DOD AND VA COLLABORATION TO ASSIST SERVICEMEMBERS RETURNING TO CIVILIAN LIFE

JOINT HEARING
with
HASC

BEFORE THE

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

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Wednesday, July 10, 2013

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

The Committees met, pursuant to call, at 10:02 a.m., in Room 2118, Rayburn House Office Building, Hon. Jeff Miller [Chairman of the Veterans' Affairs Committee] presiding.

OPENING STATEMENT OF HON. JEFF MILLER

Chairman MILLER. Thank you, everybody, for being here today for this second joint hearing of the Veterans' Affairs Committee and the House Armed Services Committee.

I welcome the Chairman, Buck McKeon, as well as the Ranking Member of the HASC, Adam Smith, and of course, my good friend from Maine, the Ranking Member of the Full VA Committee, Mike Michaud.

And as I said, this is the second time now that we have gotten these two Committees together. And I am proud to serve on both of these particular Committees.

We are going to jointly review the collaborative efforts of the DoD and VA, as it pertains to servicemembers and their transition from active duty, to civilian life.

A year ago, we were privileged to have both Secretaries Panetta and Shinseki at the witness table, and both of them testified at great length regarding the progress VA and DoD were making in several key areas.

And what I would like to do this morning first is to revisit those areas in my opening statement. First, the progress made in developing an integrated electronic health record. Secondly, the progress that has been made in reducing the wait times associated with VA disability claims, which necessarily does involve cooperation from DoD in the transfer of records.

So let's start, if we can, with the electronic health record. In a response to a direct question last year, Secretary Shinseki remarked that the two departments had finally, after 17 months of discussion, agreed on a way forward on a single, joint, common-integrated electronic health record that would be completed by 2017.

The Secretary told us that each of those words—single, joint, and common—meant something and that finally we were breaking through the cultural issues that existed between the two departments and that really stifled in the past.

And we come here today, and I say what a difference a year makes.

Contrary to the Secretary's testimony, two departments are once again moving on their own tracks, with promises we have heard before about making the two separate systems interoperable.

Pardon my frustration, folks, but it seems the only thing interoperable we get are the litany of excuses flying across both departments every year as to why it has taken so long to get this done.

In response to this latest course correction, the House included an amendment in the national defense authorization bill, an amendment that was developed in collaboration with the leadership of HASC and VA and to direct the completion of an integrated health record by October 1 of 2016. The message of the amendment is simple—no more excuses, get it done.

I am anxious to hear from the witnesses today, to hear how they will comply with the mandate of the amendment once it is enacted into law.

The second issue I will briefly touch on is on the disability claims backlog. It is interesting to note that the progress made in reducing the pending inventory of claims the last few months correlates with a heightened Congressional oversight and media scrutiny.

None of us up here are going to take our foot off the gas when it comes to ensuring progress is made on the backlog. Every member in this room will agree with that statement. And although progress has been made lately, VA is woefully short of its own goals for this year.

So going forward, ending the backlog necessarily requires a seamless record transfer from DoD. I look forward to hearing the status of the efforts and what more can be done. The problem of veterans waiting years for their disability claims to be decided must remain at the forefront of our consciences, especially as further troop draw-downs occur over the next 5 years.

It, too, is an example of where the excuses have to end and real, sustained progress must occur.

To accommodate such a large contingent of members that are with us this morning, I have agreed to last year's framework that limited to 2 minutes each member's time to ask a question of the witnesses. Therefore, I ask unanimous consent that each member have not more than 2 minutes to question the panel of witnesses, starting with my very own question.

Without objection, so ordered.

I ask unanimous consent to include all members' statements in the hearing record today.

Without objection, so ordered.

And I recognize the Full Committee Chairman of the Armed Services Committee, Buck McKeon, for his opening remarks, followed by the Ranking Member Mike Michaud, and then the Ranking Member Adam Smith, for their opening remarks.

Mr. Chairman?

[THE PREPARED STATEMENT OF CHAIRMAN MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. HOWARD P. "BUCK" MCKEON

Chairman MCKEON. Good morning. I join Chairman Miller in welcoming everyone here today to the second special joint hearing with the Veteran Affairs Committee to continue our oversight on the Department of Defense and Department of Veterans Affairs collaboration to assist these members' transition to civilian life.

After the successful joint hearing held last year, I want to thank Chairman Miller and Ranking Member Michaud for their leadership in continuing the shared efforts to provide our servicemembers and veterans and their families the assistance they need transitioning out of the military and the benefits they deserve for having served this Nation.

At a time when we are rapidly drawing down our military, which I strongly oppose, particularly while we are still actively engaged in Afghanistan, the latest announcement of the Army's plan to restructure the Army below 9/11 force levels is another reminder of the impending military draw-down that will force an additional 100,000 servicemembers and their families on an already overburdened Veterans benefits system.

Today's hearing will look at the Department of Veteran Affairs system for delivering benefits to veterans and the role of the Department of Defense, specifically providing information and documents necessary for adjudicating a claim for benefits.

It is no secret that the VA has a backlog of well over 500,000 claims from veterans. A significant portion of these claims are more than 125 days old, with some as old as 2 years.

These claims are not only from recently transitioned veterans, but are from Vietnam veterans and veterans of the wars since then. It is easy to talk about a claim as if it is an impersonal object, but behind each of these claims is a veteran.

You know, each of us, as we go home and talk to our constituents, have people come up to us and tell us horror stories of things that have happened to them. And we all—nobody in this room wants to see that happen. It is just a very difficult situation to resolve all of these issues with—we are talking so many people.

A veteran who willingly served this country now is asking only what was promised for that service. Alongside many of these veterans are the families, families who stood by these veterans while they served, enduring the hardships of military life.

These are the people behind these claims who are waiting for their benefits. We owe them an answer and we owe them our commitment to continue to ask the hard questions until we are satisfied with the accuracy and the timeliness of the benefits system.

We find ourselves in a situation where it is tempting to place blame and look for easy fixes, but that is not our purpose here today.

I want to understand the reasons for the backlog and I want to know what is being done by both departments to complete these backlog claims and expeditiously provide veterans with their benefits. Lastly, I want to know from the witnesses how the integrated electronic health directorate will assist each department to fulfill its responsibility for timely delivery of transition assistance and benefits, and what role, if any, the IEHR will play in reducing the VA backlog of claims.

Furthermore, I understand that DoD already passes a significant amount of medical information to the VA and it will be useful for all of us to better know how the IEHR will improve that sharing of information. I have been encouraged by the attention being paid the issue of electronic health records by Secretary Hagel since he took office. The DoD acquisition decision memorandum issued on June 21st certainly conveys the sense of urgency we hope to instill with the amendment to the fiscal year 2014 NDAA, that I sponsored with the Ranking Member, Mr. Smith, and in collaboration with Chairman Miller, Chairman Rogers, Chairman Young and Chairman Culberson.

Both press for aggressive deadlines for implementation and increased oversight to ensure that DoD finally is able to field a seamless, integrated electronic health record. What I hope today is to see a similar commitment from the VA Department and similar mechanisms to address the lack of measurable goals and accountability by VA that the GAO pointed out in its previous investigations in to the issue.

It is incumbent on this body to make sure that the leadership for both departments see this as an important matter deserving their personal attention and guidance. Our veterans deserve nothing less for the sacrifices they have made for this country.

With that, I thank you, Chairman Miller, for your leadership in pulling this together and look forward to this hearing.

Chairman MILLER. Thank you, Mr. Chairman.

Mr. Michaud?

STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you very much, Mr. Chairman.

I, too, want to thank the two chairmen and Ranking Member Smith for having this joint hearing today. Transition is a critical issue that greatly affects our servicemembers and veterans. This hearing is the second joint hearing our two Committees have held concerning transitions. The purpose of this hearing is to reiterate our joint oversight commitment and to ensure that the Department of Veterans Administration and the Department of Defense work together on behalf of the men and women who are sent into harm's way.

At last year's joint hearing on this topic, the two agencies' secretaries appeared before us sitting side by side. I am disappointed to see that neither is here today. I take this as a lack of personal engagement, as a sign that they care less, that they are not as committed as they have been. My big disappointment is solidified by receiving testimony in the 11th hour. Clearly, this issue in this hearing is not a priority.

I would submit to you that the government has struggled to fulfill the sacrifice, you know, trust to care for those who have served and sacrificed in defense of our Nation. After 12 years of war, we know transition is the critical first step, and it requires the cooperation of many agencies to accomplish successfully.

I do not believe that we have made measurable progress in getting the two agencies before us today to work more effectively together. The Department of Defense has announced it will put out a bid for a new system to manage its health records. Such a deci-

sion appears to back an interoperable approach over an integrated one—and integrated is integrated, not interoperable. Electronic health records is something that Congress has mandated years ago and we have spent hundreds of millions of dollars delaying the delivery of an integrated information-sharing system which runs directly against congressional intent and ultimately hurts our veterans.

Also of particular importance to our Committees is the claims backlog. Let me be clear. Both the VA and the DoD have a responsibility to end the backlog by 2015. The claims backlog is not a VA issue alone. The Department of Defense must do a better job in transferring information needed for the VA to approve or disapprove in a timely manner the claims. This includes records of our National Guards and reservists. It also includes late and loose records being sent to the VA.

Because benefits in health care affect so many servicemembers and veterans, DoD and VA must put aside their parochial differences and work more effectively together to ensure an integrated process addressing transition issues.

Over the course of the last several months, we sent letters to the secretaries and the President asking for their personal commitment and support. We requested concrete decisions being made in a timely manner. What we received in response is a no-show to this hearing from the secretaries and the press conference that kicks the decision down the road once again.

And it would appear that leadership is lacking not just at this hearing. During the recent roundtable on the IEHR, industry leaders told us progress is not due to lack of availability—available technology solutions, but rather a lack of leadership. That is right. Several of the roundtable participants said there is a lack of leadership. When two divisions in their companies can't or won't agree, the CEO steps in and mandates a direction. Where are the DoD and VA CEOs?

Just recently in a bipartisan effort and due to ongoing congressional concerns with the backlog, with the lack of unified vision between the VA and DoD electronic health records programs, language was included in part of the National Defense Authorization Act of 2014. This language creates a deliberate approach in developing joint electronic health records. I am told that strategies have been modified and collaborative efforts are ongoing for both records transfer and IEHR. However, months continue to go by with seemingly no real progress.

I look forward to hearing from the panelists today just how far you have come, and to learn about the path ahead on this transition issue, and look forward to those questions that we are going to be asking. This is a real important issue that we have to deal with, and unfortunately there has been a lack of leadership. And I don't only say that without two secretaries—also the President of the United States who made it very clear in this first term he wants both agencies to work together. And that leadership has been lacking as well on this particular issue.

So, I look forward to hearing your comments and to answering the Committees' questions.

With that, Mr. Chairman, I yield back.

[THE PREPARED STATEMENT OF HON. MICHAUD APPEARS IN THE APPENDIX]

Chairman MILLER. Mr. Smith?

STATEMENT OF HON. ADAM SMITH

Mr. SMITH. Thank you, Mr. Chairman.

I think my three colleagues have correctly raised the three issues that we are most interested in today: How do we get joint electronic medical records between the DoD and the VA; the transfer issue when a veteran goes from being part of active duty DoD over to the VA. How do the benefits transfer; how seamless is that process—there are challenges there. And then, of course, the backlog of claims that we are trying to meet. And I share my colleagues' frustration with wanting to get answers to that and wanting to make progress on all three of those issues.

But I am also mindful of a couple of other facts. Over the course of the last almost 12 years now, there has been a huge increase in the number of injured veterans who have come through, that DoD has had to process and that VA has had to process. The initial determination of whether or not a given servicemember can stay within the DoD or transfer is not an easy process. It is a difficult one for the servicemember as well as their family in making that determination. So that is a significant challenge. And the sheer numbers are a significant challenge.

And I would also like to point out that we have had—I have lost track now over the course of the last 2-plus years—four, five, six threatened government shutdowns which force both the DoD and the VA into a position where they don't know how much money they are going to have in a matter of weeks. So there are things that Congress could do that would be helpful to you as well.

