensation and may be eligible for health care and other programs. For most injured service members, military pay is more than their disability pay will be. Service members may therefore believe it is to their advantage to stay in a "pending" category for as long as possible, continue to receive their military pay, and not face the uncertainties of the disability rating system.

Once they do leave the military, most veterans with disabilities will end up with the higher of either DoD or VA disability compensation pay. Since 2004, individuals with more than 20 years of military service who have a 50 percent or greater VA disability rating for combat-related injuries may receive payment from both systems.[14]

In DoD, the objective of the disability payment system is not well-defined and, once again, it is governed by a complex set of rules and procedures. In part, DoD disability payments appear intended to compensate injured service members for the premature end to their military careers—in effect, a "retirement benefit" for those unable to reach actual retirement. The VA's system, as noted above, is intended to replace lost earnings capacity. A 21st century view acknowledges a disability's effects not just on earnings, but also on social, family, and community participation. The current system touches on these issues indirectly, not by explicit policy.

As long ago as the Bradley Commission, we were warned about the debilitating potential of policy aimed merely at income replacement. Such a focus reduces recipients' incentives to work, to obtain education and training—in short, to get on with life. In line with our belief that the goal of the disability system should be to return disabled veterans to normal activities, insofar as possible, and as *quickly as possible*, strong incentives to encourage education, training, and employment are urgently needed.

14 Receiving both benefits is called "concurrent receipt." Almost all other government programs have rules requiring that people eligible for the same type of benefit from different programs to choose one or the other; they cannot receive both.

A STREAMLINED DOD/VA RETIREMENT & DISABILITY COMPENSATION SYSTEM

At any point in time, disabled veterans would receive three types of payments:

Point of Discharge ↓ **Point of Retirement** ↓

	Throughout the "working years," veterans would receive . . .			After retirement . . .
1. DoD's Military Annuity Payments	$ amount based on rank and years of military service			
2. VA Quality of Life Disability Payments	$ amount based on impacts on quality of life			
3. VA Transition payments*			4. Followed by . . .	5. Followed by . . .
EITHER	Long-term living expense support while in school/VRE		Earnings loss payments when employment begins**	Social Security
OR	3 months	Earnings loss payments when employment begins**		Social Security

*To help veterans become established and move into work or, if unable to work, to enable independent living.
**These payments would contribute to veterans' earnings for Social Security eligibility; the amount would be recalculated periodically as veterans'

Our recommendation regarding the disability rating and compensation system for injured service members would accomplish the following:

- DoD and VA should create a single, comprehensive, standardized medical examination that DoD administers. It would serve DoD's purpose of determining fitness and VA's of determining initial disability level.
- The service branches would remain in charge of determining whether an injured service member is fit for duty
- If not, he or she would be separated from the military and receive a lifetime annuity payment, based on military rank and years of military service
- Service members' disability rating would be determined by the VA and continued eligibility for payments and benefits reassessed periodically (at least every three years)
- All disability-related payments and benefits for veterans would be obtained through the VA. Veterans would be eligible for compensation that would reflect three components, as shown in the accompanying chart:
  a. *transition payments* after they leave military service—either:
     - *short-term*, to help with expenses related to their return to the community or
     - *longer-term*, to cover family living expenses while they participate in education and training programs or prepare for independent living

b. *earnings-loss payments* to make up for any reduced earning capacity and
c. *quality-of-life payments* to compensate for permanent losses of various kinds.

- Service members found unfit because of their combat-related injuries should receive lifetime, comprehensive health care coverage and pharmacy benefits for themselves and their dependents through DoD's TRICARE program.

This recommendation gets the DoD completely out of the disability business. It eliminates the confusing, parallel systems of ratings and compensation and the notion of "concurrent receipt." The objective of the DoD system would be to maintain a fit force and acknowledge years of military service, and the objective of the VA system would be to compensate for disability.

Information Technology (IT)

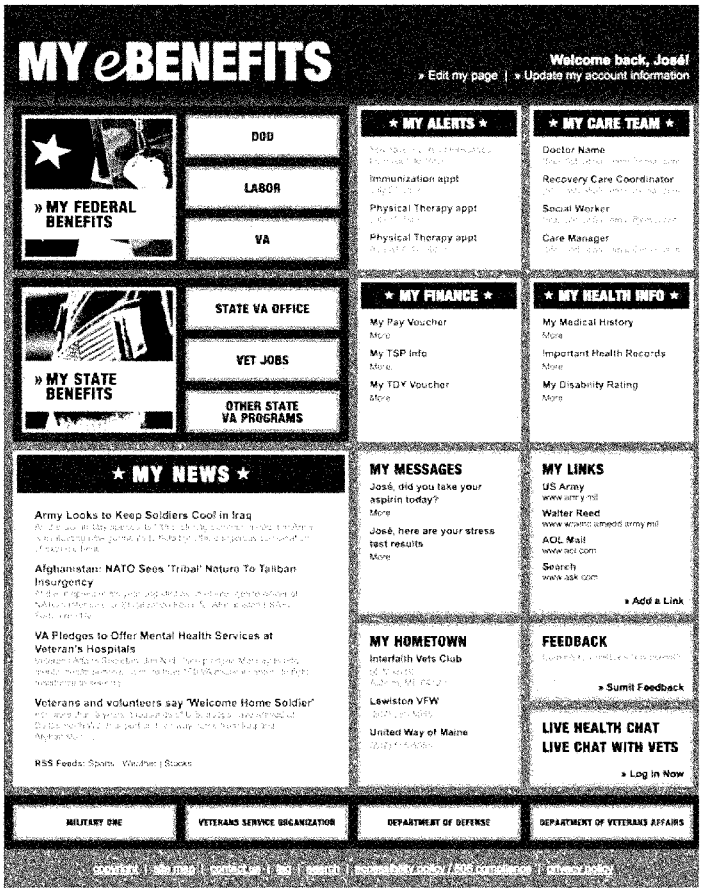
The design of information systems must be driven by the needs of an organization for effective management, operations, and support programs. The current information technology (IT) systems within DoD and VA are fragmented and compartmentalized. Information is collected and stored in isolated yet overlapping data systems that are rarely integrated. Some parts of the system collect more information than needed; others duplicate information available in other parts of the system, increasing opportunities for errors and inconsistencies. We were told that users of these complex data systems often do not know what data are already available to them.

The DoD and VA are working to facilitate the exchange of medical information and the sharing of personnel and disability information. At present, they do not fully integrate health care data with benefit information. Understanding organizational needs and simplifying the processes are the first priority. Meanwhile, congressional or departmental reform efforts should resist imposing new requirements that may result in duplicative or uncoordinated electronic systems and, instead, should encourage the streamlining of today's systems and facilitate communication across them.

With our proposed comprehensive Recovery Plan, patient records would need to be electronically available to the Recovery Coordinator, health care professionals, and program staff across the continuum—from acute care, to rehabilitation, to long-term support, education, and employment programs, if needed. The system must be secure and designed so that various professionals have access to the information germane to their work.

Drawing information from these systems, an interactive web portal, such as the prototype "My eBenefits" page shown on the next page, could provide tailored information to each service member and veteran, specific to their situation, and enable them to make appointments, do financial planning, maintain confidential personal health records, and apply for various benefits programs. Today, in order to find such information, armed service members and veterans must navigate a disparate, confusing, and cumbersome array of websites. First-rate content exists online for service members and their families; however, the presentation and organization of this information simply have not evolved to meet the needs and expectations of the next generation of service members.

There is a timely and unmistakable need for the VA and DoD to work together to create a single, one-stop "information shop." As we envision it, a site such as "My eBenefits" would be a consumer-friendly, interactive, evolving, fully customizable and personalized information portal. It would host almost every type of data important to a patient's Recovery Plan. It also would include tailored, up-to-date information on federal and state benefits, inpatient and outpatient care, disability evaluation and application status, local and national resources from veterans service organizations and community organizations, area employment opportunities, doctors' names and contact information, news, and the ability to connect easily with other armed service members and veterans.


MY eBENEFITS
Welcome back, José!
» Edit my page | » Update my account information
» MY FEDERAL BENEFITS
DOD
LABOR
VA
★ MY ALERTS ★
Immunization appt
Physical Therapy appt
Physical Therapy appt
★ MY CARE TEAM ★
Doctor Name
Recovery Care Coordinator
Social Worker
Care Manager
» MY STATE BENEFITS
STATE VA OFFICE
VET JOBS
OTHER STATE VA PROGRAMS
★ MY FINANCE ★
My Pay Voucher
More
My TSP Info
More
My TDY Voucher
More
★ MY HEALTH INFO ★
My Medical History
More
Important Health Records
More
My Disability Rating
More
★ MY NEWS ★
Army Looks to Keep Soldiers Cool in Iraq
Afghanistan: NATO Sees 'Tribal' Nature To Taliban Insurgency
VA Pledges to Offer Mental Health Services at Veteran's Hospitals
Veterans and volunteers say 'Welcome Home Soldier'
RSS Feeds: Sports | Weather | Stocks
MY MESSAGES
José, did you take your aspirin today?
More
José, here are your stress test results
More
MY LINKS
US Army
Walter Reed
AOL Mail
www.aol.com
Search
www.ask.com
» Add a Link
MY HOMETOWN
Interfaith Vets Club
Lewiston VFW
United Way of Maine
FEEDBACK
» Submit Feedback
LIVE HEALTH CHAT
LIVE CHAT WITH VETS
» Log In Now
MILITARY ONE
VETERANS SERVICE ORGANIZATION
DEPARTMENT OF DEFENSE
DEPARTMENT OF VETERANS AFFAIRS

IMPLEMENTING OUR RECOMMENDATIONS

The following chart summarizes the locus of responsibility for implementing the action steps that support our recommendations.

Recommendation Action Steps	Congress	DoD	VA
1. Implement comprehensive Recovery Plans			
• Develop integrated care teams		X	X
• Create Recovery Plans		X	X
• Develop corps of Recovery Coordinators (with Public Health Service)		X	X
2. Restructure disability and compensation systems			
• Clarify the objectives of DoD and VA disability programs	X		
• Create a single, comprehensive medical exam		X	X
• Provide lifetime TRICARE benefits for combat-injured	X		
• Restructure VA disability payments	X		
• Determine appropriate length and amounts of transition payments			X
• Update and keep current the disability rating schedule			X
• Develop flexibility within Vocational Rehabilitation and Education (VRE) program			X
3. Improve care for people with post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI)			
• Enable all Iraq & Afghanistan veterans who need PTSD care to receive it from the VA	X		
• Address shortage in mental health professionals		X	
• Establish and expand networks of experts in PTSD and TBI		X	X
• Expand training regarding PTSD and TBI		X	X
• Develop or disseminate clinical practice guidelines		X	X
4. Strengthen support for families			
• Expand eligibility for TRICARE respite care and aide and attendant care	X		
• Expand caregiver training for families		X	X
• Cover family members under the Family Medical Leave Act	X		
5. Transfer patient information across systems			
• Make patient information available to all personnel who need it, initially in readable form		X	X
• Continue efforts for fully interoperable information system		X	X
• Develop a user-friendly single web portal for service members and veterans		X	X
6. Support Walter Reed until closure			
• Assure adequate resources		X	
• Strengthen recruitment and retention of needed administrative and clinical staff		X	

APPENDIX

Bibliography

Major Past Reports by Commissions, Task Forces, and Committees

2007 (forthcoming) Institute of Medicine. *PTSD Compensation and Military Service*. Washington, DC: National Academies Press. Available at http://books.nap.edu/openbook.php?record_id=11870&page=R1

June 2007 Department of Defense Task Force on Mental Health. *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health.* Available at: http://www.ha.osd.mil/dhb/mhtf/MHTF-Report-Final.pdf

June 2007 Institute of Medicine. *A 21st Century System for Evaluating Veterans for Disability Benefits.* Washington, DC: National Academies Press. Available at http://books.nap.edu/catalog.php?record_id=11885

April 2007 President's Task Force on Returning Global War on Terror Heroes. Task Force Report, *Returning Global War on Terror Heroes.* Available at: http://www1.va.gov/taskforce/

April 2007 Independent Review Group. *Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center*. Available at: http://www.usuhs.mil/vpe/IRGReport.pdf *(AKA the West and Marsh Commission)*

March 2007 Military Health Treatment Record Interagency Task Force Report. . Available at: https://www.mpm.osd.mil/owa/jrio/pkg_jrio.page?id=HTR&wgsid=

March 2004 VA Vocational Rehabilitation and Employment Task Force. *Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st Century Veteran*. The chair's testimony regarding this report is available at http://www.va.gov/OCA/testimony/hvac/040401DH.asp.

May 2003	President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. Available at: http://veterans.senate.gov/documents/ihcdfinal.pdf *(AKA the Wilensky Commission)*
1999	Congressional Commission on Servicemembers and Veterans' Transition Assistance. *Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance*. Available at: http://www.vetbiz.gov/library/Transition%20Commission%20Report.pdf *(AKA the Dole Commission; AKA the Transition Commission)*
1996	Presidential Advisory Committee on Gulf War Veterans' Illnesses. *Final Report*. Available at: http://www.gulflink.osd.mil/gwvi/
1956	The President's Commission on Veterans' Pensions. A Report to the President, Veterans' *Benefits in the United States*. Available at: http://www.vetscommission.org/Bradley_Report.pdf *(AKA the Bradley Commission)*

GAO Reports[15]

U.S., Government Accountability Office. GAO-07-614 Veterans' Benefits Administration: Progress made in Long-Term Effort to Replace Benefits Payment System, but Challenges Persist, April 2007

U.S., Government Accountability Office. GAO-07-512T Veterans' Disability Benefits: Claims Processing Challenges Persist, March 2007

U.S., Government Accountability Office. GAO-07-589T DOD and VA Health Care: Challenges Encountered by Injured Servicemembers during Their Recovery, March 2007

U.S., Government Accountability Office. GAO-07-562T Veterans' Disability Benefits: Processing of Claims Continues to Present Challenges, March 2007

15 GAO stood for the federal government's "General Accounting Office" until July 2004, at which point the agency's name changed to Government Accountability Office.

U.S., Government Accountability Office. GAO-07-606T DOD and VA Health Care: Challenges Encountered by Injured Servicemembers during Their Recovery Process, March 2007

U.S., Government Accountability Office. GAO-06-1085 DOD Civilian Personnel: Greater Oversight and Quality Assistance Needed to Ensure Force Health Protection and Surveillance for Those Deployed, September 2006

U.S., Government Accountability Office. GAO-06-794R VA and DOD Health Care: Efforts to Provide Seamless Transition of Care for OEF & OIF Servicemembers & Veterans, June 2006

U.S., Government Accountability Office. GAO-06-648 VA Health Care: Selected Credentialing Requirements at Seven Medical Facilities Met, but an Aspect of Privileging Process Needs Improvement, May 2006

U.S., Government Accountability Office. GAO-06-561T Military Disability Evaluation: Ensuring Consistent and Timely Outcomes for Reserve and Active Duty Service Members, April 2006

U.S., Government Accountability Office. GAO-06-315 VA and DOD Health Care: Opportunities to Maximize Resource Sharing Remain, March 2006

U.S., Government Accountability Office. GAO-06-362 Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members, March 2006

U.S., Government Accountability Office. GAO-06-105 Military Personnel: Top Management Attention Is Needed to Address Long-standing Problems with Determining Medical and Physical Fitness of the Reserve Force, October 2005

U.S., Government Accountability Office. GAO-05-1051T Computer-Based Patient Records: VA and DOD Made Progress, but Much Work Remains To Fully Share Medical Information, September 2005

U.S., Government Accountability Office. GAO-05-1052T VA and DOD Health Care: VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited, September 2005

U.S., Government Accountability Office. GAO-05-626 Federal Disability Assistance - Wide Array of Program Needs to be Examined in Light of New 21st Century Challenges, June 2005

U.S., Government Accountability Office. GAO-05-722T DOD and VA: Systematic Data Sharing Would Help Expedite Servicemembers' Transition to VA Services, May 2005

U.S., Government Accountability Office. GAO-05-749T Veterans' Disability Benefits: Claims Processing Problems Persist and Major Performance Improvements May Be Difficult, May 2005

U.S., Government Accountability Office. GAO-05-655T VA Disability Benefits: Board of Veterans' Appeals Has Made Improvements in Quality Assurance, but Challenges Remain for VA in Assuring Consistency, April 2005

U.S., Government Accountability Office. GAO-05-310R DOD and VA Health Care: Incentives Program for Sharing Health Resources, February 2005

U.S., Government Accountability Office. GAO-05-167 Vocational Rehabilitation: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers, January 2005

U.S., Government Accountability Office. GAO-05-64 VA and Health Care: Efforts to Coordinate a Single Physical Exam Process for Servicemembers Leaving the Military, November 2004

U.S., Government Accountability Office. GAO-04-1031 Military Personnel: DOD Needs to Address Long-term Reserve Force Availability & Related Mobilization and Demobilization Issues, September 2004

U.S., Government Accountability Office. GAO-04-792 VA and DOD Health Care: Resource Sharing at Selected Sites, July 2004

U.S., General Accounting Office. GAO-04-853 VA Vocational Rehabilitation and Employment Program: GAO Comments on Key Task Force Findings and Recommendations, June 2004

U.S., General Accounting Office. GAO-04-687 Computer-Based Patient Records: VA and DOD Efforts to Exchange Health Data Could Benefit from Improved Planning and Project Management, June 2004

U.S., General Accounting Office. GAO-04-402T Computer-Based Patient Records: Sound Planning and Project Management Are Needed to Achieve a Two-Way Exchange of VA and DOD Health Data, March 2004

U.S., General Accounting Office. GAO-04-495R DOD and VA Health Care: Incentives Program for Sharing Resources, February 2004

U.S., General Accounting Office. GAO-04-271T Computer-Based Patient Records: Short-Term Progress Made, but Much Work Remains to Achieve a Two-Way Data Exchange between VA and DOD Health Systems, November 2003

U.S., General Accounting Office. GAO-04-158T Defense Health Care: DOD Needs to Improve Force Health Protection and Surveillance Processes, October 2003

U.S., General Accounting Office. GAO-03-904R DOD and VA Health Care: Access for Dual Eligible Beneficiaries, June 2003

U.S., General Accounting Office. GAO-01-153 SSA Disability: Other Programs May Provide Lessons for Improving Return-to-Work Efforts, January 2001

Joint Reports

U.S., General Accounting Office. GAO/HEHS-00-52 VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies, May 2000

U.S., General Accounting Office. GAO/T-HEHS/AIMD-00-146 Veterans Benefits Administration: Problems and Challenges Facing Disability Claims Processing, May 2000

U.S., General Accounting Office. GAO/NSIAD-94-36 Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards, March 1994

Serve, Support, Simplify

Report of the President's Commission on Care
For America's Returning Wounded Warriors
July 2007

Subcommittee Reports & Survey Findings

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The Work of the Commission

President George W. Bush established the President's Commission on Care for America's Returning Wounded Warriors by executive order (EO 13426, March 8, 2007). Section 3 of the order specifies:

> The mission of the Commission shall be to:
>
> (a) examine the effectiveness of returning wounded service members' transition from deployment in support of the Global War on Terror to successful return to productive military service or civilian society, and recommend needed improvements;
>
> (b) evaluate the coordination, management, and adequacy of the delivery of health care, disability, traumatic injury, education, employment, and other benefits and services to returning wounded Global War on Terror service members by Federal agencies as well as by the private sector, and recommend ways to ensure that programs provide high-quality services;
>
> (c) (i) analyze the effectiveness of existing outreach to service members regarding such benefits and services, and service members' level of awareness of and ability to access these benefits and services, and (ii) identify ways to reduce barriers to and gaps in these benefits and services; and
>
> (d) consult with foundations, veterans service organizations, non-profit groups, faith-based organizations, and others as appropriate, in performing the Commission's functions under subsections (a) through (c) of this section.

Our report is rooted in the work done by the Commission, plus the work of the several other Task Forces and Commissions that in recent months have been examining similar issues. This Commission heard testimony at seven public meetings and conducted 23 site visits to military bases, VA hospitals and treatment centers across the country. We heard from experts on providing physical and mental health care, navigating health care and disability evaluation and compensation systems, members of Congress and their staff, and most importantly, service men and women, their families, and the health care professionals charged with their care. The Commission also conducted its own nationwide survey of more than 1700 injured service men and women, and findings from this June 2007 survey are noted throughout the main report and the Subcommittee reports.

Given the short timeframe of the Commission and the desire of Commission members to reach as many service men and women and their families as possible, a public website

was established with a special "Share Your Story" feature at www.pccww.gov. From April 14th through July 9th, the Commission received 473 "Share Your Story" e-mails. Individuals also could contact the Commission by mail (P.O. Box 12588, Arlington VA 22219-2588) or toll-free telephone number (1-877-588-2035), where detailed messages could be recorded. Commission staff reviewed every in-person, electronic, written, and telephonic submission. As of July 9th, the Commission received and responded to 502 pieces of correspondence and 414 phone calls.

Site Visits

The Commission visited the following facilities:

California ▪ Camp Pendleton (San Diego) ▪ Balboa Naval Medical Center (San Diego) ▪ San Diego VA Medical Center **Florida** ▪ Miami VA Medical Center ▪ Ryder Trauma Center ▪ James A. Haley VA Medical Center (Tampa) **Illinois** ▪ North Chicago VA/Great Lakes Naval Hospital ▪ Rehabilitation Institute of Chicago **Maryland** ▪ National Naval Medical Center **Minnesota** ▪ National Guard "Beyond the Yellow Ribbon" Program **Nevada** ▪ Southern Nevada VA Medical Center	**New Jersey** ▪ New Jersey VA Medical Center – Lyons Campus **New York** ▪ Bronx VA Medical Center **North Carolina** ▪ Camp Lejeune ▪ Womack Army Medical Center (Fort Bragg) **Texas** ▪ Brooke Army Medical Center (Fort Sam Houston) ▪ Wilford Hall Medical Center (Lackland Air Force Base) ▪ Audie Murphy VA Medical Center (San Antonio) **Virginia** ▪ Hunter Holmes McGuire VA Polytrauma Rehabilitation Center (Richmond) ▪ Fort Belvoir **Washington, DC** ▪ National Rehabilitation Hospital ▪ Walter Reed Army Medical Center ▪ Washington Navy Yard

Commissioners' Biographical Profiles

President Bush named nine members to the President's Commission on Care for America's Returning Wounded Warriors, including two co-chairs. Each Commission member brought unique personal and professional experience to the work of the Commission. The following are brief biographical profiles of our Commission members:

Co-Chairs

Bob Dole: Senator Bob Dole was elected to Congress from his home state of Kansas in 1960 and to the U.S. Senate in 1968. He resigned from the Senate in 1996. His personal history of service includes active duty in World War II, during which he was gravely wounded and received for heroic achievement two Purple Hearts and a Bronze Star with Oak Leaf Cluster.

Donna Shalala: In 1993, President Clinton appointed Donna Shalala Secretary of Health and Human Services (HHS), where she served for eight years, becoming the longest serving HHS Secretary in U.S. history. She has served as President of the University of Miami since June 1, 2001.

Commissioners

Edward A. Eckenhoff: Edward A. Eckenhoff is Founder, President, and CEO of the National Rehabilitation Hospital and a Member of the District of Columbia Hospital Association Board of Directors. As the leader of one of the largest medical rehabilitation providers in the Washington-Baltimore area, he is an innovator in the field of rehabilitation medicine. Earlier in his career, he served as Vice President and Administrator at the Rehabilitation Institute of Chicago. He received his bachelor's degree from Transylvania University in Kentucky and his master's degree in Health Care Administration from the Washington University School of Medicine.

Tammy Edwards: Tammy Edwards is a strong advocate for families of wounded service members. In 2005, her husband, U.S. Army Staff Sergeant Christopher Edwards, was severely burned in Iraq when a 500-pound bomb exploded under his vehicle. Since her husband's injury, Tammy has provided support for family members of wounded veterans in her community of Cibolo, Texas. She received her bachelor's and master's degrees from Florida State University.

Kenneth Fisher: Kenneth Fisher is Senior Partner of Fisher Brothers and Chairman and CEO of Fisher House Foundation, a not-for-profit organization that constructs "comfort

homes" for families of hospitalized military personnel and veterans. Fisher Houses serve 8,500 families every year. Mr. Fisher has more than 26 years of experience in the real estate industry and attended Ithaca College.

C. Martin Harris: C. Martin Harris is Chief Information Officer and Chairman of the Information Technology Division at the Cleveland Clinic. He has been a practicing physician since 1987. He has served on government and private sector commissions that have addressed health care interoperability issues, including the Congressional Commission on Systemic Interoperability and as Chairman of the Healthcare Information and Management Systems Society's National Health Information Infrastructure Task Force. Dr. Harris received his MBA from the Wharton School of Business and his MD from the University of Pennsylvania School of Medicine.

Marc Giammatteo: Marc Giammatteo is a student at Harvard Business School, a graduate of the U.S. Military Academy at West Point, and a former Captain in the U.S. Army. In 2004, his leg was severely injured during a rocket propelled grenade attack in Iraq. He has undergone more than 30 surgeries at Walter Reed Army Medical Center. From 2004 to 2007, he served as an Unofficial Patient Advocate at Walter Reed. He is a recipient of the Bronze Star and Purple Heart.

Jose Ramos: Jose Ramos is a student at George Mason University, where he is pursuing a major in International Studies and minor in Islamic Studies and Arabic. While serving as a Hospital Corpsman 3rd Class in the U.S. Navy, he treated soldiers who were injured during unconventional warfare in Iraq. In 2004, during his second tour of duty in Iraq, he lost his arm during combat. He also served one tour of duty in Afghanistan.

Gail Wilensky: Gail Wilensky is an Economist and Senior Fellow at Project HOPE, an international health education foundation. She also serves as Co-Chair of the Task Force on Future Health Care at the U.S. Department of Defense. Earlier in her career, she served as the Chair of the 2003 President's Task Force to Improve Health Care Delivery for Our Nation's Veterans and Chair of the Medicare Payment Advisory Commission. She also directed Medicare and Medicaid programs at the U.S. Department of the Health and Human Services. Dr. Wilensky received her bachelor's, master's, and doctoral degrees from the University of Michigan.

Subcommittee Reports

THE CONTINUUM OF CARE

THE CHALLENGE

Advances in military medicine, rapid evacuation, and improved protective gear have increased survival of our injured service members compared to previous conflicts and wars. Care from the point of injury through medical evacuation is demonstrably first-class. Service members can arrive in the continental United States within 36 hours after sustaining very serious and complex injuries.

Although the military health system is responding admirably to the rapidly increasing number and complexity of injuries, evidence has arisen of gaps in care, lack of accountability, and bureaucratic mazes. Fragmentation in the health and social services systems creates frequent confusion and uncertainty.

Processes for access to care, case management, coordination of services, and inpatient to outpatient transitions lack clear and common definition. Further, these processes have not evolved to meet the changes in health care needs. Successful transition from inpatient to outpatient status requires attentive coordination and management of care, focusing on the service member's readiness to begin the journey from the inpatient environment to life in the community.

BACKGROUND

Military medicine has contributed greatly to improvements in care and management of the severely wounded. From the concept of triage—the system for prioritizing injuries for treatment, which began in World War I—to rapid transportation of the wounded to sites for definitive care, the advances and lessons learned during times of war have created and improved the system of trauma care for both U.S. service members and civilians. During World War II, for example, the process for storing blood was put to the test in the field by the British Red Cross. In Korea, MASH units were developed and used as forward surgical units to improve care for the wounded, and helicopter ambulances created the first formal air evacuation system. In Vietnam, the air evacuation system was advanced to the point where injured service members were transported from the point of injury to definitive care within two hours, compared with 12 to 48 hours in World War I.

The current wars in Iraq and Afghanistan have also seen great strides in the development of trauma medicine. Advances in body armor and hemorrhage control techniques have dramatically reduced mortality rates and limited the severity of many injuries.

According to a recent report, the proportion of *combat casualties*—active-duty service members who have to leave the theater because of a medical condition, including injury, illness, or non-combat injury[1]—who are killed in action fell from 20 percent in World War II to 13.8 percent in Afghanistan and Iraq. This decrease in the number dying instantly from their wounds is a measure of the effectiveness of early care and evacuation in the face of more deadly weapons.[2] Another way of measuring this effectiveness is the *case fatality rate*, which is the percentage of killed and wounded who die from injuries, either immediately (killed in action) or after a lapse of time (died of wounds). The case fatality rate has fallen from 19.1 percent in World War II to 10.1 percent in Iraq and Afghanistan.[3]

$$\text{Case Fatality Rate} = \frac{\text{killed in action + died of wounds}}{\text{killed in action + wounded in action}} \times 100$$

$$\text{\% Killed in Action} = \frac{\text{killed in action}}{\text{killed in action + (wounded in action – return to duty)}} \times 100$$

OVERVIEW

The military readiness mission of the military health system is twofold: 1) to maintain the health of America's fighting force and 2) to care for those service members who are ill or injured. Casualty planning for each war builds on the lessons learned from previous wars and conflicts. Allocation of medical resources for any war is based on the number of deployed troops.

For the current wars in Iraq and Afghanistan, the general plan for access to medical care for our service members encompasses five levels:

Level I :	Medic (Army or Air Force)/Corpsman (Marine) Battalion Aid Station (Army) /Regimental Aid Station (Marine)
Level II :	Forward Surgical Team (Army) / Forward Resuscitative Surgical System (Marine)
Level III :	Combat Support Hospital/Air Force Theater Hospital/Naval Hospital Ship
Level IV :	Landstuhl Regional Medical Center, Germany
Level V :	Continent of the United States

All service members are first-aid trained in order to assist a wounded comrade. When a service member is injured during combat, he or she is trained to self-apply a tourniquet if necessary. A medic (Army) or corpsman (Navy) assists if immediate lifesaving measures are required, and with evacuation. The injured service member is transported to the next appropriate level of care, depending on the type and severity of the wounds.

For some, this means being air evacuated to Landstuhl Regional Medical Center in Germany, where they receive additional care and stabilization. As of June 30, 2007, 37,851 individuals had arrived at Landstuhl from Iraq and Afghanistan, and 23,270 of these returned to duty within 72 hours.[5] Not all of these service members were injured in combat, and not all actually required hospitalization at Landstuhl. (From the beginning of Operation Iraqi Freedom until May 15, 2003, 1,236 patients were evacuated to Landstuhl, only 620 required inpatient admission; 256 of these had been injured in battle.[6])

Service members with any injury or illness which requires additional expertise, or which will prevent their returning to their military duties, are generally air evacuated to medical treatment facilities in the United States.[7] Prior to evacuation, physicians at Landstuhl determine the optimal medical treatment facility to refer the patient, given the individual's injuries or medical needs. Receiving physicians at stateside military treatment facilities are provided with a summary of the medical condition for which the patient was referred.

On arrival in the United States, injured service members are taken to the appropriate medical treatment facility where they are examined and placed into inpatient or outpatient status. After recovery, some return to duty. Others begin the process of evaluation to determine whether or not they are medically fit to continue in their military job. Service members found unfit are then evaluated for separation or medical retirement from the military. (The details of this process are fully discussed in the Subcommittee Report on Disability.)

Most veterans file for a disability rating from the VA, and all those who were deployed to Iraq and Afghanistan are eligible for two years of free medical care in the VA health system. To continue receiving health care from the VA, they must enroll. Many veterans are also eligible for other benefits, such as vocational rehabilitation or education benefits through the Montgomery GI Bill. Various federal and state programs also provide support and assistance with employment. These aspects of veteran benefits are detailed in the Subcommittee Report on Education, Training, and Employment.

On February 18, 2007, the Washington *Post* began publication of a series focusing on deficient conditions in Building 18, an outpatient unit, located on the campus of Walter Reed Army Medical Center. That and subsequent events led to the creation of a task force and an inter-agency review, along with a host of corrective actions on the part of the military and VA. Congress has held hearings, and hundreds of bills have been proposed to address the perceived problems.

PREVIOUS REPORTS AND RECOMMENDATIONS

Previous Commission and Task Force reports have examined care and services that injured service members receive. A common theme among these reports is the need for coordinated care, with a mechanism to assist service members as they transition from

inpatient to outpatient care and services. The following specific recommendations were made:

- The **Task Force on Returning Global War on Terror Heroes** (March 2007) recommended development of a system for co-management and case management for returning service members to ease the transition from DoD to VA care. Specific recommendations from this report included:
    - Standardization of VA Liaison Agreements across all military treatment facilities
    - Enhancement of electronic health records to facilitate complete reporting of medical information between DoD and VA.

- A 2007 report by the **Government Accountability Office (GAO)** on challenges encountered by injured service members during their recovery process concluded that transition of care for the seriously injured, and DoD and VA's efforts to provide rehabilitation services as soon as possible after the injury, constituted the greatest areas of challenge. This has resulted in streamlining of processes between DoD, VA, Department of Labor, and other federal agencies to develop measures to ensure better outcomes.[8]

- The **Independent Review Group** (April 2007) criticized shortcomings in the areas of continuum of care, leadership, and policy in regard to care of injured service members. The report specifically recommended:
    - Developing a tri-service policy for case management services
    - Assigning every returning service member assigned a primary care manager and a case manager as the basic unit of support
    - Creating a standard for qualifications and initial and recurring training for all case managers.

- In a 2006 report, the **GAO** observed that many outreach efforts were underway between DoD and the VA to provide seamless transition of care for Iraq and Afghanistan service members and veterans. It concluded that efforts to get information to service members and veterans about VA health care services were successful. Results of these efforts included memoranda of agreement between DoD and VA health care facilities for transfer of injured service members, and initiatives to improve the electronic exchange of information between DoD and the VA.[9]

- In a report to Congress in 2006, the Transition Assistance and Disabled Transition Assistance Programs (TAP and DTAP) were the focus. Work done in this area has led to the restructuring of the TAP program to include a web-based portal for information, increases in TAP briefings

done jointly between DoD and the VA, and measures to enhance the existing TAP program.[10]

WHAT THE COMMISSION FOUND

Introduction

The Commission learned a great deal about the care and benefits provided to America's military personnel and veterans. The Commission learned that, on the whole, we are a generous and giving Nation when it comes to providing for our service members and veterans. Benefits include health care for veterans through the VA health care system and 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.[11]

The Commission was not charged with determining if this amount is sufficient. Instead, the Commission was charged with determining if the benefits and services provided to our wounded service members are ***effective*** in maximizing their potential for a productive life—either by returning to full military service or transitioning to civilian life. This is a big challenge.