Sequestration certainly doesn't help. I know there are aspects of what you do that are exempt from that. There are other aspects that are not exempt from that, and you have to absorb those cuts while trying to deal with that increased number of veterans and while trying to deal with the backlog.

And then lastly, we have failed to pass appropriations bills in anything approaching a timely manner, and in some cases, simply outright failed to pass them so that the VA and DoD for an extended period of times are operating with a continuing resolution which, again, places them at a huge financial disadvantage.

So, I definitely want to see more leadership out of the VA and out of the DoD, but I think Congress should also take a look in the mirror and pass appropriations bills and fund what we claim to be our top priority. If we really want to get these systems integrated, if we really want to get the backlog cleaned up, then we need to start passing appropriations bills. We need to kill sequestration right now and actually fund what it is that we claim is such a huge priority for us.

So I hope all parties involved will work together to achieve what is clearly our common goal, and that is that our servicemembers who have put their lives on the line to protect our country and at our request at our order as policymakers are taken care of: that they are not part of a backlog, they do not slip through any crack in the system, they get the treatment and care that they deserve.

But this is a collective responsibility between Congress and the executive branch to get that done. I hope today we will learn more about how we can work together to make that happen.

I yield back. Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF HON. ADAM SMITH APPEARS IN THE APPENDIX]

Chairman MILLER. Thank you very much, Mr. Smith.

Ladies and gentlemen, I want to welcome our first panel and only panel to the hearing this morning. First of all, the Honorable Frank Kendall, Under Secretary of Defense for Acquisition, Technology and Logistics at the Department of Defense.

The Under Secretary is accompanied by the Honorable Jonathan Woodson, Assistant Secretary of Defense for Health Affairs and Director, TRICARE Management Activity, Department of Defense; and the Honorable Jessica Lynn Wright, Acting Under Secretary of Defense for Personnel and Readiness at the Department of Defense.

And also with us this morning is Mr. Stephen Warren, Acting Assistant Secretary for Information and Technology at the Department of Veterans Affairs. And Mr. Warren is accompanied by the Honorable Dr. Robert Petzel, Under Secretary for Health with the Department of Veterans Affairs; and Mr. Danny Pummill, the Deputy Under Secretary for Benefits with the Department of Veterans Affairs.

And I would say to Danny, congratulations on your new position. And we look forward to working with you in the future.

With that, Under Secretary Kendall, you are now recognized for between 5 and 10 minutes. If you can hold it to 5 that would be appreciated.

STATEMENT OF HON. FRANK KENDALL

Secretary KENDALL. Thank you, Mr. Chairman. I will do my best.

Chairman Miller and Chairman McKeon, Ranking Members Smith and Michaud, Members of the Committees, thank you for the opportunity to discuss the department's effort to improve and modernize our existing electronic health care records and our legacy health care management systems.

I am joined by Acting Under Secretary Wright and Assistant Secretary Woodson. And we were recently informed that we would be doing just one opening statement, so I will only cover the information technology part of our testimony.

If there are questions, obviously, the people who accompany me would be happy to answer them in terms of the backlog and other elements of health care.

I would also like to ask, Mr. Chairmen, that our written statement be admitted to the record.

Chairman MILLER. Without objection, all statements will be entered in the record.

Secretary KENDALL. My personal involvement in our health care management programs is relatively recent. In April, I was tasked by Secretary Hagel to conduct a review of the department's legacy health care management system modernization options. The options under consideration were upgrades to DoD's legacy ALTA sys-

tem, an evolved and enhanced version of VA's legacy VistA system, or conducting a competition that would include modern commercially available heath care management systems, as well as potentially systems based on existing systems like VistA.

With Acting Secretary Wright, I formed a team of senior DoD stakeholders and a working group of experts to evaluate DoD's options and formulate their recommendation. The team worked for approximately a month. It benefited greatly from prior analyses, including a recent study that the department's cost assessment and program evaluation direction had conducted, as well as from consultations with VA on the basis of their decision to adopt VistA as their future health care management system core.

CAPE's analysis was based on extensive market research. The conclusion the working group reached, which was endorsed by the senior stakeholders and then forwarded to the secretary, was that a competition to select a core set of capabilities out of a best value basis was the right business decision for the Department of Defense.

I have made the results of that review available to the Committee staffs, and I would be happy to answer your questions on the review, or to brief any of the members on the details.

Secretary Hagel made a decision to adopt the study recommendations. After VA's decision a few months ago to stay with VistA as the basis of its future health care management system core software, DoD had a very different decision to make than VA did. VA has a large installed VistA base, a large in-house staff that maintains and programs software for VistA, and a workforce that is experienced and trained with the current vision of the VistA system.

There are sound logical business reasons for VA's decision regarding VistA. But DoD is not in the same position.

The marketplace that provides health care management systems has changed significantly in the last few years as we have been going through the process that was alluded to in earlier testimony. That marketplace provides a range of products, modern products, that have advanced significantly over the period of time that I mentioned. This is a vibrant market, and we would like to be able to have the opportunity to select a product that includes some of the offerings from that market.

Our market research also showed that we would likely see VistA-based offerings from multiple competitors. The review Ms. Wright and I conducted compared cost, risk, performance and growth potential and concluded that a sole-source selection of either VistA or DoD's ALTA system was not the best business decision for DoD.

A logical and sound business decision for the department would be to conduct a competitive source selection on a best value basis.

Let me assure you that nothing in this decision affects DoD's commitment to the joint near-term fielding of fully seamless integrated health records under the iEHR, our program, being conducted by and managed by the interagency program office today.

Health care records and health care management systems are not the same thing. DoD and VA can share integrated records without having the same software to manage those records or to assist conditions as they provide care.

The secretary of defense has also asked me to take a more direct role in the management of our health records and our health care management systems. We will continue to work closely with VA on all of these efforts.

At this point, I am still in the process of reviewing and assessing the current programs for iEHR. But the DoD's commitment to fielding data management accelerators with VA this fiscal year and next year is firm.

Chairman McKeon, you mentioned my acquisition decision mandate. That was one of the first steps that I took once the secretary asked me to take responsibility. In addition, I have appointed some key leaders. Mr. David Bowen is behind me, as well as the program manager for our modernization system who will be, I hope, executing some of the leadership that was mentioned earlier. Compatibility with ongoing joint effort to provide seamless, integrated electronic health care records between DoD and VA will be a firm requirement as DoD works to select a core for its health care management software system.

I am concerned, the language in the House fiscal year 2014 NDAA and the House fiscal year 2014 MILCON and Veterans Appropriation Act may overly restrict both VA's and DoD's options going forward, as well as impose significant oversight burdens on the program.

I understand the members' frustrations—Mr. Chairman, you mentioned that, with iEHR—and I have reviewed the history of the last few years. But we would like to work with the Congress on less restrictive language that would both address your concern and allow for efficient program execution.

I commit to you that DoD will keep the Committees informed of our progress and of any major developments in our health care record and health care management acquisition programs, and that DoD will work closely with VA to ensure that our shared goals of a seamless, integrated record in the near term and modernization of our health care management systems in the mid-term are accomplished efficiently and effectively.

Our shared mission with the VA is to fundamentally and positively impact the health outcomes of active duty military, veterans and beneficiaries.

Every one on the panel before you with one exception is a veteran. We understand the needs of these people and we support them.

Health care record and management systems modernization is a part of that process. And we believe the course we have chosen is a prudent, cost-effective path to achieving our mission.

I will be happy to take your questions.

I would like to make one comment on sequestration. It was brought up by—in two of the opening remarks. I cannot sit before this Committee today, 2 days after we started furloughing our employees and not mention sequestration.

The effects of sequestration are real. They are distributed all across the department. They are not dramatic in any specific instance, but their cumulative impact is dramatic. And they are having—and they will have over time, particularly if allowed to continue in fiscal year 2014, a devastating impact on the department.

I know I am not here to testify about that, but I can't pass up the opportunity to mention that.

Mr. Chairman, with that I will conclude.

[THE PREPARED STATEMENT OF SECRETARY KENDALL APPEARS IN THE APPENDIX]

Chairman MILLER. Mr. Warren?

STATEMENT OF MR. STEPHEN W. WARREN

Mr. WARREN. Chairman Miller, Chairman McKeon, Ranking Member Smith, Ranking Member Michaud, and Members of the Committees, we appreciate the opportunity to appear before you today to discuss the collaboration taking place between the Department of Veterans Affairs and the Department of Defense.

I am accompanied today, on my far left, by Under Secretary Robert Petzel for Health, and to my immediate left, Mr. Danny Pummill, the Principal Deputy Under Secretary for Benefits.

The efforts of our two departments reflect an unprecedented level of collaboration on a number of important goals to ensure seamless transition from servicemember to veteran. Through DoD and VA channels such as the Joint Executive Committee, the Health Executive Committee, the Benefits Executive Committee, independent working groups and the day-to-day work of our respective hard-working employees, our two departments are removing barriers and challenges which impede seamless transition.

Our collaboration efforts with DoD are also helping VA meet its goals of increasing access to care, ending the benefits claims backlog and ending veterans homelessness. We are making progress together in several key areas.

Thanks to the VOW to Hire Heroes Act, we now enroll every new servicemember in eBenefits. Enrollment has grown to 2.6 million since June 2011, an increase of over 648 percent. We now have in place that single portal, whether you are a servicemember or veteran, you can, to find out not only what your benefits are, but also what the status of your claims are.

Through eBenefits, the two departments provide veterans and servicemembers a central location to research, find, access and manage a growing list of benefits. DoD and VA fully implemented the Integrated Disability Evaluation System, known as IDES, in October 2011.

IDES is an integrated DoD–VA program for servicemembers being evaluated for medical separation from military service that leads to faster processing time, increased transparency for the servicemember, and a single set of medical exams for single-source disability ratings and much more.

In April of 2009, President Obama directed the DoD and VA to work together to define and build a seamless system of integration for electronic health records. Today, DoD and VA are already exchanging a significant amount of electronic information and are taking aggressive action in 2013 to further expand these efforts.

But most of the information today is not standardized. A key priority for both departments is to standardize electronic health record data and to make it immediately available for clinicians so

that they have the information they need to make informed clinical decisions for our patients.

A critical mission of both departments is to fundamentally and positively impact the health outcomes of active duty military, veterans and eligible beneficiaries. As a result, we have two distinct goals. Create a seamless health record integrating VA, DoD and private provider data, and to modernize the software supporting DoD and VA clinicians.

We are committing to doing both of these in the most efficient and effective way possible. VA is still on track with your support to deploy our core capability at two sites by 1 October 2014, and full operational capability by the end of 2017.

We are also working closely with our DoD colleagues to address the benefits claims backlog. Today, many veterans wait too long to receive benefits they have earned and deserve. This has never been acceptable to the secretary or the dedicated employees of the Veterans Benefit Administration, over half of which are veterans themselves.

VA is implementing a robust plan to ensure we achieve our goal of eliminating the claims backlog and improving decision accuracy to 98 percent by 2015. We are making progress in reducing the processing times for disability claims, and we are on track to meet our agency priority goal of eliminating the backlog of claims, those pending longer than 125 days, in 2015.

The total inventory of claims is now below 800,000, the lowest since April 2011, and the backlog has been reduced by more than 14 percent from its highest point just 4 months ago. For the second month in a row, VA claims processors set production records by completing more claims than in any previous monthly period.

Collaboration efforts are ongoing with DoD to allow VA to receive complete service records, and to receive them electronically for faster and more efficient processing. On December 6, 2012, VBA reached an agreement with our partners in DoD requiring the military services to certify a servicemember's service treatment record as complete as possible at the point of transition to VA.

Effective January 1, 2013, all five military services began implementation of service treatment record certification. By the end of this year, each of the military services will be sending all of the service treatment records electronically to VA. This will contribute to reducing the time it takes to process future disability claims.

VA and DoD are committed to our collaborations, and we continue to look for ways to improve our decision-making, achieve greater efficiencies, and accelerate the transition process for servicemembers and veterans.

Thank you again for your support for our servicemembers, veterans and their families, and your interest in the ongoing collaboration and cooperation between the two departments. We appreciate the opportunity to appear before you today, and we are prepared to answer any questions you may have.

[THE PREPARED STATEMENT OF STEPHEN W. WARREN APPEARS IN THE APPENDIX]

Chairman MILLER. Mr. Kendall, first question is in regards to the bidding process or the request for proposals that DoD has done.

Do you anticipate VistA being one of the software solutions that will be allowed to be reviewed in the process?

Secretary KENDALL. The answer is yes. Our market research that was conducted by CAPE, as I mentioned, had a number of responses. Fifteen of those responses were fully compliant with the request.

And of those 15, three were VistA-based solutions. So we know there are vendors out there. And one of the submissions was from the VA itself, and the other two were from commercial integrators. So we would fully expect that VistA will be included in the things that we have to choose from.

Also, it won't be today's VistA. It will be a VistA that is improved over the course of the time between now and when we would actually make the award. So we will have an enhanced version of VistA, if you will, at the time we do the source selection.

Chairman MILLER. Mr. Warren, I will say that in reviewing your testimony talking about the backlog, you talked about several reasons that there is a backlog out there. The under secretary has talked about the surge of personnel that has been used to reduce the backlog.

Nowhere do I see anything about what VA has done wrong, i.e., mismanagement of personnel. And my fear is that we are going to end up right back in the same place eventually. We may draw the numbers down, but if we don't change the system and how it is done, we are going to continue to see the backlog.

The Nehmer decision and all of the claims associated with that decision, I mean, we knew that was coming. The secretary knew it was coming. He actually said that by 2013, now, we would be right back where we were prior to Nehmer. We are way above where we are.

So, does VA have any culpability in regards to the backlog, or is it just things outside their control?

Mr. WARREN. Mr. Chairman, if I could hand that to my colleague from the Benefits Administration to respond.

Mr. PUMMILL. Chairman Miller, one of the things that we have done is the VBMS, the Veterans Benefits Management System. We were in a paper system when we started doing the Nehmer cases and worked through the Nehmer cases and got the additional workload from the current conflict.

We now have a fully automated system rolled out to all 56 of our ROs. And by fully automated, I mean that its position at the ROs and we are starting to do claims electronically instead of paper. Today, about 20 percent of the total workload that we have is electronic. Eighty percent is still paper.

Our goal is to, you know, not only knock out the backlog, but to get all of that into electronic format. That will put us in a position so that if a claim comes in from Ohio, it doesn't have to be done in the state of Iowa by a claims person in Ohio. When the claim comes in, the next available person anywhere in the country can take that claim and work it because all of the records will be electronic, eliminating the need to mail records around the country and things like that.

We believe with the advent of the Veterans Benefits Management System and the electronic service treatment records that we

are going to be receiving from the Department of Defense, that that will go a long way to preventing future backlogs and ending this backlog right now.

Chairman MILLER. Mr. McKeon?

Chairman MCKEON. Mr. Chairman. Secretary Kendall, Secretary Warren, the process for gathering the necessary information to complete a veterans claim for benefits requires participation by the veteran, the DoD and the VA.

Some of the information is provided directly to the VA by the servicemember. Other information is sent from DoD to the VA either in electronic format or hard copy paper documents. I am particularly interested in the health care and medical information records that the DoD sends to the VA.

What medical information records are provided by the DoD to the VA, and when and in what format are they sent, number one? And two, who receives the information at the VA, and how is the information then linked to a veteran's claim for benefits?

Secretary KENDALL. Mr. Chairman, information is generally sent electronically in digital form. And we have been doing that for quite a few years now. We sent about—over a million elements of data per day to the VA electronically.

The problem with those records is, A, that they are incomplete. There are some paper files, often paper that is produced by commercial providers of health care that our servicemen have seen that need to be sent as well.

There are also problems at VA with how accessible and readable some of that information is and how much it can be manipulated. But we are sending electronic records, and we have been doing that for quite some time. And it is the way the bulk of the information goes.

I am going to turn it over to Ms. Wright and Dr. Woodson to give you a more full answer.

Ms. WRIGHT. Sir, if I can add to Mr. Kendall's statement, we have an agreement now with VA that I think is working very well. And that is to provide the service treatment records, which includes personnel data, it includes administrative data, it includes medical data and dental.

We also certify that at hubs within our services, within 45 days of the servicemember departing the military system and moving into the veteran system. We send that electronically and we send it paper-wise to the repository in VA.

By the 31st of December, we will be sending everything electronically to VA, which will increase the speed of processing a claim, should that individual choose to file a disability claim.

Chairman MCKEON. My time is expired. I don't know if there is time for——

Chairman MILLER. Mr. Woodson, would you like to add anything?

Secretary WOODSON. I would. Thank you very much for the question and the invitation to be here today.

As Secretary Kendall indicated, we send a lot of health record information electronically now. And for anyone who might be interested, I will give you a Web site or a CD that shows the

functionality of the type of data we send that can be used in direct patient care, as well as claim adjudication.

It is rather significant and it really has more information and functionality than I would say most private offices in the private sector and many of the great hospital systems in the private sector.

By the end of the year, not only will we be able to exchange that information so that it is read—it can be read by whomever might need the information in the Veterans Administration system, but it will be computable data.

Through the ongoing projects we have, through the inter-agency program office focusing on this accelerator for this data interoperability, which is really an important feature, it will be computable data that will be real-time, that allows providers as well as administrators to use that information for the benefit of the transitioning servicemember.

And so, I think—I would be happy to make myself available to any member or staff member to walk them through what the capabilities are. I think if you have a chance to look at it, you would be surprised at how much capability is there.

One last comment is that in trying to assist the Veterans Administration in claims adjudication, particularly interfacing with the VBA, we have a project, it is called the Health Artifacts Information System, which will take care of electronically transferring all of that loose and late paper that is so—ties up the adjudication of these claims.

So we will be able to capture all of that information that is coming from the private sector on care that was delivered to servicemen and women. And remember, from the DoD's point of view, about 60 percent of care comes from the private sector. But we will be able to capture that and be able to transfer that electronically and interface with their VBMS system, which is part of their reengineering.

One more point, perhaps, is that as we have gone through this process, we have also learned that it is about not only the technology—it is not only about the technology solutions, but it is also about the business process reengineering.

And I want to thank actually our VA colleagues, because we have—through information-sharing summits and the like, have illuminated areas where the business processing reengineering needs to occur so that they can take advantage of the technology solutions.

So thanks very much for the question.

Chairman MILLER. Mr. Michaud?

Mr. MICHAUD. Thank you, Mr. Chairman. This question—I have got two questions.

So the first one is for Mr. Warren and Mr. Kendall. When will the two departments have the full capabilities of an integrated, seamless health care records that can be used as the President had envisioned? The first question.

The second question is for Mr. Kendall. And I would like to read to you from the text of a March 28, 2013 memo from the Office of the Secretary of Defense, regarding the pursuit of the President's open standards for electronic health records.

And it reads, in part, and I quote—"Throughout the first term, the Department's actions have been inconsistent with the President's agenda. The Department's past and current desire is to completely replace its health care information technology package with an existing commercial health care advantage package."

It goes on to say that, and I quote—"The Department's resistance to the President's open standard agenda appears to be founded largely on an incorrect assumption."

My question to those quotes is, do you believe that the President's agenda was worth pursuing, or was there some mix-up at the Department of Defense? And please help me understand this because this has been going on for 4 years, long before sequester. I hoped that you would be able to give us some idea.

So those are my two questions.

Chairman MILLER. In 25 seconds or less.

Secretary KENDALL. All of these terms have—like integrated record, carry an awful lot of weight and are interpreted differently by different people.

My view is that by 2014, we will have integrated records that we share with VA. That is what the near-term projects are doing. That is what the accelerators, which Dr. Woodson mentioned, are doing.

And it is important for the Committees to distinguish between integrated records and health care management software. The health care management software doesn't just make a record. It helps the physicians do their job. And that is a very important reason for us to modernize our systems.

But as far as the records are concerned, we will have records to common standards and they will be movable seamlessly between DoD and VA, for use by both benefits adjudication purposes and for health care purposes.

Your second question is about the comments that you made about the President's agenda. We are fully supportive of the President's agenda. So is VA. We are united in our effort to develop common standards and to support the national standards that the President articulated as a goal and that we are working on with HHS.

So I don't know what the source of that quote was, but I think it is entirely incorrect.

Mr. MICHAUD. Actually, the quote was from the Department of Defense, the Secretary's office. And I will give you the memo from DoD. They made it very clear it is inconsistent with what the President directed them to do.

Secretary KENDALL. I understand, but it is not correct.

Chairman MILLER. Mr. Smith?

Mr. SMITH. As following up on the computer records a little bit, is it the case that you are going—and I think you mentioned this, but I just want to clarify—is it the case that you are going to have to develop a brand new system that both departments can use, or do you think that there is a software fix that can get your two systems to begin to better talk to each other?

Secretary KENDALL. We are currently talking to each other. I think there is a misconception about this. We are sending electronic records today.

So in that sense, we are talking to each other. VA can read DoD's records when we send them, okay. We want to have an improved system from that, where we are not just reading the records, but actually using them and using the data that is provided.

We also want to eliminate paper that is currently part of the records that we are sending, for the reasons that I mentioned that were discussed earlier. So we are moving very quickly to accomplish those two things.

That is a separate thing from the software that manages health care provision.

Mr. SMITH. Right.

Secretary KENDALL. And that is a distinction I want to make.

Mr. SMITH. And the software management system, you are saying that you are going to come up with a new, relatively new system beyond what you have now?

Secretary KENDALL. Our choices are not between—we were on the path at one time to develop an entirely new system.

Mr. SMITH. Right.

Secretary KENDALL. That was the history of this——

Mr. SMITH. That is a tough path.

Secretary KENDALL. It is a tough path, but we decided to get off of it.

Mr. SMITH. Yes.

Secretary KENDALL. The costs for that were going to be exorbitant. The last estimate that I saw was $28 billion of lifecycle cost. So the decision was made a few months ago to get off of that path.

Once we were off that path, VA made a decision that the best path for VA was to continue with VistA and evolve and enhance VistA to a modern project—a more modern product.

For DoD, as I mentioned in my opening comments, we have a little different situation, we have a very different situation. So we are not going to develop a new system. We are going to look at a range of options that will include commercial, mature products that are modern products that are being used throughout the health care industry.

Mr. SMITH. That is where the software improvement comes from. We are working with a ton of companies and I think, gosh, going back 20 years, we have had this history in a variety of different government agencies where they try to come up with some brand new system, where what has evolved is software solutions to get old systems to better communicate with each other. And that is—seems like the better approach.

Secretary KENDALL. For DoD, it is better to have a choice among a range of options that includes those types of systems.

Mr. SMITH. Right.

Secretary KENDALL. VA, as I said, is in a different position, and I am not—they have VistA and they have in-house programs to work with VistA, et cetera. So they have an established base they can build on. It is not where we are.

There is an analogy that you will probably be familiar with from your Armed Services Committee activities, with radios, tactical radios that DoD acquires. Where we were doing a program of records that took years and years and years, and meanwhile the commercial industry was moving forward very quickly. And we came to a

conclusion to cancel some of those programs and go out and do commercial like competitions in lieu of doing our own development. We are in a little bit of that situation here.

Mr. SMITH. The tyranny of the program of record is a phrase that occurs to me many times when I look at some of our acquisition challenges. And I know you have done a lot of work to try to get around that.

Mr. SMITH. I yield back. Thanks.

Chairman MILLER. Mr. Runyan?

Mr. RUNYAN. Thank you, Mr. Chairman.

I know we have been talking here a lot about moving forward. I sit on both of these Committees, both HASC and VA, and I chaired a subcommittee that deals with disability assistance and memorial affairs. My question is really directed both at the VA and the DoD. And this comes from a past VA hearing.

In the hearing, it was discovered that VA initially—when VA initially requests records from the DoD, and we are talking about paper records—we are talking about dealing with the current backlog—VA will wait 60 days before sending a follow-up request. Following that request, VA will wait an additional 30 days to respond—for DoD to respond before making another contact at DoD.