The Commission recognized that it could not tackle every problem in the care of injured service members within its four-month time frame and determined to focus on the disability system for the military and the VA, rehabilitation, education/training and employment, families, post-traumatic stress disorder and traumatic brain injury, and information transfer. Each of these areas is discussed in the subcommittee reports that follow. The remainder of this Subcommittee Report discusses coordination and delivery of care and benefits to our injured service members.

Transition: Becoming a Patient

From the time of injury, service members progress through a series of recovery transitions. The first occurs at the front lines, when the service member is injured and becomes a patient. Experience in the field has documented that the greatest threat to life is the immediate blood loss associated with the injury.[12],[13] In response, the combat health support system has provided more first responder training and has positioned advanced trauma management capabilities closer to the front lines.[14] As a result, if an injured service member arrives at any level of theater medical care, he or she has a 97.5 percent chance of surviving.[15]

The process of getting injured services members the care they need while remaining in a combat zone is excellent. The Army, Marines, Air Force, and Navy have each created a system of combat care and evacuation that quickly moves the injured individual through the various levels of care and back to military treatment facilities in

the United States. It is not uncommon for an injured service member to arrive at a stateside military treatment facility within 36 hours after injury. [16]

The Commission found no area of concern regarding in-theater care and evacuation of injured service members.

Transition: Evacuation & Triage

A later transition involves the decision to evacuate an active-duty service member to the United States, typically from Landstuhl Regional Medical Center in Germany (Table 1). This decision is based on a determination that the patient's condition is so serious that returning to duty is not feasible or that additional resources are required to care for the individual. The physicians at Landstuhl first match the patient's needs with a referral hospital that can provide the necessary services. The referral hospital is notified, and arrangements are made for transfer. The air evacuation manifest, containing specific information about the patient, is sent to the referring hospital prior to the patient's arrival.

Upon arrival at the destination facility, the patient is triaged to either inpatient or outpatient status. Within 24 hours, outpatients are usually seen in a clinic, where an evaluation is completed and referrals are made for needed services. Inpatients receive further stabilization for their injuries and additional procedures before being discharged to outpatient status or transferred to another hospital.

In general, patients with traumatic amputations are cared for at Walter Reed Army Medical Center, Brooke Army Medical Center, and Naval Medical Center San Diego. Burn patients are admitted directly to the burn unit at Brooke Army Medical Center. Patients with spinal cord injuries are stabilized and then transferred to a VA spinal cord center. Patients with penetrating head injuries are primarily cared for at National Naval Medical Center, Bethesda, Maryland. Service members with multiple injuries are stabilized at one of the military treatment facilities and may, afterwards, be transferred to one of four VA Polytrauma Rehabilitation Facilities.

As of July 23, 2007, 911 service members experienced an amputation from injuries sustained in Iraq or Afghanistan. Of these, 644 have been for the loss of an arm, leg , han d, or foot, including those individuals with multiple amputations. Approximately 76 percent of these have been cared for at Walter Reed Army Medical Center.

Accounting for all patients with traumatic brain injury is more difficult (see Subcommittee Report on Post-Traumatic Stress Disorder and Traumatic Brain Injury). As of March 2007, 2,726 service members had been reported to the Defense Veterans Brain Injury Center with the diagnosis of traumatic brain injury. Of these, 2,094 were classified as mild and 255 as moderate. Another 192 had severe traumatic brain injuries and 171 had penetrating brain injuries.

Ninety-one service members had been treated for spinal cord injuries in the VA, as of June 8, 2007. Brooke Army Medical Center's burn unit reports receiving 598 service members evacuated from Iraq and Afghanistan with burns as of June 30, 2007. Fifty-three service members have received blind rehabilitation services from the VA as of April 3, 2007.

The Commission found no area of great concern with the inpatient treatment of patients evacuated from Landstuhl. The medical care at Walter Reed Army Medical Center, Brooke Army Medical Center, National Naval Medical Center at Bethesda, Naval Medical Center San Diego, and other military treatment facilities is compassionate and complete. The specialized services and programs for amputations and burns, in particular, are world-class.

Transition: Inpatient to Outpatient

Transitioning from an inpatient to outpatient setting can be difficult for patients—in or out of the military. Being an outpatient places the burden to follow through with instructions and plans for recovery directly on the patient and family. This may be an easier task for those with relatively minor injuries.

Patients with complex and chronic problems are less likely to do well without additional guidance and attention. The Commission heard concerns that care in the outpatient setting was less well coordinated, difficult to access, and fragmented. Some injured service members reported waiting two to three weeks between appointments for specialty services, consistent with the access standard for all military patients. In addition, access to support and administrative services is challenging. Outpatient care can be further complicated by the structure, rules, and regulations required by the military.

Transition to VA: Medical Hold & Holdover

In the Army, ***medical hold*** is a term used to describe the duty status of active-duty service members who are unable to perform in their duty capacity.[17] ***Medical holdover*** is the term used for the duty status of Army reservists who need medical care at any time during their mobilization or who experienced a medical condition in the line of duty.[18] The Air Force has a similar concept for airmen, called ***patient squadrons***, although an airman who can work at any duty is returned to his unit. The Navy and Marines also use the terms medical hold and medical holdover. Service members who require more than 30 days for recovery prior to returning to duty are placed in medical hold/medical holdover/patient squadrons.

These administrative terms are used to maintain command and control of service members during outpatient recovery or treatment. The ability to reassign an individual to medical hold also enables commanders to maintain unit strength by filling the position.

For those whose medical condition precludes a return to their military duties, the evaluation process for separation or medical retirement begins. Medical hold is not intended to be permanent or a means to maintain active-duty status.

Currently in the Army, there are 1,530 active duty and 2,069 reservists on medical hold or medical holdover. The average length of time spent in medical hold or medical holdover is 174 days, with many spending 122 days.[19]

Durations are similar for the Air Force, where the average length of time is 222 days, and, for sailors and Marines, the average time spent in medical hold is 130 days. There have been instances, however, when service members have spent more than years in medical hold.[20]

Although the Army's Office of the Surgeon General was unable to provide the number of soldiers in medical hold or holdover status since 2001, it did provide data on soldiers in medical hold and holdover status at each military treatment facility (Table 2). The highest number of soldiers in medical hold or holdover status continues to be at Walter Reed Army Medical Center, followed closely by Fort Sam Houston. While soldiers in medical hold or holdover status at other military treatment facilities may actually be recovering at home, those recovering at Walter Reed present a housing issue. Walter Reed is not co-located with an active troop command center, such as Fort Bragg , and therefore housing for outpatients is limited.

Many long lengths of stay in medical hold and holdover status are the result of injury complexity and the natural progression of recovery. Other delays, however, appear to result from suboptimal care coordination and planning, long waits for outpatient appointments, lack of accountability for soldiers' whereabouts, and service members' desire to remain on active duty for as long as possible, in order to receive active-duty pay and benefits.

Recently, the Army Medical Department implemented the Army Medical Action Plan to address problems at Walter Reed.[22] The plan includes development of Warrior Transition Units. These units are intended to replace medical hold and holdover with a formal military unit structure and will be located at every medical treatment facility where at least 35 soldiers qualify. A primary care provider, case manager, and squad leader are assigned to each recovering soldier. The plan also calls for expedited access for outpatient appointments and appropriate diagnostic tests.

The Wounded Warrior Regiment, established in April 2007, is the comparable Marine Corps program. This is a centralized unit with command and control of all wounded and ill Marines. Some of these Marines live in Wounded Warrior barracks; others live on or off base with their families. Medical case management is provided by the closest naval medical center, and coordination between the regiment and the medical team is facilitated with biweekly meetings. The Regiment commands two Wounded Warrior Battalions; East at Camp Lejeune, North Carolina, and West at Camp Pendleton, California.

The Navy and Air Force also have similar programs. Safe Harbor (Navy) assists injured sailors with access to existing support resources, while encouraging them to remain in the Navy. While the Palace HART (Air Force) program works to retain combat-injured service members on active duty, provides benefits counseling, and facilitates civilian employment for those medically separated.

These programs are commendable and will assist service members while reducing medical hold and holdover excesses. But, they are not sufficient to solve the fundamental problem of transitioning service members through a complex and, at times, convoluted process.

Transition: From Active Duty to Veteran

Prior to 2000, access to VA health care was only possible after leaving the military. Today, however, many active-duty services members are treated for their injuries in VA Polytrauma Rehabilitation Centers and Spinal Cord Centers. Furthermore, they may be transferred back to a military treatment facility for additional care. These transitions and transfers can be challenging. Few service members or their families know how to navigate the VA system.

To help resolve some of these problems, in January 2005, the VA established the Office of Seamless Transition. This Office provides oversight and assistance for military-VA facility patient transitions.[23] The VA provides social work liaisons in ten of the major military hospitals. These liaisons serve as part of the health care team, and facilitate transfer to a VA facility when the team thinks it is in the patient's best interest. When a service member is transferred to a VA facility, he or she is assigned a case manager to assist with care and help educate the patient and the family.

Transitioning to the VA after leaving the military can be difficult as well. For veterans who served in Iraq and Afghanistan, two years of health care is provided in the VA health care system without the need to enroll. Veterans who believe they have service-related or service-aggravated conditions must apply for VA disability benefits. Under a new VA program, Benefits Delivery at Discharge, injured service members can file for VA claims if they are within 180 days of military discharge. This program is working quite well and appears to be achieving the goal of providing injured service members with disability income by the time they leave the hospital.

A host of programs and benefits assist veterans at the federal, state, and community levels. Identifying these programs and benefits, the requirements for eligibility, and the forms needed to apply can be complicated and difficult to access, even for those posted on the Internet. Sometimes there appears to be too much information provided and, at others, not enough. A contemporary, interactive personalized online resource is needed for service members and veterans to access this information. (This concept is more fully discussed in the Subcommittee Report on Information Systems.)

Managing Transitions

Optimally, case management assists and guides patients in a collaborative process, using a defined plan to meet the individual's health needs.[24] It can include both clinical and non-clinical components. The concept is an important one—coordination of care. Unfortunately, in the military health care system, every process and point of health care delivery now "does" case management. Consistency is further weakened by differences among the Services in requirements for case management positions, training, certification, and case load ratios.

At a recent Military Health System Case Management Summit, at least 16 areas were identified as providing case management services at 11 types of facilities (Table 3). An injured service member hospitalized at one military treatment facility and discharged to outpatient status may have as many as 15 case managers—all at the same facility. Patients requiring more complex care get more case managers; patients going between DoD and VA facilities for care get even more. The individual's health needs may be met, but it appears that much of the time case managers are managing the patient through a set of services or episodes of care instead of coordinating service. *The end result for the service member and his or her family is confusion and redundancy in a system that was intended to coordinate care. No one is in charge.*

Survey and Survey Results

The Commission conducted a telephone survey of 1,730 current and former service members who sustained injuries in Iraq and Afghanistan that necessitated their medical evacuation to the United States. In general, these are young people inexperienced in navigating any health system, who find themselves thrust into a highly complex one (Table 4). Most were satisfied with their inpatient care (Figure 1). To a lesser degree, they were generally satisfied with rehabilitative care and outpatient care.

We asked respondents whether they could easily find a doctor or other provider, and most could do so (Figure 2). When asked whether they had a medical provider to coordinate their care, only half of active duty said they did, and a fifth of reserve component or separated/retired said they had such a person.

ACTION STEPS

Integrated *care* management offers a better approach than fragmented *case* management for managing and assisting injured service members and their families in navigating difficult and cumbersome systems of care and benefits. Integrated care management provides patients with the right care and benefits at the right time in the right place by leveraging all resources appropriate to the needs. For injured service members—particularly the severely injured—integrated care management would build

bridges across health care services in a single facility and across health care services and benefits provided by DoD and VA.

Integrated care management begins with a comprehensive, patient-centered evaluation by a multidisciplinary team of physicians, nurses, allied health care professionals, mental health professionals, rehabilitation and vocational rehabilitation specialists, and social workers, as needed, completed as early in the acute care phase of a service member's recovery as possible. This evaluation guides the development of a comprehensive, but flexible, ***recovery plan***.

Components of the recovery plan include:

- Identifying the patient's goals for rehabilitation and outpatient care, taking into account plans for returning to military duty or transitioning to civilian life, including identification of any education, training, or employment needs
- Specifying all resources needed to meet these goals
- Setting milestones and estimates of time for recovery
- Identifying the most appropriate facilities to meet the needs for rehabilitation and clinical care
- Evaluating the needs of the family and providing the necessary resources for support.

In our vision, the recovery plan is managed by a ***Recovery Coordinator***. These highly skilled and cross-trained individuals work with existing case managers and other personnel involved in the various aspects of care needed by the patient to recover. In addition, the Recovery Coordinator arranges for any support program services required and serves as the patient's advocate. The Recovery Coordinator must be able to operate across Departments to access the best that each has to offer in helping an injured service member to reach his or her maximum potential. The Recovery Coordinator will need to be knowledgeable not only about health care, but about benefits provided at the local, state, and federal levels, particularly the broad range of services provided by the VA.

This will not be an easy task and will require a certain type of individual with extraordinary skills. We have developed a job description that includes a listing of the capabilities we expect these individuals will need (Appendix). We believe that, to be effective, these individuals should become part of the Commissioned Corps in the Public Health Service of the Department of Health and Human Services. This new unit's commander would report directly to the U.S. Surgeon General.

We thought long and hard about placing the Recovery Coordinators outside of the two Departments. In the end we believe that this is necessary. Placing these individuals in either Department is unlikely to work in the manner we have described. We do not suggest creating another agency or office, but propose using an existing, well respected source of strength—the U.S. Public Health Service's Commissioned Corps.

To make sure that this approach works, we believe the Surgeon General (Public Health Service [PHS], Department of Health and Human Services) should sit on the current Strategic Operating Committee and hold a permanent place on the Joint Executive Committee. The PHS Surgeon General should work with the service Surgeons General and the Under Secretaries for VA Health and Benefits to quickly develop a memorandum of understanding that would provide the authority and access needed to implement this strategy.

The Recovery Coordinators can immediately be recruited from individuals currently working in the Commissioned Corps, DoD, and VA. A training course also must be immediately developed jointly with the DoD and VA, under direction of the Surgeon General. We believe that our approach will ultimately reduce the current number of case managers and VA health and benefits liaisons. This adjustment should take place over time, with evaluation, and as experience is gained with the Recovery Coordinator concept.

The effectiveness of the Recovery Coordinators—their annual performance reviews—should be conducted by the Unit Commander, Hospital Commanders, VA Hospital Chiefs of Staff, patients, and families. The case load for each Recovery Coordinator should not be mandated, but must be flexible to meet the needs of patients. Because patients tend to improve with time, a Recovery Coordinator may manage up to 20 or so patients, depending on their combined needs and time required. Most important, these individuals *must have the authority to tap all resources necessary to implement each patient's Recovery Plan*. Everyone, regardless of Department affiliation, rank, or seniority, must cooperate.

Recovery Coordinators will need timely access to medical and benefits information in order to properly coordinate services. This will not require any new information systems, but improved access to existing electronic resources. As the information technology in each Department continues to evolve, the information needs of the Recovery Coordinators must be considered and incorporated. An important component is the proposed "My eBenefits" web portal (discussed in the Subcommittee Report on Information Systems). This would serve as an integrated care management tool and allow instant communication between Recovery Coordinator and patient, assisting in the overall coordination of care and benefits.

The Commission believes that many current injured and recovering service members, as well as those arriving daily from Iraq and Afghanistan, will benefit from this approach.

Table 1. DESTINATIONS FOR MEDICAL EVACUATIONS FROM IRAQ AND AFGHANISTAN, January 2005 – March 2007.

Destination Facility Name	Number	Percent
Walter Reed Army Medical Center, Washington D.C.	2236	18
Eisenhower Army Medical Center, Ft. Gordon	1015	8
Darnall Army Medical Center, Ft. Hood	903	7
National Naval Medical Center, Bethesda	801	7
Brooke Army Medical Center, Ft. Sam Houston	766	6
Womack Army Medical Center, Ft. Bragg	671	6
Naval Hospital Camp Lejeune, North Carolina	435	4
Madigan Army Medical Center Ft. Lewis	379	3
Blanchfield Army Community Hospital, Ft. Campbell	357	3
Naval Hospital Camp Pendleton, California	348	3
All other facilities combined	4177	35
Total	**12,088**	**100**

Source: USTRANSCOM TRAC2ES, January 2005 to March 2007

Table 2. NUMBER OF SERVICE MEMBERS ON MEDICAL HOLD OR HOLDOVER STATUS, BY SITE, JULY 2007.

Walter Reed AMC	628	Tripler	68
Ft. Sam Houston	512	Ft. Eustis	38
Ft. Hood	184	Ft. Buchanan	66
Ft. Bragg	306	West Point	25
Ft. Lewis	269	Ft. Dix	103
Ft. Gordon	252	Ft. Sill	48
Ft. Bliss	163	Ft. Polk	94
Ft. Knox	219	Ft. Leonard Wood	5
Ft. Benning	96	Ft. Richardson	34
Ft. Carson	67	Ft. Irwin	16
Ft. Campbell	73	Ft. Jackson	6
Ft. Drum	162	Ft. Belvoir	10
Ft. Stewart	73	Ft. Leavenworth	3
Ft. Riley	40	Camp Shelby	39

TOTAL: 3599

Table 3. Range of Case Management Services

	Military MTF	Base Clinics	Co. CMD	Med Hold	AD/RC Centers	VAMC	VA Clinics	Day Programs	Trans Programs	State Rehab Centers
Nurse CM	✓	✓	✓	✓		✓	✓	✓	✓	✓
SW CM	✓	✓		✓	✓	✓	✓	✓	✓	✓
Clergy	✓	✓	✓	✓	✓	✓		✓	✓	✓
PEBLO	✓	✓	✓	✓	✓	✓			✓	✓
SSL	✓	✓	✓	✓	✓			✓		✓
Service F SCP	✓	✓		✓	✓			✓	✓	
VA STL	✓			✓		✓	✓	✓	✓	
VA OEF/OIF PM	✓			✓		✓	✓	✓	✓	✓
VA Poly CM	✓			✓		✓				
VA Vet Centers	✓				✓	✓	✓	✓	✓	
VA Women's VPM	✓	✓		✓		✓	✓	✓	✓	✓
VA TPA	✓					✓				
VA VIST, SCI CM	✓			✓		✓	✓	✓	✓	✓
VBO and VSO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CBO	✓	✓		✓	✓	✓	✓	✓	✓	✓
Others	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

LEGEND:

MTF – Military Treatment Facility
Co CMD – Company Command
Med Hold – Medical Hold Facilities
AD/RC Centers – Active Duty and Reserve Component Service Centers
VAMC – VA Medical Centers
VA Clinics – VA Community Based Outpatient Clinics
Day Programs – Structured Day Programs
Trans Programs – Independent Living Programs
State Rehab Centers – State Rehabilitation Centers

CM – Case Manager
SW – Social Worker
SSL – Service Support Liaison
Service FSC – Service Family Support Center Personnel
VA STL – VA Seamless Transition Liaisons
VA OEF/OIF PM – VA OEF/OIF Program Managers
VA Poly CM – VA Polytrauma Case Managers
VA Vet Centers – VA Community Based Vet Centers
VA Women's VPM – VA Women's Veteran Program Manager
VA TPA – VA Transition Patient Advocates
VA VIST, SCI CM – VA VIST, SCI Case Managers
VBO and VSO – Veterans Benefits Organizations and Veterans Service Organizations
CBO – Community Based Organizations

Table 4. DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS, PCCWW SURVEY

Characteristic	Active Duty Component (%)	Guard/Reserve Components (%)
Age		
▪ 18-24	42	16
▪ 25-34	41	30
▪ 35+	17	54
Military rank		
▪ Junior enlisted	52	36
▪ Senior enlisted	39	57
▪ Officer	9	7
Male	94	92

Figure 1. INJURED SERVICE MEMBERS' SATISFACTION WITH MEDICAL CARE, PCCWW SURVEY

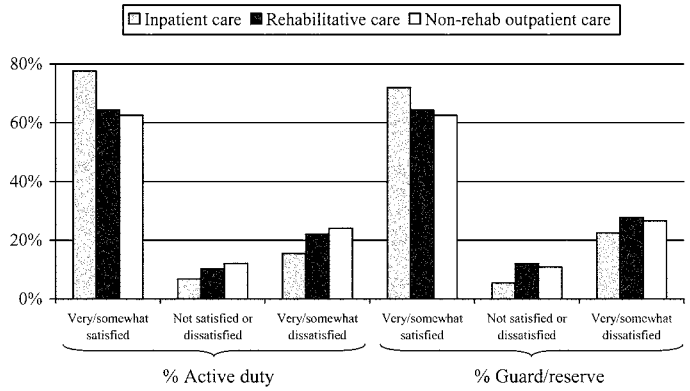


Figure 2. INJURED SERVICE MEMBERS' ACCESS TO MEDICAL PROVIDERS AND CARE COORDINATORS, PCCWW SURVEY

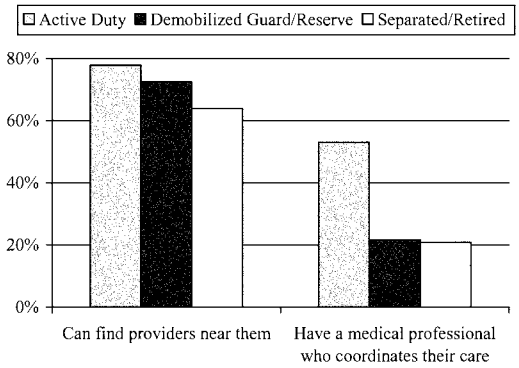
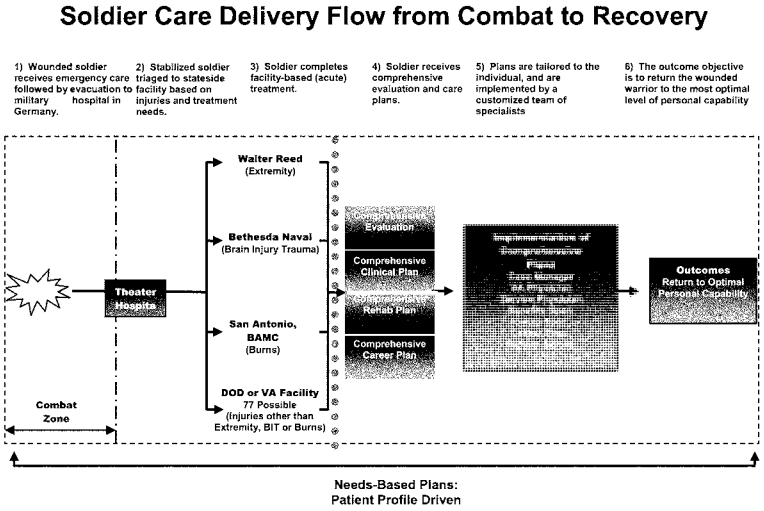


Figure 3.


Soldier Care Delivery Flow from Combat to Recovery
1) Wounded soldier receives emergency care followed by evacuation to military hospital in Germany.
2) Stabilized soldier triaged to stateside facility based on injuries and treatment needs.
3) Soldier completes facility-based (acute) treatment.
4) Soldier receives comprehensive evaluation and care plans.
5) Plans are tailored to the individual, and are implemented by a customized team of specialists
6) The outcome objective is to return the wounded warrior to the most optimal level of personal capability
Theater Hospital
Combat Zone
Walter Reed (Extremity)
Bethesda Naval (Brain Injury Trauma)
San Antonio, BAMC (Burns)
DOD or VA Facility 77 Possible (Injuries other than Extremity, BIT or Burns)
Evaluation
Comprehensive Clinical Plan
Rehab Plan
Comprehensive Career Plan
Outcomes
Return to Optimal Personal Capability
Needs-Based Plans:
Patient Profile Driven

Endnotes

[1] Holcomb JB, Stansbury LG, Champion HR, Wade C, Bellamy RF. Understanding Combat Casualty Care Statistics. J Trauma. 2006;60:397-401.
[2] *ibid.*
[3] Force Health Protection and Readiness Programs, TRICARE Management Activity, Office of the Assistant Secretary of Defense (Health Affairs), July 23, 2007.
[4] http://www.defenselink.mil/news/newsarticle.aspx?id=45404. Accessed July 19, 2007.
[5] Personal communication, Defense Manpower Data Center.
[6] Johnson B, Carmack D, Neary M, et al. Operation Iraqi Freedom: The Landstuhl Regional Medical Center Experience. *J of Foot and Ankle Surgery 44*:177-183, 2005.
[7] Personal communication, Defense Manpower Data Center.
[8] U.S., Government Accountability Office, GAO-07-589T. *DoD and VA Health Care: Challenges Encountered by Injured Servicemembers during their recovery process.* March 2007.
[9] U.S., Government Accountability Office, GAO-06-794R. *VA and DoD Healthcare: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans*, June 2006.
[10] *Report to Congress, 4 May 06 Transition Assistance and Disabled Transition Assistance Programs (TAP/DTAP).*
[11] In 2006, the annual budget for the Department of Veterans Affairs was $70.8 billion. That same year, the annual budget for retired military personnel and survivors was $40.5 billion and the cost for retiree health care approximately $16 billion.
[12] Heydorn WH. Basic and advanced combat casualty care: a military problem. *Military Medicine 155*: 229-231, 1990.
[13] Chambers LW, Rhee P, Baker BC, et al. Initial experience of US Marine Corps forward resuscitative surgical system during operation Iraqi Freedom. *Arch Surg 140*:26-32, 2005.
[14] Strawder GS. The "golden hour" standard: transforming combat health support. *JFQ 41:* 60-67, 2006.
[15] Defense Medical Data Center, Force Health Protection and Readiness Programs.
[16] Montgomery SP, Swiecki CW, and Shriver CD. The evaluation of casualties from Operation Iraqi Freedom on return to the continental United States from March to June 2003. *J Am Coll Surg 205*:7-13, 2005.
[17] Army Regulation 40-400.
[18] Definition *from Annex S (Glossary of Terms) to EXORD 118-07 [Healing Warriors]).*
[19] Army medical hold data from Col Michael J Carion, OTSG, 9 July 2007.
[20] Personal communication, Carol J. Thompson, Assistant Deputy (Health Policy) Force Management Integration (SAF/MRM).
[21] Montgomery SP, *op. cit.*
[22] Independent Review Group. *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center*, April 2007.
[23] U.S., Government Accountability Office, GAO-06-794R. *Transition of Care for OEF and OIF Servicemembers,* 2006.
[24] Case Management Society of America. Available at: http:www.cmsa.org.

Appendix to
Subcommittee Report on Continuum of Care

Interagency Recovery Coordinator
Position Description & Qualifications

JOB SUMMARY:

The Interagency Recovery Coordinator (IRC) must be a member of the Commissioned Corps of the United States Public Health Service (USPHS) and will serve as the executive-level coordinator for the delivery of health care and benefits to severely injured, ill and wounded service members and their families. The IRC is responsible for the implementation and oversight of a full recovery plan, working with existing DoD and VA case managers to provide the optimal services that meet the individual needs of each severely injured, ill or wounded service member. The IRC must be cross trained by the DoD and VA in all existing programs, rules and regulations pertaining to their mission.

MAJOR DUTIES:

The IRC has overall responsibility for coordinating medical, administrative and supporting operations across the spectrum of patient care services and benefits between the DoD, VA and private sector. The individual, in collaboration with others, implements a three part recovery plan that consists of acute care, rehabilitative care, outpatient care, and benefits and services. This plan is designed to assist service members in achieving their maximum potential.

The individual will exercise executive-level authority to coordinate the necessary services and programs in order to implement a patient's full recovery plan. The individual must possess excellent communication skills in order to work with Federal, State, local, nonprofit and private sector organizations in implementing recovery plans. In addition, the individual must have excellent judgment, initiative, and drive.

SUPERVISORY CONTROLS:

The Coordinator reports directly to and is rated by the CEO of the supported DoD or VA facility; a senior member of the USPHS, as designated by the United States Surgeon General, will review and approve the performance appraisal in accordance with Health & Human Service Instruction 430-4.

TECHNICAL QUALIFICATION:

Knowledge of health care and benefits systems and the ability to manage and direct a health care recovery program for seriously wounded or injured patients are essential.

Individuals with personal knowledge and experience in DoD or VA health care services or benefit programs are considered ideal candidates.

QUALIFICATIONS REQUIRED:

As a basic requirement for entry for this position, applicants must provide evidence of leadership experience indicative of senior level management capability, familiarity with clinical care, and skills and abilities related to the Technical Qualifications and Executive Core Qualifications listed below. Typically, experience of this nature will have been gained at or above the GS-13 or 0-5 grade level in the federal service or its equivalent in the private sector.

EDUCATION REQUIREMENTS:

Master's of Public Health or Master of Social Work or Master of Science in Nursing or Social Science Ph.D. or Master's of Health Care Administration

Incumbent will have a minimum of 10 years' documented experience in a health care and/or benefits environment.

U.S. citizen

Background Investigation: This position is a sensitive position and the tentative selectee must undergo and successfully complete a background investigation as a condition of placement/retention in the position. A Secret security clearance is required.

HOW YOU WILL BE EVALUATED:

Please provide a narrative, **not to exceed three (3) pages for each Technical Qualification (TQ) below:**

TQ-1: Expert knowledge of and ability to plan, coordinate and participate in developing and implementing policies and procedures for a variety of complex health care and/or benefits delivery systems.

TQ-2: Specialized experience with highly sensitive and potentially controversial management and administrative matters that affect the planning, delivery, and evaluation of health care/benefits.

You will also be evaluated on the following Executive Core Qualifications. Please provide a narrative **not to exceed two pages per ECQ and not more than 10 pages in total**:

ECQ 1 - LEADING CHANGE . This core qualification involves the ability to bring

about strategic change, both within and outside the organization, to meet patient life recovery goals. Inherent to this ECQ is the ability to establish a patient/family focused plan recovery plan and to implement it in a continuously changing environment.

Leadership Competencies:

1. **Creativity and Innovation**
   Develops new insights into situations; questions conventional approaches; encourages new ideas and innovations.

2. **External Awareness**
   Understands and keeps up-to-date on local, national, and international policies and trends that affect the DoD and the VA and shape stakeholders' views; is aware of the organization's impact on the external environment.

3. **Flexibility**
   Is open to change and new information; rapidly adapts to new information, changing conditions, or unexpected obstacles.

4. **Resilience**
   Deals effectively with pressure; remains optimistic and persistent, even under adversity. Recovers quickly from setbacks.

5. **Strategic Thinking**
   Formulates objectives and priorities, and implements plans consistent with the long-term interests of the patient. Capitalizes on opportunities and manages risks.

6. **Vision**
   Takes a long-term view and builds a shared vision with others; acts as a catalyst for organizational change. Influences others to translate vision into action.

ECQ 2 - LEADING PEOPLE. This core qualification involves the ability to lead people toward meeting the goal of promoting a rapid recovery for the injured with a return to military or civilian life. Inherent to this ECQ is the ability to provide an inclusive workplace that fosters the development of others, facilitates cooperation and teamwork, and supports constructive resolution of conflicts.

Leadership Competencies:

1. **Conflict Management -** Encourages creative tension and differences of opinions. Anticipates and takes steps to prevent counter-productive confrontations. Manages and resolves conflicts and disagreements in a constructive manner.

2. **Leveraging Diversity -** Fosters an inclusive workplace where diversity and individual differences are valued and leveraged to achieve the vision and mission

of the organization.

3. **Developing Others -** Develops the ability of others to perform and contribute to the organization by providing ongoing feedback and by providing opportunities to learn through formal and informal methods.

4. **Team Building -**Inspires and fosters team commitment, spirit, pride, and trust. Facilitates cooperation and motivates team members to accomplish group goals.

ECQ 3 - RESULTS DRIVEN. This core qualification involves the ability to meet recovery plan goals and objectives. Inherent to this ECQ is the ability to make decisions that produce high-quality results by applying technical knowledge, analyzing problems, and calculating risks.

Leadership Competencies:

1. **Accountability** – Primarily accountable to the patient, but takes into account the control systems and rules of the respective departments. Holds self and others accountable for measurable high-quality, timely, and cost-effective results. Determines objectives, sets priorities, and facilitates work. Accepts responsibility for mistakes.

2. **Customer Service -** Anticipates and meets the needs of patients and families. Delivers timely and strategic counseling and support; is committed to continuous improvement.

3. **Decisiveness -** Makes well-informed, effective, and timely decisions, even when data are limited or solutions produce unpleasant consequences; perceives the impact and implications of decisions.

4. **Entrepreneurship -** Positions the patient for future success by identifying new opportunities; contributes to DoD and VA processes and policies by developing or improving products or services.

5. **Problem Solving -** Identifies and analyzes problems; weighs relevance and accuracy of information; generates and evaluates alternative solutions; makes recommendations.

6. **Technical Credibility -** Understands and appropriately applies principles, procedures, requirements, regulations, and policies related to specialized expertise.

ECQ 4 - BUSINESS ACUMEN. This core qualification involves the ability to contribute to the management of human, financial, and information resources strategically.

Leadership Competencies:

1. **Technology Management**
   Keeps up-to-date on technological developments. Makes effective use of technology to achieve results. Ensures access to and security of technology systems.

ECQ 5 – SEAMLESS TRANSITIONS. This core qualification involves the ability to guide Service Members and Veterans within and across Departments and to bring together Federal agencies, State and local governments, nonprofit and private sector organizations, foreign governments, or international organizations to achieve recovery goals.

Leadership Competencies:

1. **Partnering**
   Develops networks and builds alliances; collaborates across boundaries to build strategic relationships and achieve common goals.

2. **Political Savvy**
   Identifies the internal and external politics that impact the work of the Departments. Perceives organizational and political reality and acts accordingly.

3. **Influencing/Negotiating**
   Persuades others; builds consensus through give and take; gains cooperation from others to obtain information and accomplish goals.

Fundamental Competencies These competencies are the foundation for success in each of the Executive Core Qualifications.

Competencies:

1. **Interpersonal Skills**
   Treats others with courtesy, sensitivity, and respect. Considers and responds appropriately to the needs and feelings of different people in different situations.

2. **Oral Communication**
   Makes clear and convincing oral presentations. Listens effectively; clarifies information as needed.

3. **Integrity/Honesty**
   Behaves in an honest, fair, and ethical manner. Shows consistency in words and actions. Models high standards of ethics.

4. **Written Communication**

Writes in a clear, concise, organized, and convincing manner for the intended audience.

5. **Continual Learning**
   Assesses and recognizes own strengths and weaknesses; pursues self-development.