This is a very large work window. And as VA is trying to adjudicate these claims in 125 days or less, that leaves 35 days before they can actually get their hands on the paperwork. It was discovered through the hearing that this rule was probably self-promulgated from the VA's adjudication manual.

Is this window necessarily that large? Does the VA need to change their protocols on that? And why does it take the DoD so long to get the—request of materials?

Mr. WARREN. If I could hand that to Mr. Pummill to answer.

Mr. PUMMILL. Congressman, it is the timeframes that you quoted are accurate timeframes. And those timeframes are based on the requirement that we have in the Veterans Benefits Administration to assist veterans—a duty to assist that says that if we get a record and we believe that the record is not a complete record, that we have certain timeframes that we have to re-request the record again.

Now, we have actually fixed that in some work that we have done with Ms. Wright's office in that the Department of Defense has already started, as of January of this year, working to give us from the five services certified service treatment records. Basically, what they do now is they give us a service treatment record with a document on top saying that the Department of Defense certifies that this is a full and complete record. That means that the record has all of the—we have their personnel information, their dental information, their medical information, and not just treatment from a military treatment facility, but maybe if they went outside for TRICARE or something, that eliminates the need for the VA to go out and ask for any additional information—no more 60-day letter, no more 30-day letter.

This will improve again when we get to December of this year and we start receiving all of that information electronically, because we will be able to shift it around to different places to adjudicate it. But yes, that was a problem. That still is a problem with

veterans that are from previous conflicts that are not coming directly from the Department of Defense, because we still have to go out and request any place they may have been for all their records, to ensure that we have everything possible to give that veteran every benefit of the doubt when we are adjudicating their claim.

Mr. RUNYAN. Thank you.

Mr. Chairman, I yield back.

Chairman MILLER. Mr. Takano?

Mr. TAKANO. Thank you, Mr. Chairman.

I am pleased that DoD and VA, along with several other agencies, have collaborated to improve and reinvent the transition assistance program. However, I heard from the California Department of Veterans Affairs that they are being excluded from participation in transition GPS, the new program. State governments provide key resources and services for veterans, and I think it is important that they are included in the transition program.

Can any of you address why the California Veterans Affairs Department is being excluded? Or if that is a mistake, what will you do to address the issue?

Ms. WRIGHT. Sir, I would like to address that issue, please.

Any individual that spends 180 days on active duty is—goes through the transition assistance program that is now a very active program at 206 installations throughout our system. It is a collaborative effort between Department of Defense, between VA and between Department of Labor.

The transition GPS will be up and running in the first of October of 2013. In fact, we just all had a meeting about that yesterday. But there are tracks to that, that those individuals that come through the transition program still do. They do MOS comparison to civilian. They do a transition plan. They do a financial plan. And they do a career readiness solution.

What will be added onto the transition GPS are three additional tracks that could potentially—that are volunteer, the individual does not have to go through. So my concern is, I don't know if you are talking about a reservist or guardsman who is leaving the Guard and Reserve system, or if you are talking about somebody who is leaving the active duty system.

So, what I have explained is for somebody that has been on active duty. I would like to make an appointment with you and follow up to see if it is clearly on the Reserve and Guard side, and then I can answer your question.

Mr. TAKANO. I would appreciate that effort. Thank you.

Chairman MCKEON. Mr. Forbes?

Mr. FORBES. Thank you, Mr. Chairman.

You have heard both Chairman Miller and Chairman McKeon mention the collaborative effort we have with DoD and VA. One of the concerns that I have is with these furloughs that the secretary of defense has ordered. We know that the VA employees are exempt from that, but not DoD employees.

So my concern is, what impact is that going to have on the transfer of this information over from DoD. And if we have a 20 percent loss in the time that these employees have, are we concerned about the messaging that we are sending to our servicemembers that after a decade of war that they have served their country, that the

country is somehow content to give them 80 percent effort in this transitioning.

Ms. WRIGHT. Sir, if I may, thank you for the question.

I would like to piggyback onto what Mr. Kendall said. Sequestration is real in our department.

Mr. FORBES. I understand sequestration is real. Some of us didn't support it, but the decision on the furloughs was the secretary's.

Ms. WRIGHT. Absolutely, sir. And furloughs are real and they are catastrophic to the department and they are catastrophic to the great civilian employees that work for the department.

Saying that, we realize how important this is for those individuals that have served our country admirably in the military, to transfer their records to VA in a whole certified manner, as Mr. Pummill brought up—the agreement that we have between the two departments.

We are making that 45-day window. The reason we have a 45-day window is to collect all that loose-flowing information from TRICARE and other agencies where we can then certify that they are correct and send them over to VBA to their repository. So, should the individual choose to file a disability, his or her records are there and correct.

So, yes, furloughs are real. Yes, they are damning. But we have kind of locked this down as hugely important and we are putting a full-court press on it, sir.

Mr. FORBES. In my 4 seconds, I don't think you have answered the question. But if you could at some point in time give us a metrics of a plan so that we can measure independently that we are reaching our goals.

And with that, Mr. Chairman, I yield back.

Ms. WRIGHT. Sir, we have the—if I may?

Mr. FORBES. Please.

Ms. WRIGHT. We have a metric of 100 percent. The last report from VA, and we get our numbers from VA, we were at 97 percent success rate of getting our records to VA on time. We collaborate every day on this. I can provide you more metrics if you choose.

Mr. FORBES. Thank you. I would love to. Thank you.

Ms. WRIGHT. Thank you.

Chairman MILLER. Mrs. Davis?

Mrs. DAVIS. Thank you, Mr. Chairman.

Just quickly, since we have little time. How is—how are VA and the DoD working together on after-action reports regarding suicides? I am familiar that the different services have their own ways of doing that, but how are you integrating those discussions? And what have we learned from it?

And secondly, what are we doing to reduce the stigma so that people who are having difficulties actually report those difficulties so that that goes on their medical reports when they do apply for benefits later on? I understand that a number of people actually do not, and so when the VA has to rate them down the line, they have nothing on which to base it, even though they have been serving for a number of years.

Secretary PETZEL. Congresswoman Davis, let me begin, at least, to answer that question.

The VA and DoD have a joint integrated mental health strategy. One element of that strategy is suicide. We recently jointly developed an integrated recordkeeping system for suicide where we collect the data from each one of the states as to the rate of suicide, et cetera, amongst veterans; collate that data; and then use it to analyze our experiences in the DoD on one hand, and in the VA on the other hand.

The second thing is that we have a number of joint efforts going on right now to de-stigmatize suicide. The make-the-connection campaign and the stand-by-them campaign are two efforts to destigmatize mental health in general, but suicide in particular, and to not glorify suicide.

The third element is the military-VA crisis hotline, where people that are having a difficulty can call. We have received almost 900,000 calls since it began almost 4–1/2 years ago; 26,000 saves from that. That is, people who were in danger of harming themselves or someone else that were rescued from doing that.

The suicide work group, the mental health work group of our health executive council, that VA and DoD jointly chair, regularly reviews the suicide experiences within each organization and looks for, in further joint efforts——

Mrs. DAVIS. Excuse me, are those shared with the family as well? Are those reports shared with the family?

Secretary PETZEL. I can speak only for the VA in terms of the family, that when we do a, what we call a psychological autopsy on a patient or a review, yes, we would do what we call institutional disclosure and discuss that with the family.

Mrs. DAVIS. Okay, thank you.

Chairman MILLER. Dr. Benishek?

Mr. BENISHEK. Thank you, Mr. Chairman. My question is actually for Dr. Petzel.

In 2008, the NDNA, a joint DoD–VA vision center of excellence was established at Walter Reed. The purpose of this center, along with two other joint centers of excellence, was to improve clinical coordination and best practices between the DoD and the VA.

The center was also tasked with developing a joint trauma registry containing up-to-date info on the diagnosis, treatment and the follow up for injuries received by our Nation's military. The vision center alone was allocated $6.9 million over 5 years.

Apparently, there are two current staff members from the VA located at the vision center of excellence, and this is despite repeated promises from the Secretary that there would be no less than six. Why hasn't more staff been committed to the vision center?

Secretary PETZEL. Thank you, Dr. Benishek. My understanding is that we have committed the staff that was initially agreed to. I will go back, sir, and find out——

Mr. BENISHEK. See, I have also heard reports that the VA plans to pull out of the centers of excellence. Is there any truth to that?

Secretary PETZEL. No, we do not plan on—we fully support the concept of the centers of excellence.

Mr. BENISHEK. Well, I would like to be sure that there are six staff members as the Secretary promised.

I have also heard reports that the VA has been refusing DoD IT personnel with security clearance to access the VA health records

for purpose of building the trauma registry. Do you have any knowledge of that?

Secretary PETZEL. I do not, sir. I would ask Mr. Warren if he has any knowledge of that.

Mr. WARREN. I would like to take that for the record, but I am not aware of that taking place, sir.

Mr. BENISHEK. Well, let's follow up with your staffs, so we get these answers, because I have got some credible reports that indicate that these questions are valid.

Mr. WARREN. And can we reach out to your staff for further information?

Mr. BENISHEK. Yup.

Mr. WARREN. Thank you.

Mr. BENISHEK. Thank you. My time is up.

Chairman MILLER. Mr. Wilson?

Mr. WILSON. Thank you, Mr. Chairman.

And thank you, Chairman Miller, Chairman McKeon, for your leadership to promote DoD–VA collaboration on behalf of our military servicemembers and military families and retirees.

Mr. Pummill, how many of the pending claims that VA is waiting to process require information to be provided from the DoD to be processed?

Mr. PUMMILL. About 4 percent. It is not very much.

Mr. WILSON. That is impressive. That is good.

Ms. Wright, how many pending claims does DoD need to provide the VA information?

Ms. WRIGHT. Sir, we are working on the 4 percent that we are required to provide. We are also providing the current service treatment records of those that are leaving. But those that are within the backlog is about 4 percent.

Mr. WILSON. And this 4 percent has been a significant reduction apparently, is that correct?

Ms. WRIGHT. We are working together, sir. We have a team on the ground, two teams on the ground at VA at their request and they are working hand in glove with VA to bring down that number.

Mr. WILSON. Well, I appreciate very much that information and please keep us informed.

Mr. Pummill, do you believe that a joint DoD–VA integrated electronic health care record would substantially aid the VA in eliminating the current backlog?

Mr. PUMMILL. A joint electronic health record probably won't do anything for the current backlog. It would be wonderful for the future to have everybody in the government to be able to look at one medical record and grab all their information.

Right now, what we need is the electronic personnel dental and medical records, which we have got a commitment from the Department of Defense to get by the end of this calendar year.

And for claims purposes, that is what I need. The electronic health record, if that ever works out for the future, that would be great. That would help in the future. But it would not help us in eliminating the current backlog.

Mr. WILSON. And finally, for the health and safety, I certainly hope every effort is made to expedite the electronic health care records. It is just got—for all of you, it is just so important.

Thank you very much for your service.

Chairman MILLER. Mr. O'Rourke?

Mr. O'ROURKE. Thank you, Mr. Chairman.

And for Under Secretary Kendall, I wanted to draw your attention to a Reuters investigative piece that was published yesterday, entitled "The Pentagon's Payroll Quagmire Traps America's Soldiers."

And one of the soldiers that they focus on is based at Fort Bliss in El Paso, Texas, the community I have the honor of representing. And after returning from two combat tours, suffering from severe PTSD, traumatic brain injury, nerve damage and chronic pain, his pay is mysteriously garnished, and going from $3,300 a month to about $1,000 less, without explanation.

After he complains about it, his pay goes down to a little over $115 a month, forcing he and his family to go to food pantries to be able to feed themselves. He has three children. Having to go through Operation Santa Claus to get Christmas gifts for his children.

And the Reuters reporter was able to find that this is not an isolated incident. It is widespread throughout the Department of Defense. There was also a GAO report in 2012 that cited some of these same problems. The response from the Department of Defense was to call the GAO report overblown.

One of the other findings in the article shows that the Department of Defense's system is a jury-rigged network of incompatible computer systems for payroll and accounting that are obsolete and unable to speak with each other or communicate with each other within the DoD.

And so, I knew we had a problem communicating DoD to VA, I didn't know we had a problem communicating DoD to DoD.

Considering the GAO report, the Reuters report, this case of medic Aiken, what is your response to this? How are you going to fix this and when will you fix this?

Secretary KENDALL. Congressman, I have to pass that question over to Ms. Wright.

Ms. WRIGHT. I apologize for the microphone.

First thing I will tell you that I have not seen the article, but I will absolutely read it today. It is very important. It is catastrophic if this is happening to our servicemembers, if it is happening to one or if it is happening to a multitude. So I would like to do that.

I am the personnel and readiness person, so I am not responsible for DFAS, but I am responsible for the health and welfare of our soldiers and our military members.

So, sir, I don't have an answer for you. I would like to take it for the record, but more importantly, I would like to follow up on the one particular person and fix that right away, see what we have for the system issues, involve the comptroller, and get back to you, if that is okay?

Mr. O'ROURKE. I look forward to following up with you, thank you.

Ms. WRIGHT. Thank you.

Chairman MILLER. Mr. Loebsack?

Mr. LOEBSACK. I thank the Chairman. I want to thank the two Chairs and the Ranking Members for this hearing. I had seven veterans' forums last week at the beginning of the week, and what Congressman O'Rourke mentioned is something I hear often.

I could just spend all of my 2 minutes sort of recounting all the stories that I have heard over the 7 years that I have been in office, so I won't do that. I just want to broaden out the discussion of mental health a little bit, if I may.

Good to see you again, Dr. Woodson. I hope you will chime in on this, as well. And Dr. Petzel, it is really important what Congresswoman Davis brought up, the suicide issue, but I would like to go a little bit further than that, talk about transitioning from DoD to VA, in particular from active duty to the VA, and with respect to the mental health care system that is in existence now with DoD and then going to the VA.

Can both of you speak to that issue, please?

Secretary WOODSON. Yes, I would be happy to start and thank you again for this question, which is a really important topic.

As we know, mental health issues have become one of the signature health issues out of the decade-plus of war. As Dr. Petzel said several moments ago, he and I have worked very, very closely together to harmonize and advance the care relative to mental health.

It begins with a group that has been working on an integrated mental health strategy, so that we are enhancing the practice guidelines even as we hand off servicemembers who are transitioning to veteran status.

We have a robust, collaborative effort on research to advance our understanding of treatment strategies that are important. We have a significant collaborative effort to insure transition is smooth in transition programs. Making sure that there is follow up at VA. We have developed a series of initiatives that are looking at what kind of care is being delivered and its effectiveness. And we discuss this every month in terms of how to move this ball forward.

The development of applications that can be used by individuals who might have PTSD to enhance resolution of their symptoms. What has been interesting and this goes to a question that was asked earlier about suicide, is that we have learned something from the studies that have been done in the Department of Defense and in the Department of Veteran's Affairs. That in fact we have slightly different issues relative to the cohorts that we need to focus on and how we need to tailor some of our suicide prevention programs and campaigns.

So within the Department of Defense, the biggest profile at risk are the young individual, first-time enlisted who has financial problems, relation problems, maybe previous family problems prior to coming into the service. Whereas in the Veteran's Affairs, it is the vet in their 50s or 60s with additional qualifiers. And so it has been very important to understand that bimodal set of events so that we can individually address what might be the factors for the people in our society and the people that we are responsible for that are most at risk.

But the bottom line message I want to leave you with is that Dr. Petzel and I, as the people principally responsible for this, work enormously closely together to try and enhance our understanding, treatment strategies, prevention. And I would just say that you know, we are doctors, so we don't just concentrate on medical issues, we are talking about how to develop comprehensive programs writ large to get communities involved, crisis line. Try and educate families about risk factors and profiles of people at risk. So we co-sponsor suicide prevention conferences to bring our people together to look at what we should be doing and what advances should be made. So difficult problem, but we are 110% after this together.

Secretary PETZEL. Thank you. Mr. Chairman could I add just 30 seconds to what Dr. Woodson said?

Chairman MILLER. Yes sir.

Secretary PETZEL. Thank you. Two things. Number one is that we have a series of case managers that we share that transit the seriously ill and injured people from the DoD into the VA Health Care System. And this includes people with serious mental illness. We are hoping that the Transition Assistance Program, the new TAP, is going to have in it an even better way of making a hot transfer for people that are ill, not necessarily in the seriously ill or injured group, but do need that kind of transition.

And the last thing I would comment on, just to reiterate what Dr. Woodson said, I have been in the VA for a long time and worked with DoD for a long time. The level of collaboration and cooperation in the clinical sphere in medicine right now is unprecedented. I mean absolutely. We share so much and do so many things now jointly that we wouldn't have even dreamed of 5 or 6 years ago.

Mr. LOEBSACK. Thank you. And thank you, Mr. Chair, for indulging for such a lengthy period.

Chairman MILLER. Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman. Secretary Wright, there has been a three-point series by the Colorado Springs Gazette that an investigative report, reporting, that talked about soldiers receiving less than honorable discharges due to minor infractions. And a lot of those soldiers are combat veterans from Iraq and from Afghanistan who also it was reported that had TBI and posttraumatic stress disorder in some of those instances.

These, the nature of this discharges, disallowed these combat veterans from receiving any care under the VA. And so I am wondering if you, I am very concerned about this, and I wonder if you can comment on this?

Ms. WRIGHT. Sir I can comment on the transition portion and then I am going to turn it over to Dr. Woodson to comment on the medical diagnosis portion. So the minor infraction that you talked about could be a multitude of things. These individuals, whether they receive an honorable discharge or whether they receive a less than honorable, would still go through the transition program that all servicemembers leaving the program must go through. During that period of time, they receive not only counseling from the Department of Defense and Department of Labor, they also receive 6 hours of counseling classes from the VA.

So what the Secretary of VA is concerned about is even when people leave with a dishonorable discharge, people going into kind of the homeless category, and so he wants that warm handoff through the VA system and we are working together.

Now your question involved those that may have PTSD or another type of diagnosis that could have related to the dishonorable discharge——

Mr. COFFMAN. Less than honorable. There is a difference—less than honorable discharge versus dishonorable. There is a pretty significant difference.

Ms. WRIGHT. Yes sir, less than honorable versus dishonorable. So I am going to turn that over to Dr. Woodson because we are doing something to review those cases.

Secretary WOODSON. Again, thank you for the question and again, just to restate. I think at the heart of your question is whether or not some individuals are being discharged with less than honorable discharge, being denied benefits, and in fact have an injury of war. And so we have enhanced our screening and require screening that if someone is being discharged for what is considered bad conduct, bad conduct discharge, that they have to go through certain screening for PTSD and TBI to insure that that is not a contributing factor.

So you know, heretofore, there were examples of individuals because, you know, line leadership just was not clinically oriented and someone did a bad thing. But the question was what was the root cause of that change in behavior? Was it a brain injury or was it PTSD? We now have screening mechanisms to look at those issues.

Ms. WRIGHT. Sir if I can follow up on one more thing. At the beginning of a war, we may have diagnosed them as having an adjustment disorder, which is different than PTSD or TBI of course.

Mr. COFFMAN. Right.

Ms. WRIGHT. So we have rescreened those cases within the services. That doesn't mean we can reverse the discharge because it may not have been, you know, I don't know what the particular issue was that created that particular discharge. But we are working through each individual case to see if we, if the missed diagnosis was there, which could have resulted in the, in an unfavorable discharge.

Mr. COFFMAN. Thank you Mr. Chairman I yield back. I would just like to see treatment available to these soldiers, marines, airmen and sailors who have served this country in combat and are being discharged for minor, were discharged for minor infractions.

Chairman MILLER. Mr. Conaway.

Mr. CONAWAY. Thank you, Mr. Chairman. I was struck by the sincerity of each one of your answers, particularly when confronted with what appears to be a fail, like Mr. O'Rourke was mentioning earlier and wanted to get at. But I would like Mr. Kendall and Mr. Warren to think about the word accountability.

Each of you have talked about deadlines and progress to be made in the future and those kind of things. If those things aren't met, what is, is anybody's performance evaluation effected? Are there consequences to anybody in the system for failure to meet the deadlines which are being set?

Secretary KENDALL. Absolutely. One of the things I have asked for the IPO to do and we will be doing this together with Mr. Warren is to lay out a set of commitments, a list of deliverables with schedules that we expect them to deliver. Those will be shared commitments between ourselves and DoD and VA And the IPO will be held responsible. It is similar to what we do with all of our Program Managers and Program Executive Officers. We are going to be managing this program——

Mr. CONAWAY. So a year from now, we would be able to look at an evaluation report from somebody who had a standard to be met, didn't meet it. There would be a consequence on their personnel evaluation and they would either be fired or demoted or held accountable some way?

Secretary KENDALL. Yes.

Mr. CONAWAY. Okay. Mr. Warren how about your side?

Mr. WARREN. The same sir.

Mr. CONAWAY. Say again?

Mr. WARREN. Yes, the accountability and the responsibility to perform to the standards and the commitments we have made is in the performance plans and individuals are held accountable for those sir.

Mr. CONAWAY. Okay. You just used the word "past tense" are or currently. So we could look at your system——

Mr. WARREN. Are and will be, sir.

Mr. CONAWAY. But we could look at your system and actually see where somebody was disciplined or demoted or fired or something because they didn't meet some important deadline?

Mr. WARREN. Or their performance rating was less than outstanding. So again, remember the way the performance program works is you lay out——

Mr. CONAWAY. How many get outstanding?

Mr. WARREN. I will get you back that number for the record, sir.

Mr. CONAWAY. My issue is if everybody gets an outstanding, then that doesn't mean anything. So if——

Mr. WARREN. I will assure you, sir, that in the senior executive cadre at the VA, the number of outstandings has steadily decreased over the last couple of years as a result of the system of accountability that Secretary Shinseki has brought to the department, and not just for the senior execs but in other areas. And we are glad to get that to you for the record, sir.

Mr. CONAWAY. I appreciate that.

I yield back. Thank you.

Chairman MILLER. Which means there are a lot of bonuses being given out.

Ms. Brownley?

Ms. BROWNLEY. Thank you, Mr. Chair. And I also wanted to sort of follow up on this accountability issue and benchmarks, et cetera.

So you are saying that you have provided them, and I want to know how you are going to report back to us and your process by which you are meeting those benchmarks, how—what is your recommendation and the best ways for us to hold—to monitor what you are doing over the course of the next 18 months, I think you said.

I wasn't here for part of the testimony, but my understanding was that you would have this complete by 2014, the integrated system—health system.

Secretary KENDALL. We have a set of near-term goals that we share that the IPO is executing. I haven't reviewed them in detail yet, but I will be doing that very shortly. And we will have commitments on what we will deliver and when. I don't think it will change substantially from the current plan.

I am concerned about some of the schedule risk in some of the things we are doing. We will be in close contact with the Committees and their staffs as we go throughout this process. We know there is a lot of interest in these programs and in their success for very good reasons. And we also know that the history has been a source of some frustration.

So we are going to keep in close contact. We will have specific benchmarks that we have to met, and we will inform you of how we are doing against them.

Ms. BROWNLEY. And you will have those complete by?

Secretary KENDALL. I should have some of those in place within the next few months from my perspective, although I think some already exist from the perspective of the VA that they are more confident of than I am right now.

Mr. WARREN. The VA has commitments in place. In fact, the near-term accelerators that we have been speaking about today, there are sites where we are deploying the integrated viewer. It is taking place during the month of July. At the end of the month of July, we will have it all—the polytrauma units. So we will complete that.

By the end of December, we will have built that viewer. Where today you are seeing the information separate, but as a result of the work on data translation, you will be able to see a blended view. That will be by the end of December. So that is on the joint side. We are still finalizing the deployment schedule of that joint viewer at different facilities and capabilities in 2014. That is the piece Secretary Kendall was referring to.