6. **Public Service Motivation**
   Shows a commitment to serve the public. Ensures that actions meet public needs; aligns organizational objectives and practices with public interests.

POST-TRAUMATIC STRESS DISORDER & TRAUMATIC BRAIN INJURY

THE CHALLENGE

Post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) can be serious problems for service members returning from the conflicts in Iraq and Afghanistan. *PTSD* is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. *TBI* can occur when a sudden trauma causes damage to the brain, such as when the head violently hits or is hit by an object, or when the head is exposed to significant external forces including those that may be generated from an explosive blast. PTSD and TBI are sometimes referred to as "invisible injuries" because outwardly the individual's appearance is just as it was before the injury or onset of symptoms. Although they are distinct disorders, a number of service members have both PTSD and TBI. Diagnostic confusion between the two disorders can result because both can result from the same trauma and some symptoms of PTSD overlap those of TBI. Although service members with more severe PTSD or TBI are generally diagnosed and treated, many mild cases go unrecognized by the service member, commanding officers, family, friends, and health care providers, and so are left untreated. Even in cases with significant additional physical trauma, the presence of TBI and/or PTSD may be initially overlooked as the immediate focus is on the more readily identifiable, "visible" injuries.

BACKGROUND

Although PTSD and TBI are relatively common medical conditions of the Iraq and Afghanistan wars, both conditions have been recognized for decades, and much is known about their causes, diagnosis, and treatment.

PTSD Overview

Reactions to a traumatic event depend on, among other things, details of the situation and the specific individual's personality, level of resiliency, and past experiences. Many symptoms of anxiety are considered normal responses in the immediate aftermath of a traumatic event. Fortunately, for most individuals, emotional and behavioral reactions to a stressful event—stress responses—resolve over time.[1] However, when symptoms like frequent flashbacks or nightmares, withdrawal, or

[1] Although approximately 60% of men and 50% of women in the general population experience the type of traumatic event that *may* lead to PTSD, only about 8% of the men and 20 % of women develop PTSD. National Center for Post Traumatic Stress Disorder Fact Sheet "How Common is PTSD?" http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_how_common_is_ptsd.html

difficulty controlling anger last longer than 30 days and impair the individual's day-to-day functioning, the individual should be evaluated for PTSD.

At present, there is no test that reliably shows whether a person does or does not have PTSD. Instead, the diagnosis is based mainly on a detailed clinical interview by a qualified mental health[2] professional. Because symptoms can emerge or change long after the traumatic event, it can be useful to educate individuals exposed to trauma regarding what is considered a healthy versus unhealthy response, in addition to what resources are available should they require them in the future.

The course of PTSD is variable. The National Co-Morbidity Survey, a large nationally representative mental health survey, found that individuals who receive treatment for PTSD typically experience symptoms for about three years, whereas those who do not receive treatment experience symptoms for about 5 years.[3] However, for many individuals PTSD is a chronic condition characterized by periods of symptom improvement and worsening. Additionally, the initial onset of PTSD symptoms can occur days, weeks or even years after the traumatic event is experienced. The National Co-Morbidity Survey also demonstrated that men who experience combat trauma are more likely to have chronic or delayed onset of PTSD symptoms.[4]

The goal of treatment for PTSD is to reduce symptoms and return the affected individual to optimal functioning. The choice of treatment is based on many variables, including the patient's other health problems, the home and social environment, therapists' skills, and potential side effects. Four-fifths of people diagnosed with PTSD also have a major depressive disorder, or some other psychiatric condition, such as substance abuse.[5] Treatment approaches for PTSD, therefore, must also include interventions for these other conditions. Evidence-based treatment for PTSD typically includes one or more of the following:

- Cognitive behavioral therapies,
- Exposure therapies,
- Targeted anxiety therapies,
- Drug therapy.

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[2] For ease, the term "mental health" is utilized in an all-inclusive manner in this report, at times referring to disorders or services that could alternatively be accurately described using the terms "behavioral health" or "psychological health."

[3] "Evidence Relevant to Compensation Awards for PTSD; A Report to the Institute of Medicine" Presentation by Matthew J. Friedman, MD, PhD, Executive Director of VA National Center for Post Traumatic Stress Disorder. Information from the National Co-Morbidity Survey, a large scale survey used to establish benchmarks for the prevalence of mental health disorders in the U.S.

[4] *Ibid.*

[5] Institute of Medicine, *PTSD Compensation and Military Service,* May 2007. Committee on Veterans' Compensation for Posttraumatic Stress Disorder. The National Academies Press, Washington, DC.

PTSD and DoD/VA

Exposure to traumatic events, such as terrorist attacks, natural disasters, motor vehicle accidents, and violent personal crimes including sexual assaults can lead to PTSD. For service members, the realities of war may result in combat stress reactions which, in turn, can develop into acute stress disorder and ultimately, PTSD:

- The current conflicts involve intense urban fighting, often against civilian combatants, and many service members see or experience acts of terrorism.[6]
- A study of four Marine and Army infantry units found that nearly all unit members had been shot at or exposed to small arms fire. Eighty-five percent had known someone who was killed or seriously injured, and half had handled or uncovered human remains.[7]
- Five hundred thousand service members have been deployed multiple times. Service members who have been deployed multiple times or for longer periods are more likely to experience more symptoms of acute stress disorder.[8]

A 2006 study found that in the year following their deployment, 35 percent of Iraq veterans used mental health services.[9] Best estimates are that PTSD occurs in approximately 6 to 11% of veterans serving in Operation Enduring Freedom and in approximately 12 to 20 % of Operation Iraqi Freedom veterans.[10] These rates are lower than the rates for the Vietnam War, after which 30% of veterans experienced PTSD. The reason for the difference is not entirely clear. The lower OEF/OIF rate may reflect earlier identification and treatment of symptoms and preventative efforts before and during deployment. However, it is still early in the recovery process for veterans of this war, and those with delayed symptoms may not have sought care yet. Clearly though, not everyone experiencing a traumatic event develops symptoms of PTSD, and not everyone who is symptomatic develops PTSD.

Recent DoD efforts to mitigate PTSD have centered on prevention and early intervention. *Prevention* efforts identify and enhance factors that help protect individuals from developing PTSD if they experience a traumatic event. According to former Army

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[6] Litz, BT. "The Mental Health Impact of the Wars in Afghanistan and Iraq: What Can We Expect?" (Information for Professionals), Department of Veterans Affairs, National Center for post-traumatic stress disorder, available at [http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_iraq_afghanistan_lay_audien.html?opm=1&rr=rr140&srt=d&cchorr=true]

[7] Hoge, CW, Castro, CA, Messer, SC, et al. "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care." *New England Journal of Medicine 351:* 13-22, 2004.

[8] Mental Health Advisory Team IV Operation Iraqi Freedom 05-07 Final Report, November 2006. (www.armymedicine.army.mil)

[9] Hoge, CW, Auchterlonie, JL, and CS Milliken. "Mental Health Problems, Use of Mental Health Services, and Attrition From Military Service After Returning from Deployment to Iraq and Afghanistan." *Journal of the American Medical Association 295*: 1023-32, 2006.

[10] National Center for PTSD Fact Sheet, "How common is PTSD?" (http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_how_common_is_ptsd.html)

Surgeon General Kevin C. Kiley, "the Army has found that soldiers who undergo the most intense, realistic training before deploying to combat tend to experience the fewest associated mental health problems."[11] By using live ammunition and having realistic, harsh, extended in-field exercises away from families, the Army prepares soldiers for the realities of battle. The Army also employs "battlemind training,"[12] which trains leaders how to mitigate risk and build resilience in their soldiers, and trains deploying soldiers in potential emotional responses to combat. However, even with the best training and prevention methods, many service members with multiple or extremely stressful deployments to combat zones require additional assistance to prevent PTSD.

The objective of *early intervention* techniques is to identify individuals at risk for developing PTSD and equip them with coping strategies to prevent the condition from occurring and to make any case that does emerge as manageable as possible. To this end, the Army deploys mental health teams along with operational units to bring early intervention techniques to the battlefield. Similarly, the Marine Corps' Operational Stress Control and Readiness (OSCAR) program embeds mental health professionals in combat units to enhance access to mental health care and build resilience. Another objective of embedding these providers with operational units is to break down the stigma associated with mental health problems.

Brief screening questions for PTSD and other mental health issues are included on the standard form for post-deployment health assessment, which is administered prior to the service member's return from deployment, along with the post-deployment health reassessment, which takes place 3 to 6 months after return in order to detect delayed or previously unacknowledged symptoms. Upon departure from theater, many service members may choose not to report symptoms they assume will require further evaluation and delay their return to family or limit their military activities. To illustrate, in the post-deployment health assessment, only 5 percent of active-duty service members and 6 percent of reservists report symptoms consistent with PTSD. But, in the reassessment, fully 27 percent of active-duty members and 42 percent of reservists note mental health concerns.[13] The increased reporting of mental health concerns on the reassessment also may reflect adjustments inherent in homecoming. Administering the reassessment is difficult, though, due to repeat deployments and other factors. Although initially not consistently provided to Reservists, the post-deployment health reassessment is now offered, with VA assistance, to all active and reserve service members.

Once identified through screening, self-referral, medical referral, or another way, individuals still on active duty can obtain mental health services in settings ranging from medical centers with research and training programs to small-scale community clinics to

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[11] Miles, D. Army "Providing 'Unprecedented' Mental-Health Support to Troops." American Forces Press Service, July 2006.
[12] Battlemind website [www.battlemind.org].
[13] Statement of Michael E. Kilpatrick, MD, Deputy Director, Force Health Protection and Readiness Programs, Department of Defense, to House Committee on Oversight on Government Reform Hearing on Mental Health Concerns of May 24, 2007.

rugged deployed settings. DoD mental health professionals include uniformed and civilian psychologists, psychiatrists, social workers, psychiatric nurses, and mental health technicians.

The difficulties with PTSD care in the military reflect larger problems that exist in military mental health care, as well as in the civilian mental health care community[14]. A widespread reluctance to disclose symptoms, due to the stigma of mental health problems, delays treatment and may lead to worse outcomes of care. Clinical approaches and structures vary across and even within the same organization, producing inconsistencies in care. Gaps in care occur and are in part due to significant personnel shortages. To improve services, some practitioners and organizations have developed innovative programs that could serve as models for broader use.[15] Today, DoD resources include:

- The Deployment Health Clinical Center that performs deployment-related health research, develops deployment-related health education and training programs for conditions including PTSD, and offers an intensive 3-week day treatment program for patients with PTSD at Walter Reed Army Medical Center
- The Center for Deployment Psychology, which trains military and civilian providers treating mental health conditions of returning combat veterans
- U.S. Army Center for Health Promotion and Preventative Medicine, which produces combat and operational stress research and education materials
- Walter Reed Army Institute of Research, whose research has resulted in the implementation of military programs such as "Battlemind."

Recognizing the fragmentation and duplication of mental health efforts among different agencies, the Army established the Proponency Office for Behavioral Health in March 2007 to assist in coordinating and integrating efforts within their jurisdiction.

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, some of which are directed at underserved populations, minorities, or women. VA excellence in PTSD clinical care and research was sparked by the National Vietnam Veterans Readjustment Study which examined the psychological effects of war on combatants, published in 1988.[16] Today, VA resources include:

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[14] "Each State faces individual legislative, financial, and social constraints and uses different opportunities in its efforts to transform the mental health delivery system. Yet, they all confront similar challenges: shrinking resources, increasing needs, and a desire to provide the most effective treatments and services." U.S. Department of Health and Human Services "Trends in Mental Health System Transformation: 2005" page 3. www.samhsa.gov

[15] For example, to assist in combating stigma and improving access to mental health care many individual military facilities have integrated qualified mental health providers into primary care settings, a strategy that many states have supported and the VA has recently implemented. Ibid reference 14 for state details.

[16] Testimony of Terence M. Keane, PhD, Director, Behavioral Sciences Division, National Center for Post-Traumatic Stress Disorder, VA Boston Healthcare System, to Presidential Commission on Care for America's Returning Wounded Warriors on May 24, 2007.

- The National Center for Posttraumatic Stress Disorder, consisting of seven VA academic centers of excellence located throughout the country
- Ten Mental Illness Research, Education, and Clinical Centers, one of which specifically focuses on the post-deployment needs of Iraq and Afghanistan war veterans
- 209 Vet Center clinics that provide community-based mental health services.[17, 18]

VA provides routine screening for PTSD, substance abuse, depression, and sexual trauma. Of the more than 225,000 Iraq and Afghanistan war veterans who sought care at a VA facility through December 2006, 17 percent reported concerns indicating possible PTSD.[19]

TBI Overview

A traumatic brain injury occurs when a blow or jolt to the head is significant enough to change the person's normal level of neurological functioning, often producing an immediate change in consciousness, orientation, awareness, or recall of events surrounding the injury. The consequences of TBI can be temporary or permanent, and many factors combine to result in highly individualized injuries. An array of physical, cognitive, emotional, and behavioral problems may result from TBI, such as sleep disturbances, headaches, sensitivity to light and noise, decreased attention and poor frustration tolerance.

When a traumatic injury to the head results in an object entering the brain, it is labeled a penetrating brain injury. In contrast, a closed head injury occurs with blunt force trauma. Closed brain injuries are typically classified as mild, moderate, or severe, depending on the length of time the individual lost consciousness and the level of post-traumatic amnesia. Penetrating head injuries are not further classified by level of severity. Most TBI cases are mild closed brain injuries, with good prospects for recovery.[20] In one study, 89 percent of TBI patients injured in terrorist attacks in Israel returned to independent living.[21]

Mild TBI can be difficult to identify. Some patients have other, more "visible" injuries; radiological brain scans often fail to identify a problem; and frequently the

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[17] Department of Veteran's Affairs Fact Sheet (2006). "Veterans with Post Traumatic Stress Disorder (PTSD)", Washington D.C.
[18] Statement of Antoinette Zeiss, PhD, Deputy Chief Consultant, Office of Mental Health Services, Department of Veterans Affairs, for House Committee on Oversight and Government Reform on May 24, 2007.
[19] Overall, 37 percent had possible mental health conditions. Other high frequency mental health diagnoses included non-dependent abuse of drugs (33,099) and depressive disorders (27,023). Ibid reference 18.
[20] Langlois, J., Rutland-Brown, W. and Thomas, K. "Traumatic Brain Injury in the United States: Emergency Visits, Hospitalizations, and Deaths." Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2006.
[21] Schwartz, I, Tsenter, J, Schochina, M, et al. "Rehabilitation Outcomes of Terror Victims with Multiple Traumas." *Archives of Physical Medicine and Rehabilitation 88*: 440-448, 2007.

patient attributes the subtle changes in thinking and feeling to something else. To aid in diagnosis and document recovery, neuropsychological tests are used with all severity of brain injuries in order to examine cognitive functioning, including attention, processing speed, memory, problem solving, language, visual perception, and testing effort. Tests are also given that evaluate emotional and behavioral symptoms, such as depression, anxiety, aggression, and motivation.

TBI and DoD/VA

The four most common causes of traumatic brain injury for service members in Iraq and Afghanistan are blast exposure, motor vehicle accident, falls, and gunshot wounds.[22] Consistent with civilian population findings, the majority of these traumatic brain injuries are identified as mild, closed head injuries. However, it is important to note that a person who has previously experienced even a mild traumatic brain injury may be at risk for greater impairment from subsequent TBIs.

It is not known how many service members have suffered a mild TBI that went undiagnosed. Recently, over 35,000 otherwise healthy service members returning from deployment were screened for TBI and approximately 10-20% screened positive for having experienced a mild TBI while deployed.[23] The majority of this group was no longer symptomatic at the time of screening.

Most individuals with mild TBI recover completely within a few months, although a minority may experience more persistent symptoms.[24] A primary component of current evidence-based treatments for mild TBI is psycho-educational counseling for the patient and family members.[25] Mild TBI cases are identified in theatre through the use of recently established clinical practice guidelines. These individuals are not typically evacuated out of the combat theatre; rather the Defense Veteran Brain Injury Center recommends that these individuals receive rest, education and symptomatic treatment of their complaints (for example, pain medicine for headaches) as close to their units as possible. Mild to moderate TBI cases identified after returning from deployment may be managed by local military, VA, TRICARE network providers, or some combination thereof depending on the geographic location and capabilities of their local military medical facility.

In 2007, TBI screening questions were added to the post-deployment health assessment and reassessment questionnaires in order to identify individuals who may

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[22] "Traumatic Brain Injury in Returning Warfighters," Presentation by Dr. Louis French, Defense Veterans Brain Injury Center, to the President's Commission on America's Returning Wounded Warriors, May 4, 2007.

[23] Zoroya, G. Army Times Lawmakers may halve brain injury funding August 21, 2006.

[24] Schatz, P. & Barth, J. "Assessment of Severity of TBI and Functional Outcome Measurement:" http://nanonline.org/nandistance/mtbi/modules/outcome/outcome.html.

[25] Ponsford, J, Willmott, C, Rothwell, A, et al. "Impact of early intervention on outcome following mild head injury in adults." *J Neurol Neurosurg Psychiatry 73*: 330-332, 2002.

have experienced a mild TBI in theatre, but never sought or received care.[26] In addition, the VA has designed an electronic prompt to remind health professionals to screen Iraq and Afghanistan veterans for TBI on their first VA health care visit.

Compared to previous wars, the proportion of injured service members surviving serious brain injury has increased greatly due to state-of-the-art care. Penetrating traumatic brain injuries in OIF/OEF are treated early using American Association of Neurological Surgeons guidelines for severe and penetrating TBI. Moderate to severe closed traumatic brain injuries are also typically identified early and evacuated for care.

The multi-site Defense and Veterans Brain Injury Center also plays a major role in identifying and evaluating moderate to severe TBI patients at selected DoD hospitals. Many of the moderate to severe TBI patients are then referred to VA Polytrauma Rehabilitation Centers for neurobehavioral rehabilitation.

The goal of TBI treatment is to maximize functioning and provide techniques for managing any remaining cognitive deficits. Prompt identification and treatment enhance the chances of recovery. In relatively serious cases, treatment usually includes medical stabilization in the acute-care hospital, followed by rehabilitative care by a multi-disciplinary team of providers in diverse settings:

- Acute-care hospitals
- Post-acute care units
- Rehabilitation hospitals
- Outpatient rehabilitation departments
- Day treatment centers
- Transitional treatment facilities
- Home.

The scope, duration, and intensity of rehabilitation vary markedly, depending on individual patient needs. Certain permanently disabled patients may require significant supervision and care, in nursing or assisted care facilities or at home with family caregivers or hired attendants.

PREVIOUS RECOMMENDATIONS AND FINDINGS

Over the past few years many task forces have focused on PTSD, and TBI is beginning to receive the same level of attention. Summarized findings from several of the most recent of these studies are presented here.

Although the VA formally disagreed with the findings, the **Government Accountability Office (GAO)** asserted[27] in 2005 that the VA had failed to implement

[26] Winkenwerder, W. Traumatic Brain Injury: Questions for the Post-Deployment Health Assessment Memorandum of March 8, 2007.

many 2004 recommendations of VA's own congressionally mandated Special Committee on PTSD, including the following:

- Provide increased access to PTSD services through VA community-based clinics and Vet Centers
- Develop effective dual treatment for veterans with both PTSD and substance abuse problems, and a dual rehabilitation approach to PTSD and coexisting conditions
- Improve the continuum of care, supported by electronic health records that follow veterans across VA's system of care
- Expand treatment to include family assessment and treatment services.

Additionally, in 2006, the GAO called on DoD to investigate differences across the Services in referral rates for PTSD treatment following positive screening on post deployment health assessment evaluations.[28]

In April 2007, the Presidential **Task Force on Returning Global War on Terror Heroes** made two recommendations on PTSD and TBI:

- DoD and VA should train clinicians in PTSD and TBI, and ensure that patients are referred to facilities with appropriate multi-disciplinary teams
- VA staff should attend PDHA events to provide information about VA health care and benefits, enroll eligible veterans, and schedule outpatient appointments.

After noting inconsistencies in early TBI diagnosis and treatment in DoD in April 2007, the **Independent Review Group** recommended a more structured approach, including:

- Development of functional and cognitive measures for all new service members, as a baseline for evaluating any future changes in the member's condition
- Inclusion of functional and cognitive screening in the post-deployment health assessment and post-deployment health reassessment
- Documentation of all exposures to blast in service members' health records
- Development of a clinical practice guideline for TBI
- Coding guidelines for TBI to facilitate standard documentation in medical records, research, and education
- Cognitive remediation for service members who experience a decrease in cognitive ability at any point during their service
- Establishment of a DoD/VA center of excellence in PTSD and TBI for research, training, and patient care
- Improvement in mental health staffing through changes in compensation and recruiting.

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[27] U.S., Government Accountability Office, GAO-05-287, *VA Health Care: VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services*, February 2005.

[28] U.S., Government Accountability Office, GAO-06-397, *DoD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers.*

In May 2007, the **Institute of Medicine (IOM)** issued a report, for the Veterans Disability Benefits Commission, on VA's practices in evaluating and compensating veterans for PTSD.[29] The IOM panel recommended that VA should:

- Develop a new method for evaluating how well PTSD patients are functioning, and, while the form is being developed, use the PTSD rating criteria of the Diagnostic and Statistical Manual of Mental Disorders
- Develop training programs for clinicians who evaluate patients for PTSD and for personnel who administer PTSD claims
- In light of the recurring and relapsing nature of the condition, consider a minimum level of benefits for all veterans with service-connected PTSD, regardless of their initial health status
- Use experienced mental health professionals to evaluate all new applicants for VA benefits for PTSD
- Establish a database and research program to improve evaluation in the future, paying special attention to female and minority veterans
- Adopt an integrated benefits approach for achieving maximum mental functioning, using case managers.

The congressionally mandated **DoD Mental Health Task Force** released an extensive report in June 2007[30]. The Task Force found that the stigma about mental health problems remains pervasive in the military and often prevents service members from seeking needed care. It further found significant gaps in the continuum of care, due mostly to shortages of mental health professionals, as well as quality-of-care deficits involving inadequate monitoring and insufficient use of evidence-based treatment. In addition, it found that TRICARE mental health benefits are hindered by fragmented rules and policies, inadequate oversight, and insufficient reimbursement. The Task Force recommended that DoD:

- Build a culture of support for psychological health and dispel stigma
    - Establish visible leadership and advocacy for psychological health
    - Embed training about psychological health throughout military life
    - Revise military policies to reflect up-to-date knowledge about mental health
    - Make professional mental health services easily accessible
    - Make psychological assessments an effective, efficient, and normal part of military life.
- Ensure that service members and their families receive a full continuum of excellent care
    - Make prevention, early intervention, and treatment universally available to service members and their families

[29] Institute of Medicine, *PTSD Compensation and Military Service,* May 2007. Committee on Veterans' Compensation for Posttraumatic Stress Disorder. The National Academies Press, Washington, DC.
[30] *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health*, June 2007.

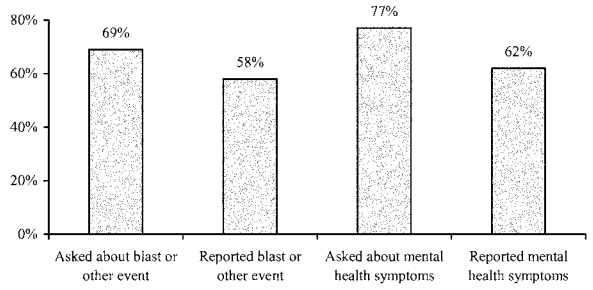
- Ensure an adequate number of uniformed providers and other staff in military treatment facilities and a robust network of TRICARE providers
- Maintain continuity of care across transitions to new assignments and out of service
- Use evidence-based treatments.

WHAT THE COMMISSION LEARNED

The Commission's survey of injured service members sought to determine whether medical providers were screening for traumatic brain injury and deployment-related mental health conditions in injured, medically evacuated patients (Figure 1). Nearly 70 percent of those surveyed reported having been asked if they experienced a blast or event causing blow or jolt to the head and almost 60 percent said that they reported such an event to a medical provider. Recognizing that not all individuals were appropriately screened for TBI risk factors, the DoD has added screening questions to the post deployment health assessment forms, and the major military hospitals have implemented universal screening of all injured, medically evacuated patients.

In assessing the screening of mental health issues, the survey results indicate that close to 80 percent of respondents reported having been asked about mood changes, nervousness or hopelessness; about 20 percent of these individuals said that they were asked about these symptoms at every clinic visit. A majority of respondents said that they reported these symptoms to a medical provider.

Figure 1—Percent of Injured Service Members Reporting Screening for and Symptoms of PTSD and TBI, PCCWW Survey



Through site visits, meetings and reviews of programs, studies, and earlier reports, the Commission has identified key issues in PTSD and TBI workforce requirements, quality of care, disability evaluation, family support, and research.

Workforce Requirements

Evidence consistently supports the DoD Mental Health Task Force's conclusion that "the Military Health System lacks the fiscal resources and fully-trained personnel to fulfill its mission to support psychological health in peacetime or fulfill the enhanced requirements imposed during times of conflict."[31] DoD methods for determining the number of providers required do not allow for the large prevention and education mission needed in military mental health. Recently, even when positions are authorized, filling them with qualified professionals has been difficult:

- The number of uniformed mental health professionals has significantly decreased, and those remaining on active duty are frequently deployed to theatre. For example, attrition of Army psychologists increased 55 percent between 2004 and 2006, whereas the authorizations for psychologists increased 11 percent between 2005 and 2007.[32]
- The current strategy of using temporary contract positions to replace deployed mental health professionals is problematic in part because it is difficult to attract experienced professionals to positions that are only 12 months in length.
- Government Service (GS) civilian positions are filled through cumbersome hiring practices[33] and provide inadequate salaries, especially in rural locations and for subspecialists.[34]

VA also faces challenges in filling mental health positions, especially in rural communities where some community-based outpatient clinics have no mental health professionals at all. The mental health component of VA's new Quality Enhancement Research Initiative, along with the expansion of telehealth services that link community facilities to experts in distant locations, may alleviate some of these needs.

Quality of Care

Treatment approaches for PTSD and TBI continue to evolve, but knowledge generated through research and clinical experience is not systematically disseminated to all DoD and VA providers of care. One survey conducted found that 90 percent of DoD providers had received no training on, or even were unaware of, a joint DoD/VA clinical

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[31] *Ibid.*

[32] Statement of Bruce Crow, Army Psychology Consultant to the Surgeon General, to the President's Commission on America's Returning Wounded Warriors, May 3, 2007.

[33] Among other things, those hiring permanent GS non-physician mental health specialists do not have direct hire authority, resulting in extended delays in hiring - on average 83 days for social workers and 87 days for psychologists. *Ibid.*

[34] For example, a 2005 Salary Survey of Neuropsychologists (The TCN/AACN 2005 Salary Survey, Professional Practices, Beliefs, and Incomes of U.S. Neuropsychologists, *The Clinical Neuropsychologist, 20*: 325–364, 2006) identifies the median salary of a Neuropsychologist practicing in Maryland as $102,000. At that same time, the GS Locality Pay table for Maryland identified the salary range of a GS-13 employee (the advertised level for a GS Neuropsychologist) at $74,782 to $97,213.

practice guideline for PTSD.[35] DoD mental health providers tend not to be fully informed about what services are available through VA, and *vice-versa.*

Joint DoD/VA clinical practice guidelines exist for the diagnosis and treatment of PTSD, although as just mentioned, awareness and use of these guidelines may be limited. Clinical practice guidelines were also identified for the in-theatre care of TBI;[36] however there is some question about the consistency with which these are utilized. American Association of Neurological Surgeons' guidelines on the acute management of severe and penetrating TBI are utilized in theatre. The Commission found no universal or joint clinical practice guidelines in use for the management of mild or moderate TBI patients following return from deployment. DoD facilities that were visited frequently had individual practices and policies regarding the identification, treatment and management of TBI patients, however these varied from site to site. At the time of this report, joint clinical management guidelines for symptomatic mild TBI were being developed and the DoD and VA planning group described below was meeting to develop clinical practice guidelines for the primary care management of TBI.

On the TBI front specifically, the Armed Forces Epidemiological Board concluded that DoD "lacks a system-wide approach for proper identification, management, and surveillance" of TBI patients.[37] Providers and case managers have varying levels of training and incomplete knowledge in the recognition and management of TBI. Confronting the same problem in recent years, the VA developed a web based independent study course in TBI symptom identification, evaluation and treatment. VA providers in primary care, mental health, spinal cord injury, and rehabilitation care are required to participate in this training.

Commission members observed during site visits that appropriate educational counseling is not consistently provided to patients with mild TBI. Some symptomatic TBI patients may go without formally coordinated care and referral.

DoD and VA recently have developed initiatives to remedy poor information dissemination and training regarding PTSD and TBI, including:

- A requirement that all Army social workers attend combat and operational stress training classes[38]

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[35] "The Future of Mental Health Care in DoD: Carpe Diem." Presentation by CDR Mark Russell to DoD Mental Health Task Force in San Diego, Calif., 19 Oct 06.

[36] Defense and Veterans Brain Injury Center (DVBIC) Working Group on the Acute Management of Mild Traumatic Brain Injury in Military Operational Settings Clinical Practice Guideline and Recommendations; *Joint Theater Trauma System (JTTS) Clinical Practice Guidelines for In-Theatre Management of Mild Traumatic Brain Injury (Concussion), Updated Aug 06; Guidelines for Field Management of Combat-Related Head Trauma, 2005.*

[37] Armed Forces Epidemiological Board. Memorandum dated August 11, 2006, on Traumatic Brain Injury in Military Service Members 2006-02 to The Honorable William Winkenwerder, Jr., MD.

[38] Department of the Army Executive Order 118-07, "Healing Warriors."

- Collaborative efforts allowing DoD mental health providers to attend VA training sessions in PTSD and to take the VA's independent study course in TBI
- A DoD/VA consolidation initiative on TBI, in which a multidisciplinary group of DoD, VA, and Defense and Veterans Brain Injury Center experts are developing a common definition of TBI, a standard curriculum for provider and patient/family training, and model programs for long-term care, disability assessment, research, testing, and treatment.

Disability Evaluation

The IOM panel has convincingly argued that VA's system of evaluating and rating individual veterans' PTSD status is seriously inadequate. Similar shortcomings may be present in the DoD disability system. Not only might current evaluations miss true cases, but also some healthy service members may be able to intentionally report non-existent symptoms in order to receive compensation.

Recently, a concern was raised that DoD, and the Army specifically, may be discharging large numbers OIF/OEF veterans with PTSD under a personality disorder diagnosis in order to save money.[39] A discharge for a personality disorder is an administrative action that is different from a medical discharge. In investigating this allegation the Commission found that

- As Figure 2 demonstrates, the annual number of personality disorder discharges in the DoD has dropped since the late 1990's and has remained relatively stable since the beginning of the Global War on Terrorism.[40]
- While the raw number of Army personality disorder discharges has increased, the Army's total number of discharges is quite comparable to the other Services despite having a far larger troop contingency.
- The number of Army personality discharges over the past 10 years represents only between approximately 1 to 1.5 percent of total Army discharges per year.
- 88 percent of the total DoD personality disorder discharges from 2001-2006 and 78 percent of total Army personality disorder discharges from that same time frame had never been deployed in Operations Iraqi or Enduring Freedom.[41]

These facts do not support the assertion that the Army or DoD is supporting a large scale effort to use the administrative personality disorder discharge for OIF/OEF veterans suffering from PTSD in order to save money. Further, Army policy requires that

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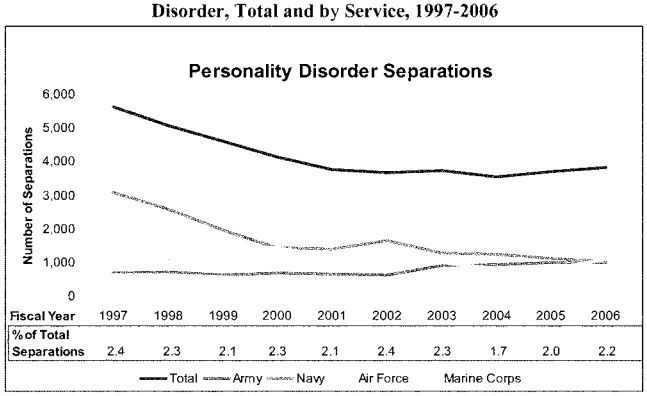
[39] Kors, Joshua. "How Specialist Town Lost His Benefits." *The Nation*, April 9, 2007. Available at http://www.thenation.com/doc/20070409/kors.
[40] Defense Manpower Data Center (DMDC). Personality Disorder Separations by Service and Component by Fiscal Year, FY 97-07, prepared July 16, 2007 Active component data used.
[41] *Op. cit.*, reference 39.

a psychiatrist or doctoral-level clinical psychologist establish the diagnosis of a personality disorder prior to administrative discharge. Any large scale effort to save money using the personality disorder discharge instead of a medical discharge for PTSD would require large numbers of these licensed professionals to act unethically, something we found no evidence to support.[42]

Figure 2–Number of Service Members Discharged with a Diagnosis of Personality Disorder, Total and by Service, 1997-2006



Within the DoD and VA, TBI disability evaluation and rating similarly is inconsistent, due to the absence of clear criteria and standardized training for raters. Unlike PTSD, TBI involves well-validated neuropsychological assessment methods to confirm symptoms, aid in diagnosis, and quantify cognitive impairments. The use of recent neuropsychological assessment by qualified professionals and well-trained raters may improve disability determinations, particularly in cases where a decline in functioning is subtle or brain abnormality is not readily observable; however the use of neuropsychological testing is frequently non-specific and non-prescriptive.

Family Support

The Commission has repeatedly heard about dedicated family members whose financial, family, and professional sacrifices allowed them to participate in their loved one's TBI care. Some patients with severe TBI may need family members or others to

[42] Individual instances of service members feeling pressured by commanders, practitioners or peers to accept administrative discharges were beyond the purview of this Commission, however, the Government Accountability Office has been commissioned to investigate this matter further.

provide care for an extended period. Families are often thrust into an intensive long-term caregiving role for which they are ill-prepared and are offered limited respite care options for occasional relief. Although caregiver education is crucial, the Commission found only very limited caregiver educational training opportunities.

For PTSD, family members need to be educated about symptom identification and management in order to provide support and better understand their service member's symptoms. This education may help keep the family intact and provide a supportive environment for recovery. Currently DoD and VA provide limited mental health services for family members in their own facilities. Family members of active-duty personnel typically use TRICARE network providers, while almost all family members of veterans must use other third-party insurers to receive community-based care. The limitations of TRICARE mental health care benefits described in the DoD Mental Health Task Force report were voiced repeatedly to this Commission.

Recent Research on PTSD

Over the past ten years, research into the mental and biological foundations of PTSD has rapidly progressed and scientists and practitioners now frequently focus their efforts on prevention in addition to treatment efficacy. Examples of prevention include everything from identifying and enhancing cognitive, emotional and social protective factors, to a current NIMH study exploring medications believed to target underlying causes of PTSD in order to prevent the development of the disorder. Within DoD there has been interest in large scale testing of all service members' "hardiness" or "resiliency" in order to predict vulnerability to PTSD. However research has not been completed to establish the predictive validity of any specific testing instrument for this purpose; policies have not been developed to determine what decisions will be based on the findings; and the potential ethical misuse of such findings has not been adequately addressed. Notably, previous attempts to use personality variables to screen out individuals presumed at risk for becoming psychiatric casualties resulted in "the elimination of nine out of ten who would have succeeded in order to eliminate the one out of ten who would not succeed in the military."[43]

Research into primary prevention and early intervention in TBI is also ongoing in the military and includes among other things, the use of personnel sensors to monitor blast exposure. There are also interesting developments in evaluating cognition in deploying troops. Mandatory and universal pre-deployment cognitive testing for use as a baseline comparison post deployment is a very popular recommendation at the time of report. The use of pre-injury cognitive baselines is typically quite beneficial in determining declines in cognitive functioning following an identified brain injury. However, ongoing research demonstrates that the impact of war-zone deployment on cognitive performance needs to be further examined before testing results are

[43] Glass, A. & Jones, F. "Psychiatry in the U.S. Army: Lessons for Community Psychiatry" Monograph, Uniformed Services University of the Health Sciences, (2005).

implemented for purposes that may include the identification of mild TBI post deployment. For example, a major study that conducted cognitive testing both before and after deployment found that deployment alone (independent of head injury, depressive symptoms, or stress) was associated with changes in some measures of attention, learning and memory in the post-deployment evaluation.[44] The Defense Veteran's Brain Injury Center currently has targeted pilot studies further examining the utility of pre-deployment baseline testing, including the effectiveness of neurocognitive instruments that may be used for such.

It was clear to the Commission that DoD needed to direct research and policy development efforts toward identifying the utility of mandatory, large scale service entry or pre-deployment cognitive and/or personality testing for the purposes described above. While universal testing to predict risk for PTSD or establish a cognitive baseline appears meritorious in concept, science and military policy development at this time do not support large scale implementation of such.

Difficulties in preventing TBI and PTSD, and in determining the utility of interventions directed at both are not unique to the DoD and VA, but the two departments are in a unique position to address these issues through research.

ACTION STEPS

DoD and VA should make a maximum effort, visibly backed by leadership, to improve the diagnosis and care for these significant combat injuries, while fostering a culture that promotes mental health care.

Action Step: DoD should establish a TBI "network of excellence" utilizing and expanding upon existing DoD, VA, and private sector resources. A lead office should coordinate policy, research, education, clinical guidelines, and foster intercommunication among the network of clinical programs. Clinical coordination should promote seamless transitions as patients move from one setting to another. Areas of immediate focus for the lead office should include:

- Comprehensive training programs in TBI designed to educate military leaders, VA and DoD medical personnel, family members, and caregivers
- The distribution of existing TBI clinical practice guidelines to all involved providers; where no guidelines exist in the continuum of care for TBI, DoD and VA should work together with other national experts to develop them
- Development of a state-of-the-art quality improvement program to assure services consistently meet the highest standards.

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[44] Vasterling, J, Proctor, S., Amoroso, P., et al. Neuropsychological outcomes of army personnel following deployment to the Iraq war. JAMA, 2006: 296(6):519-29.

Action Step: DoD and VA must move rapidly to resolve shortages in the mental health workforce that serves injured service members and veterans. DoD personnel requirements must allow for the practitioners needed for prevention and education missions, in addition to the expected long term demand that may arise from chronic or delayed onset symptoms of PTSD.

Action Step: Any service member or veteran who has deployed to Afghanistan, Iraq, and other theaters in the current war and presents with PTSD symptoms should be eligible at anytime, without restriction within the VA to receive an expedited initial evaluation by a qualified VA mental health provider. If determined to have combat related PTSD symptoms, the veteran should have access to VA PTSD care regardless of eligibility category.

REHABILITATION

PROBLEM STATEMENT

The rehabilitation needs of injured service members are currently met through an array of military, Department of Veterans Affairs (VA), and private-sector health facilities. Many of these facilities are state-of-the-art centers of excellence. Some facilities specialize in a particular injury, whereas others have the capability to care for a full spectrum of injuries.

The process of rehabilitation requires time, a complex array of services, and multiple levels of care, depending on the patient's needs and abilities. By marshaling the expertise in the nation's best rehabilitation facilities, injured service members can be restored to the highest possible level of functioning and independence.

Within the Department of Defense (DoD) and VA, the resources required to develop specialized centers limit their number, so that severely injured service members and veterans often are treated far from home. To expand geographic access and assure excellence, a comprehensive system of rehabilitation for our injured service members is needed that taps into the private sector as well as the public sector.

BACKGROUND

The Role of Rehabilitation

Through a series of individually designed interventions, rehabilitation restores the skills—lost through illness or injury—which an individual needs in order to function at the highest possible level. Rehabilitation programs and services improve the patient's functional recovery, health care outcome, and quality of life, and include the family in the scope of support.

Components of rehabilitation include:

- Preventing additional impairments or disabilities
- Protecting uninjured or uninvolved body systems
- Improving functional capacity lost from injury
- Promoting use of adaptive equipment and technology
- Enhancing patient and family adjustment through education, and
- Removing barriers from the patient's environment.

Rehabilitation programs are intensive, individualized, and coordinated programs designed to achieve total optimal functioning after a major event, such as severe traumatic brain injury or amputation. (This report focuses on rehabilitation programs related to injury recovery, although civilian and military rehabilitation facilities also treat

other conditions, such as stroke and joint replacement.) ***Rehabilitation services*** involve physical therapy or occupational therapy after relatively minor injuries and include, for example, an exercise protocol following a sprains and strength training after a fracture has healed.

For most injured patients, rehabilitation should begin as early as the patient's medical condition allows and progresses through a carefully orchestrated sequence of inpatient and outpatient services provided by a team of rehabilitation specialists. For our injured service members, rehabilitation services are available from military, the VA, and private sector sources. *The goal is to achieve optimal physical, psychological, social, and vocational functioning.*

Rehabilitation in the Military

Even preparing for war and maintaining the peace is a hazardous occupation. In the peacetime year of 1994, for example, 4,500 soldiers were disabled, 20,000 were hospitalized, and 400,000 took sick call because of injuries.[45] In peacetime, injuries sustained by service members range from minor (such as the result of a fall during a training fitness run) to severe (such as the result of a helicopter crash). Most of the time, particularly for those serving in the Army, hospitalizations are for musculoskeletal problems related to training and athletic activities.[46]

These peacetime needs establish the ongoing *baseline* requirements for rehabilitation in the military. To meet baseline needs, most military treatment facilities provide a consistent level of rehabilitation services, either in the facility itself or through referral to other military treatment facilities, the VA, or the private sector.
In wartime, both the number of injured service members and the complexity of their injuries increase, creating occasional peak needs for rehabilitation.

The military's major rehabilitation programs were developed around specific, high-incidence injuries and are scattered across the country (Figures 1 and 2).

Burns

The vast majority of service members with major burns are transported to the burn unit at Brooke Army Medical Center in San Antonio, Texas, for acute care. The unit contains 16 intensive care unit beds, 24 step-down beds, and an outpatient clinic, and is accredited by the American Burn Association. Burn rehabilitation begins during the acute care phase and continues after the patient is discharged to a rehabilitation facility, usually Brooke's burn rehabilitation center. Complete burn rehabilitation can take from two to four years.

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[45] Amoroso PJ, NS Bell, SP Baker, & L. Senier. "Understanding injuries in the military environment." In *Injury Control Part I.* U.S. Army Research Institute of Environmental Medicine, 1999.

[46] Smith GS, AL Dannenberg, & PJ Amoroso. "Hospitalization due to injuries in the military: evaluation of current data and recommendations on their use for injury prevention," *Am J Prev Med 18*: 41-53, 2000.

Brooke Army Medical Center's burn unit reports receiving 598 service members evacuated from Iraq and Afghanistan with burns as of June 30, 2007.

Amputation

Service members with traumatic amputations are generally taken to Walter Reed Army Medical Center, in Washington, DC, for both acute care and rehabilitation. With the opening of the Center for the Intrepid at Brooke Army Medical Center and a new amputee rehabilitation center at Naval Medical Center San Diego, in California, capacity and capability to care for service members with amputations have been greatly expanded.

As of 7/23/2007, 911 service members had an amputation from injuries sustained in Iraq or Afghanistan. Of these, 644 have been for the loss of an arm, leg, had, or foot, including those individuals with multiple amputations. Approximately 76% of these have been cared for at Walter Reed Army Medical Center; the rest were cared for at Brooke Army Medical Center.

Traumatic Brain Injury

Most traumatic brain injuries (TBI) are mild and improve with time (see the Subcommittee Report on Post-Traumatic Stress Disorder and Traumatic Brain Injury). Most patients only need education about their injury, which can be furnished in a military outpatient clinic or by TRICARE[47] network providers. Other patients, with moderate to severe TBI, receive some inpatient rehabilitation services during their acute medical stabilization in military treatment facilities. After stabilization, most of these patients are transferred to VA Polytrauma Rehabilitation Centers or to specialty private-sector facilities for inpatient or outpatient rehabilitation programs.

Accounting for all patients with traumatic brain injury is more difficult (see subcommittee report on Post Traumatic Stress Disorder and Traumatic Brain Injury). As of March 2007, 2,726 service members had been reported to the Defense Veterans Brain Injury Center with the diagnosis of traumatic brain injury. Of these, 2,094 were classified as mild and 255 as moderate. Another 192 had severe traumatic brain injuries and 171 had penetrating brain injuries.

Spinal Cord Injury and Blindness

Acute hospital care for spinal cord injuries is generally provided at Walter Reed. After stabilization, these patients are transferred to specialized VA spinal cord rehabilitation facilities. The military does not provide specialized *vision* rehabilitation care.

Ninety one service members had been treated for spinal cord injuries as of June 8, 2007, in the VA. Fifty-three service members have received blind rehabilitation services from the VA as of April 3, 2007.

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[47] TRICARE is DoD's health care program for members of the uniformed services, their families, and survivors, as well as some retired military personnel.

Community Based Care

In 2004, the Army created eight Community Based Health Care Organizations to provide case management—coordinating rehabilitation and other health care needs—for injured National Guard and Reserve members who return home. Care is arranged with military, VA, and (through TRICARE) private-sector facilities throughout the United States. The Army plans to expand Community Based Health Care Organizations to cover members on active duty.

Rehabilitation at VA

The VA has developed rehabilitation capability and capacity with a specific focus on certain types of injuries and on the needs of veterans. VA rehabilitation programs and services—on which the military also relies—are typically organized in "hub-and-spoke" systems with a few highly specialized research, treatment, and training centers linked to a larger number of less specialized treatment facilities throughout the country (Figures 1 and 2). This arrangement maximizes efficiency and helps the patient gradually achieve reintegration into the community.

All VA rehabilitation facilities are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Accreditation means that these facilities meet national standards of care and that the quality and effectiveness of programs and services are monitored by an independent entity.

Polytrauma Rehabilitation Network

In 1991, the VA, with funding support from DoD, designated three VA facilities as TBI centers for active-duty service members, with a fourth center added in 1993. Under 2004 legislation requiring the VA to expand the centers so they could treat multi-injured service members,[48] the centers were renamed "Polytrauma Rehabilitation Centers."

The Polytrauma Rehabilitation Centers are located in Palo Alto, California, Richmond, Virginia, Tampa, Florida, and Minneapolis, Minnesota. Admission criteria are:

- Must be active duty or a veteran discharged from military service under other than dishonorable circumstances
- Medically stable
- Have sustained multiple physical, cognitive, and/or emotional injuries secondary to trauma
- Not require one-to-one staffing for medical or behavioral reasons
- Not require a ventilator to breathe
- Have the potential to benefit from rehabilitation OR need an initial, comprehensive rehabilitation evaluation and care plan.

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[48] Veterans Health Programs Improvement Act of 2004, P.L. 108-422; Consolidated Appropriations Act for 2005, P.L. 108-447.

In addition to the four inpatient Polytrauma Rehabilitation Centers, with a total bed capacity of 48, the VA developed a rehabilitation network to address the ongoing needs of multi-injured service members and veterans:

- 23 Polytrauma Network sites provide both inpatient and outpatient rehabilitation care
- 72 Polytrauma Support Clinic Teams are distributed in VA facilities across the country to assist veterans and service members with rehabilitation needs close to their home communities
- A Polytrauma Telehealth Network provides additional support for patients throughout the system, by using communications technologies to involve experts from distant locations in the patient's care.

Amputations

Once separated from active duty, amputee patients can receive care at one of 76 VA facilities with amputation outpatient rehabilitation clinics. The VA also has 58 VA prosthetic labs and contracts with local prosthetists for ongoing care close to veterans' homes.

Spinal Cord Injury

The VA supports 23 regional Spinal Cord Injury Centers, with 150 acute rehabilitation beds, dedicated to the acute care and rehabilitation needs of spinal cord injury patients. These centers provide a multi-disciplinary team approach to the care of approximately 400 spinal cord injured veterans and active-duty service members each year. After patients leave these centers, their medical needs are cared for by specifically trained primary care physicians at 135 VA medical centers.

Blind Care and Rehabilitation

The VA has made a substantial investment in the care of veterans who are visually impaired:

- 10 blind inpatient rehabilitation centers located at VA facilities provide training in orientation and mobility, independent living, and computer access
- Day outpatient rehabilitation programs are available through the Visual Impairment Services Outpatient Rehabilitation Program for veterans with low vision who can live independently but need additional training in specific skills, such as orientation and mobility
- Four VICTORS (Visual Impairment Centers To Optimize Remaining Sight) provide diagnosis, evaluation, and training for patients with low vision
- Blind Rehabilitation Outpatient Specialists provide training to visually impaired veterans in diverse settings, including nursing homes, assisted living facilities, Walter Reed Army Medical Center, and National Naval Medical Center

- Visual impairment service teams and coordinators, placed at several VA medical centers and outpatient clinics, identify, evaluate, and provide direct services and case management to veterans adjusting to vision loss.

Private Sector Rehabilitation

Private-sector rehabilitation programs and services are provided to injured service members in a variety of ways and locations, depending on the needs and capabilities of the patient. According to the Centers for Medicare and Medicaid Services, there now are 224 free-standing ***inpatient rehabilitation hospitals***—where the most intensive rehabilitation programs are based—and 1,010 ***inpatient rehabilitation units within acute care hospitals***.

Patients in private-sector inpatient programs engage in a series of daily activities, such as occupational and physical therapy and speech and language recovery, usually for three to six hours per day, five to seven days per week. For patients whose conditions allow them to stay at home, ***day rehabilitation programs*** typically provide at least two different types of therapy for three hours per day, five days per week. Many patients participate in day programs, as a next step toward independence, after being discharged from inpatient settings. Another post-hospitalization option, ***residential programs***, are similar to day rehabilitation programs but provide additional, limited assistance with activities of daily living.

Other settings include:

- ***Moderately intensive rehabilitation*** programs in outpatient departments for one to two hours per day, three days per week
- ***Low to moderately intensive rehabilitation*** programs at home or in skilled nursing facilities
- ***Limited rehabilitation*** services during an acute hospitalization, such as assistance with early mobilization, ambulation aids (crutches, walkers, etc.), and training.

The choice of setting depends on several factors:

- the patient's diagnosis
- ability to recover
- other diseases or conditions
- level of functioning prior to the illness or injury
- support systems
- mental status
- ability to tolerate the intensive nature of the program.

For each level of rehabilitation, health insurers enforce specific criteria for demonstrating positive progress toward goals and time benchmarks for program completion (such as 45 days for spinal cord injury recovery at an inpatient rehabilitation facility).

The Commission on Accreditation of Rehabilitation Facilities (CARF) currently accredits civilian facilities (Figure 3).

PREVIOUS RECOMMENDATIONS AND REPORT FINDINGS

Previous Commission and Task Force reports examining injured service members' needs have not addressed rehabilitation specifically. However, several reports did issue broad recommendations that would affect rehabilitation in important ways. A common theme emerging from these reports is the need for greater collaboration and resource-sharing between the military and VA to improve access to high-quality care and allow patients to be treated closer to home. Previous commissions and their key recommendations are:

- The ***Congressional Commission on Service Members and Veterans Assistance*** (1999) recommended a review of the geographic structure of the DoD and VA health systems. The Commission observed that "both systems have beneficiaries who could more conveniently obtain care at facilities operated by the other system."
- The ***Independent Review Group*** (April 2007) criticized the unavailability of technologically advanced follow-up care for amputees in the VA (a breakdown in the transition from inpatient to outpatient status). It cited the need for more extensive training for case managers and a need to develop practice guidelines and research on TBI. Specifically, the report recommended:
    - Creating a DoD-VA partnership to provide ongoing amputee treatment and prosthetic serviees
    - Providing greater access to private-seetor health facilities and stronger incentives for private providers to participate in TRICARE
    - Reviewing post-service care for reservists and considering expansion of the Army's Community Based Health Care Organization network.
- The ***President's Task Force to Improve Healthcare Delivery for Our Nation's Veterans*** (2003) recommended:
    - Identifying and correcting staff shortages
    - Creating consistent clinical scopes of practice for non-physician practitioners
    - Creating an interfaee between VA and DoD systems for credentialing individual and institutional providers.
- In support of warriors returning home for outpatient rehabilitation, the ***Task Force on Returning Global War on Terror Heroes*** (April 2007) recommended that Adapted Housing and Special Home Adaptation Grant claims be expedited.
- A 2004 report by the ***Government Accountability Office (GAO)*** on outpatient rehabilitation services for blind veterans concluded that the VA's outpatient care capacity was inadequate and recommended that inpatient and outpatient

services be made more widely available to legally blind veterans.[49] The VA has responded by expanding blind rehabilitation centers across the country.

- In a 2007 report, ***GAO*** observed that allowing injured service members to receive early rehabilitation at VA facilities should be coordinated with DoD's evaluation of whether they could become fit to return to duty.[50]

WHAT THE COMMISSION LEARNED

The Commission has learned that access to high-quality, comprehensive rehabilitation programs and services should be part of the recovery plan of every injured service member, to provide the opportunity to reach one's full potential.

The Effectiveness of Rehabilitation

Rehabilitation is essential to the recovery of injured individuals.[51] Although randomized clinical trials demonstrating the effectiveness of rehabilitation are seldom conducted, because that would deprive patients of basic and standard care, many studies document that rehabilitation improves health care outcomes. Examples for TBI, amputation, and burns follow.

For TBI, rehabilitation—along with clinical pathways and early consultation—improves efficiency, optimizes outpatient care, and decreases hospital lengths of stay. *Patients with severe TBI* experience fewer complications and spend less time in the hospital if they are given clearly defined goals and a structured progression of rehabilitation services.[52,53] Early consultation with a physiatrist (physical medicine specialist) and prompt referral to rehabilitation programs apparently improve functional outcomes for these patients.[54] Similarly, *patients with moderate to severe TBI* recover their personal independence faster when they are provided with more intensive

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[49] U.S., Government Accountability Office. *VA HEALTH CARE: More Outpatient Rehabilitation Services for Blind Veterans Could Better Meet Their Needs.* GAO-04-996T, July 22, 2004.
[50] U.S., Government Accountability Office. *Challenges Encountered by Injured Servicemembers During Their Recovery Process.* GAO-07-589T, March 5, 2007.
[51] Mock C, Lormand JD, Goosen J, et al. *Guidelines for essential trauma care.* Geneva, World Health Organization, 2004.
[52] Vitaz TW McIlvoy L, Raque GH, et al. Development and implementation of a clinical pathway for severe traumatic brain injury. *J of Trauma 51*:369-375, 2001.
[53] Wagner AK, Fabio T, Azfonte RD, et al. Physical medicine and rehabilitation consultation: relationships with acute functional outcome, length of stay, and discharge planning after traumatic brain injury. *Am J Phys Med Rehabil 82*: 526-536, 2003.
[54] *Ibid.*

treatment,[55,56] and comprehensive, integrated outpatient rehabilitation programs improve these patients' functioning even if provided one year after the acute injury.[57]

For amputations, prosthetics has changed dramatically over the years.[58] Accompanying the development of sophisticated artificial limbs was the rise of structured rehabilitation programs to return amputees to functional independence.[59] A coordinated, multi-disciplinary approach to prosthetic rehabilitation reduces the length of time patients spend in the hospital and decreases the amount of physical therapy needed in the outpatient setting.[60] Structured programs that include vocational rehabilitation, community reintegration, and sports activities improve the quality of life for these individuals.[61]

Burn patients face significant rehabilitation challenges. Serious burns often require multiple operations and generate chronic pain and psychological problems.[62] Moreover, burned service members frequently have other injuries and are at risk for PTSD.[63] A comprehensive multidisciplinary approach to burn rehabilitation is, therefore, critical.[64] Providing burn care in a burn center with a rehabilitation unit decreases lengths of stay and more rapidly restores function to the patient.[65] Because of the intensive nature of the care required, along with the resources needed, burn care in the United States is provided through a regional approach.

Optimal Rehabilitation Staffing

Staffing for rehabilitation programs and services varies by type of facility, such as (as categorized by the World Health Organization's 2004 "Guidelines for Essential Trauma Care") basic (clinic), general practice (non-specialty hospital), specialist hospital,

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[55] Shiel A, Burn JPS, Henry D, et al. The effects of increased rehabilitation therapy after brain injury: results of a prospective controlled trial. *Clinical Rehabilitation 15*:501-514, 2001.
[56] Zhu XL, Poon WS, Chan CH, & Chan SH. Does intensive rehabilitation improve the functional outcome of patients with traumatic brain injury? Interim result of a randomized controlled trial. *British Jounal of Neurosurgery 15*:464-473, 2001.
[57] High WM, Roebuck-Spencer T, Sander AM, et al. Early versus later admission to postacute rehabilitation: impact on functional outcome after traumatic brain injury. *Arch Phys Med Rehabil 87*: 334-342, 2006.
[58] Eldar R & Jelic M. The association of rehabilitation and war. *Disability and Rehab 25*: 1019-1023, 2003.
[59] Pezzin LE, Dillingham TR, & MacKenzie EJ. Rehabilitation and the Long-Term Outcomes of Persons with Trauma-related Amputations. *Arch Phys Med Rehabil 81*: 292-300, 2000.
[60] Kent R & Fyfe, Neil. Effectiveness of rehabilitation following amputation. *Clinical Rehab 13*: S43-S50, 1999.
[61] Pasquina PF, Bryant PR, Huang ME, et al. Advances in Amputee Care. *Arch Phys Med Rehabil 871:* S34-S43, 2001.
[62] Esselman, PC, Thombs, BD, Magyar-Russell, G, & Fauerbach, JA. Burn Rehabilitation: state of the science. *Am J Phys Med Rehab 85*: 383-413, 2006.
[63] *Ibid.*
[64] Jonsson, CE, et al. Rehabilitative, psychiatric, functional and aesthetic problems in patients treated for burn injuries--A Preliminary follow-up study. *Act Chir Plast 39*:3-8, 1997.
[65] DeSanti, L, et al. Development of a burn rehabilitation unit: Impact on burn center length of stay and functional outcome. *J Burn Care Rehabil 19*: 414-419, 1998.

and tertiary care facility for extremity injuries. In order to determine the types of staffing available, the Commission obtained data from selected military treatment facilities where a majority of injured service members are taken when evacuated and compared these staffing levels with WHO standards (Table 1).

Community hospitals provide primary and general acute care with a limited number of specialty providers. Tertiary referral hospitals, by contrast, have a concentration of specialists and few primary care providers. Medical centers have a mix of primary care and specialty care, but neither as many specialists as tertiary hospitals nor as many primary care providers as community hospitals.

Most tertiary referral military hospitals generally meet WHO standards, but only two—Walter Reed and Brooke Army Medical Centers—have rehabilitation nurses on staff. Staffing at military treatment facilities is always vulnerable to deployment and the routine base rotational life of military personnel. While every attempt is made to "back fill" these positions, periods of staff unavailability occur throughout DoD, not only for rehabilitation staff, but also for general medical staff.

Matching rehabilitation needs with capability and capacity at each facility should be a priority. For those injuries with specialized needs, plans need to be in place for obtaining rehabilitation services elsewhere, including in the private sector.

Optimal Rehabilitation Programs and Services

Only three facilities have specialized rehabilitation programs for upper and lower extremity amputations (Walter Reed Army Medical Center, Brooke Army Medical Center, and Naval Medical Center, San Diego). Five facilities have had programs for mild TBI, and two have specialized rehabilitation programs for moderate TBI. There are no programs in the military for rehabilitation for severe TBI. Brooke is the only facility with specialized burn rehabilitation.

In responding to the Commission's data request, only Walter Reed expressed the belief that it had facilities meeting a strict definition of both inpatient and outpatient rehabilitation units and services. Most of the other facilities reported that services were obtained by referral to military specialty hospitals, TRICARE network providers (Figure 4), or through the VA.

Recently, the Army Surgeon General created an office of Rehabilitative Care Proponency. Working in coordination with other DoD, federal, and community rehabilitation authorities, this office will identify the rehabilitation capabilities of the Army's military treatment facilities and recommend improvements. This initiative is specific to the Army, and thought does not appear to have been given to a DoD-wide activity.

Challenges for War-Related Injury Rehabilitation

The military has state-of -the-art amputee and burn centers; the VA maintains special expertise in spinal cord injuries and blindness; and both treat TBI patients depending on the level of severity. It is clear, however, that no unified rehabilitation strategy exists between the two departments or with private-sector providers, particularly during this peak need for additional rehabilitation services and programs. The lack of strategic planning results in uneven availability of community-based rehabilitation, unused capacity in some costly specialized facilities, and stretched capacity in other facilities. The recently established Army's Rehabilitative Care Proponency Office should be able to determine needs and create opportunities to coordinate the best rehabilitation care, but the extent to which the other Services are conducting similar efforts is unknown.

A contemporary rehabilitation system would adjust resources according to the *volume* of patients and the severity of their injuries and needs. This would prevent congestion, excessively low patient volumes, and gaps in care. Research shows that, for other types of highly specialized care, the number of patients treated at a facility is related to better outcomes.[66, 67] In some specialty fields, this research has led to patient care guidelines that incorporate minimum patient volume standards.[68] In rehabilitation, too, it is difficult to justify the ongoing expense of equipment and a skilled multidisciplinary team, if that team is not fully utilized, and of course, that team will become less skilled over time.

The military faces a special challenge in planning for successive generations of war injuries. Once war ends, specialized military rehabilitation facilities and programs may lose the patient volume necessary to sustain excellence. The burn center at Brooke has met this challenge by serving as the sole treatment site for all military beneficiaries with severe burns and by treating other patients from around the world. This model can be adapted to other specialized care facilities, such as Walter Reed's amputee center. An alternative strategy would be to rely on leading VA or private-sector facilities, providing support to ensure that the particular expertise needed to treat service members is sustained through research and training.

Most private sector and all VA rehabilitation facilities are accredited by CARF. Military rehabilitation facilities do not participate in CARF accreditation. (An Army spokesperson explained to the Commission that military hospitals primarily provide acute rehabilitation services and so do not require specialized accreditation.) In light of the

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[66] DiSario, JA. Hospital volume and ERCP outcomes: the writing is on the wall. *Gastrointestinal Endoscopy 64*: 348-350, 2006.

[67] Harmon JW, Tang DG, Gordon TA, et al. Hospital volume can serve as a surrogate for surgeon volume for achieving excellent outcomes in colorectal resection. *Ann Surg 230*: 404-411, 2000.

[68] Birkmeyer JD, Finlayson EV, Birkmeyer CM. Volume standards for high risk surgical procedures: potential benefits of the Leapfrog initiative. *Surgery 130*:415-422, 2001.

expansion in inpatient and outpatient rehabilitation programs and services, several large Army and Navy medical centers reasonably would seek and obtain CARF accreditation to assure that they meet the highest standards.

Using Community-Based Rehabilitation

Specialized military and VA centers for rehabilitating seriously injured service members and veterans provide technologically advanced treatment, and research at these facilities has led to improvements in prosthetics, burn care, and other rehabilitation services. Yet *prolonged stays* at these centers keep some patients from returning to their homes and may require their families to relocate for extended periods. These long stays may also delay community reintegration and social, vocational, and psychological adjustment needed for optimal recovery.[69] Some patients, particularly National Guard and reserve members, may prefer to receive their care at private-sector rehabilitation facilities closer to their homes.

In general, very little is understood about long-term outcomes of care in different settings,[70] although some evidence suggests that early vocational rehabilitation and medical rehabilitation care close to the patient's home improve long-term recovery.[71] In any event, patients should be transferred to other facilities if the type of rehabilitation available is consistent with their recovery plan.

ACTION STEPS

- The military should maintain a level of rehabilitation services and programs in keeping with the need to maintain America's fighting force.
- The military should develop a strategy to adjust peak demands for rehabilitation services and programs utilizing military, VA, and private sector sources.
- The military should develop a plan for utilization and maintenance of specialty rehabilitation centers and programs.
- The military should assess the specific staffing needs of each rehabilitation programs to assure adequacy.
- The VA should maintain an inventory of contemporary prosthetics consistent with those supplied by the military.

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[69] U.S., Government Accountability Office (GAO), *DoD and VA Health Care: Challenges Encountered by Injured Servicemembers during Their Recovery Process.* GAO 07-606T, March 2007; GAO , *Vocational Rehabilitation: More DOD and VA Collaboration Needed to Expedite Services for Seriously Injured Servicemembers,* GAO 05-167, January 2005.

[70] Dillingham, TR. Musculoskeletal Rehabilitation: Current Understandings and Future Directions. *Am J of Phys Med Rehab 86:* S19-S28, 2007.

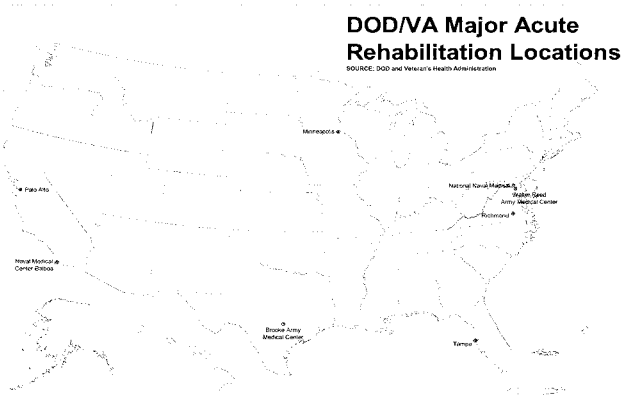
[71] The two GAO reports cited above recommend early intervention to maximize work potential and rehabilitation needs

Table 1: STAFFING AT MILITARY TREATMENT FACILITIES

Services	Community Hospitals					Medical Centers				Tertiary Referral Hospitals						
	* WHO	IACH	LNCH	BACH	PNCH	* WHO	DAMC	EAMC	WAMC	* WHO	WRAMC	NNMC	BAMC	NMCSD	MAMC	NMCP
Physical Medicine and Rehabilitation Physician	I	○		★		D	★	★		D	★	■	★	★	★	★
Rehabilitation Nurses	I					D				D	★		★			
Physical Therapists	I	■	★	★	★	D	★	★	★	D	★	★	★	★	★	★
Occupational Therapists	I	■	★	★	★	D	★	★	★	D	★	★	★	★	★	★
Speech Pathologists	I	●		○		D	★	★	★	D	★	★	★	★	★	○
Neuropsychology/ Psychological counseling	I/E	●			○	D/E	★	★	★	D/E	★	★	★	★	★	○
Vocational Therapists							★	★			★	○	★			
Prosthetists	I	○	○	○	○	D	○	★	○	E	★		★	★	○	○
Orthotists		○	○	★	○		★		○		★	○	★	★	○	○

- E = essential, D = desirable, I = ideal
- Stars indicate staff in that hospital;
- Filled boxes indicate that the service at that facility and by referral to TRICARE, VA or military specialty hospitals
- Open circles indicate that the service is available by referral to TRICARE, VA or to military specialty hospitals
- Open boxes indicate emerging capability at this military hospital
- WHO = World Health Organization
- WRAMC = Walter Reed Army Medical Center
- NNMC = National Naval Medical Center
- BAMC = Brooke Army Medical Center
- MAMC = Madigan Army Medical Center
- NMCP = Naval Medical Center Portsmouth
- NMCSD = Naval Medical Center San Diego
- DAMC = Darnall Army Medical Center
- EAMC = Eisenhower Army Medical Center
- WAMC = Womack Army Medical Center
- IACH = Ireland Army Community Hospital
- LNHC-LeJune = Naval Hospital Community Hospital – Lejeune
- BACH = Blanchfield Army Community Hospital
- PNCH=Naval Community Hospital - Pendleton

Figures 1 and 2. DOD AND VA ACUTE AND POST-ACUTE REHABILITATION LOCATIONS



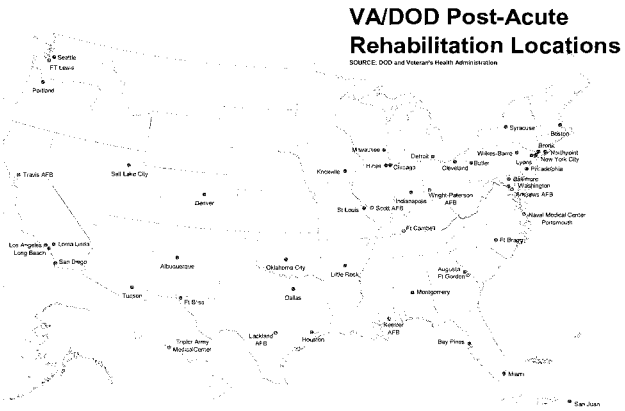


Figure 3. DISTRIBUTION OF COMMISSION ON ACCREDITATION OF REHABILITATION ACCREDITED FACILITIES

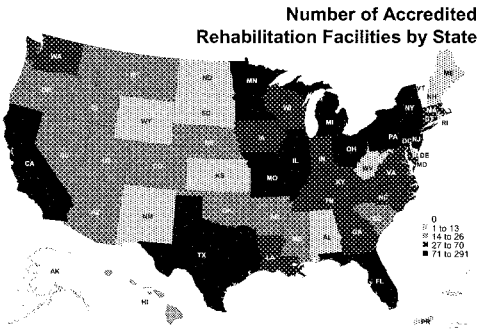
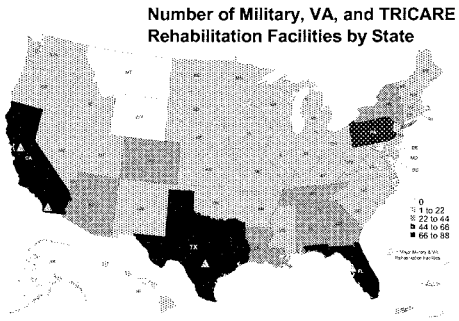


Figure 4. DENSITY OF TRICARE NETWORK REHABILITATION FACILITIES



FAMILY SUPPORT

THE CHALLENGE

Families are a vital aspect of injured service members' concerns, attitude, treatment, recovery, and ongoing state of health and social connections. During the current conflict, the military and other organizations have made great strides in integrating families into the programs and services available to injured service members.