On the VA side, we have a commitment to ensure that we are deploying the core capability, which is about 15 percent of the IHR that the VA made the decision on back in September, by 1 October next year at two locations, Hampton Roads and San Antonio.

So there is a set of near-term that we are making great process on, and there are some out-year commitments that we have made in terms of deploying systems and making the necessary enhancements.

Ms. BROWNLEY. Thank you. I yield back.

Chairman MILLER. Ms. Tsongas?

Ms. TSONGAS. Thank you, Mr. Chairman. And thank you all for being here today. I am glad that this joint Armed Services-Veterans Affairs hearing is becoming an annual exercise. This is our second, and I hope we continue to have it in the coming years.

There are a wide number of continuum of care issues which we have been discussing here today. So I think it just shows us how obvious it is and how little sense it makes to treat DoD and the VA as two separate stovepipes, when it comes to addressing some

of the most critical health challenges our veterans are facing. And I appreciate all the work that you are putting into it.

Certainly, survivors of military sexual assault are among the most vulnerable members of this population, and I greatly appreciate the efforts over the last several years by both DoD and the VA to improve the treatment of the victims of this crime within the Armed Services.

I was heartened to learn yesterday in a meeting with senior representatives from the VA, including Assistant Secretary Mooney, that the documentary film "The Invisible War" is now mandatory viewing for senior VA managers. This is a movie that has really helped to draw very important attention to the great challenge of this issue.

Among its many ways in which it did do so, it also painfully highlighted the multiple bureaucratic hurdles that a survivor of such assault has to endure to prove that their physical and mental health symptoms are connected to an incident of military sexual trauma within the VA, and shows that too often, victims are unsuccessful in pursuing their claims for assistance.

So to address one aspect of this problem, the fiscal year 2012 defense authorization included language that required the secretary of defense, in consultation with the secretary of the VA, to develop a comprehensive policy for the Department of Defense on going about the retention of and access to evidence and records relating to sexual assault involving members of the Armed Services, because that was one of the issues that we have come to understand.

So my office continues to closely monitor implementation of this and other vital measures. I want to honor the 2-minute time limit. I will submit some questions for the record. But just to let you know that this is an issue that this Committee takes very seriously.

And I look forward to—I heard some feedback yesterday as to the work you all are doing, and we will continue to monitor it closely. Thank you, and I yield back.

Chairman MILLER. I thank the gentlelady for yielding. Dr. Heck?

Dr. HECK. Thank you, Mr. Chairman. Thank you all for taking the time to be here. My question has to do with the Integrated Disability Evaluation System, which attempts to take what was an almost 540 day process and get it down to about 295 days from profile initiation to either unit reintegration or separation.

Can you give me an update on the progress of IDES and the cooperation between both DoD and the VA, specifically phase one, the MEB process, and phase two, the PEB/PDA process?

Secondarily, do you believe that when an integrated electronic health record is finally achieved that that will help expedite the process even further? And what more, if anything, can Congress do to help the IDES process along?

Secretary WOODSON. Thank you, Congressman, for that question. Obviously, the Integrated Disability Evaluation System has been troublesome, particularly over the early parts of the war. Since we have brought a collaborative effort to looking at the process from beginning to end, I think a lot of improvement has been made.

So that if you look particularly in the Navy and the Air Force, they are meeting standards relative to the MEB and the PEB proc-

ess. The Army still has some outlier sites. And the reason of course is they have got the bulk of the wounded warriors and the folks in the IDES system. There still are about 36,000 folks in the IDES system.

But we have made a commitment to improving the process of that information. So the single disability rating and the information flowing back from the VA to inform the final narrative summaries has improved tremendously.

And so most of the medical boards are now meeting standards, and most of the PEB boards are now meeting standards. We have increased of course the number of personnel assigned, and we continue to refine the information management.

So to the last part of your question about electronic transfer of information, it is not only about transfer of the health information, which most of the current-era servicemen and women have electronic records, but it is about getting that loose paper that we have talked about. And we have got a solution for that which will be in place in the near term basically.

So my expectation is that we will be able to drive down even more the number of days relative to that particular process. There are some things that contribute to the total number on the periphery which are probably not as important, such as the number of leave days that are accrued and those kinds of things.

But I don't know that that impacts sort of the quality of the experience and the fairness of the process. But there have been a significant improvement in the overall system.

Chairman MILLER. Dr. Wenstrup?

Dr. WENSTRUP. Thank you, Mr. Chairman.

Dr. WENSTRUP. A couple questions on the health electronic medical records, if you will. And I am just curious how much provider input is being given as to how this system is set up. Is there an ease for them? And is there anything being done to reduce some of the administrative load to the providers so that they can see more patients?

And then lastly, I just want to clarify. Hopefully, we are headed towards a goal of not just sharing two systems and having access to two systems, but actually having one DoD–VA record.

And I will address that to both doctors. Thank you.

Secretary WOODSON. So, thank you so much for that question, because I want to point out a couple of things that in the proposed legislation, I was struck by the fact that as the Congress was requiring us to set up this advisory committee, there was no requirement for clinical input on that advisory board. And so I am taking you have some experience with electronic health records from the provider point of view.

Let me assure you that Dr. Petzel and I represent the functional community and we have extensive integrated clinical informatics boards made up of clinicians that help develop the requirements. So it is functional community-driven, even as we know that the system has got to support other administrative processes.

But it is not the pyramid turned upside-down where the administrative process, which is probably the mistake we made earlier in the Department of Defense, where the administrative process

drives the development of the record so that it becomes difficult to use by the provider.

So, I wholeheartedly accept your challenge in your question, and I think Dr. Petzel and I are meeting that in terms of how we are developing the requirements.

Secretary PETZEL. Thank you. I would echo what Dr. Woodson has said. And I would also point out that the VA record was really developed by a group of clinicians as a clinical management platform. It had nothing to do with the administrative functions.

And the tradition within our organization is that the clinicians set the requirements and really drive the process of developing the record. And the IPO, with its clinical advisory board, has really adopted that principle. The two groups of clinicians from DoD and VA have worked very well together developing the requirements for the various packets of applications that are going to eventually hang on this record.

And I would also point out that it is my sincere desire that we have a single record between these two organizations, as well as eventually across the Federal government.

Dr. WENSTRUP. Thank you.

Secretary WOODSON. Sir, if I might just add one particular point. I would be very happy to work with any clinicians or members of Congress who want to look at the functionality of what we are rolling out this year, to make sure that you understand what we are really delivering on in terms of that integrated interoperability piece. It is usable. That is the key thing. It is usable. So we would be happy to demonstrate it to you.

Dr. WENSTRUP. Thank you. And I would like to get that Web site you mentioned earlier.

Chairman MILLER. Mr. Walz?

Mr. WALZ. Thank you, Mr. Chairman.

As a veteran and a citizen, thank you all for what you do. I appreciate the Chairman for holding this, again getting us together, and echo my colleagues' statement this is important.

Mr. Pummill, two questions to you. I will ask them both together and get my response. You have the authority to issue interim, partial or temporary disability benefits. That obviously speeds the process along. It gets important things like voc-rehab to our folks right away before these become chronic problems.

I have to tell you it doesn't appear to be happening in southern Minnesota, and when I check around the country. My question to you is: Are VA opposed to interim ratings and compensation that has been determined there is going to be at least 30 percent? Because I don't see it happening.

My other question deals with private medical evidence. You use them for—DBQs, but we are having a problem getting that in to get some of the ratings done. I have a piece of legislation, along with Mr. Denham, to try and use that. Let's maximize our resources. Let's have a force-multiplier and use this medical evidence. Get them in. You already use them for DBQs, why not further them along?

Those are my two questions.

Mr. PUMMILL. The first question, are we opposed to the interim ratings? No, we are not. And I will have to check and find out what is going on.

On the second one, we do have a problem getting private medical evidence. A lot of the raters that are out there that are actually doing the rating of the servicemembers, when I go around and talk to them, tell me that, you know, sometimes you have to query a doctor's office three, four times trying to get the private medical evidence. So, anything that we can get that would help us speed up getting that private medical evidence. We are hoping that the DBQs will be a big step in that, where the servicemember can walk in and say, "Doctor, could you please fill out this DBQ?" It is pretty self-explanatory; easy to fill in the blanks. And they can do it electronically or by hand, and get that from the doctor. And that would forego the need for those private medical records. But in the cases where we need them, it is tough.

Mr. WALZ. We have got folks that wander off. Anecdotally, there seems to be that the thought is that there is a bias against using that outside information, which always sticks in the craw of my folks because it is Mayo Clinic in some of those. I hope that is not the case.

Mr. PUMMILL. No, it is not the case. From VBA, not only are we not opposed to the private medical records, we actively seek those private records and we are required by law to contact those doctors and attempt to get those records.

Mr. WALZ. I am glad to hear it. Thank you.

I yield back.

Chairman MILLER. Mr. Barber?

Mr. BARBER. Thank you, Mr. Chairman. Thank you for convening this important hearing.

I join with my colleagues in wishing that we were listening also to the secretaries of defense and veterans affairs, but I am pleased, of course, that the witnesses are here.

I represent a district where there are about 90,000 veterans, one of the largest in the country. I also represent the men and women of two military installations, Fort Huachuca and Davis-Monthan Air Force Base.

The veterans' caseload is the highest of any in our office. I think that is probably true of all of my colleagues. And the frustration that they feel, the veterans that come to us, and my staff feel, in getting progress is never-ending.

And while I understand and appreciate your efforts to develop systems that will take care of this backlog, I think one of the ways that you might understand our frustration is to spend an hour in one of our offices taking calls from veterans and listening to their frustration and their concerns. It is very enlightening and obviously a very emotional experience.

So, my question to you is this. What are leaders of DoD and the Veterans Administration doing to set measurable progress metrics and holding people accountable? Leadership is about setting goals, holding people accountable, measuring progress. And I would like to know concretely from both of the departments what concrete measurements are you putting in place and how are you holding your staff accountable for meeting those measurements.

That is the only way we are going to get this job done, and I would appreciate your answers. Thank you.

Mr. PUMMILL. Congressman, from the benefits side, the compensation side and the backlog, we now, at the behest of Under Secretary Hickey, have some very strong and stringent metrics in place for not only the individual raters, but their coaches, their supervisors, the regional office directors, all the way up through the leadership.

We know it is—you can look at the math. You can see what we have to do to knock out the number of claims that are coming in and the backlog. And we have set standards that people have to do that.

We in VBA didn't meet what we were supposed to meet last year. We were—the backlog grew for a lot of reasons. We pushed our automation program, VBMS. We now have it out there. As a result of our performance last year, no senior executives in VBA received a performance award at the end of the year because we felt that it was an overall goal of our administration, of VBA, to make positive progress on the backlog. We didn't get there, so no performance awards were paid out.

This year, we will look at the standards. We do see that some of the regional offices have really turned the corner. The ones that have got—some are really embracing VBMS and starting to churn out the claims. Thus, 2 months in a row of breaking an all-time record, but it is still not enough. We are still not where we need to be. We have a higher standard that we need to reach and we will hold people to that standard.

Mr. BARBER. Thank you.

And from Defense?

Ms. WRIGHT. Thank you, sir, for the question.

As we talked about before, we are the providers of information so VA can process the claims. We are not the claims processor. So it is our responsibility to provide that information.

So, working with VA, there was about 4 percent that we owe. We have—and those are for the backlog—so we have two teams on the ground that are hands-on going through these records, calling back, and getting—seeing if this information is in DoD and providing that to the disability claims adjusters so they can adjust the claim.

We also, according to VA, they said the single most important thing that we can do to assist them was to provide them with the certified service treatment records. So to hold people accountable, both myself as the Acting Under Secretary and the Vice Chairman of the Joint Chiefs of Staff, receive reports weekly to make sure that we are working towards the metric of 100 percent. We are at the 97 percentile now and we are working towards the metric of 100 percent within a 45-day window of when the servicemember departs DoD.

Mr. BARBER. Thank you.

Mr. Chairman, I yield back.

Chairman MILLER. Mr. Scott?

Then Dr. Roe?

Mr. SCOTT. Thank you, Mr. Chairman.

And ladies and gentlemen, thank you for being here.