Nevertheless, family members often are left confused and needing assistance as they navigate the complicated military and veterans systems. Families would benefit from—and deserve—greater and more systematic involvement in information-sharing, care of injured service members, and the shaping of programs and policies.

BACKGROUND

Initial Support

Families of injured service members usually learn of the injury in a telephone call placed to the next of kin, as designated by the member before deployment, by either a military casualty affairs staff member or the unit commander in the field. Family members quickly receive information about travel, lodging, and support at the treating medical facility. If the injury falls into defined serious or very serious categories, Invitational Travel Orders can be issued for up to three family members, usually for 14 days and sometimes for 30 days (or even longer, under the Service Secretary's order). Travel orders provide:

- Travel expenses
- Lodging
- Local transportation expenses
- Daily allowance.

An official of the Service meets family members at the airport and drives them to the local finance office—to receive a five- to 15-day advance—and then to their lodging and the hospital. If the hospital has a Family Assistance Center, it is the first stop. As soon as possible thereafter, the family is escorted to meet the charge nurse at the hospital and then to the bedside.

When the service member is discharged from the hospital, a Non-Medical Attendant Order can be issued if the attending physician believes that having a family member in attendance will aid in the patient's recovery. These orders cover transportation and meals and are usually issued in 14-day increments to only one family

member, although additional family members may receive them in extraordinary circumstances.

All families need support at some point, but some families need more services than others and for much longer periods of time. In cases where recovery will take a long time—for example, severe burn cases—the military Service may decide to move the family permanently. Moving the family facilitates normal family interactions, which may be especially important if there are children, but uproots families from their community. To fill the resulting gap, an abundance of military and community support organizations—including more than a thousand non-profit organizations—play a vital role in family support.

Family members' bedside lengths of stay range from one day to six months, with an average of 45 days. Most injured service members recover quickly and return to duty. Others take longer to recover, but eventually return to full functioning. A small number of the most severely injured never fully recover and remain dependent on family members for care-giving and economic support.

Walter Reed and Brooke Army Medical Centers have Soldier and Family Assistance Centers, where family members are connected on-site with a host of programs and referral services. The Army recently directed all its medical facilities to develop a capability to open such Centers if needed, while the other Services offer family support in other ways. Additionally, DoD and VA treatment facilities offer family members:

- Education about the service member's specific injuries and the physical, psychological, and social functioning changes that will result in both the short and long term
- Training for family members who will need to be caregivers
- Counseling to deal with their emotional reactions and adjustments.

Fisher Houses—which provide a "home away from home" for families of injured and wounded service members, at no charge—are located near all military medical centers as well as several VA medical centers and military community hospitals on large bases. In this private-public partnership, the private Fisher House Foundation raises funds, constructs the houses, and provides programs and other support services to family members, while the Department of Defense (DoD) or Department of Veterans Affairs (VA) operates and maintains the house. Currently, 38 Fisher Houses house 8,500 families per year. The foundation now plans to construct 22 more houses, mostly at VA medical facilities.

Ongoing Support

Each Service has a program to help seriously wounded and injured service members and their families:

- Army Wounded Warrior Program
- Navy Casualty and Safe Harbor Program
- Marines Wounded Warrior Regiment

- Air Force Palace HART (Helping Airmen Recover Together) Program.

These wounded warrior programs help in many ways:

- furnishing advice and assistance during treatment, recovery, and reentry to military or civilian life
- cutting through bureaucratic red tape
- providing referrals to public and private agencies
- facilitating job searches
- helping to remedy communication problems affecting families and injured service members
- identifying needed changes in policies or procedures.

In addition, DoD's Military OneSource program gives assistance around the clock to service and family members and is accessible electronically and by telephone. This program provides information and referrals for support services ranging from child day care to elder care, from education to employment, from financial to legal aid, and from housing to relocation. It also can arrange up to six counseling sessions for service or family members experiencing problems. Military OneSource's partners include VA, the Departments of Labor and Education, veterans service organizations, state agencies, and non-profit organizations.

Military OneSource also manages the Military Severely Injured Center. In close collaboration with the Services' wounded warrior programs, the Center helps injured service members and their families with:

- Financial planning
- Education, training, and job placement
- Information on VA benefits and other entitlements
- Home, transportation, and workplace accommodations for disabilities
- Personal, couples, and family issues counseling
- Personal mobility and functioning.

After leaving the hospital, some service members need personal caregiver services, sometimes for a long time or even permanently. VA provides two kinds of support:

- An *aid and attendance allowance* ranges from $1,851 to $2,757 per month for veterans living at home who are blind, need routine assistance with activities of daily living, or have at least two significant impairments. This allowance pays for nursing assistants or other aides; the higher amounts cover licensed health professionals who provide services directly or supervise the aides. (Most beneficiaries of this allowance are rated as 100 percent disabled and a veteran with a spouse and two children receive monthly disability compensation ranging from $2,781 to as much as $7,380 if severely impaired.)
- *Respite care* is available for up to 30 days a year for all disabled veterans. Respite care provides care-giving services while family caregivers take a break from their daily burden.

DoD provides no explicit benefits for care-giving. Aid/attendance and respite care are not available to injured service members on active duty—even though the TRICARE Extended Health Care Option provides these benefits to service members whose children or other dependents have special needs. A few states provide benefits to disabled adults who need care-giving (in most states, this benefit is only for the elderly), and some charitable organizations offer respite care to military families.

While the service member is on active duty, spouses and dependents receive comprehensive health benefits through TRICARE. This coverage continues after a medical retirement from service—but, for regular service members who receive a medical separation (with a DoD disability rating of zero to 20 percent) and for demobilized reservists, this extension lasts only 180 days.[72]

PREVIOUS RECOMMENDATIONS AND REPORT FINDINGS

Prior to this year, family issues received little attention in the multitude of task force and commission reports published. However, recent reports have cited areas in need of attention.

The **Independent Review Group** is the only recent task force that made specific recommendations for family support. These called on DoD to:

- Inform family members about the support they are entitled to, and assign individuals to assist with travel, lodging, and other support
- Consider permanently moving families of wounded, ill, and seriously injured service members who need long-term rehabilitative care in outpatient settings. Moves should be considered on a case-by-case basis with consideration given to the needs of the family.

The **DoD Task Force on Mental Health** included services for family members in its extensive review of the military's mental health system. The task force concluded:

- Families receive inadequate education about psychological health
- The military health system lacks the resources and personnel needed to provide adequate mental health service to family members
- Coordination among the many DoD organizations that provide psychological care is lacking.

The **Army's Wounded Warrior Program** sponsors regular symposia twice a year for severely injured service members and their family members. The top issues identified by participants at the last two meetings included several recommendations for improving family support:

[72] For more details about medical retirement, separation, and TRICARE benefits, see the Subcommittee Report on Disability Evaluation and Compensation. Separated individuals may purchase up to 18 months of additional coverage; the cost for a family is about $8,000 per year.

- Provide support groups, led by trained social workers, and counseling for family members at military treatment facilities, and inform families about the groups when they first arrive
- Provide a stipend for caregivers until the soldier returns to duty or VA benefits begin
- Before the service member's discharge from the hospital, train family caregivers and provide them with specific instructions and medical supplies and equipment
- Develop a package of materials for families about the notification process, the importance of powers of attorney, and mental health issues.

WHAT THE COMMISSION LEARNED

Families are integral to the care and recovery process. They contribute critical emotional and practical support to recovering service members, sometimes for life. *Patient-centered care,* as advocated by the Commission, integrates families along the continuum of care and provides them with information and support.

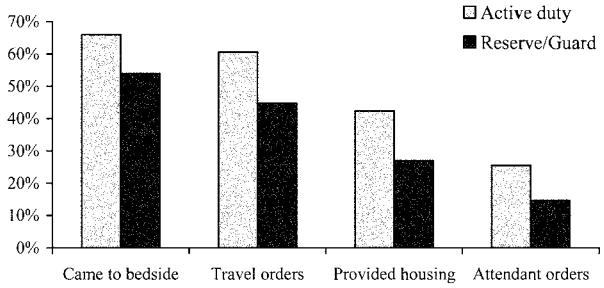
Typically, a family's first concern is to get to the bedside, and the Services appear to have developed effective procedures for meeting this fairly basic need. Once the family's immediate needs for travel and temporary lodging are satisfied, it requires more individualized support, depending on the service member's medical condition and the family's own situation. Beyond issues involving in bringing the family to the injured service member, information gathered through the Commission's site visits and DoD and VA expert consultations revealed issues in four other areas:

- Information and administrative help
- Financial support during the recovery phase
- Health care for the family
- Special needs for family caregivers.

Bringing Families to Injured Service Members

Most injured service members, especially active-duty personnel, have had family members join them soon after they are medically evacuated to the United States (Figure 1). In almost all cases, these family members have traveled at government expense, and two-thirds were provided housing. Only one-third were issued Non-Medical Attendant Orders after the service member left the hospital, however.

Figure 1—Percentage of Returning Injured Service Members with Families in Attendance, PCCWW Survey



Over the past five years, the Services have fine-tuned their policies and practices for bringing family members to the bedside. The level of support is impressive. Travel arrangements are made quickly, and family members are escorted upon arrival and then prepared for their initial bedside encounter.

Family members who will stay for an extended period of time deserve comfortable and safe temporary lodging. The Fisher Houses and certain other facilities meet this need. When a military medical center's capacity for temporary housing is exceeded, local officials are usually able to arrange off-base housing in hotels until the family can be moved to the base.

Large bases with military medical centers have extensive services for families, including commissaries, child care, and recreational facilities. Military spouses have immediate and permanent access to these services, and parents and other relatives usually can obtain temporary access to them.

Information and Administrative Help for Families

In conversations with many injured service members and their families at different stages along the continuum of care, the Commission heard a recurring theme of confusion and frustration in navigating the medical and benefits systems. Some families described receiving very limited or inconsistent information about the anticipated course of treatment and recovery—and recovery is families' overriding concern—and how that course would affect eligibility for, and appropriateness of, specific services and benefits.

Many family members' knowledge of the military is quite limited, and they could use a "crash course" in the many administrative processes and service programs relevant to their situation. The Army's Soldier and Family Assistance Centers and the Services'

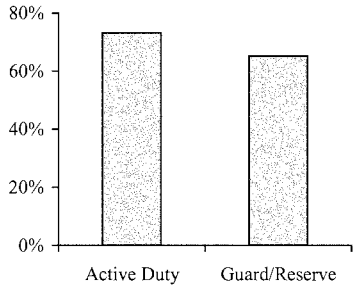
wounded warrior programs—developed during the current conflict—help meet this need. VA also has expanded the number and locations of liaison staff at military treatment facilities. These VA staff members inform patients and families about VA benefits and facilitate the transition to civilian life and VA care.

As the Subcommittee Report on the Continuum of Care describes, a host of "case managers," assigned at various stages of the treatment and recovery process, help patients and families navigate the complex system of care and benefits. Some patients and families are fortunate to find a single person at each stage of the process—such as a medical case manager or hospital social worker—to serve as a single coordinator.

Once a service member (including National Guard and reserve personnel) leaves the military, the flow of information and support tends to become more fragmented. Various websites, supported by the wounded warrior programs and other sponsors, try to make information readily available to this dispersed population. These websites contain a wealth of information, but navigating them to get answers to specific questions can be difficult.

The Commission's survey asked injured service members whether their families received all the information they needed and wanted. Three-fourths of active-duty personnel, and slightly lower proportions of National Guard members and reservists, said their families were well-informed (Figure 2). (Note that this is second-hand information related by the service member, and some family members might have responded differently.) This finding suggests that information was a problem for a substantial minority of families.

Figure 2—Percentage of Families Who Received All the Information They Needed, PCCWW Survey

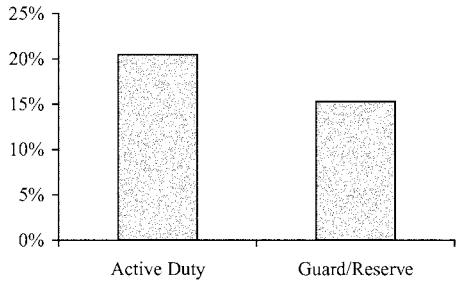


Family Financial Support During Recovery

While the injured service member remains on active duty, military income and benefits continue, which provides some stability to the family. But, almost one in five respondents to the PCCWW Survey reported that family members gave up a job to help care for them after they were injured (Figure 3). Sixty percent of the medically evacuated service members who were surveyed were married and 42 percent had children living with them. Supporting the family when the injury is severe and the recovery is long can be a challenge.

For families of the most seriously injured, the income from these jobs can be replaced, temporarily, by the Traumatic Servicemembers Group Life Insurance program. This program, which most service members join, pays up to $100,000 for injuries involving loss of limb, eyesight, hearing, burns, and severe traumatic brain injuries (TBI) that impede the ability to perform activities of daily living. In the first nine months after the program began in December 2005, roughly 400 claims were paid, assisting about half of combat-injured patients evacuated to a DoD medical center. Payment is lump-sum (averaging $52,000) except for service members with TBI, who receive $25,000 per month while they are unable to perform activities of daily living. The program does not provide benefits to individuals who can perform such daily living activities as bathing and dressing but are unable to work, prepare meals, or perform other functions necessary to live independently

Figure 3—Percent of Service Members with a Family Member Who Gave Up a Job, PCCWW Survey



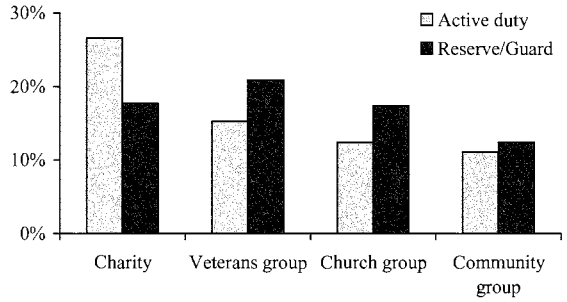
Recalling that some family members average 45 days on travel orders and some stay for up to six months, returning to the same job may not be possible. The Family

Medical Leave Act protects employment for up to 12 weeks, which covers the average leave but not the long leaves necessitated by the most serious injuries.[73]

Returning to work can be especially problematic for spouses and parents of injured service members who are permanently dependent on attendant care. When employer taxes and agency overhead are taken into account, the VA aid and attendance allowance barely covers the costs of full-time attendant care.[74] Family members who assume the caregiver role themselves—and manage to qualify for payment through the VA allowance, which isn't always easy—may earn less in this "job" than they would otherwise. Families are financially strapped whether they hire caregivers or serve as caregivers themselves.

Many charitable organizations have stepped up to assist families—starting as early as April 2003 with the American Red Cross, Walter Reed Army Community Service, Fisher House Foundation, and United Services Organization (USO). Today the number of organizations serving inured service members and their families exceeds 1,000. Families benefit enormously from this philanthropy (Figure 4), but a key problem for families is that no centralized clearing-house lists all these organizations, many of which are local. The DoD-approved "America Supports You" and Military OneSource websites, for example, list only those organizations that register with the website.

Figure 4—Percent of Families Helped by Non-Profit Groups, PCCWW Survey



[73] The Family Medical Leave Act requires reinstatement in a comparable position for immediate family members only (spouses and parents) who work for a public employer or private employer with 50 or more employees. Up to 12 weeks are authorized each year.

[74] *See* Small, VD. "What is a Fair Wage When Provided by Family or Friend?" *The Case Manager 17*: 63-66, 2006.

Caregivers often experience considerable financial, physical, and emotional stress. Studies of caregivers consistently show high levels of psychological stress and unmet service needs. Multi-faceted programs that tailor benefits and services to family needs are the most effective.[75]

Health Care for Families

While injured service members are receiving acute care and rehabilitation, their families—spouses, children, parents, and others—also need unencumbered access to health care. Military treatment facilities care only for TRICARE beneficiaries, including active-duty and retired families, and are not authorized to provide non-emergency services such as prescription refill orders or primary care to others.

A clear area of family need is psychological services directed, in part, at healing the family unit. Family members bear the brunt of daily care for long periods of rehabilitation and recovery, while their own emotional stability and well-being, along with those of the injured service member, are placed at great risk. Ideally, these family members could obtain psychological services at the military medical facility, where they could be coordinated with other health services; referral to community providers in the TRICARE network is a less desirable alternative. But, the shortage of mental health professionals throughout the military, coupled with the deployment of many mental health professionals to theaters of operations, prevents the military facilities from being able to offer such services to family members routinely.

For health care generally, TRICARE provides a comprehensive health benefit at no cost to active-duty personnel (including activated reservists) for themselves and their dependents. This is helpful, because few spouses of active-duty personnel have their own health insurance. That makes the loss of TRICARE coverage significant, though, when the injured service member separates from the military, especially if recovery will be a long haul. The Subcommittee Report on Disability Evaluation and Compensation discusses offering TRICARE to all service members whose injuries lead to their leaving military service. This change would fill an important gap in support for a number of families.

Overall Satisfaction with Family Support

The PCCWW survey asked injured service members how satisfied they were overall with the support provided to their families. Sixty percent were very or somewhat satisfied and only 27 percent were very or somewhat dissatisfied (top panel of Figure 5).

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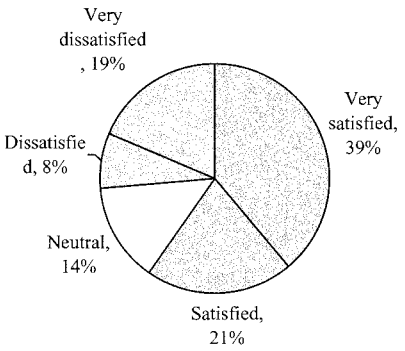
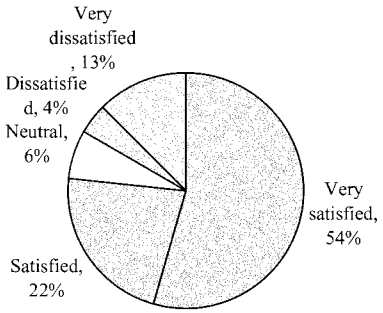
[75] U.S., Department of Health and Human Services, National Institutes of Health. "Caring for the Caregivers: The Hidden Victims of Long-Term Illness." *News in Health*, August 2006. Available at http://www.newsinhealth.nih.gov/pdf/NIHNiH%20August06.pdf.

This figure is for all evacuated service members. We expected that the results might differ for the more seriously injured, whose families need more support. Using whether the military issued non-medical attendant orders to flag seriously injured service members, we find noticeably higher satisfaction levels in this group (bottom panel of Figure 5).

Figure 5—Satisfaction with Support for Families, PCCWW Survey



All Evacuees



Evacuees with Attendant Orders

ACTION STEPS

Complementing action steps presented in other subcommittee reports—such as including family members in discussions about the recovery plan, having a single Recovery Coordinator, and extending TRICARE coverage to all service members who leave the military because of a combat-related injury—the following measures would help support families of injured service members now and in the future:

Action Step: DoD should establish a standby plan for family support of injured service members in future conflicts, drawing on the experiences and model programs developed during this conflict.

Action Step: Congress should make injured service members eligible for the TRICARE respite care and aid and attendance services benefits through the Extended Care Health Option.

Action Step (suggested): DoD and VA should standardize, and assure universal access to, family services early in the treatment process. This package should include education about the service member's injuries and expected progress, caregiver training, and counseling and psychological services.

Action Step: DoD and VA, in regularly evaluating their programs for injured service members, should routinely consider the interests of families and solicit family members' comments, suggestions, and feedback on proposed changes.

Action Step: Congress should amend the Family Medical Leave Act to allow up to six months' leave for a family member of a service member who has a combat-related injury and meets the other eligibility requirements in the law.

EDUCATION, TRAINING, AND EMPLOYMENT

THE CHALLENGE

The Department of Veterans Affairs (DVA), Department of Labor (DOL), Department of Defense (DoD), state, private, faith based, community based, and other organizations are providing employment services to assist veterans with disabilities returning from the war to become suitably employed. VA and DoD along with the other organizations, work together to assist veterans with disabilities obtain suitable employment for veterans. Each organization provides employment, education and training services through different venues. The primary function of these organizations is to assist in providing the veteran with the tools necessary to return to work, attain self-sufficiency, and participate in family and community life.

BACKGROUND

Education and Training Services

Employment is the dominant concern for most veterans making their transition to civilian life. A veteran with a suitable job is in a position to face the challenges that come with beginning a new life. The VA's Vocational Rehabilitation and Employment program provides education, training, and employment services to disabled veterans who have an **employment handicap**—defined by VA as "an impairment of a veteran's ability to prepare for, obtain or retain employment consistent with his or her abilities, aptitudes and interests." To apply for the program, veterans must have at least a 10% disability rating to receive the comprehensive evaluation that determines the presence of an employment handicap. If the veteran's disability rating is right at 10%, the employment handicap has to be serious. The many services offered in this program and other DoD and VA programs are summarized in Table 1.

While recovering on active duty, injured service members whose condition permits it could begin an educational program under DoD's tuition assistance program. However, it is unclear how many could or would want to do this.

The objective of vocational rehabilitation services is to prepare veterans for suitable employment that is consistent with their aptitudes, interests, and abilities. Services—such as vocational assessment, labor market surveys, developing alternative work plans, retraining, and assistance with job-seeking skills—focus primarily on helping individuals with disabilities enter a different job or career. For severely disabled veterans for whom employment is not an option, the program focuses on enhancing their ability to live more independently in their home and/or community.

Table 1--DoD and DoD Education, Training, and Employment Benefits

Benefit Type	Eligibility Criteria	Services/Benefits
Tuition Assistance (DoD)	Active Duty	• Up to $4500/ year
Computer/ Electronics Accommodation Program (DoD)	Service members with injuries that have caused: • Dexterity impairment • Vision/hearing loss • Cognitive injury	• Assistive technology and services for: • Active duty during medical recovery • Veterans in a federal job
Vocational-educational counseling (VA)	• Eligible for a VA education program: e.g., o Montgomery GI Bill o Reservists Education Program • If active duty, within 6 months of separation	• Interest and aptitude testing • Setting occupational goal • Locating appropriate educational or training program
Vocational rehabilitation and employment (VA)	• Honorable or other than dishonorable discharge; • Service-connected disability at least 20%; • Comprehensive evaluation shows employment handicap • Period of eligibility is 12 years	• Full tuition in approved training programs • Subsistence allowance (e.g., $508/mo if single, $799 for a family of 4) • Employment assistance • Independent living assistance
Educational assistance for veterans not eligible for the services above (DoD/VA)	Montgomery GI Bill • High school degree • Active Duty: 2-3 yrs service, honorable discharge, $100/mo while serving • Selected Reserve: 6 year obligation, in good standing with a reserve unit Reserve Educational Assistance Program • Reserve component members with 90+ days on active duty after 9/11/2001	• Monthly benefit varies by benefits program, type of educational program, attendance level (standard benefit for full-time college is $1,075/mo.) • 36 months over 10 years after discharge • Some recruiting contracts include higher benefits
Dependents' educational assistance (VA)	• Dependent of service member or veteran who is permanently and totally disabled due to a service-related condition	• Up to $860/month for 48 months

Finally, the VA program also provides education and training for spouses and dependents of service members who are permanently and totally disabled. This benefit recognizes that most of these veterans cannot work, making their family members' earnings especially important.

Research has shown that vocational rehabilitation and employment services should be provided as early as possible after the onset of the disability to significantly impact the service members' return to work.[76]

In collaboration with DoD, VA has several policies that expedite entry into its programs:

- VA places a vocational rehabilitation counselor at eight military medical centers[77] to advise assist those service members who need to prepare for civilian life. The counselor can arrange through the Coming Home to Work program for service members qualified for vocational rehabilitation and facing separation to work in a government office, gain on-the-job training, and be considered for post-service employment
- Since 1992, DoD and VA have collaborated to offer the Disabled Transition Assistance Program, an expanded version of an educational program offered to all service members when they leave the military.
- DoD provides VA with data on all OIF/OEF veterans who have been discharged from service. VA identifies those with pending claims and these claims receive expedited processing.
- Veterans who are newly separated, disabled, or burdened with a barrier to employment have priority for receiving vocational and employment services.

Employment Services

An array of employment services and employer incentives has been developed to promote employment opportunities for veterans in general and disabled veterans in particular. Federal and state hiring gives veterans preference. Disabled veterans qualify for 10 extra points on the federal civil service examination. For scientific and professional positions at GS-9 or higher, candidates are rank-ordered by points including preference points. For other positions, veterans with a disability rating of 10% or higher are listed above all other candidates for the position. In general, a veteran may not be passed over for a non-veteran without good reason. Disabled veterans also may be appointed without competition through a Veterans Recruitment Appointment. Finally,

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[76] GAO-05-167, Vocational Rehabilitation: More VA and DoD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers, January 2005; GAO-96-133, SSA Disability: Return-to-Work Strategies from Other Systems May Improve Federal Programs, July 1996; Michigan Bureau of Disability Workers' Compensation, Report of The Task Force on Vocational Rehabilitation in Workers' Compensation.

[77] Walter Reed Army Medical Center; National Naval Medical Center at Bethesda, Brooke Army Medical Center, Naval Medical Center San Diego, Eisenhower Medical Center (Fort Gordon, Georgia), Evans Army Community Hospital (Fort Carson, Colorado), Darnall Army Community Hospital (Fort Hood, Texas), and Madigan Army Medical Center (Fort Lewis, Washington).

federal agencies are required by law to establish a separate affirmative action program for disabled veterans to promote their "maximum of employment and job advancement opportunities."[78] In fiscal year 2005, 92,642 disabled veterans were employed in non-postal federal jobs—an 18% increase since 2001. An additional 63,456 disabled veterans were employed in postal jobs. Reflecting an overall decline in postal employment, this number was down 18% since 2001.[79]

The Department of Labor's Veterans Employment and Training provides funding through grants to the states ($225 million in fiscal year 2006) to hire staff to assist veterans in finding employment:

- Disabled Veterans Outreach Program specialists work from VA facilities, state or local veterans service offices, or nonprofit agencies. They act as case managers for veterans with a serious employment handicap and work with DoD and VA, employers in the veteran's community, Veterans Service Organizations, and others to identify appropriate training and employment opportunities. They also follow up with veterans who find jobs and their employers to assist in job retention.
- Local Veteran Employment Representatives are state employees who work in local state employment offices and assist veterans with all the employment services provided by these offices.

The grants carry a requirement to give "special disabled veterans"[80] preference in referrals to potential employers.

The Workforce Investment Act of 1998 authorized a network of community One-Stop Career Centers around the country. The Department of Labor coordinates with other federal agencies, state and local employment boards, and other public and community-based organizations to operate offices where people can receive or be referred to all the qualified education, training, and employment services in the area. There are currently 3500 Centers and an online portal (Career One Stop). Combined, 62 percent of service members, including those in transition, entered employment and most retained it.

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[78] Section 4214 of Title 38, United States Code.

[79] U.S. Office of Personnel Management, Report to the Congress: The Employment of Veterans in the Federal Government: FY 2005, November 2006.

[80] **Special Disabled Veteran** - A Veteran (see definition above) entitled to disability compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the U.S. Department of Veterans' Affairs for a disability:

- Rated at 30 percent or more; or
- Rated at 10 or 20 percent in the case of a veteran who has been determined by the U.S. Department of Veterans' Affairs to have a serious employment handicap under Chapter 31, Training and Rehabilitation for Veterans with Service Connected Disabilities; or
- A person who was discharged or released from active duty because of a service connected disability.

Employers have incentives to hire veterans from the VA's Vocational Rehabilitation and Employment Program, who are eligible for special incentives in addition to incentives that apply to all veterans. Incentives offered by VA include:

- **VA On-the Job Training Program:** VA supplements entry wages for disabled veterans hired through the Vocational Rehabilitation and Employment program. The employer pays an apprentice wage and VA increases the wage to the journeyman level. The employer is eligible for the federal Work Opportunity Tax Credit (see below).
- **VA Special Employer Incentive Program:** Employers who hire veterans judged to have extraordinary obstacles to employment are reimbursed for up to 50% of the veteran's pay for up to six months and also qualify for the federal Work Opportunity Tax Credit.
- **VA Non-Paid Work Experience Program:** This program places veterans in local, state, or federal government agencies to gain particular skills and, hopefully, obtain a permanent position in the agency. VA pays the veteran its standard monthly subsistence allowance for trainees.

Other federal incentives include:

- **Architectural / Transportation Tax Deduction:** Businesses can deduct up to $15,000 per year to make facilities or work vehicles more accessible and usable by disabled persons.
- **Disabled Access Credit:** Small businesses that incur expenses to provide access to persons with disabilities can take a tax credit of 50% of costs per year above $250 and up to $5125. The expenses must be necessary for compliance with the Americans with Disabilities Act.
- **Veterans Job Training Act:** VA provides training costs incurred by employers who hire long-term unemployed veterans. This program currently applies only to veterans from the Korean and Vietnam eras; it will likely be extended to veterans of the current war when the time comes.
- **Work Opportunity Tax Credit:** One-time tax credit of up to $2400 for businesses that hire individuals with disabilities who have completed or are in the process of completing rehabilitative services, including the VA's.

Federal contractors must comply with several veteran hiring provisions. Contractors and subcontractors must list all job openings with state employment offices, file an annual report on veteran employment, and have an affirmative action plan that addresses disabled veteran hiring.

To raise employer and veteran awareness of these programs and incentives for veteran employment, the Jobs for Veterans Act in 2002 established the President's National Hire Veterans Committee within the Department of Labor. The committee brings together representatives from private employers, organized labor, and service organizations with officials from the Small Business Administration, Office of Personal Management, United States Postal Service, VA, DoD, and Department of Labor; most of the members are veterans themselves.

Roughly half of service members injured in Iraq and Afghanistan are reservists, most of whom took leave from a civilian job when they were called to active duty and deployed. The Uniform Services Employment and Reemployment Rights Act (USERRA) requires that civilian employers rehire reservists after they return from deployment in the same or comparable position and precludes employment discrimination based on military service, particularly in the Guard and Reserve. The National Committee for Employer Support of the Guard and Reserve, operated within the Office of the Secretary of Defense, educates Reserve component members and civilian employers about the provisions of USERRA and assists in the resolution of conflicts arising from an employee's military commitment.

PREVIOUS RECOMMENDATIONS AND REPORT FINDINGS

The 1999 report of the Congressional **Commission on Servicemembers and Veterans Transition Assistance** reviewed the many programs and services that assist service members making the transition to civilian life. Among the Commission's recommendations was one that has not so far been implemented:

- DOL, DoD, and VA should establish a customized, separate Veterans and Servicemembers Internet Site (VASIS) on the Department of Labor's web site.[81]

In 2004, the **VA Task Force on Vocational Rehabilitation and Employment** was convened to analyze and assess the VA's Vocational Rehabilitation and Employment program. It concluded that "over the past decade, the Veterans Benefits Administration (VBA) has reduced its focus on the ultimate VA mission of returning veterans with service-connected disabilities to the workforce and the preeminent role of vocational rehabilitation in achieving that goal." The task force recommended reorganization and increased staffing to support the following actions:

- Streamline eligibility and entitlement for those veterans in most critical need,
- Replace the current vocational rehabilitation and employment process with a five-track employment-driven service delivery process,
- Expand counseling benefits to provide VR&E services to service members before they leave military service and veterans,
- Improve the capacity of the information technology systems and
- Develop online systems for job placement instead of relying on other agencies' systems,
- Improve intra-and interagency coordination within VA and with DoD, the Department of Labor, and the states,
- Implement a long-term research and program evaluation agenda to assess the life cycle outcomes of the vocational rehabilitation program.

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[81] This targeted web site would be similar to MonsterTRAK, which assists college students and recent alumni as they transition from school to the job market. The website includes job listings, a resume database, statistics about the jobs being offered and accepted, job fair and campus interview schedules, and a network of mentors. The President's National Hire Veterans Committee maintains a web site with links to existing employment resources (www.HireVetsFirst.gov) but it is not the full-service site envisioned in the 1999 report.

A 2005 **Government Accountability Office** (GAO) report on DoD reviewed VA's ability to expedite vocational rehabilitation and employment services for seriously injured service members.[82] The report notes that the recovery process differs substantially across patients with similar injuries and, for many, prospects for return to duty may be uncertain for some time. Under these circumstances, determining when to approach injured service members about these VA services is not straightforward. GAO recommended that:

- VA and DoD should reach an agreement about providing information that VA needs to promote the recovery and return to work of seriously injured service members,
- The need for VA to develop policies and procedures for regional offices to maintain contact with seriously injured service members who do not initially apply for vocational rehabilitation and employment services.

In light of the GAO recommendations, VA and DoD signed an agreement in June 2005 to lay the groundwork for sharing data and improving their assistance to seriously injured service members, including reservists, as they transition to civilian life.

The 2007 **Presidential Task Force on Returning Global War on Terror Heroes** made the following employment related recommendations:

- Increase attendance at TAP and DTAP Sessions.
- Department of Education staff participate in Department of Labor-sponsored job fairs
- Integrate the "Hire Vets First" Campaign into existing job and career fairs.
- Improve civilian workforce credentialing and certification.
- Train active duty, Guard and Reserve personnel on the Uniformed Services Employment and Reemployment Rights Act (USERRA)
- Develop a financial education module for transitioning service members on the benefits
- Increasing Employment Within The Federal, State, Private and Faith Based Sectors

WHAT THE COMMISSION LEARNED

Other studies find that disabled veterans are slightly less likely to be working than their non-disabled counterparts and, among workers, disabled veterans earn somewhat less. Almost all of these differences are concentrated among veterans with a VA disability rating above 50%.[83] These veterans make up more than one-third of the Vocational Rehabilitation and Employment program's caseload—about the same fraction that are under age 30

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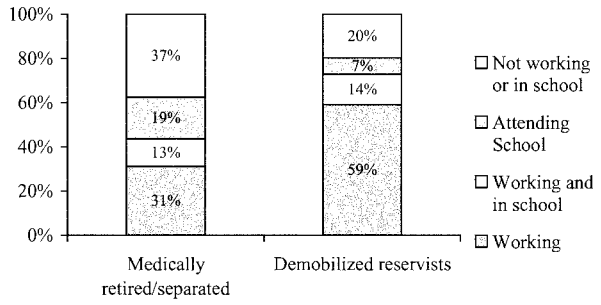
[82] U.S., Government Accountability Office, GAO-05-167. *Vocational Rehabilitation: More VA and DoD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers*, January 2005.

[83] Buddin, Richard J. and Kanika Kapur. *An Analysis of Military Disability Compensation*, MG-369-OSD, RAND Corporation, 2005; U.S., Bureau of Labor Statistics, *Employment Situation of Veterans: August 2005*, news release, May 26, 2006; U.S., Bureau of Labor Statistics, *Employment Situation of Veterans Summary*, USDL 06-897, 2006.

The survey fielded for this Commission also found relatively high employment rates even for those who were medically evacuated to the U.S. and subsequently left active service (Figure 1). The employment and school attendance rates were similar for veterans in their first and second years post-service.

Figure 1—Employment and School Attendance for OIF/OEF Veterans and Demobilized Reservists, PCCWW Survey



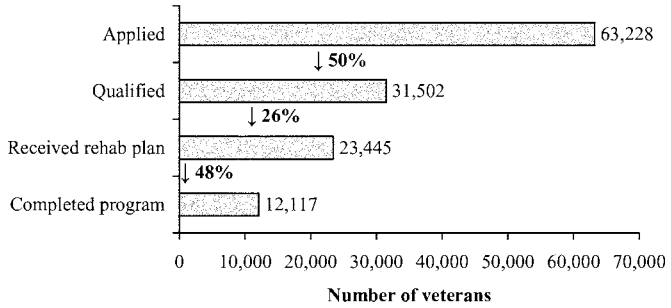
The VA Task Force on Vocational Rehabilitation and Employment found that VA data on program participants could not support an evaluation of program outcomes over time. Studies of other vocational education programs have found that they can substantially improve employment outcomes in the first few years.[84] For men with musculoskeletal and mental health disabilities, a $1 investment by the public in federally subsidized state vocational rehabilitation has been estimated to return $3 in (discounted) future earnings.

Each year, about 65,000 veterans apply for the VA's Vocational Rehabilitation and Employment program (Figure 2). Historically, most applicants were seeking the program's generous education and training benefits—more generous than the benefits available through the GI Bill. All program participants must be judged to have an employment handicap, but for many participants their goal is to improve their employment opportunities and earnings. As the 2004 Task Force on Veterans Vocational Rehabilitation and Employment observed, many more veterans apply for the program than are accepted and dropouts are relatively common over the course of a program that traditionally averaged three or more years to complete. The task force anticipated that its five-track employment program, individually tailored to the veteran's goals, would

[84] Jellinek HM and Harvey RF. "Vocational/Educational Services in a Medical Rehabilitation Facility: Outcomes in Spinal Cord and Brain Injured Patients." *Archives of Physical Medicine and Rehabilitation 63*, 87-88, 1982. Dean, DH, RC Dolan, RM Schmidt. "Evaluating the Vocation Rehabilitation Program Using Longitudinal Data: Evidence for a Quasiexperimental Research Design" *Evaluation Review 23*, 162-89, 1999.

decrease the dropout rate. VA data for fiscal year 2006 show that about half of the applicants qualify for the program and fewer than 40% of qualified veterans complete the program. These statistics differ little from the statistics quoted in the task force report for 2003.

Figure 2—Vocational Rehabilitation and Employment Program Statistics, Fiscal Year 2006



Three-quarters of the disabled veterans who complete the Vocational Rehabilitation and Employment Program are on a job track rather than an independent living track. Over 90 percent found jobs, most in the private sector (Figure 3) where their monthly pay averaged almost $3000 (Figure 4). The most lucrative jobs were in the federal government, where 12% found a position.

The earnings for veterans who complete vocational rehabilitation appear to compare favorably with earnings achieved through the state vocational rehabilitation programs that serve the general population with disabilities.[85] However, earnings for the state programs were measured three years after completion, whereas the VA data are initial earnings. Both employment and earnings outcomes have been shown to slip over time and disabled workers may find that their ability to perform their jobs is limited.[86] VA does not routinely track vocational rehabilitation participants over time to evaluate program outcomes and identify factors associated with success. Therefore, it is difficult

[85] Hayward, BJ and H Schmidt-Davis, *Longitudinal Study of the VocationalRehabilitation Services Program, Final Report: VR Services and Outcomes*, RTI International, May 2003.
[86] Butler, RJ, WG Johnson, and ML Baldwin, "Managing Work Disability: Why First Return to Works is Not a Measure of Success," *Industrial and Labor Relations Review*, 48:3, April, 1995. MacKenzie EJ, MJ Bosse, JF Kellam, et al. "Early Predictors of Long-Term Work Disability after Major Limb Trauma. *Journal of Trauma 61*, 688-94, 2006. Pezzin, LP, TR Dillingham, and EJ MacKenzie. "Rehabilitation and the Long-Term Outcomes of Persons with Traum-Related Amputations." *Archives of Physical Medicine and Rehabilitation 81*, 292-300, 2000.

to assess the patchwork of programs and hiring incentives described earlier. We cannot determine whether these programs are allowing disabled veterans to reach their full potential after they return to civilian life.

Figure 3—Sector Where Veterans with Disabilities Found Employment, FY 2006

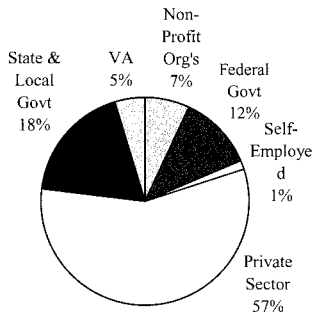
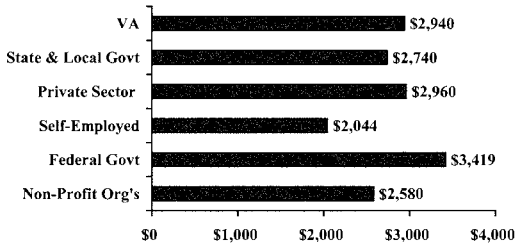


Figure 4—Average Monthly Pay Offered to Veterans with Disabilities by Sector, FY 2006



Although not definitive, the evidence points to the effectiveness of vocational rehabilitation in improving employment opportunities for the disabled and the benefits of early intervention. VA's Vocational Rehabilitation and Employment program appears to have good results with those veterans who are eligible for and complete the program. However, of the 65,000 veterans who apply for the program each year, at most 10,000 of all ages complete the employment track in the program each year (another 2,000 or more complete the independent living track). Including a vocational rehabilitation plan in the recovery plan outlined by this Commission's Subcommittee on the Continuum of Care

may lead to more injured service members benefiting from the VA's program. This could be accomplished by expanding the Coming Home to Work program that provides vocational evaluation and assistance to injured service members in eight military treatment facilities. Some other disability systems in the U.S. and overseas require participation in vocational rehabilitation, where it is likely to be beneficial, for continued receipt of disability compensation.[87] This would be a dramatic departure in policy for disabled veterans, however.

On the surface, it appears likely that expanding eligibility for the program and improving the completion rate would be highly cost-effective, substantially improve long-term outcomes for injured service members, and decrease the substantial lifetime earnings losses experience by the most severely disabled veterans. More systematic collection of information on the life course of disabled veterans and the employers who hire them will be needed to develop the most effective strategy for vocational rehabilitation and employment.

ACTION STEPS

The Commission believes that the public investment in education, training, and employment services for injured service members should be increased and incentives should be provided to encourage veterans to complete their education and training programs. Veterans who have been injured in service to their country should be given the education or training they need for the most complete life recovery possible and help finding a job.

Action Step: VA should intervene early to plan for and provide education, training, and employment services for injured service members.

- The recovery plan for seriously injured service members should include an initial vocational rehabilitation plan based on a vocational evaluation by a VA counselor as early as the member's medical condition allows.
- Vocational services should begin as early as possible, whether or not the service member is still on active duty and be closely coordinated with the state employment and veteran agencies where the service member will live.
- VA vocational staffing and location must be adequate to support early intervention.

Action Step: VA should make the following modifications in its Vocational Rehabilitation and Education program to improve completion rates:

- Extend the maximum number of months for a veteran who attends part-time (up to 72 months), with approval of their Recovery Coordinators and vocational counselor
- In addition to providing financial support for participants through transition pay (as described in the Subcommittee Report on Disability Evaluation and

[87] U.S., General Accounting Office, GAO-01-153. *SSA Disability: Other Programs May Provide Lessons for Improving Return-to-Work Efforts*, January 2004.

Compensation), pay a retention bonus equal to 10 percent of annual transition pay for completion of the first and second years and 5 percent for completion of the third year.

Action Step: VA should institute a quality improvement program for vocation rehabilitation involving systematic collection of data on employment and earnings of disabled veterans over time and employer hiring practices. Through regular program evaluation and well-designed experimental interventions, VA should evaluate its methods for identifying candidates for vocational rehabilitation and employment services, retaining them in the programs, and providing incentives for employers to hire them.

DISABILITY EVALUATION & COMPENSATION

THE CHALLENGE

The current disability evaluation and compensation systems within the Departments of Defense and Veterans Affairs were developed after World War II. Their methods for rating the level of an injured service member's disability need to be updated. DoD's disability evaluation process appears to have multiple objectives and can be overly complicated; VA's system compensates for the inability to earn what a non-disabled veteran earns. The two systems provide different amounts of compensation for the same injury, based on their different approaches to rating disabilities. The procedures for obtaining benefits have, over many years, become overly bureaucratic, hard to navigate, and confusing for some. Injured service members who received excellent medical care on the battlefield and in the acute care hospital setting sometimes find themselves in a maze of disability policies and procedures.

BACKGROUND

A service member who is injured and cannot continue in military service navigates the military disability system and then the VA disability system. Each system rates the member's disability level and each has a disability compensation package. Most service members can receive disability compensation from only one department. This section first describes the military and VA evaluation (rating) systems and then the compensation systems.

DoD's Physical Disability Evaluation System

The Secretaries of each branch of the military have the authority to develop systems to assess whether service members are capable of carrying out the activities of their military occupation (Figure 1). Service members deemed "unfit" to carry out these activities are given a disability rating from zero to 100 percent (in 10 percent increments), based on the condition or conditions that make them unfit for duty. They are then discharged from the military into one of three categories:

- Medical separation: 0-20% rating
- Temporary disability retirement: 30-100% rating, but level of impairment may change
- Permanent disability retirement: 30-100% rating and level of impairment is stable.

The Department calculates the disability compensation that members will receive based upon either years of service or percent disability rating; the final rating is permanent.

The disability evaluation process generally begins at a military treatment facility, after medical personnel determine that a service member has received the maximum

benefit from medical care for his or her injuries. At that point, the member undergoes a complete physical examination, the results of which are summarized in a written report to a **Medical Evaluation Board**, which typically includes at least two physicians from the military treatment facility. The Board receives additional information from the service member's commanding officer, addressing his or her ability to perform assigned duties, and, if necessary, evidence that the injury was not due to the member's own misconduct. The report from the medical examination conducted when the member entered service is included in the package, if it is available. If the member fails to meet general medical standards for continuing in service, the Medical Evaluation Board refers the case to the **Physical Evaluation Board.**

This Board determines the member's specific fitness for continued military service. The standard for determining fitness is whether the medical condition precludes the member from reasonably performing the duties of his or her military occupation and rank.[88] For those found unfit, the Board further determines whether the member qualifies for medical separation or retirement and, if so, assigns a disability rating based on the **Veterans' Affairs Schedule for Rating Disabilities**. Only the medical conditions affecting fitness are rated. Membership on the Physical Evaluation Board varies by service, but generally includes a physician and two line officers or civilian equivalents. The initial Board review is considered informal. Service members who do not concur with its findings may request reconsideration and submit new medical information or additional supporting evidence. If found unfit, they may demand a formal Physical Evaluation Board hearing and, if found unfit again, may petition the Secretary of their Service for relief.

Physical Evaluation Board Liaison Officers are available at all military treatment facilities to counsel service members on their legal rights and benefits during each step of the disability evaluation process. These liaison officers inform service members of the Physical Evaluation Board's findings and help them complete an "election of options" form, indicating whether they accept the Board's findings. The liaison officer then notifies the Board as to how members have decided to proceed. Liaison officers receive annual training, but at present that training is not standardized, and there is no certification program.

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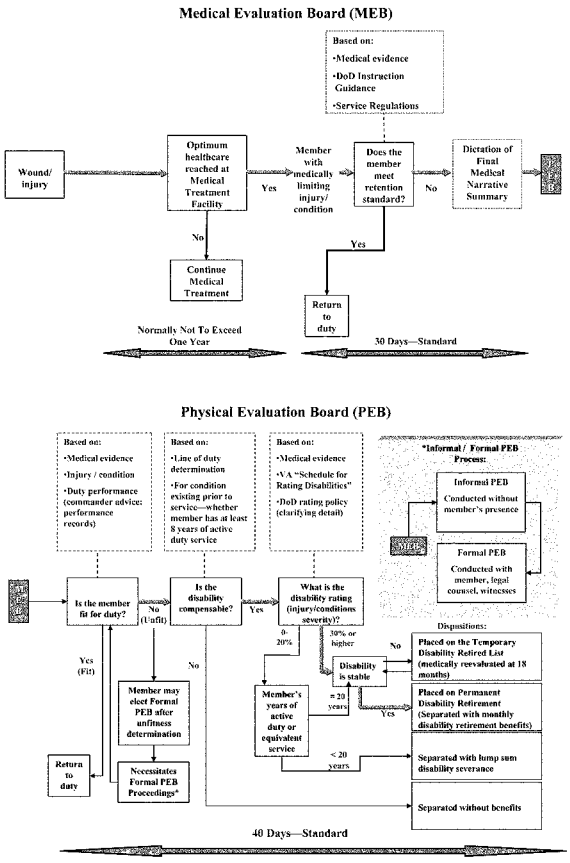
[88] DoDD 1332.18 states: "The sole standard to be used in making determinations of unfitness due to physical disability shall be unfitness to perform the duties of the member's office, grade, rank or rating because of disease or injury." The Directive also specifies the requirements for medical separation and retirement. For members with less than eight years of service, the medical condition must have arisen during service after 30 days or in the line of duty during the first 30 days. If they have more than eight years' active service, they are eligible for disability compensation, even if the disabling condition existed prior to service. Conditions must be permanent and not the result of misconduct or neglect.

Figure 1—DoD Disability Evaluation System



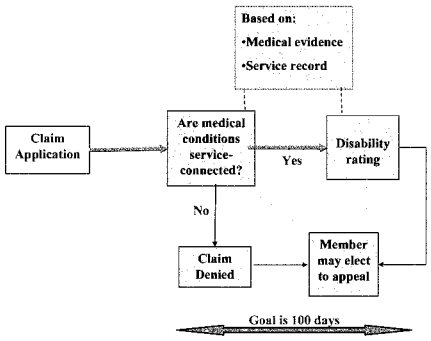
Note: Modified from Commission presentation, Mr. William Carr, Principal Director, Military Personnel Programs, April 14, 2007.

VA's Disability Claims Process

When a veteran files a VA disability claim, the VA's disability evaluation system is set in motion (Figure 2). VA is required by statute to obtain evidence supporting the claim, and claimants may need to undergo a physical examination. VA's rating decision determines whether a claimed disability is service-connected, its severity, and its effective date. VA rates service-connected medical conditions that are service connected, as well as conditions that might have been aggravated by military service. Unlike DoD's rating, VA's rating is not permanent and may be adjusted over time as a veteran's condition improves or worsens.

Approximately 80 percent of all service members who go through DoD's Physical Disability Evaluation System also file a VA claim. VA claims may be filed any time after discharge. Claims by veterans of Iraq and Afghanistan are given top priority for processing, and VA is meeting its goal to complete these claims within 100 days. Veterans who have a single-disability rating of 60 percent or more, or a combined-disability rating of 70 percent or more, and who are unable to work receive compensation at the 100 percent level. Over the past decade, the number of veterans rated **unemployable** has more than tripled.[89]

Figure 2—VA Disability Evaluation System



[89] U.S., Government Accountability Office. *Veterans' Disability Benefits: VA Should Improve Its Management of Individual Unemployability Benefits by Strengthening Criteria, Guidance, and Procedures.* GAO-06-309, May 30, 2006. Available at http://www.gao.gov/new.items/d06309.

A joint VA/DoD initiative, the **Benefits Delivery at Discharge Program,** helps medically separating or retiring service members file for VA service-connected disability compensation up to 180 days before they are discharged. The program is intended to provide a smooth transition into the VA health care system and enable prompt receipt of VA disability compensation. About half of the service members who might be eligible for the program file their claims this way, according to VA.

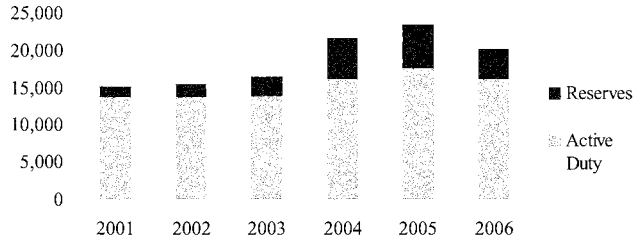
VA and DoD agreed in November 2004 on specific criteria to establish a **single medical examination** at the time of separation from the military. This cooperative examination was intended to improve the quality of service, provide a single portal for establishing eligibility for all benefits to which the veteran is entitled, and enhance the efficiency of the claims process. Local agreements between military installations and VA facilities to implement the single medical examination have been signed at almost all locations, but we could find no data to show how many separating service members complete DoD and VA disability processing with a single medical examination.

Volume of Cases and Timeliness

The volume of disability cases handled by DoD's Physical Evaluation Board system increased 55 percent across all Services between 2001 and 2005 (Figure 3) and then dropped in 2006. The Army has had the largest gain, driven by an almost seven-fold increase in cases for members of the Guard and Reserve Components.

DoD standards call for the Medical Evaluation Board and the Physical Evaluation Board to be completed in 70 days. But, in fiscal year 2005, the Army process exceeded 90 days for 26 percent of active-duty personnel and 52 percent of Guard/Reserve members.[90]

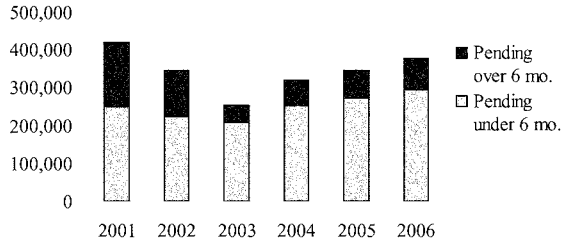
Figure 3—Number of Cases in the Physical Evaluation Board System, 2001-2006



[90] U.S., Government Accountability Office. *Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members.* GAO-06-362, March 31, 2006. Available at http://www.gao.gov/new.items/d06362.

In 2006, 806,000 VA claims were filed (Figure 4); only about one-fourth of these were first time or new claims. Between 2001 and 2003, the number of VA claims pending decreased 40 percent, and the number of claims pending for more than six months decreased by almost three-fourths. This progress, however, was stopped by a 2003 court decision which required that VA allow a year for veterans to submit all claim related information before reaching a final determination.[91]

Figure 4—Number of Cases in the VA Disability Claims System, 2001-2006



The growing VA claims workload has caused the average number of days required to process a claim to reach 180. Veterans who appeal their decisions can expect to lengthen the process by, on average, another 657 days[92]—well over two years. The Benefits Delivery at Discharge, described earlier, has been effective in expediting VA claim processing; in fiscal year 2006, it took an average of only 68 days to complete a claim under this program. Since the member is still on active duty, the ready availability of complete medical information facilitates claims review.

VA Schedule for Rating Disabilities

The current VA **Schedule for Rating Disabilities** is the latest in a long list of disability rating schedules dating back to 1921. A 1945 revision is the basis for today's schedule. DoD and VA both use this schedule to evaluate disabilities resulting from diseases or injuries incurred in, or aggravated by, military service. The schedule lists more than 700 disabilities in 15 body systems and provides evaluation criteria for each. The schedule's rating outcomes range between zero and 100 percent, at 10-point increments, depending on severity.

In 1988, the General Accounting Office (later the Government Accountability Office) reported that there had been no comprehensive review of the disability rating

[91] *Paralyzed Veterans of America* et al. v. *Secretary of Veterans Affairs*, U.S. Court of Appeals for the Federal Circuit, 02-7007,-7008,-7009,-7010, decided September 22, 2003.

[92] U.S., Government Accountability Office. "Processing of Claims Continues to Present Challenges." Testimony before President's Commission on Care for America's Returning Wounded Warriors, March 13, 2007.

schedule since 1945, and that the schedule contained outdated terminology, ambiguous classifications, and criteria that threaten consistency in ratings.[93] GAO recommended that VA thoroughly review the schedule and establish a process for systematic review and updating. VA followed up on the recommendation, and over the past 20 years, ratings for 12 of 15 body systems have been revised. The three unrevised body systems account for a disproportionate number of claims, however.

HOW DISABILITIES ARE COMPENSATED

DoD Disability Compensation

A service member's disability rating determines whether he or she receives lifelong **disability retirement** payments or a lump-sum **disability severance** payment. Service members with a zero, 10 or 20 percent disability rating and less than 20 years' service receive a lump-sum payment upon separation from the military. The payment equals twice the number of years served multiplied by monthly base pay at separation. Those with combined disability ratings of at least 30 percent or who have at least 20 years of service, regardless of the percentage rating, receive disability retirement compensation. The monthly benefit is the higher of two calculations, where the base pay amount used is an average over 36 months prior to discharge:

- Disability rating % multiplied by monthly base pay, *or*
- Years of service (up to 12) times 2.5% times monthly base pay.

Disability retirement pay is capped at 75 percent of base pay.[94] DoD also provides a lifetime TRICARE benefit to veterans with disabilities rated at 30 percent or higher or who have at least 20 years of service, regardless of the disability rating percentage. DoD disability pay is taxable unless the medical condition is combat-related.

Table 1 provides approximate disability pay for enlisted personnel and officers at different levels of experience and with different medical conditions. The examples are the same ones used in a recent GAO report comparing disability compensation for military personnel with disability compensation for public safety officers across the nation.[95] The table assumes only one unfitting medical condition in each case; many of the most serious injured personnel would have more than one condition that would be rated. The values are only approximate because the table uses the current level of base pay for calculating disability retirement pay. In reality, the calculation would be based on base pay over the past 36 months. Nevertheless, the table provides a reasonable picture of how disability pay changes across medical conditions and personnel with different ranks and years of service. Since all the calculations are based on monthly base pay,

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[93] U.S., Government Accounting Office. *Veterans' Benefits: Need to Update Medical Criteria Used in VA's Disability Rating Schedule.* HRD-89-28, December 29, 1988. Available at http://www.gao.gov/cgi-bin/getrpt?.

[94] While on the temporary disability retirement list, discharged personnel receive an amount equal to their disability rating times base pay, with a minimum of 50 percent.

[95] U.S., Government Accountability Office. *Disability Benefits: Benefit Amounts for Military Personnel and Civilian Public Safety Officers Vary by Program Provisions and Individual Circumstances.* GAO-06-4, April 7, 2006. Available at http://www.gao.gov/new.items/d064.

officers receive more than enlisted personnel and senior personnel receive more than junior personnel.

Table 1—Monthly DoD Disability Compensation for Selected Cases

Medical Condition	Years of Service	Enlisted Rank	Enlisted Compensation	Officer Rank	Officer Compensation
Tinnitus—10% rating	1	E-2	$2,900*	O-1	$4,900*
	6	E-5	$27,900*	O-3	$55,200*
	12	E-6	$72,000*	O-4	$141,200*
	22	E-9	$3,000	O-5	$4,400
Amputation below knee—40% rating	1	E-2	$ 580	O-1	$ 990
	6	E-5	$ 930	O-3	$1,840
	12	E-6	$1,200	O-4	$2,350
	22	E-9	$3,000	O-5	$4,400
Quadriplegia—100% rating	1	E-2	$1,090	O-1	$1,850
	6	E-5	$1,740	O-3	$3,450
	12	E-6	$2,250	O-4	$4,410
	22	E-9	$3,800	O-5	$5,530

* Amounts shown in blue are lump-sum severance payments; these service members get no monthly pay check.

VA Disability Compensation

Veterans given a VA disability rating of 10 percent or higher can receive monthly compensation from the Department of Veterans Affairs. The base amount of the payment depends on the percent rating and family status—whether the veteran has a spouse and dependents, including parents, and the ages of any children. Congress authorizes the payment amounts annually. VA disability compensation is tax free. The basic compensation rates for single veterans and veterans with a spouse and two children amounts are plotted in Figure 5. Compensation increases with disability level, with a sharp increase from the 90 percent to the 100 percent level. The added amounts for dependents are very modest.

VA also increases the amount provided to veterans with specific impairments through a schedule of Special Monthly Compensation payments. These may add only a modest amount to the basic compensation level, but the most severely impaired veterans can receive almost $7500/month.

Figure 5— Monthly VA Basic Disability Compensation

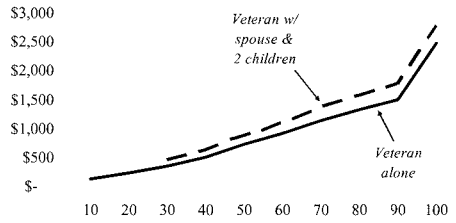


Table 2 shows VA compensation for the same cases used in Table 1 (showing DoD compensation). VA varies its compensation with disability rating level and the number of family dependents, but not with military experience or rank, as DoD does.

Table 2– Monthly VA Disability Compensation for Selected Cases

Medical Condition	Dependents	Basic Amount	Total with Special Monthly Compensation
Tinnitus—10% rating	Any[a]	$ 115	$ 115
Amputation below knee—40% rating	None	$ 501	$ 590
	Spouse	$ 556	$ 645
	Spouse, 2 children	$ 625	$ 714
Quadriplegia—100% rating	None	$2471	$6164
	Spouse	$2610	$6303
	Spouse, 2 children	$2781	$6474

[a]Compensation for veterans with disabilities rated at 10% or 20% do not include additional amounts for dependents.

The law pertaining to VA disability programs specifies that VA's disability ratings should be based on "average impairments of earning capacity resulting from such injuries in civil occupations,"[96] implying that VA compensation should replace lost earnings capacity.

[96] Title 38, U.S.C., Section 1155.

A recent study loss compared survey data on labor force participation and earnings of military retirees with and without a service-connected disability.[97] Military retirees with disabilities rated 50 to 90 percent are less likely to work and work fewer hours than nondisabled retirees. Disabled retirees rated at 100 percent work even less. Conversely, the research shows very little difference in labor force participation or hours for those with lower disability levels. Generally, full-time work yields relatively comparable earnings for disabled and nondisabled retirees. Earnings are lower for individuals at higher disability ratings primarily because of their lower labor force participation rates. Finally, the research showed that VA disability compensation failed to make up for the modest earnings loss at lower disability ratings and more than made up for earnings loss at higher disability ratings, after accounting for the tax exemption.

Various other benefits VA provides—for example, vocational rehabilitation, retraining, and job counseling—are designed to increase disabled veterans' ability to function and work. These various benefits have different eligibility requirements. For health care, a veteran's disability rating determines the priority group he or she falls into and thereby affects eligibility for enrollment, priority for care, and out-of-pocket costs.

Coordination of DoD & VA Disability Payments

All veterans can apply for VA disability pay. Most veterans who are medically separated or retired cannot receive disability pay from both VA and DoD. They must offset one pay with the other. Veterans who receive the lump-sum severance payment do not receive a VA check until VA pays back the DoD severance pay. For example, an enlisted member who separated after a year with only a 10 percent disability rating would not receive any VA disability pay for about the first two years. An ex-officer with 12 years of service would have to wait more than ten years before seeing a VA check; this veteran might not bother to file a VA claim.

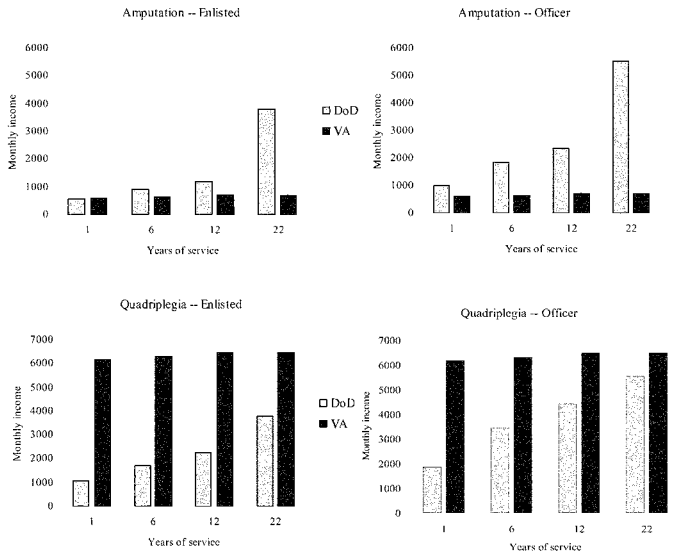
Individuals who are medically retired receive the higher of the two payments. Disabled veterans who have completed 20 years of military service and who have received at least a 50 percent VA disability rating are eligible for *both* DoD and VA disability pay—this is called "concurrent receipt."

Figure 6 illustrates how the two disability compensation systems compare for veterans who were medically retired—in the examples we use, amputees and quadriplegics. In the charts, the higher of the two payments is outlined in black. Except for junior enlisted personnel, DoD disability pay is higher for amputees, whereas Special Monthly Compensation for quadriplegics raises their VA disability pay significantly above their DoD pay. Recall that personnel who reach 20 years of service, have a DoD disability rating at or above 50 percent, and are wounded or injured in the line of duty receive both checks. In the cases shown in Figure 4, only the quadriplegics are eligible for concurrent receipt and they receive a combined annual income of well over $100,000

[97] Buddin, R and K Kapur, *An Analysis of Military Disability Compensation,* Santa Monica, CA: RAND, 2005.

(tax-free). Stepping over the eligibility thresholds for concurrent receipt (50 percent DoD rating and 20 years of service) is worth a considerable amount of money.

Figure 6—Comparison of DoD and VA Disability Compensation for Selected Single Medical Conditions



PREVIOUS RECOMMENDATIONS AND REPORT FINDINGS

The Commission drew on a wealth of information from numerous reports on the veterans' disability system, going back to the 1956 report by the President's Commission on Veterans' Pensions, chaired by General of the Army (Ret.) Omar N. Bradley. Over the years, recommendations similar to those of the Bradley Commission have been made repeatedly.

In 1956, the Bradley Commission concluded that there was *"no clear national philosophy of veterans' benefits."* That Commission's report contains the first clearest statement of goals for veterans' disability benefits programs:

- "Veterans' benefits are one means by which society attempts to ameliorate the human tragedy of war and distribute its burdens....It is clearly a national desire—and fully within our national economic capacity—to do justice by those who were injured or disabled as a consequence of their military service." (page 10)
- "The Government's obligation is to help veterans overcome special, significant handicaps incurred as a consequence of their military service. The objective should be to return veterans as nearly as possible to the status they would have achieved had they not been in military service." (page 4)
- "The rehabilitation of disabled veterans and their reintegration into useful economic and social life should be our primary objective."[98] (page 11)

More recent reports on the military and veterans disability systems have focused on the pressing need for improvement in the system's processes for assessing disabilities, assigning ratings, and determining compensation. Within the DoD disability system, reports issued in spring 2007 by the Army Inspector General and the Independent Review Group (IRG) note that the Services' disability evaluation systems vary significantly in the way they are implemented. The Independent Review Group also found that the various processes are unnecessarily cumbersome and adversarial. It recommended a complete overhaul to create a single DoD-wide Physical Evaluation Board and a common guideline for DoD and VA ratings.

Similarly, the 2003 President's Task Force to Improve Health Care Delivery for Our Nation's Veterans specifically recommended a single discharge examination to document conditions that might indicate a compensable condition[99] and make the transition from DoD to VA more seamless. The Task Force on Returning Global War on Terror Heroes went a step further and recommended "a joint DoD/VA process for disability benefit determinations by establishing a cooperative Medical and Physical Evaluation Board process within the military service branches and VA."[100]

The National Defense Authorization Act for 2004 established the Veterans Disability Benefits Commission and directed it to report on (1) eligibility for disability benefits, and other assistance for veterans and (2) the rates of compensation, including the "appropriateness of a schedule for rating disabilities based on average impairment of earning capacity." The Commission is scheduled to send its report to Congress in October 2007. Although we did not have the benefit of this report, the findings and recommendations of an Institute of Medicine study conducted for the Commission

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[98] The Americans with Disabilities Act of 1990 established similar national goals for all individuals with disabilities: "To assure equality of opportunity, full participation, independent living, and economic self-sufficiency." 42 U.S.C. sec. 12101(a)(8), P.L. 101-336.

[99] U.S., President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. *Final Report.* May 2003, pp. 29-30

[100] U.S., Task Force on Returning Global War on Terror Heroes. *Final Report.* March 2007, p. 4.

provided valuable information and recommendations. The study's findings and recommendations can be summarized as follows:[101]

- Consistent with current models of disability, the veterans' disability compensation program should expand its purpose to compensate for "work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life."
- The VA Rating Schedule is out of date and rates impairments with little or no assessment of a veteran's ability to work, engage in other daily activities, or enjoy quality of life. "VA should immediately update the current Rating Schedule…and devise a system for keeping it up to date." The study recommended adopting a new classification system using standard diagnostic coding systems and either incorporating functional limitation criteria in the schedule or developing a separate mechanism to support compensation for non-work disability.
- Numerous recommendations were directed at improving the implementation of the rating schedule, including better training, access to medical expertise during the rating process, and regular monitoring of consistency in ratings.
- VA should undertake a program of research on the ability of the schedule to predict earnings loss, methods for measuring functional limitation and quality of life, and the outcomes achieved by the services provided to disabled veterans.