And I do believe you are sincere in trying to cure this backlog. And my questions will be more for Dr. Petzel and Mr. Warren, if you will.

And we all know, as I just said, that the veterans are waiting too long to have their benefits processed and receive the benefits. And in the private sector, beneficiaries would actually be receiving an interest payment for the time between when the claim should have been adjudicated and when it actually was, and that is something that we may need to look at from our side.

I am glad to hear about the VBMS software, the continued progress there that is going in. And my concern comes from the reports and the delays—and I know you have addressed this—just the months that may take place before the veteran's records are processed into that VBMS system.

And I know many of them have to be manually scanned and many of them probably have to be transcribed, and that contributes to the delay. But some of the things that I think also contributes to the confusion, the delays, veterans, because they are unable to track their records, resubmit their records, which means there is more paper coming into the system and more files.

And so what is being done to speed up that or at the least track the records? And I think if there was a tracking system so that the veterans could go online and see that all of the paperwork had been received and that their claim was in process and where it was in line in being processed that may resolve some of that. And if you would speak to that I would appreciate it.

Mr. PUMMILL. Yes, Congressman, I will answer that question.

You hit the nail right on the head. Our big problem in VBA is always going to be—for the next few years, we are gonna receive a million claims a year. Most of those claims are gonna come from outside the Department of Defense. The Department of Defense claims that we are gonna get from servicemembers that are leaving active Guard and Reserve will have the electronic personnel, dental and medical records, so we will be able to do exactly what you say.

For all the other veterans that send us in the paper and multiple copies of the paper, we are still going to have to take those records, ingest them through some scanning system that we have in place and put them into VBMS.

Right now, as I stated before, we are only at 20 percent done with that right now. We still have 80 percent to go, and it is probably gonna take us about a year to get the ones that we have in. Meantime, a million new ones are gonna come in, in the same status. So it is a never ending problem that is always gonna be there.

One of the future things that we have in VBMS is if you go into my eBenefits right now and you file a claim, you can see when your claim is filed. But what you can't see is, have we received your records, what is the status of your claim. Future upgrades of VBMS—I think it is December, 6.0, will allow the veteran to see when the claim arrived, what the status of their claim is, and the VBMS software has built into it right now for the scanning—if you—scan a document and a medical record and then 6 months later you send us the same medical record, the system will identify it that there is a duplicate of that record, because it is a semi-intelligent system, and will prevent that new record from going in.

What it doesn't prevent is when it arrives, the clerk that gets it doesn't know that it is already in there, so somebody has to take that record and get it to the scanning operation, re-scan it, and then once it is there we realize we already have it.

It will prevent having extra records, but we don't know how to prevent the work in the first place other than to notify the veterans, please go online, my eBenefits, register, look. You will see that we did get your file. You will be able to actually go online and look at your file.

Right now I can go into my eBenefits—I went in there last week—and I was missing one of my personal files from my time in the Army. And through my eBenefits, I linked into my Army electronic record, was able to get the personal file downloaded and ship it over to the VA.

It is still a little complicated, but we are getting better and better at it, Congressman.

Chairman MILLER. Dr. Roe?

And then Mrs. Kirkpatrick.

Dr. ROE. Thank the Chairman.

And thank you all for being here. It is good to see you all again.

And just a couple or three quick things. One of the—as Mr. Scott and Barbara both mentioned, the most common thing that a Congressman, probably everybody up here has, are a backlog of VA claims—why can't they get adjudicated quicker?

And I know these 800,000 claims are likely a hodge podge of World War II, Korea, Vietnam, Desert Storm and so forth. So I think that is correct.

How many of those are in an electronic format where you could actually look at them, that you have scanned them in? Where are they? That is one.

And then the second question that I still want to get an answer to that I am still not sure I do. I know that the DoD has an orphaned electronic health system, and they are going to have to replace either the software or do new hardware upgrades.

I think what everybody has asked but is still not clear to me is that when a young soldier, an 18-year-old soldier takes the oath and goes into the military, will that system that the DoD has, is an electronic record, be able to transfer directly to the VA and speak seamlessly to the VA when we have spent billions of dollars—we just spent a billion and we couldn't do that. It just didn't happen.

So is that gonna happen? Because it is not clear to me—I have heard yes or no on that yet. So those are two questions I have.

Secretary WOODSON. So maybe I can respond to the last question first and then my VA colleagues can respond to your questions to them.

The answer is yes. And that is why we have got to concentrate on the data interoperability.

Dr. ROE. Yes. And then when?

Secretary WOODSON. So, again, by the end of 2013 and rolling out in 2014. And, again, I will show you the functionality if you would like, as to what that means.

So the answer is yes.

It is important to understand that we will always be evolving system, and we have to communicate, again, with the private sector. Many times this morning we have talked about the loose paper and issues relative to what we need to capture from the private sector. So it has got to be about data standards so that we can transfer information rather than what systems and when it is on, because we will never get the entire Nation to be on the same system.

Dr. ROE. Correct.

Secretary WOODSON. But we do need to capture that data.

Dr. ROE. One last thing, Mr. Chairman, just—and I will yield my time back—is one of the things the VA is doing I think is very good is the video conferencing for VA—for veterans who want to appeal. We did our first one in the district the other day. So that a disabled veteran doesn't have to go to Nashville and then drive to Washington, D.C. You can video conference that.

And that will save tons of money, make it much easier. So I want to commend you on doing that and encourage you to continue to do that.

I yield back.

Chairman MILLER. Ms. Kirkpatrick—then Mr. Kilmer.

Ms. KIRKPATRICK. Thank you, Mr. Chairman.

My question to the panel has to do with immediate mental health treatment. Twenty-two veterans commit suicide every day. Every time a new patient goes to the VA they have to go through the enrollment and eligibility process, which includes a physical exam. Oftentimes, this physical exam takes 2 months or more to set up, and this includes patients who need immediate mental health treatment.

My VA caseworker is contacting hospitals directly to schedule these emergency physicals for these veterans who need immediate treatment.

I know the Department of Defense does a quick evaluation before discharge, but there is no direct handoff of that evaluation to the VA. So my question is, how can the VA and the Department of Defense work together? What kind of system has to be put in place as soon as possible to make sure that these veterans get their immediate mental health treatment?

Secretary PETZEL. Congresswoman Kirkpatrick, let me just address the emergency part of this. If someone has an urgent or emergent medical—mental health condition, they will be seen immediately. They don't have to have a physical, they don't have to have anything else. They will be seen and evaluated for that mental health condition.

And if it should transpire that they need to be admitted, et cetera, they can be admitted. The rest of the work in terms of determining eligibility, et cetera, will occur.

I would like to talk personally with you about the specific cases. If they are something less than urgent or emergent, then, yes, there is a step process that one goes through, but it can be done in a pretty expeditious way.

Ms. KIRKPATRICK. Let's follow up, because evidently it is not happening. And it may be the criteria that is used for what is an emergency. So——

Secretary PETZEL. I would be delighted to talk with you about it.

Ms. KIRKPATRICK. The response from the Department of Defense, please?

Secretary WOODSON. Yes, I think previously in testimony, both Dr. Petzel and I talked about integrated mental health strategy, warm hand-off, case managers that handle servicemembers with identified mental health problems that need immediate and follow-up care.

So I think over the last couple of years, we have really enhanced greatly identifying individuals who have particular mental health problems that need to be seen right away, and making sure that they get to those——

Ms. KIRKPATRICK. Doctor, let me ask, with that evaluation that is done right before discharge is there any way to make a quick hand-off of to the VA of that information and the results of that?

Secretary WOODSON. Absolutely. We do that. We transfer——

Ms. KIRKPATRICK. That is being done?

Secretary WOODSON. Yes. We transfer those——

Ms. KIRKPATRICK. It—okay.

Secretary WOODSON. —records.

Ms. KIRKPATRICK. I yield back. Thank you for the courtesy, Mr. Chairman.

Chairman MILLER. Mr. Kilmer and then Mr. Nugent.

Mr. KILMER. Thank you, Mr. Chairman.

My question is for Dr. Petzel and Mr. Pummill. Obviously, admirably, many employers have shown leadership in hiring those who served.

But I want to raise a concern that I have heard over the years from servicemembers reintegrating into civilian life who have reported that their military or veteran status has occasionally been used against them in the pursuit of employment or in the pursuit of housing, with employers or landlords raising concerns—raising from fears that someone would potentially get redeployed or—and in some cases, folks raising concerns about things like post-traumatic stress.

In my state, I work with a coalition of veterans' groups and a bipartisan group to try to address this and expand nondiscrimination protections in our state.

I was hoping if you could briefly tell us if you are aware of this type of discrimination against veterans and returning servicemembers?

Mr. PUMMILL. Congressman, I have heard that kind of stuff anecdotally, but I can't relate a specific incident. I do know that there was a bill being pushed forward about antidiscrimination against veterans.

And from a VA perspective, we are advocates of veterans. We are very supportive of any efforts in that area. We haven't had a chance to study the bill yet.

I haven't actually seen it, but because of the subject matter discretion—discrimination, it would probably be an Office of Personnel Management and Department of Justice would have to be giving the opinions on that. But from a VA perspective, we support it.

Mr. KILMER. Thank you.

Secretary PETZEL. I would, Congressman, just make a comment. The VA has developed an educational package for employers that we use often at the employee forums that we have around hiring veterans that tend to debunk, if you will, the myths about veteran employees around mental health issues, as well as the rest of the issues that might arise, as you say, because of someone's veteran status.

We are trying, working very hard to have employers understand that these are excellent employees. They are very well trained. They are disciplined. They are used to working hard and they are bright and they can contribute tremendously to a workplace.

Mr. KILMER. Thank you. I certainly agree with you and I am hopeful we can have more comprehensive protections. We will be getting a copy of that bill to you. Senator Blumenthal and I are working on a bill together and we will get that to you. Thank you.

Chairman MILLER. Mr. Nugent and Ms. Duckworth.

Mr. NUGENT. Thank you, Mr. Chairman, and I want to thank this panel for your service to our country and what you do for our veterans. And being a father of three veterans currently serving, I do appreciate it.

But one of the things I hear, and I have about 100,000 veterans in my district, is that the vernacular between doctors and claim processors sometimes does not match up, which causes them issues when it goes to VBA, because they are looking for certain key words as they are scanning through it, because there is so much there.

And I understand that. So my question to you is what are we doing to try to marry up or delineate the vernacular so it doesn't cause our veterans the problem? Because we know what the doctor's intent is. They go to the VA, but they haven't filled out the form with the proper wording and then it gets kicked.

What, if anything, are we doing to address that?

Secretary PETZEL. Thank you, Congressman Nugent. And you have articulated an issue which, in the most part, is in the past.

The development of the disability questionnaires, we call them DBQs, that are to be filled out by the VA doctor or the private doctor, basically answer all the questions. So there is no ambiguity in terms of the language. And a rater can take that DBQ and can do the rating basically from the DBQ, because it forces the clinician to answer the questions in a fashion that will be understood by the rater. I would ask Mr. Pummill if he has any other comment about that?

Mr. PUMMILL. I would agree with Dr. Petzel.

Mr. NUGENT. Let me ask you this question I have. I don't mean to interrupt, we have a short time. Is that currently being done, particularly with docs at the VA, believe it or not, that is part of the problem. We are hearing that specifically today, still.

Secretary PETZEL. Yes, it is. And the other thing that I wanted to add is that we have, in the main, a separate group of physicians that do—and providers that do pension and compensation exams that are trained in the vocabulary, if you will, of claims and adjudication.

I can't say that there isn't an occasional issue or problem, but in the main, these two systems I think work very well together.

If you have a specific instance, I would love to talk to you about it and see if we can find out what happened.

Mr. NUGENT. Thank you, sir, very much. I yield back.

Chairman MILLER. Ms. Duckworth? Then Mr. Gibson.

Ms. DUCKWORTH. Thank you, Mr. Chairman. Well, I first want to just note that it is very clear that this panel is very much dedicated to our military men and women and to our veterans. Many of you have your own military service, decades of military service, as well as your decades in civilian service.