WHAT THE COMMISSION LEARNED

Current anecdotal evidence of problems in the care of injured service members focuses heavily on the disability systems of DoD and VA. They and their family members describe a lengthy, hard-to-understand, and difficult-to-navigate process of assessing the individual's extent of disability. Delays in obtaining a VA disability rating can delay receipt of services and benefits. To many, the disability rating systems appear inherently unfair, because of inconsistencies in ratings granted between the different services, the services and VA, and for active-duty versus Reserve or National Guard service members.

From the Service perspective, injured service members unable to perform their duties—but maintained on active-duty status while hospitalized or in rehabilitation—reduce the effectiveness of their units. Given the rapid redeployment turn-around seen in this war, units with injured service members may not be able to replace those members and thus must return to battle shorthanded. The recent formation of an Army Wounded Warrior Regiment, complete with command structure, will allow injured members to be "reassigned," and their units to replace them.

An additional complicating factor is the need for certain service members to remain on active-duty status in order to receive necessary medical and rehabilitation care. This has led to an increase in the amount of time service members spend in medical hold

[101] Institute of Medicine. *A 21st Century System for Evaluating Veterans for Disability Benefits.* Washington, DC: National Academy Press, 2007.

or medical holdover status, bringing some members closer to 20 years of service. The incentive is to stay until the 20-year mark in order to qualify for full retirement benefits—particularly if the disability rating is less than 30 percent. For others with less time in service, the incentive is to appeal their disability rating to achieve 30 percent or higher in order to also qualify for full retirement benefits.

Earlier studies also have concluded that the disability process needs improvement. These studies, as well as media reports and information gathered during the Commission's meetings and site visits, raised concerns in the following four areas:

- Inadequate and outdated rating schedule
- Inconsistent evaluation processes and ratings outcomes
- Long delays in making determinations and
- Compensation formulas with unclear objectives.

Adequacy of Rating Schedule

As stated earlier, in the current DoD/VA disability systems, **the disability rating** service members and veterans receive determines the health care services, vocational rehabilitation, and other benefits they are eligible for as they recover, become rehabilitated, and adjust to any remaining impairments throughout their lives. The ratings also determine how much they will receive in disability compensation and whether this compensation is one-time-only or lifelong and whether it is tax-exempt.

It has taken 20 years to revise and update 12 of the 15 chapters in the VA disability rating schedule. The slow progress has important implications for service members injured in Iraq and Afghanistan because many of them experience injuries, such as traumatic brain injury and post-traumatic stress disorder, for which the ratings schedule is especially inadequate. The evolving nature of warfare and advances in trauma care change the "signature conditions" associated with new conflicts, and a more rapid and responsive updating and revision of any rating schedule must be a priority.

In its several reports on disability, the Institute of Medicine has stressed the importance of a new **concept** for rating disability.[102] When the Rating Schedule was initially developed, the degree of disability was measured by the degree of impairment. A more comprehensive rating system would:

- Consider disability as the product of a dynamic interaction among a person's health status, environment, and personal context
- Recognize that disability affects more aspects of a person's life than the ability to work and limits all kinds of activity and participation in community and family life and
- Measure the person's ability to function directly instead of inferring it from physical impairments.

VA's rating system, which focuses on limitations or loss of specific bodily parts or functions, does not map well to the more complex understanding of disability that has

[102] The most recent report in the series is Institute of Medicine. *The Future of Disability in America.* Washington, DC: National Academies Press, 2007.

developed over the past few decades. In particular, it does not *directly measure* functional losses relevant to ability to work or participate in other activities.

Consistency of Evaluation Process and Rating Outcomes

Although DoD and VA both use the VA Schedule for Rating Disabilities, the two departments often base their overall ratings on a different set of medical conditions. DoD assigns disability ratings for **service-limiting medical conditions** only, whereas VA ratings take into account **all medical conditions** incurred during or aggravated by military service. For this reason, VA's combined disability ratings for all medical conditions are often higher than DoD's.

For the same medical condition, the ratings should be consistent across and within the departments, because they use the same rating schedule. However, a Center for Naval Analyses comparison of DoD and VA ratings for about 65,000 veterans showed that VA ratings within a year or two of discharge are 20 to 40 percentage points higher than DoD ratings for the same individuals.[103] The higher VA ratings result primarily from the rating of more medical conditions, not higher ratings for individual conditions. Within DoD, the Army's Physical Evaluation Board has granted substantially more zero percent ratings (30 percent of all ratings) than have the other Services' boards (which average 4 to 5 percent).[104] Similar rating inconsistencies have been found across the 57 regional offices where VA claims are processed.[105]

The Physical Evaluation Board procedures described above for active-duty personnel are supposed to be the same for Reserve Component members. However, some of the rules may affect reservists differently, and the process may not unfold in the same way. Indeed, Government Accountability Office (GAO) reports from 2005 and 2006 analyzed Army data and found differences in the handling of Army active-duty and Reserve Component cases, including:

- Reservists declared unfit by a Physical Evaluation Board were less likely to receive permanent disability retirement or lump-sum disability severance pay;
- Reservist cases take longer to resolve and
- The process for extending a reservist's period of active duty, so that he or she may receive medical treatment, is "convoluted and poorly defined," according to the GAO, resulting in some reservists' being inappropriately dropped from active duty and consequent gaps in pay and benefits.[106]

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[103] Commission on Veterans Disability Benefits. Statement Of James Terry Scott, Ltg Usa (Ret) before the United States Senate Joint Hearing of the Armed Services and Veterans' Affairs Committees on April 12, 2007.

[104] This comparison was part of ongoing research for the Veterans Disability Benefits Commission and involved service members who had medical separations or retirements from 2000 to 2004.

[105] U.S., Government Accountability Office. *Veterans' Benefits: Further Changes in VBA's Field Office Structure Could Help Improve Disability Claims Processing*. GAO-06-149, December 9, 2005. Available at http://gao.gov/new.items/d06149.

[106] U.S., Government Accountability Office. *Military Disability Evaluation: Ensuring Consistent and Timely Outcomes for Reserve and Active Duty Service Members*. GAO-06-561T, April 6, 2006. Available at http://www.gao.gov/new.items/d06561t. U.S., Government Accountability Office.

These differences for reservists are compounded by differences in the application of policy between active and reserve personnel. For example, DoD will consider medical conditions that existed before military service only after eight years of service. Part-time reservists do not accumulate eight years' service for many years.

As expected, the Commission's survey shows relatively high DoD disability ratings for injured service members who are medically evacuated to the United States (Figure 7). Three-fourths of those who have completed the ratings process qualified for medical retirement and two-fifths received a rating above 50 percent. Nevertheless, 60 percent thought their DoD rating should be higher and, even thought their VA was substantially higher (Figure 8), almost as many thought it should be higher, too.

Figure 7— DoD Disability Ratings Reported in PCCWW Survey

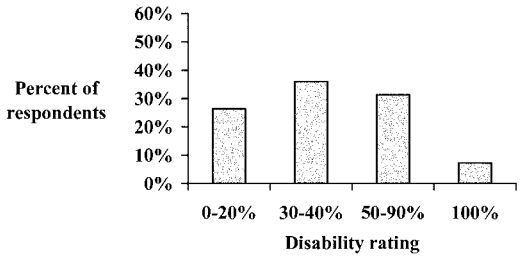
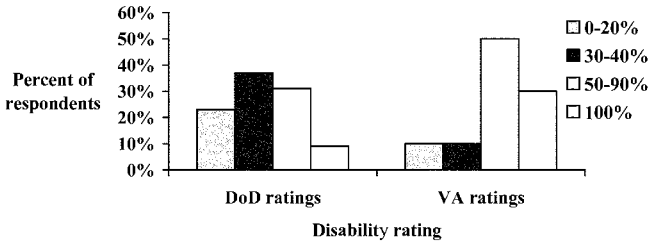


Figure 8— Comparison of DoD and VA Disability Ratings for Separated/Retired Survey Respondents



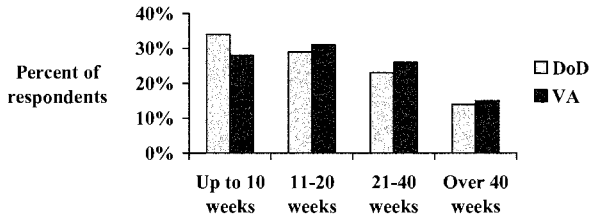
Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers. GAO-05-322T, February 17, 2005. Available at http://www.gao.gov/new.items/d05322t.

Long Processing Delays

Survey respondents who completed the DoD and VA disability processes reported their estimates of the length of time each process took (Figure 9). One-third reported that they received an answer from the DoD process within the 10-week standard; at the high end, 14 percent said their medical and physical evaluation board process took more than 40 weeks. The VA disability process took a similar amount of time.

Lost or incomplete paperwork likely added to the DoD and VA processing times; 40 to 50 percent of service members reported that they had to resubmit paperwork. Two-thirds said they were kept informed of progress during this time, but one-third said they were not kept informed.

Figure 9—Length of Time to Complete DoD and VA Disability Processes, PCCWW Survey



Compensation Structure

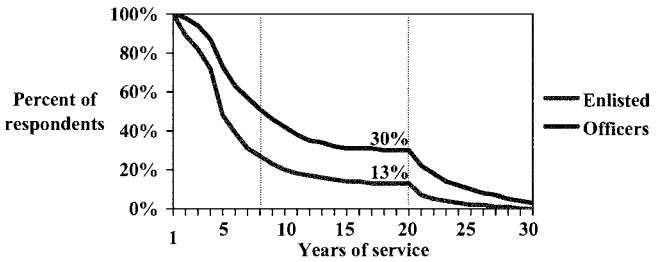
The objectives of the two Departments' disability compensation systems are unclear. The Commission identified four potential rationales for offering disabled veterans a compensation benefit, which this paper will discuss in turn:

1. Military personnel found unfit for duty lose the option to complete a 20-year career and thereby earn substantial retirement benefits
2. Civilian employment opportunities may be more limited, possibly leading to lower earnings and the loss of preferred occupations
3. The disabled veteran potentially suffers other quality-of-life losses—including disfigurement, inability to participate in favorite activities, and social problems
4. Transition to civilian life and employment takes some time, especially if the veteran takes full advantage of the VA's education, training, and job search programs.

Annuity Pay for Loss of Military Retirement Opportunity. Service members who are separated or retired because of disability lose the opportunity to qualify for generous retirement benefits after a 20- to 30-year military career. These benefits can be

thought of as "deferred earnings" that vest only after 20 years of service.[107] This is called cliff vesting because there is no retirement benefit at all before the service member reaches 20 years and a large benefit at 20 years. Most injured service members who must leave the military do not reach the cliff at 20 years of service. A reasonable objective of DoD's disability compensation system would be give them a retirement benefit in the form of annuity pay scaled to the years of service they did provide. Indeed, the DoD compensation formula for medical retirees mirrors in part the formula of retirement pay for qualifying individuals.

Figure 10— Percent of Enlisted and Officer Personnel Who Remain in Service



Source: Defense Manpower Data Center continuation rates for 2006.

The loss of benefit is higher the greater the likelihood that the service member would have stayed for 20 years. The vast majority of service members do not plan on a military career and return to civilian life after four to eight years of service (Figure 10). After the eighth year of service, however, most members who intend to leave have done so, and those remaining are likely to be committed to a military career. Since most career personnel retire promptly when they become eligible to do so, at 20 years of service, the value of military retirement pay and benefits appears to be an important reason to stay in service to that point. A service member who is medically discharged after reaching the eight year "career stage" does lose significant lifetime income by not qualifying for retirement.

[107] Any change in military retirement would call for a change in military disability pay. The military retirement system has been a subject of policy debate for some years. The current system largely drives the tenure profile shown in Figure D-4. It provides no benefit for service members who leave before 20 years of service and offers little incentive to stay in service after 20 years. The most recent retirement reform proposal was in 2006, when the Defense Advisory Committee on Military Compensation recommended full vesting at 10 years of service in an annuity beginning at age 60. If this proposal were adopted, and if the goal were to replace the retirement benefit for injured service members, then military disability compensation would be needed only for personnel in their first 10 years of service.

The retirement benefit lost when the career is cut short depends on rank (enlisted personnel earn less than officers) and years of service (members in higher years of service are more likely to reach retirement), but not on the level of disability. The current policy (which substantially increases disability compensation at 20 years in service or 30 percent or higher disability ratings) creates incentives to reach these thresholds.

A new compensation system that provides all medically discharged service members annuity pay, scaled to their years of service, would eliminate the thresholds in the current system. Different formulas could be used to calculate the annuity pay, including for example:

- The formula currently used to calculate regular retirement pay, which is 2.5% multiplied by the years of service and base pay.
- A formula that calculates the actuarially fair value of retirement pay accrued at each year of service, based on the formula now used to compute the accrual cost of retirement pay for current service.

Table 3 presents monthly estimates of DoD annuity pay for injured service members in a new system, applying the first method to the cases we used earlier for Tables 1 and 2.

Table 3—Estimated Monthly Pay under a DoD Disability Retirement Pay System

Years of Service	Enlisted Pay	Officer Pay
1	$ 36	$ 62
6	$ 349	$ 690
12	$ 900	$1,765
22	$3,800	$5,530

Table 4 shows how total DoD and VA pay would be affected by the change to a DoD compensation system. If, as the Institute of Medicine has recommended, VA disability pay is restructured with a substantially revised rating schedule and compensation for quality of life loss, there would be a further change. Unlike Figure 6, the comparison in Table 4 incorporates the higher VA disability rating for amputees to account for other service-connected medical conditions. Under the current VA disability compensation scheme and adding a DoD annuity payment, all of the cases would gain under the new DoD system.

An increasingly valuable benefit is lifetime TRICARE coverage for retired service members and dependents. However, the current policy of offering TRICARE only to those whose disability is rated at 30 percent or more appears arbitrary. Providing TRICARE to all medically discharged members whose injuries are determined to be combat related would ensure access to needed health care services for them and their families.

Work Disability Pay for Loss of Civilian Earnings Capacity. Congress has directed that the VA disability compensation system should replace lost civilian earnings.

It is not easy to know what those earnings might have been. More important, disability pay can reduce an individual's incentive to work or to invest in additional education and training, and warnings about these disincentives have been repeatedly cited, going back to the Bradley Commission.[108] Too generous compensation interfere with the goal of returning disabled veterans to as near-normal life as possible—a goal that this Commission strongly endorses.

Table 4—Effect of DoD Disability Retirement Pay Change on Total Disability Compensation for Selected Cases

Completed years of service	Enlisted		Officer	
	Current System	New System	Current System	New System
		Amputation		
1	$1,165	$ 1,201	$1,165	$1,227
6	$1,220	$ 1,569	$1,840	$1,910
12	$1,289	$2,189	$2,350	$3.054
22	$4,514	$4,514	$6,244	$6,244
		Quadriplegia		
1	$ 6,164	$ 6,200	$ 6,164	$ 6,226
6	$ 6,303	$ 6,652	$ 6,303	$ 6,993
12	$ 6,474	$ 7,374	$ 6,474	$ 8,239
22	$10,274	$10,274	$12,004	$12,004

Preliminary research results show that, *on average,* veterans with a disability rating below 50 percent suffer little earnings loss. This is an average finding and, at each disability rating level, some veterans do make less than they would have without the injury. Others who take advantage of the education and training benefits may earn more than they would have. New models for replacing earnings loss associated with disability are being developed and tested by a number of state workers compensation programs.[109] For example, one new approach replaces the average earnings loss for those who earn less than comparable non-disabled workers but phases out disability pay out for those who earn more. Regardless of the approach used, keeping work disability pay at modest levels for those who should be able to work will support incentives for work.

Quality of Life Pay. Aside from earnings, the disabled veteran potentially suffers a wide array of "quality of life" losses—including the inability to participate in favorite activities, social problems related to disfigurement or cognitive difficulties, and

[108] Research has shown that workers compensation or disability pay tends to decrease employment, functioning, and quality of life. See, for example: Duggan M, R Rosenheck, *Federal Policy and the Rise in Disability Enrollment: Evidence for the VA's Disability Compensation Program,* NBER Working Paper No. 12323, 2006 and Atlas SJ, Y Chang , RB Keller, et al. "The Impact of Disability Compensation on Long-Term Treatment Outcomes of Patients with Sciatica due to A Lumbar Disc Herniation," *Spine 31:* 3061-9, 2006.

[109] Barth, PS. "Compensating Workers for Permanent Partial Disabilities" *Social Security Bulletin 65:*16-23, 2003/2004.

the need to spend a great deal of time performing activities of daily living. VA's monthly payment add-ons for specific impairments—primarily anatomical losses[110] —arguably compensate for some functional limitations not related to work (such as loss of reproductive organs), but basing compensation on the specific loss and whether the veteran has suffered multiple losses is not a good measure of quality of life loss.

A different approach to quality of life loss would be more consistent with the concept of disability advocated by the World Health Organization and the Institute of Medicine. This system would consider the effects of medical conditions on a broad array of outcomes: activities of independent living, recreational and community activities, and personal relationships. Measures of these outcomes are available that could be used as the basis for quality of life pay for veterans and the Canadian and Australian veterans disability system include quality of life payments.[111]

Transitional Income Gap. The current DoD-VA compensation system does not guarantee an uninterrupted income as service members with disabling injuries transition from active duty to veteran status. Even if VA disability pay begins immediately after discharge, all but the most severely disabled veterans experience a decrease in income until the veteran completes rehabilitation, acquires any further education and training, and finds a job.[112] A stipend during rehabilitation, education and training, and a reasonable period for job search would support the veteran and family during this critical recovery and reentry period. The Subcommittee Report on Education, Training, and Employment emphasizes the importance of providing a stipend to encourage and support veterans to invest in education and training to enhance their employment prospects and, for the most disabled, their independent living skills. A similar stipend for a few months would allow veterans who do not pursue education and training to search for a job with help from the VA and other federal and state agencies.

Figure 11 shows how the four types of compensation would be synchronized to support the service member and family during the transition to civilian life and work. All medically discharged service members would receive the following three pay streams:

1. Annuity pay, beginning at discharge and continuing throughout the individual's life
2. Quality of life disability pay, also paid from discharge to death
3. Work disability pay, with two components:
    a. Transition pay while the veteran looks for a civilian job or participates in an intensive medical or vocational rehabilitation program, as called

[110] The anatomical losses include: loss, or loss of use, of a hand, foot, reproductive organ, both buttocks; immobility of a joint or paralysis; loss of sight of an eye; deafness of both ears; inability to communicate by speech; loss of a percentage of tissue from a single breast, or both breasts, from mastectomy or radiation treatment.

[111] Institute of Medicine. *A 21st Century System for Evaluating Veterans for Disability Benefits.* Washington, DC: National Academy Press, 2007.

[112] Testimony by William Carr, Principal Director of Military Personnel Policy, Office of the Secretary of Defense before the Commission on April 14, 2007 indicated that the average medically discharged service member has experienced an annual income drop from $38,000 to $18,000 during the transition to civilian employment.

for in their recovery plan[113]; those who immediately look for a civilian job would receive transition pay for only three months.

b. Work disability pay, if needed to replace an earnings loss, to begin when the transition pay ends; veterans who receive this pay but are able to work would need to reapply for this pay and be reevaluated on a fixed schedule (such as every five years).

Figure 11. A Streamlined DoD/VA Retirement and Disability Compensation System

At any point in time, disabled veterans would receive three types of payments:

Point of Discharge ▼ Point of Retirement ▼

	Throughout "working years," veterans would receive . . .		After retirement . . .
1. DoD's Military Annuity Payments	*$ amount based on rank and years of military service*		
2. VA Quality of Life Disability Payments	*$ amount based on impacts on quality of life*		
3. Transition payments*		**4. Followed by . . .**	**5. Followed by . . .**
►EITHER	*Long-term living expense support while in school/VRE*	*Earnings loss payments when employment begins***	*Social Security*
►OR	*3 months*	*Earnings loss payments when employment begins **	*Social Security*

*To help veterans become established and move into work or, if unable to work, to enable independent living.

**These payments would contribute to veterans' earnings for Social Security eligibility; the amount would be recalculated periodically as veterans' condition or earnings change.

If carefully designed, the compensation package could provide incentives for veterans to make the investment in recovery and education that will enable them to lead productive and active lives. In this way, VA's resources can be redirected over time to education and training investments that make income support for most disabled veterans unnecessary. The Bradley Commission endorsed this strategy 50 years ago, stating:

> Timely assistance on a temporary basis to help wartime veterans become self-sufficient and productive members of society is an effective alternative to the backward-looking, less constructive 'old soldiers' pensions. Education and training and related readjustment benefits are now recognized as the best way of discharging the Government's obligation to the non-disabled.

[113] The recovery plan is described in the Subcommittee Report on the Continuum of Care.

ACTION STEPS

The President's Commission supports a major restructuring of disability benefits that is tailored to the unique needs of individual service members injured in the line of duty and provides the incentives and services necessary to bring disabled individuals back into the mainstream of American life. The restructuring should also substantially simplify the disability program and the processes for evaluating disability and determining fitness for continued military service.

Action: Congress should clarify the objectives for DoD and VA disability systems to reflect the goal of returning injured service members to optimal functioning in American society.

Action: Create a *clear and timely* disability evaluation process that:

- Uses a single medical examination to provide baseline data at the time of military discharge for the initial disability rating
- Allows the different Services to continue to determine fitness to serve
- Applies a single baseline disability rating for all service-connected conditions at the time of discharge from the military
- Updates the disability rating schedule to reflect injuries sustained in modern warfare and modern concepts of the impact of disability on multiple domains of a veteran's life and
- Keeps the rating schedule current as warfare, rehabilitation technology, and medical care changes

Action: *Redesign disability compensation*, based on clarified objectives and clearly differentiating the responsibilities of DoD and VA for separate components of a coordinated system.

- DoD would compensate injured service members for the loss of a military career, with an annuity payment commensurate with time served
- VA would provide transition pay while veterans adjust to civilian life or participate in the Vocational Rehabilitation and Employment program.
- VA would base subsequent compensation on diminished civilian earnings capacity and quality of life.

VA compensation rates would be regularly updated based on frequent evaluation of earnings and quality of life of disabled veterans.

INFORMATION SYSTEMS

THE CHALLENGE

The medical system required to meet the long-term care and rehabilitation needs of America's injured service members has become highly complex. The treatment path stretches from the battlefield to acute and post-acute inpatient/outpatient care to the service members' transition back into military duty and/or civilian life. Vital medical information is captured during the acute phase of this process. However, integration of the information systems necessary to make information available for the comprehensive care and recovery planning needed to return injured individuals to the fullest possible state of health and personal independence has yet to occur. This situation has been recognized for some years and must change.

Electronic information systems are not an end in themselves, but *a means to an end*. The ideal health care outcome is well-managed, high-quality patient care in efficiently run facilities by staff who can obtain the information they need, when they need it, and easily enter important new information. A smoothly functioning benefits process needs to be coordinated with the health care process to ensure that injured service members and their families are supported throughout recovery. The movement towards information interoperability that is under way in some critical systems must be accelerated and expanded to include other information needed day-to-day. Simply put, our nation's service men and women would be underserved if we failed to take this opportunity to improve IT systems at the Department of Defense and Department of Veterans Affairs to create, manage, and transmit vital data that make navigating the system of care and benefits easier, more efficient, and more effective.

BACKGROUND

Information Is Essential for Patient-Focused Integrated Care & Services

Given the complexity of the medical and rehabilitative services required to care for seriously injured military personnel, it is necessary to carefully coordinate the expertise of multiple medical, rehabilitative, and benefits specialists in multiple facilities over an extended period of time. This commission has recommended that care delivery be guided by comprehensive, patient-centric recovery plans, developed by the patient's multi-disciplinary care team, with a Recovery Coordinator responsible for seeing that the plan is implemented.[114] To develop and implement the recovery plan, every Department of Defense (DoD) and Department of Veterans Affairs (VA) physician, allied health professional, and benefits specialist involved in the treatment, rehabilitation, and support

[114] See the Subcommittee Report on the Continuum of Care.

of an injured service member should have immediate access to the relevant medical and administrative information for that individual

The recovery plan program will expand both the quantity and the types of information that the DoD and VA need to share. For example, acute rehabilitation for amputees is provided by DoD, but vocational rehabilitation services are a VA responsibility. All caregivers involved in this example will require immediate access to timely information on a patient's status, service use, and outcomes to create an effective individualized treatment, rehabilitation, health promotion, retraining, and reemployment or independent living plan. Our present challenge centers on integrating DoD and VA information systems that were originally designed to focus on specific components of the care or administrative process and do not readily exchange the information necessary to support a recovery plan.

Current IT Systems Supporting DoD Patient Care

Over the years, information systems have been developed to support specific health care processes of the various military services. As a result, segregated data are often collected in many systems that each support a portion of the overall patient care process. The information needed for care of injured service members currently resides in the following systems:

- **Electronic Health Record.** AHLTA[115], the DoD's electronic health record, is available wherever the military delivers health care services, around the world. At present, the electronic record includes outpatient encounters and laboratory and radiology reports; it does not yet include inpatient medical records, but does include discharge summaries from inpatient hospitalizations.
- **Electronic Health Record-Theater Version**. Military medical personnel in Iraq and Afghanistan have access to a theater version of AHLTA, AHLTA-T.[116] The implementation of AHLTA-T began in 2003 with a fully integrated outpatient record and, as of May 2007, the theater data are globally available for inpatient encounters, pharmacy, laboratory, and radiology reports through a central theater data repository. Providers outside the theater—at Landstuhl Regional Medical Center in Ramstein, Germany, and in the United States—can access information from this repository through a web-based application.
- **Joint Theater Trauma Record**. **This system was developed during the current conflict to** collect theater battle-trauma patient data across all levels of care.
- **Patient Movement and Patient Tracking. The** TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES) provides in-transit visibility on patients as they are evacuated from a theater hospital to Landstuhl and U.S. facilities. The Joint Patient Tracking Application (JPTA), deployed

[115] AHLTA - Armed Forces Health Longitudinal Technology Application.
[116] AHLTA-T outpatient encounters are transmitted through a theater data repository (Theater Medical Data Store, or TMDS) to the AHLTA Central Data Repository and are viewable in TMDS and AHLTA. Inpatient and ancillary encounters are transmitted to TMDS and are viewable through the TMDS web-based application.

in January 2004, locates patients within military medical treatment facilities, captures diagnoses, and documents patient treatment notes. DoD grants VA providers access to the patient tracking database via the Veteran Tracking Application.

AHLTA resides on networked computers and, because there are separate networks for the different military services, problems occur. Even if the system operates as designed at individual military treatment facilities, the network infrastructures can impede access to information across facilities. For example, Brooke Army Medical Center frequently cannot obtain ready access to the Air Force network to retrieve AHLTA records at the Wilford Hall Medical Center, 18 miles away, even though these two large medical centers treat some of the same patients. As a result, clinicians do not have access to critical patient information and have become increasingly distrustful of the IT community's ability to provide reliable support to patient care.[117]

Current IT Systems Supporting DoD Benefits & Disability Processes

A comprehensive, patient-centric recovery plan would integrate planning for the care of seriously injured service members with their benefits and post-recovery activities. A fully interoperable electronic health record system would provide much of the information needed. However, a relevant picture for each patient is fully achieved when clinical and administrative systems are integrated. Within DoD, the key administrative systems are:

- **Personnel and Pay Systems.** The military services have maintained their own independent personnel systems. Next year, the new Defense Integrated Military Human Resources System will begin to replace these separate systems with a single, integrated system for active duty and reserve component personnel.
- **Disability Systems.** Service disability information systems also are stand-alone, and, in many cases, are using outdated applications to document the medical and physical evaluation processes.

The complexity of moving wounded and injured patients from point of injury to medical facilities throughout the continuum of care is measured by the myriad of Joint- and Service- sponsored systems available (Figure 1). However, despite the number of systems deployed to support this process, there are gaps in available information. Although seriously-injured patients are receiving excellent direct care from health care providers in theater, patients can be invisible to the system during certain phases of evacuation. In addition, health care providers and administrators are often required to enter the same information in several different systems, while information users must access multiple sources in order to piece together a full picture.

[117] Commission staff site visit to Brook Army Medical Center, San Antonio, TX – June 4, 2007. In 2006-2007, DoD expert teams concluded that the current IT network environment is unsustainable and seriously detrimental to patient care.

Current IT Systems Supporting VA Health Care

The majority of VA's IT systems involve multiple sub-systems that have been designed to address specific needs, not to work together in an efficient, coordinated way. In general, VA employees who work in one functional area can see some data from another area, but cannot exchange data from one system to another. Information provided by external sources—DoD, other federal agencies, such as the Internal Revenue Service or the Social Security Administration, or the private sector—that may be of value for care or benefits is rarely available across organizational functions to serve common needs. Figure 2 depicts the existing systems that support the VA's medical and other benefits programs.

Developed in the early 1980's, VistA, VA's electronic medical record system was one of the first such systems. It was revolutionary in its ability to support the clinical decision making process, but it has become rapidly outdated and is increasingly difficult to maintain. VistA currently consists of 128 stand-alone systems[118] that generally run the same software, but different institutions use different formats and include different content, which makes system data difficult to meaningfully integrate and compare. Records for patients usually treated at one facility are viewable by providers at other facilities. However, because the data are not standardized, VistA is not fully interoperable across VHA facilities and can not be used for clinical decision support systems. (Such systems automatically produce clinical reminders or notify providers when there is a potential drug/drug or drug/allergy interaction, for example.)

VA has a long-range plan to update VistA. Like AHLTA, patient data will be stored in a single repository where providers can access and contribute information. The plan involves data standardization and the replacement or re-engineering of the majority of the existing VistA components by 2014. This future system, VistA 2.0, is intended to provide all of the necessary information to support the provision of health care throughout the VA.

Current IT Systems for Administering VA Benefits & Disability Processes

VA also uses a grouping of stand-alone electronic systems to support each of its major service areas: compensation and benefits, education, loan guarantees, vocational rehabilitation and employment, and insurance. Modifications and upgrades to these systems have been ongoing for several years and have undergone a degree of critical scrutiny from several oversight bodies. The information systems share information and computer applications on only a limited basis. Although there has been some degree of re-engineering, for the most part the systems are antiquated, difficult to maintain, and not easily updated when there are changes to the benefits provided to eligible veterans and family members. Additionally integration between these systems and VistA is limited,

[118] Testimony of Dr. Steven H. Rappaport at the Commissions public hearing in Washington, DC – May 16, 2007.

which complicates the consistent provision of benefits or health services. For example, claims for benefits decisions are maintained in multiple places in both benefits and health systems and are not synchronized when the authoritative sources are changed. This can lead to incorrect benefits determinations, mistakenly billing the veteran for care or services that they are entitled to without charge, and general frustration for the veteran and users of these systems.

Current Status of DoD-VA Interoperability: Exchanging Information on Health, Benefits, Disability, & Support Programs

The Center for Information Technology at the National Institutes of Health has defined four levels of data interoperability:[119]

- Level 1: Non-electronic data—paper and phone calls
- Level 2: Machine transportable data—unindexed documents, fax, and email
- Level 3: Machine organizable data—indexed documents and images
- Level 4: Machine interpretable data—transfer of data from one system to another without need for further translation or interpretation.

Calls for DoD-VA data interoperability typically envision exchanges at level 4, whereas much of the current data exchange is at level 3 or below. If the data being exchanged are comprehensive and timely, level 3 exchange can be highly effective as a step toward the much more difficult level 4 exchange.

The missions of DoD and VA are closely intertwined when it comes to the delivery of health care, benefits, and other support services. In addition to its mission to support health care and benefits for disabled veterans, the VA is required to maintain and document additional inpatient capacity during times of war. Today, the VA provides injured or ill service members with:

- Complex medical care at VA Polytrauma Rehabilitation Centers;
- Physical therapy and rehabilitation care;
- Treatment for combat-related Post-Traumatic Stress Disorder (PTSD);

Post–deployment, the VA, in conjunction with the military health system may be heavily involved in assessing and tracking conditions related to service members' environmental exposures, such as Gulf War Syndrome, or other delayed-onset illnesses, such as undetected PTSD.

VA disability determination requires accurate and timely information from DoD, confirming military service and describing the claimant's medical condition. The automated sharing of this information has been a long-standing initiative of the two Departments and has received a significant amount of attention from multiple administrations and legislative bodies.

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[119] http://www.nahit.org/cms/index.php?option=com_content&task=view&id=220&Itemid=115, accessed July 19, 2007.

Interoperability of Health Care Information

Figure 3 depicts the current and planned health information flows between the departments. Prior to combat operations in Afghanistan and Iraq, the focus was on the unidirectional exchange of information from DoD to VA, in order to help the VA understand the care that veterans had received within the military. As efforts progressed, a bi-directional exchange seemed more desirable, to include information about, for example, patients' allergies, lab and radiology results, and pharmacy data. In support of the complex medical needs of service members transferring to VA Polytrauma Rehabilitation Centers, scans of patients' radiology and medical records are now being transferred to the VA's integrated imaging system. At present, the information exchanged between the two Departments is fully viewable within the VA system while the DoD uses a web-based application to view information passed back from the VA.

The Clinical Health Data Repository interface, currently being tested in several locations, supports the interchange of data elements in real time rather than via the movement of batches of data at regular intervals. This system leverages the DoD's Clinical Data Repository and VA's Health Data Repository–the standardized, authoritative source for the exchange of clinical data within each Department. The interface will extend this capability to support exchange between the Departments and guarantee that providers can have the most current patient data available at the point of care.

Electronic information exchange began in 2001 and progressed slowly through 2004, but the pace of progress has increased steadily beginning in 2005. The full timeline and critical milestones supporting the exchange of medical information between the two departments is reflected in Figure 4. External reviews have determined that DoD and VA have made progress in improving the interoperability of their electronic health record systems (level 3) but are far from having comprehensive electronic medical records (level 4).[120]

Interoperability of Benefits & Support Services

The flow of administrative and benefits data between the two Departments is more rudimentary. The current data exchange consists of 31 separate data feeds from DoD's Defense Manpower Data Center to various VA entities and 11 feeds from VA to DoD. In 2003, as part of an Electronic Government (e-Gov) initiative, the Departments began the process of combining these feeds into a single incoming and outgoing data stream. Progress has been made in identifying the business needs for the data and the nature of the information each Department needs. Systems in both Departments are being modified and brought on-line to leverage the new data.

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[120] U.S., Government Accountability Office. Information Technology: VA and DoD Are Making Progress in Sharing Medical Information, but are Far from Comprehensive Electronic Medical Records. GAO-07-852T. Testimony, May 8, 2007.

To support VA's outreach efforts to service members and veterans and to support the provision of VA health care for two years post-deployment, the interfaces were recently upgraded to include information on activations and de-mobilization of reservists. Additionally, as part of the efforts to support the educational benefits program, data were added to the bi-directional exchange of information provided between VA and DoD. The Departments are currently discussing plans for further improvements to support administrative and benefits processes, with emphasis on improving e-benefits systems.

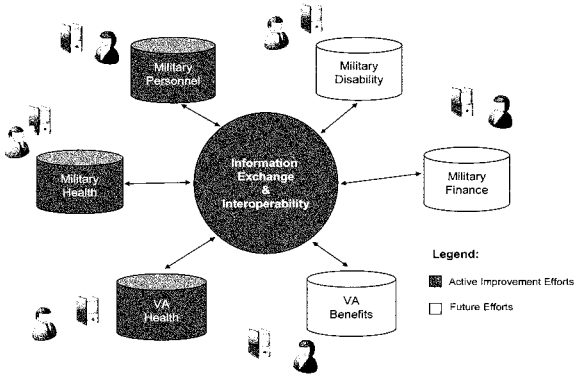
The Future Direction of DoD & VA Health & Benefits IT Systems: What's In the Works...

DoD and VA plan to build data repositories that contain information based on industry or other agreed-upon standards. Figure 5 presents a schematic view of what the Departments are trying to achieve. In summary, they believe that:

- The repository concept will allow for information to be easily exchanged or accessed to meet the health care and benefits needs of any service member or veteran.
- Timely and relevant information will be available from any of the repositories to support care or administrative decisions.

As reflected by the data sources in grey, we observed that little has been done to support the availability of Military Disability and Finance and VA benefits and ratings information.

Figure 5—Overview of DoD/VA Information Exchange Efforts



PREVIOUS TASK FORCE RECOMMENDATIONS AND REPORT FINDINGS

This Commission reviewed numerous reports and task force recommendations that addressed the information systems in the DoD, VA, and private sector and how well they support health care delivery to injured service members and veterans. A common theme among these reports, going back to 2001, is the need for interoperability between the DoD and VA medical information systems. In 1996, the Presidential Advisory Committee on Gulf War Veterans' Illnesses[121] reported on the many deficiencies in the two Departments' capabilities for handling service members' health information. In November 1997, the President called for the Departments to start developing a "comprehensive, lifelong medical record for each service member," and in 1998 issued a directive requiring them to develop a "computer-based patient record system that will accurately and efficiently exchange information."

According to the GAO's most recent congressional testimony regarding the departments' progress toward information-sharing,

> "To achieve this goal, significant work remains to be done, including agreeing to standards for the remaining categories of medical information, populating the data repositories with all this information, completing the development of their modernized systems, and transitioning from the legacy systems. Consequently, it is essential for the departments to develop a comprehensive plan to guide this effort to completion, in line with our earlier recommendations."[122]

In this testimony, GAO summarized several of its recurring recommendations and findings regarding VA and DoD's efforts to create a comprehensive electronic medical record:

- VA and DoD need a comprehensive strategy for implementing a comprehensive medical record;
- Progress has been made exchanging clinical information but a comprehensive medical record would better achieve the departments' long-term goal of comprehensive, seamless exchange of health information;
- Program delays and target date slippage in the implementation of elements of a comprehensive approach have been impeding the exchange of information between the organizations, delaying accomplishment of the long-term objectives;
- It is not clear how short-term initiatives to share health information between existing systems fit into the overall strategy;
- In some areas VA and DoD still need to agree on the information standards needed to facilitate the transfer of information between Departments;
- VA and DoD must address data quality and availability challenges. For example, VA still has to convert its electronic records into the interoperable

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[121] Presidential Advisory Committee on Gulf War Veterans' Illnesses. *Final Report*. Washington, DC: U.S. Government Printing Office, December 1996.

[122] U.S., Government Accountability Office. Information Technology: VA and DoD Are Making Progress in Sharing Medical Information, but are Far from Comprehensive Electronic Medical Records. GAO-07-852T. Testimony, May 8, 2007

format appropriate for a repository. DoD, in addition to converting current records from its systems supporting each [military] service, must also address medical records that are not automated.

The influx and complex medical needs of service members injured in Iraq and Afghanistan has intensified the stress on the two Departments' ability to exchange clinical and administrative information. Recent GAO reviews have underscored the need for more rapid progress in information-sharing, in order to streamline delivery of benefits and services. Specific types of information that need to be shared efficiently include:

- Clinical information necessary to help determine the level of services that will be needed once a patient is transferred to a VA Polytrauma Rehabilitation Center[123]
- True interoperability of medical records for active duty service members treated in VA facilities;
- Appropriate and necessary DoD medical and personnel information electronically viewable for VA benefits determination;
- Routine transmittal to VA of health information on service members likely to be discharged from the military due to their medical condition;
- Post-Deployment Health Reassessment Program (PHDRA) data to VA[124]

The 2007 report of the Task Force on Returning Global War on Terror Heroes has provided several short, mid, and long-term recommendations related to the use of information technology to address gaps in services provided to injured service members. Several of these recommendations support of the two Departments' ongoing plans to improve clinical information exchange and interoperability. However, the Task Force identified immediate goals to address issues related to tracking service members and signature injuries and illnesses:

- The provision of increased access by VA and DoD staff to available information systems to assure continuity of care and coordinated patient hand-off.
- The increased use of interfaces that allow scanned records (medical images and inpatient records) to be exchanged between DoD and VA.
- The creation of data markers, clinical reminders and databases to track current combat veterans' identification, and patients with traumatic brain injuries, embedded fragments, and polytrauma.
- Improvements to the VA's Electronic Benefits Claims Enrollment processes and IT systems.

The DoD Task Force on Mental Health also supported the need for the exchange of all relevant medical records between DoD and VA. It also recommended faster development of a mental health module in AHLTA.

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[123] U.S., Government Accountability Office, DOD and VA Health Care: Challenges Encountered by Injured Service members During Their Recovery Process. GAO-07-606T. Testimony, March 8, 2007.
[124] U.S., Government Accountability Office. Computer-Based Patient Records: A and DOD Have Made Progress, but Much Work Remains to Fully Share Medical Information. GAO-05-1051T. Testimony, September 28, 2005

The thread throughout all of these reviews and recommendations is that process improvements to support the needs of returning service members must be supported by improved information systems.

WHAT THE PRESIDENT'S COMMISSION LEARNED

Based on the Commission's recommendation to create a comprehensive patient-centric recovery plan, the first step in implementing this vision is to take a hard look at the Departments' processes, and improving them as needed. The information system can then be designed to reflect best organizational practices.

This Commission is recommending the development of a recovery plan for each seriously injured service member transitioning between the in-patient (hospital) and out-patient (ambulatory) care environments. The recovery plan is fundamental to retaining a patient-focused care philosophy through an injured service member's complete path towards recovery. For the recovery plan to function effectively, every health-care professional and service provider involved in the treatment, rehabilitation, reintegration, and support of injured service members must have immediate access to the medical and appropriate personnel and benefits information.

The recovery planning model would expand both the quantity and the types of information that the two Departments would need to share. The services provided by the multi-disciplinary teams reside in both Departments—for example, acute rehabilitation for amputees is provided by DoD, but vocational rehabilitation services are a VA responsibility. Therefore, the seriously injured service members whose care and recovery will be complex will have provider teams that include DoD and VA staff and require coordinated administrative actions. The recovery plan will guide post-acute treatment, rehabilitation, health promotion, retraining, and reemployment. Service members will be periodically reevaluated, and their plans updated, as their medical condition, functioning, and circumstances dictate. Timely information on service members' status, service use, and outcomes will enable the Recovery Coordinator, the care team, and service providers to design and implement the recovery plan and maximize the patient's health and life outcomes.

Capability of Current DoD/VA IT Systems to Support Patient Care

Through testimonies to the Commission during public meetings and opportunities to review the information systems during site visits,[125] the Commission learned that existing information systems within DoD and VA focus on specific components of the care process and have not been built to support activities that cross organizational boundaries. As clinical and administrative processes have been modified to support the seamless transition of the injured service member, the pace of information system development has lagged. Today's information systems are not appropriately aligned to

[125] Testimony of Dr. Paul Tibbits at the Commissions public hearing in San Diego, CA – May 24, 2007.

efficiently support the proposed recovery plan process or effective case management.[126] Examples and observations include:

- The systems have been built to support episodic care and not care based on a long-term treatment plan. The DoD health care model is focused on capturing treatment information and being able to pass it along to the next location where the service member is cared for. The VA's system has traditionally been designed to support care provided within VA medical facilities and other clinical settings. Neither system has been designed to support care across multiple specialties and administrative processes.
- We observed that the existing systems do not support fully the tracking, and health information needs of injured service members who are moving between the DoD and VA medical facilities.

The impact of these weaknesses is particularly evident for polytrauma cases that receive acute care in the military hospital, then are transferred to a VA Polytrauma Rehabilitation Center, and eventually may return to the military health system. To address the shortfall in the availability of electronic clinical data, DoD and VA health providers have established informal standards for what should be included in the paper record that accompanies the patient being transferred. Acute-care information that may be missing is obtained through phone calls and fax requests.[127] VA staff then review the available paper-based information and scan indexed information into VistA Imaging—an interface that allows providers to view scanned records. Though manually intensive, the scanning of information into VistA Imaging will make the image available to all other VA facilities; referring to the definition presented above, this process increases interoperability of information for polytrauma patients from level 1 to level 3. The same level of interoperability is not achieved for all injured service members, however.

In an effort to provide an electronic view of the military's patient record, DoD has begun scanning inpatient medical records and transferring this information to VA's Polytrauma Rehabilitation Centers. As an interim solution, until a standardized data exchange methodology can be determined, VA staff then manually imports this file into VistA Imaging. However, the Commission observed that, since the full record is contained in a single file which is quite voluminous and difficult to search, it may not meet the needs of the providers and are ignored. This is a time-consuming manual process that, if it works at all, works only because of the small number of patients being transferred between the two organizations.

The commission staff also observed that while the information that is currently interoperable at higher levels—such as pharmacy, allergy and laboratory information—may be of some use, other information—such as progress notes, radiology reports, discharge summaries—are not readily available, even though it would be of tremendous value in determining past treatment received or the established care plan. The VA has

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[126] Testimony of Dr. Lynda Davis at the Commissions public hearing in San Diego, CA – May 24, 2007

[127] Only a portion of the outpatient data that is available electronically in AHLTA or VistA electronically is currently exchanged. The paper record that accompanies patients transferred to VA facilities primarily contains inpatient and acute care information from the referring military facility.

modified VistA to support the tracking of service members who have symptoms of traumatic brain injury and post-traumatic stress disorder. Automated clinical reminders in VistA notify clinicians and other health care providers when specific treatment protocols should be consulted. Because a similar automated clinical decision support system does not exist within AHLTA, reminders are generated manually, based on protocols used during the post-deployment health reassessment process.

The DoD and VA's existing interoperability strategy was determined after Operation Desert Storm, and was a logical one. Its focus was on environmental disease surveillance, managed care for TRICARE beneficiaries and exchange of information when service members moved to veteran status. DoD gave priority to the development of an electronic outpatient medical record system because at the time, it had no automated record of ambulatory care in military treatment facilities. Also, there were relatively few traumatic injuries requiring coordinated care by the VA and DoD.

Regardless of the interoperability approach that is taken, the migration of data between complex information systems must start with the standardization of the information to be shared. There is little point in exchanging data if the receiving system is incapable of using it efficiently. Figures 3 and 4 (referenced above) illustrates a strategy that sequences the exchange of data from component systems—such as pharmacy and radiology—based on the amount of work needed to make them interoperable at levels 3 or 4. DoD and VA are partly through the implementation of this strategy, with only some component systems currently interoperable.

Care for injured service members would have been better supported by a different strategy that made all the information needed by clinicians available at the highest level of interoperability possible in the short run and subsequently worked towards a higher level of interoperability through a component-cased strategy. DoD and VA have recognized the current need to support the care of injured service members and developed short-term solutions. Examples include the exchange of data from the Joint Patient Tracking Application to a Veterans Tracking Application and the manual process for scanning more complete medical records for polytrauma patients. A more complete solution would identify the information needed for the current conflicts' most complex and common medical conditions, including polytrauma, traumatic brain injuries, amputations, and post-traumatic stress disorder. The information necessary to care for these patients can be determined by the providers who care for them. Where highly structured data are necessary and available, the Departments can determine the best route to be taken to achieve level 4 interoperability. In the interim, providers could use non-structured data, such as text-based progress notes documenting previous care, information can be made interoperable at level 3.

Capability of Current DoD/VA IT Systems to Support Non-Clinical Services

Over the years the major focus of information exchange between DoD and VA has been on the movement of clinical data. In retrospect, the Departments are finding gaps in supporting case management, disability evaluation, benefits determination, and other

administrative processes that support the seamless transition of patients between DoD and VA. Based on discussions with officials in both Departments, the Commission learned that:

- The DoD disability evaluation process is highly paper-intensive and requires extensive case files to support the workings of the evaluation boards. Currently, little automation supports this process.
- The official report of separation from active duty or from 90 days or more of active service by reservists (DD Form 214) is required before the VA can initiate its disability rating process. VA raters view an image of this form through a web interface, interpret the information they need, and manually enter it in the information system they use. The DD 214 is scheduled to be automated as part of the new Defense Integrated Military Human Resources System (DIMHRS) within the next 12 months.
- As we described earlier, DoD's Joint Patient Tracking System and VA's Veteran Tracking System were developed during the current conflict to fill the information void on patient movement from theater to the VA.[128] The VA uses this information to initiate timely contact with returning service members and initiate the disability claims process as soon as possible

With the prevalence of case management and the increased emphasis on seamless transition between DoD and VA, users often resort to manual processes to exchange information. During the Commission's site visits, users often expressed their frustration with the slowness of the systems or with needing to sign into multiple systems, each having only a portion of the information they need. Interim solutions are coming on line to replace or augment these manual processes, but there is the risk that further stand-alone solutions are being created because a more comprehensive approach has not been identified.

DoD and VA have developed several websites to give service members and veterans access to their personal health information, disability evaluation and benefits, and a host of government and private support programs. We reviewed numerous web sites that may be useful to service members and their families. However, in some cases these web sites do not appear to be well coordinated. Similar information concerning disability benefits, services, military retirement, and so on, was noted on several different sites. Without a coordinated effort to update similar sites' information, they will soon be out of sync and the accuracy of their information will be compromised. We observed that there is no single authoritative web site that can serve as the starting point for injured service members and families.[129] The existing web sites typically focus on linking individuals seeking information to other websites. The wealth of linked information can make it difficult for users to find the specific information they need. A more effective approach would tailor sites to the user's interests and needs (as many commercial web sites now do) and would be interactive, giving the user tools to update information, make

[128] Commission staff meeting with DoD/VA representatives re: Joint Patient Tracking Application/Veteran Tracking Application, June 5, 2007.
[129] Web sites reviewed: www.va.gov, www.dod.gov, www.myhealth.va.gov, www.myarmybenefits.com

appointments, and so on. This would require access to authoritative clinical and non-clinical information systems and more sophisticated software.

Drawing information from DoD and VA information systems, an interactive web portal, such as the prototype "My eBenefits" pages appended to this report, could provide tailored information to each service member and veteran, specific to their situation, and enable them to make appointments, do financial planning, maintain confidential personal health records, and apply for various benefits programs. Today, in order to find such information, armed service members and veterans must navigate a disparate, confusing, and cumbersome array of websites. First-rate content exists online for service members and their families; however, the presentation and organization of this information simply have not evolved to meet the needs and expectations of the next generation of service members.

A one-stop "information shop," such as the prototype "My eBenefits," would be a consumer-friendly, interactive, evolving, fully customizable and personalized information portal. It would host almost every type of data important to a patient's Recovery Plan. It also would include tailored, up-to-date information on federal and state benefits, in-patient and out-patient care, disability evaluation and application status, local and national resources from veterans service organizations and community organizations, area employment opportunities, doctors' names and contact information, news, and the ability to connect easily with other armed service members and veterans.

Capability of Proposed Future DoD/VA IT System Designs to Meet Recommendations of the President's Commission

A number of appropriate information strategies are being implemented to meet the immediate needs of injured service members. DoD's AHLTA is becoming the standard system to support health care from theater to military treatment facilities in the United States, and the VA has plans for a next generation of VistA. Both systems are being designed around clinical and administrative data repositories, which will give providers throughout both Departments access to their patients' health information. Initiatives such as the Clinical Health Data Repository, which supports the real-time exchange of data between DoD and VA, are significant advances and need rapid implementation. Yet, the health information systems provide only some of the information needed to manage the needs of injured service members.

System redesigns should emphasize leveraging single, authoritative data sources rather than duplicating information across multiple systems, which may threaten data integrity and confidentiality. When independent systems maintain separate copies of similar data elements, the ability to control changes in the data and data integrity becomes nearly impossible.[130] Inaccurate information can jeopardize patient safety. Maintaining confidentiality and privacy becomes more difficult.

[130] Commission staff meeting with DoD/VA representatives re: Joint Patient Tracking Application/Veteran Tracking Application, June 5, 2007: JPTA collects data about patient care, but does not connect to

Interoperable systems based on a repository concept are developed with standardized data elements, definitions, and formats, in order to facilitate information exchange. For example, critical data fields, such as names, dates and times, and laboratory results must look the same across systems.

Efforts are under way to determine whether the two Departments could run the same inpatient information system. However, given DoD's requirement to provide medical support to deployment forces in austere environments, it is not always practical for the Departments to deploy the same information system. Where this is the case, DoD and VA have been able to develop a strategy to exchange data at the level of interoperability necessary. These two approaches can live together to produce an DoD-VA information system that is interoperable, functions well for users, and supports ongoing care and program requirements.

Achieving interoperability even at the highest level does not require adoption of the same computer systems or operation of the same software. Nor does all information present in the electronic health or administrative databases need to be exchanged in order to support health care or administrative action. While universal system interoperability may be an important and appropriate goal, the tasks involved are so varied and complex that it will take years to complete them. Meanwhile, DoD and VA have the ability to achieve a practical level of interoperability in the near term.

ACTION STEPS

The primary concern of this Commission is to ensure that each and every service member injured in the performance of their duty receives all the ongoing healthcare services and benefits they require to achieve and enjoy the greatest possible quality of life. Reaching this objective will be facilitated by the following DoD and VA information systems and process modifications:

Action Step: Within 12 months, DoD and VA should make all essential health, administrative, and benefits data are made immediately available in viewable form to any clinician, allied health professional, or program administrator who needs it.

Action Step: DoD and VA should also develop information support for the recovery plan and its implementation by the recovery coordinator, health care and rehabilitation teams, and benefits administrators. This should include a tool that the recovery coordinator will use in coordinating the development and implementation of the recovery plan and in monitoring patient outcomes

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AHLTA. This creates confusion among providers, and requires them to view separate systems to piece together a puzzle of patient care documentation.

Action Step: DoD should create an interactive web site for injured service members, personalized according to their individual needs. A design for the website is included at the end of this subcommittee report.

Action Step: Without delaying the accomplishment of the first two steps, DoD and VA should expedite the work presently underway to create a fully interoperable information system that will meet the long-term clinical and administrative needs of all injured service members over time.

Action Step: DoD and VA need to report their progress on all steps to higher authority using a detailed scorecard with measures of exact status of information interoperability at each type of medical facility by essential health, administrative, and benefits categories. A template for the scorecard follows.

Scorecard for Information Exchanges – Health

Health Information	In Theater	In Europe	DoD Medical Centers	DoD Other Facilities	VA Polytrauma Facilities	VA Other Facilities

Legend

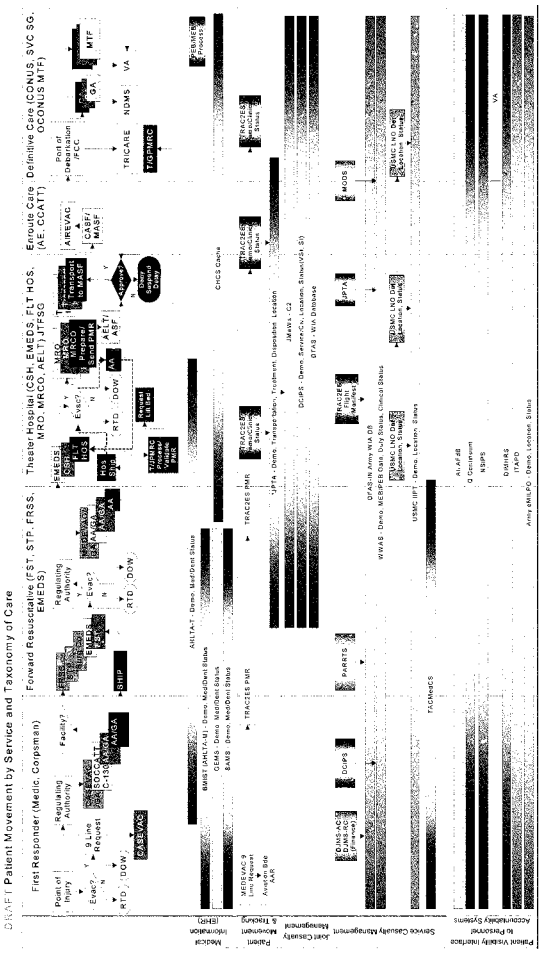

Figure 1: *Source:* DoD Capability Area Management, Joint Logistics Test Case to Improve Patient Tracking Visibility Throughout the Medical Continuum.

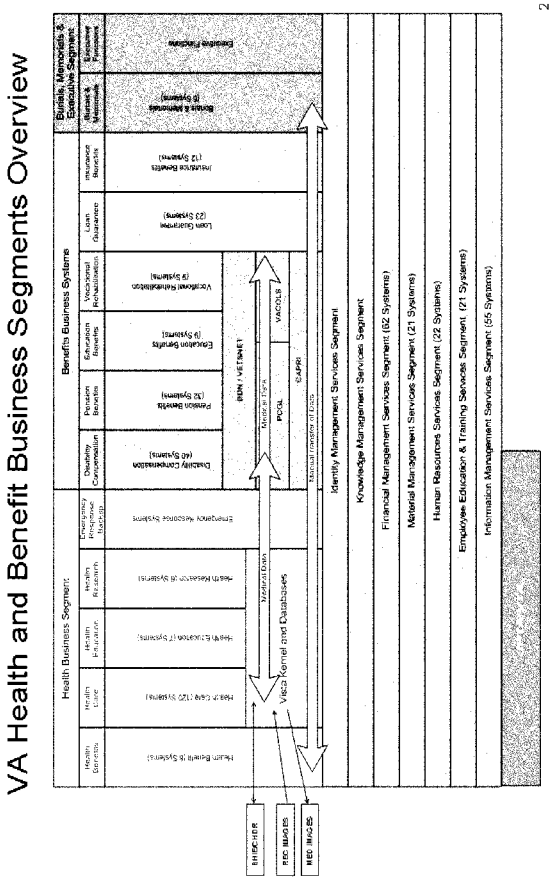

Figure 2: Source: Provided to commission staff by the VA Office of Information & Technology – Enterprise Architecture Department, June 7, 2007

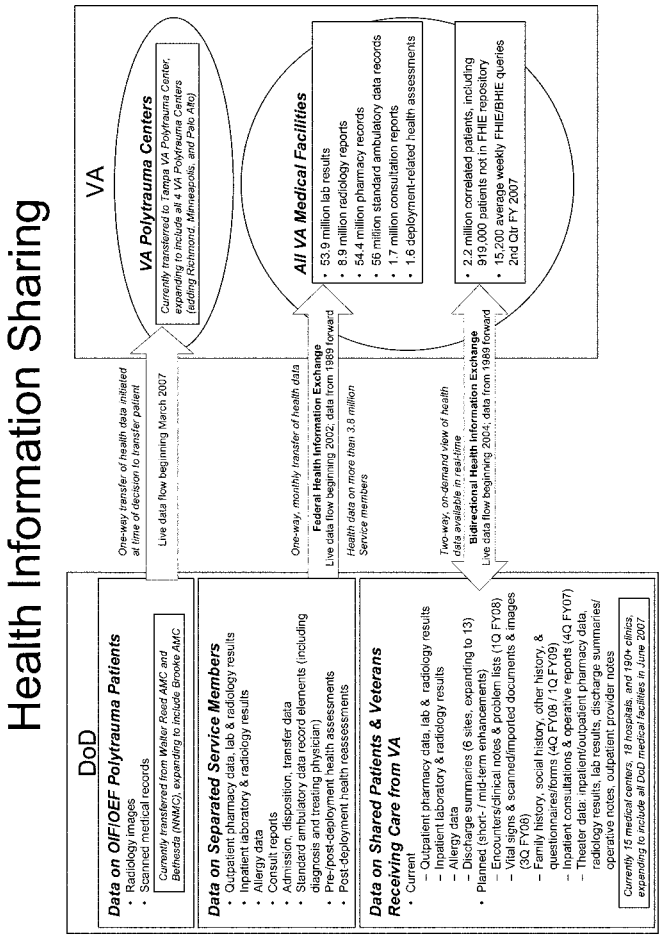

Figure 3, Source: Testimony of Dr. Paul Tibbits at the Commissions public hearing in San Diego, CA – May 24, 2007

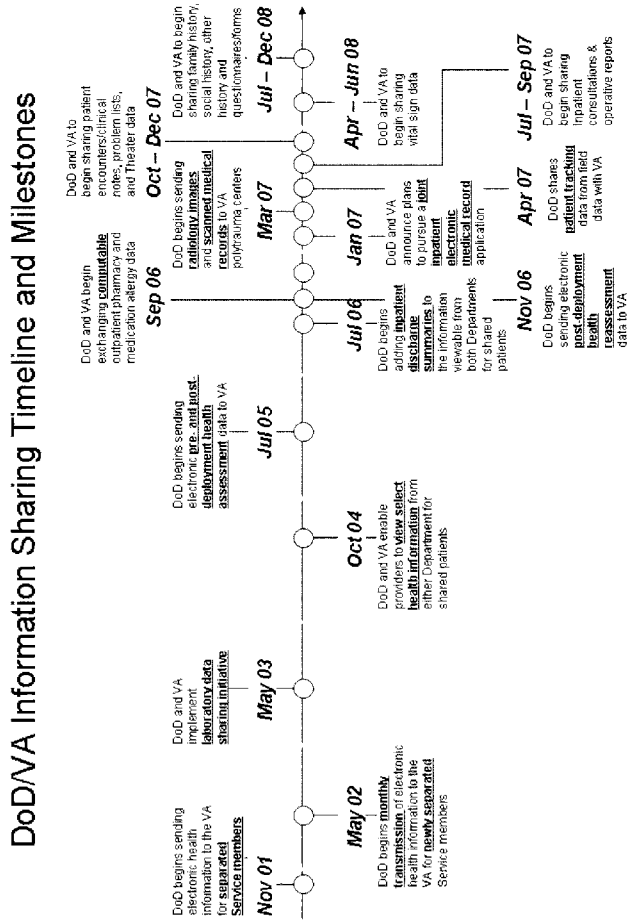

Figure 4 DoD/VA Health Information Sharing Timeline: Sources: Testimony of Dr. Paul Tibbits at the Commissions public hearing in San Diego, CA – May 24, 2007

APPENDIXES TO
Subcommittee Report on Information Systems

Figure: Current Websites for Military Personnel & Veterans

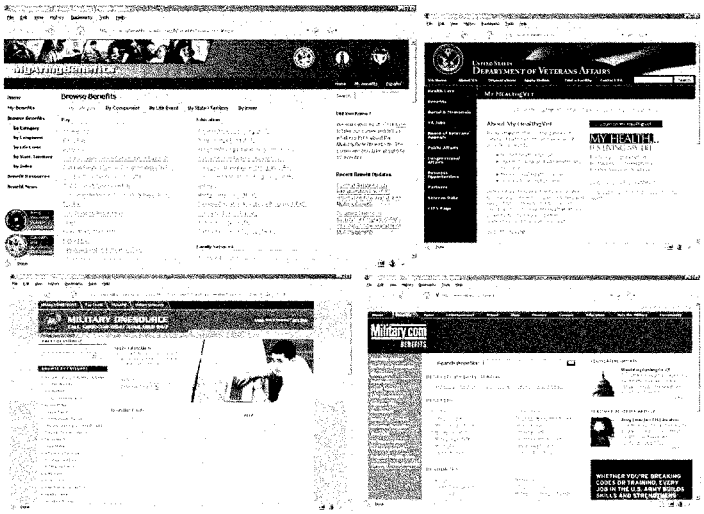

Figure: A comprehensive site home page: My e-Benefits

Figure: A personalized My e-Benefits Page

Abbreviations and Acronyms used in the charts in the Information Systems Subcommittee Report

Abbreviation/Acronym	Definition
AA	Air Ambulance
AAR	After Action Report
AE	Aeromedical Evacuation
AELT	Aeromedical Evacuation Liaison Team
AHLTA	Armed Forces Health Longitudinal Technology Application
AIREVAC	Aero-Medical Evacuation
All AFdB	All Air Force Data Bases
Army eMILPO	Army Electronic Military Personnel Office
ASF	Aerial Staging Facility
BMIST	Battlefield Medical Information System Telemedicine
CASEVAC	Casualty Evacuation
CASF	Contingency Aeromedical Staging Facility
CCATT	Critical Care Air Transport Team
CHCS	Composite Health Care System
CONUS	Continental United States
CSH	Combat Support Hospital
C2	Command and Control
DFAS – IN	Defense Finance and Accounting Service - Indianapolis
DCIPS	Defense Casualty Information Processing System

DENT	Dental
DIMHRS	Defense Integrated Military Human Resources System
DJMS	Defense Joint Military System
DOW	Died of Wounds
DTAS	Deployed Theater Accountability System
EMEDS	Expeditionary Medical Support
EVAC	Evacuation
FCC	Flight Clinical Coordinator
FLT HOS	Fleet Hospital
FRSS	Forward Resuscitative Surgical System
FST	Forward Surgical Team
GA	Ground Ambulance
GEMS	Global Expeditionary Medical System
GPMRC	Global Patient Movements Requirement Center
JMeWS	Joint Medical Work Station
JPTA	Joint Patient Tracking Application
MASF	Mobile Staging Facility
MEB	Medical Evaluation Board
MED	Medical
MEDEVAC	Medical Evacuation
MODS	Medical Operational Data System
MRCO	Medical Regulating Officer
MRO	Medical Readiness Officer

MTF	Medical Treatment Facility
NDMS	National Disaster Medical System
PARRTS	Patient Accounting and Reporting Real-Time Tracking System
PEB	Physical Evaluation Report
PMR	Patient Movement Request
RTD	Return to Duty
SAMS	Shipboard Automated Medical System
SI	Seriously Injured
STP	Site Treatment Plan
SURG CO	Surgical Company
SVC SG	Servicing Surgeon General
T/JPMRC	Theater Joint Patient Movement Requirements Center
TACMedCS	Tactical Medical Coordination System
TRAC2ES	US Transportation Command Regulating and Command and Control Evacuation System
VA	Department of Veterans Affairs
VSI	Very Seriously Injured
USMC II PT	United States Marine Corps Injured/Ill Patient Tracking
WIA DB	Wounded in Action Data Base
WWAS	World Wide Airfield Summaries

Key Survey Findings

President' Commission on Care for America's Returning Wounded Warriors (PCCWW) National Survey on Health Care Experiences of Service Members Injured in Iraq and Afghanistan

The President's Commission on Care for America's Returning Wounded Warriors released today preliminary results of a nationwide telephone survey it conducted to help assess the health care experiences of service members injured in Iraq and Afghanistan.

The Commission survey was conducted from June 7 to June 19, 2007. Participants were military members and veterans who had undergone medical treatment for wounds sustained in Iraq and Afghanistan that led to medical evacuation to the United States. 1,730 interviews were completed.

The following are preliminary results from the Commission survey for the following three segments of the survey population:

- Active Duty
- National Guard/Reserve members serving on active duty or with home units
- Active duty and National Guard/Reserve members who have left the military, most of them with a medical separation or retirement.

The Injured

- The typical active duty service member injured in Iraq and Afghanistan is young. In the survey, 40% are under the age of 25. Guard/Reserve veterans are older—only 16% are under 25 and one of three are from the junior ranks.

- Both active and Guard/Reserve have modest levels of education, with 10 to 15% having some college.

- Overall, 60% are married.

Care System

- These young service members need help navigating the complex medical and disability systems, but many have not had a single coordinator. While on active duty, half of respondents said they had a professional to help coordinate care. After leaving the military, just one in five said they had a coordinator.

Disability System

The survey confirms that the disability evaluation system is source of concern.

- Just over 40% *fully* understood the disability evaluation system and another 30% *mostly* understood the system.
- Help is available for injured veterans moving through the disability evaluation process—two-thirds said they had help. Nevertheless, under 40% were satisfied with the disability system.

- The survey includes 500 medically separated/retired injured veterans who left service in the past two years. Most of them—60% in the Reserve and Guard and 85% of veterans—reported their injuries limit the work they can do. They appear to be overcoming their limits, as 80% of Guard/Reserve and 63% of veterans are either working or in school.

Family

- Two third of injured active duty service members had family come for an extended period to be with them in their recovery; slightly less for Guard and Reserve. Most family members who came were provided housing through Fisher Houses and other local accommodations.

- One in five family members gave up a job in order to stay with their injured family member.

- Family members often act as care coordinators and care takers. Most respondents said family members got the information needed to support this role.

- Non-profit organizations play an important role in family support. 40% of survey respondents said their families receive help from at least one of these groups.

Post-Traumatic Stress Disorder and Traumatic Brain Injury

- The survey confirms the significance of post traumatic stress disorder (PTSD) and traumatic brain injury (TBI) in this conflict. Over 40% of respondents said they reported systems of PTSD or other mental bealth problems to a health care professional. Sixty percent experienced a blast or other event that could be severe enough to cause brain injury.

- DoD and VA have stepped up screening for these conditions. Almost three-fourths of respondents report being asked questions about PTSD and TBI symptoms.

Information Technology

- Most of the time, the role of information technology is invisible to the service member. They often notice when information is *not* available. A common complaint is lost paperwork. For example, 40% of survey respondents had to resubmit paperwork during the disability evaluation process.

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