I just have to note that we have in our midst General Wright, who is the first female helicopter pilot in the National Guard. And women in aviation stand on your shoulders. So thank you for that.

Mr. Warren, I think it is widely known that VA's chief information office has had many successes in terms of the delivery of PMAS and other cost-saving measures and new systems.

I want to make sure that we, as members of Congress, are doing the right thing in terms of how we work with you, both Mr. Warren and Mr. Kendall, in developing the electronic—integrated electronic records system.

I would like Mr. Warren to answer first and then, if we have time, Mr. Kendall. What can we do to help with this process as members of Congress? Are there—you mentioned, specifically Mr. Warren, there are a lot of reports that you have to do that take up a lot of time.

But are there other things—restrictions on decisions you are making, budget authority? Are there different colors of money, developmental money versus acquisition money? What is there that Congress can do to help you move forward with this effort?

Mr. WARREN. Thank you for that question and the offer. I would say that holding—continuing to hold us accountable for progress is key. And I think a lot of the effort and a lot of the overcoming of institutional barriers has been a result of the interest and the desire to make sure we do not only what is right for our servicemembers and for our veterans. So thank you for that and I believe that is important.

The challenge we are facing today is that there is language that constrains where we can execute dollars. It is pretty acute on the VA side. We have made a commitment to make deliveries by the end of December and by 1 October next year. Those are at risk because of some of the constraints on us with respect to execution.

There is an ask for plans. Those are in process to be delivered up to the appropriate Committee staff for their review. And any help that we could get on making sure those get cleared so we can continue to make that critical progress would be greatly appreciated, ma'am.

Ms. DUCKWORTH. Could you provide that information to my office in writing at a later time?

Mr. WARREN. I would be glad to, ma'am.

Ms. DUCKWORTH. Thank you.

Mr. Kendall, just——

Secretary KENDALL. If I may, Mr. Chairman, what I would ask from you is that you not over-constrain us. So I am very concerned, as I mentioned in my opening statement, about some of the language in various bills right now.

But essentially we have to take some steps to get this program on track, these programs on track, that if we are overly constrained it will be very, very difficult for us. I need a little bit of time to sort a few things out. I have just recently been asked to take over this by the Secretary.

For example, tying us to a strategic plan that was written last fall, which is very much overcome by events now, is not particularly helpful, I am afraid. It was only submitted to Congress relatively recently, but that plan does not really reflect some very fundamental changes that have been made since it was initially written.

So there are things like that that would—that kind of tie our hands. There are also a lot of reporting requirements. We have no problem with keeping the Committees informed. We are happy to do that.

The withholds that are in some of the language, I think, also, are becoming increasingly problematic for us. And particularly, right now for VA, that is a concern we have that is somewhat imminent.

So I am—we are very happy to work with the Committees, very happy to work with the members and their staffs, and to be very transparent about what we are doing, but we ask that, in return, you be—relieve some of the constraints that you have in mind right now and allow us to take the best path forward and give us the opportunity to explain that to you.

Ms. DUCKWORTH. Thank you. I yield back, Mr. Chairman.

Chairman MILLER. Mr. Kendall, I appreciate your comments and the fact that you just came on board, but there were people before you, there is time before you, and there were billions of dollars spent before you.

Mr. Gibson? Then Mr. Johnson.

Mr. GIBSON. Thank you, Mr. Chairman. I appreciate very much your leadership and I found this hearing very helpful this morning. Thank you to the panelists for your leadership and your commitment.

The single integrated health care record, something that we are all endeavoring towards. I am the author of a bipartisan, bicameral bill to hold us towards that end, towards Mr. Warren's comment just moments ago.

And my question may have been answered, but I want to just offer it again to see if there might be further clarification. It has to do with Mr. Kendall's opening remarks where he alluded to onerous language. And I just heard a listing.

And I also heard Mr. Woodson, earlier he mentioned that it would have been helpful if the language included clinical input. I appreciate those remarks. And so, I guess I will ask Mr. Kendall, is there anything else that you want to highlight when you were talking about onerous language?

Because we are trying to strike a balance here between, you know, not getting in the way of somebody trying to get to where we all think we need to go, and at the same time what Mr. Warren said, that we have got to hold everyone accountable because the American people expect it, and of course they should. So Mr. Kendall?

Secretary KENDALL. Thank you, Congressman. It is a good question. I would like to take it for the record in order to give you a more detailed answer. We have been reviewing the language. I am a lawyer. I respect lawyers more than most people perhaps. I would like to have our lawyers have a chance to take a look at it because there is some language in there that isn't quite clear to us what the intent is or what it really does to us.

I would like to give you a response for the record that just kind of lays out specifically what it is that we might have a problem with, if that is all right with you.

Mr. GIBSON. I do appreciate it, and of course that would be fine. I just want you to understand that part of the reason why we are concerned is because we think we are all moving towards that same objective, and then we get these comments that, well, we are—it appeared to us like we are taking a step back. Now we have gotten some further context about that. But what we really want to do is just make sure we all get up on the objective because we know we need to get there. So thank you. I look forward to receiving that for the record. And with that, I yield back, Mr. Chairman.

Chairman MILLER. Mr. Johnson, then Mr. Wittman.

Mr. JOHNSON. Thank you, Mr. Chairman. And thank you all for your service to the Nation. Mr. Petzel and Pummill, I would like to ask, are you aware of the situation in Atlanta where three mental health patients were—ended up dead and poor recordkeeping and poor management has been cited as one of the reasons for that?

Secretary PETZEL. Yes, sir. I am aware.

Mr. JOHNSON. And are you aware of the allegation—and it may be a fact—that a former top administrator at the Atlanta VA medical center received performance bonuses over a 4-year span as internal audits revealed lengthy wait times for mental health care and mismanagement that led to the deaths?

Secretary PETZEL. I am not specifically aware of the track record or the award record for senior managers there, but I certainly can find out.

Mr. JOHNSON. How about you, Mr. Pummill?

Mr. PUMMILL. No, Congressman. I wouldn't be involved in the Veterans Health Administration. I work over at the Veterans Benefit Administration.

Mr. JOHNSON. Okay. Well, Dr. Petzel, do top administrators at the VA still receive bonuses?

Secretary PETZEL. Congressman Johnson, yes. Some of the top administrators in the VHA, which is what I can speak for, do receive bonuses. They have been dramatically reduced. We call them awards, not bonuses. They have been dramatically reduced by almost I believe 50 percent over the last 3 years. But yes, there are some people who do receive awards.

Mr. JOHNSON. And those awards would be based on what?

Secretary PETZEL. On their performance. They have—all senior executives have a performance contract and the awards have to be based upon the performance in relationship to their performance contract.

Mr. JOHNSON. And who or what entity determines who gets the awards?

Secretary PETZEL. Well, the recommendation for an award, sir, is made by the supervisor of the individual. And that then works its way up through the administration. It would pass in the case of the Veterans Health Administration through me up to the department level. And eventually, all the awards are signed off on at the department level.

Mr. JOHNSON. I see. And so approximately how many awards have been granted for the 2013 fiscal year?

Secretary PETZEL. I would have to take that for the record, Congressman. But the awards I think that we are talking about would be administered after the end of the fiscal year. They are based upon the performance during this fiscal year, which would be 2013. So technically there would be no awards that have been administered yet.

Mr. JOHNSON. I see. What about 2012?

Secretary PETZEL. I would have to take that back for the record, sir. I do not have that on my mind.

Mr. JOHNSON. All right. And I yield back. Thank you.

Chairman MILLER. Mr. Wittman?

Mr. WITTMAN. Thank you, Mr. Chairman. Panelists, thank you so much for joining us today. I want to ask, if you would, to just limit your responses to yes or no so I can get through these questions.

I will begin with Secretary Pummill. With appropriate privacy release consent, are you willing to work with pro bono law schools like the College of William and Mary's Veterans Law Clinic and let them inside the benefit claims process?

Mr. PUMMILL. Yes.

Mr. WITTMAN. Secretary Warren, is a recently discharged, combat-wounded soldier flagged in a system in a way that their claim is streamlined electronically for immediate review and processing?

Mr. WARREN. Sir, I can't answer that question. But I will get it for the record, sir.

Mr. WITTMAN. Okay. Thank you. Secretary Warren, again, you know, you heard from Mr. Runyan, with today's technology, we can pull records faster than we can in the past. The VA's internal procedure is to wait 60 days after requesting a record, and then an additional 30 days to follow up. Ninety days of waiting. This is your procedure. Yes or no. Can you change it and reduce the time?

Mr. WARREN. I believe testimony will show that for individuals on active duty that are going through the transition, we have changed that. But because of the duty-to-assist requirements—and Mr. Pummill can answer that better than I can in terms of what legal and legislative requirements are with respect to that. But glad to get you a more detailed answer for the record.

Mr. WITTMAN. Okay. I would like just a straightforward yes or no. Seems to be pretty significant. Can you or can you not reduce the time?

Mr. PUMMILL. Yes.

Mr. WITTMAN. Okay. Thank you. Secretary Woodson, you are discharging servicemembers who you know have serious injuries. Amputees, suicidal PTSD patients. Yes or no. Do you communicate with the VA to prioritize these veterans and ensure they have the proper paperwork transitioning to the VA?

Secretary WOODSON. Yes.

Mr. WITTMAN. Also, can a veteran with no recorded—and I will ask this of the VA panel members—can a veteran with no recorded medical history documenting a service-connected disability claim something as service-connected in a VA claim years, even decades after the fact, for an injury that very well could be connected with aging?

Mr. PUMMILL. Congressman, I can't answer that with a yes or no. Sorry. You could have something in our personnel record or your dental record or a buddy statement, or in the case of military sexual trauma, change in performance that would allow you to make a claim later on in your life.

But for most cases, unless you have something in your medical record that is—substantiates a disease, injury or illness that occurred during active duty or a period of active duty for the Guard or Reserve, you would not be able to file a claim.

Mr. WITTMAN. Okay. Very good. Thank you, Mr. Chairman. I yield back.

Chairman MILLER. Mr. Langevin?

Mr. LANGEVIN. Thank you, Mr. Chairman. I want to thank our witnesses for their testimony today, and especially appreciate the update on the move to complete the project of transitioning over to electronic medical records and hopefully once and for all significantly reducing or eliminating the backlog that our veterans are facing.

It is one of the number-one complaints and problems that I hear from among veterans in my district. So I do thank you for your work on that, and I hope that the project is completed as expeditiously as possible. The—obviously, the issues that are under discussion today are of course of critical importance and interest to all of us, and we certainly appreciate our witnesses sharing their expertise with us today. I want to focus on the path through the DoD and VA system for veterans suffering from neurological traumas such as TBI and spinal cord injury.

And I wanted to ask if you can describe for us how their treatment and benefit trajectory varies from the baseline and what supplemental assistance is available other than normal benefits for those no longer able to move around comfortably in their homes.

And let me say that in response to unmet needs that veterans organizations throughout—that are brought to my attention, I have introduced what is called the Veterans Home Buyer Accessibility Act last Congress to aid our injured servicemembers, modify their homes to ensure that they are accessible. And I certainly plan to introduce it again in this Congress. Has there been an examination of benefits shortfalls specific to neurological traumas, particularly with regard to adaptive modifications to homes? So if you could take both of those questions.

Secretary PETZEL. Congressman, I can begin. The VA does have an adaptive home modification program. Substantial—thousands, I think even tens of thousands of dollars can be spent on modifying a veteran's home for mobility with, you know, within that home. I am not aware of the fact that there are restrictions or shortfalls in the benefit. And I would certainly like to work with you directly

to find out exactly what those shortfalls are. We are not aware of them.

And I would ask Mr. Pummill if he has any other comments, because VBA does administer some of those programs.

Mr. PUMMILL. No, Congressman, I am not aware either. But what I will do is I will get with our veterans service organizations, our partners out there. They are our eyes and ears in America, provide us good information on veterans, and see what they have to say and what they can provide back to us.

And I would just like to add, too, that, you know, as we are making progress on the backlog because of the assist we are getting from DoD, it is tri-fold. It is VA. It is DoD. And it is the veterans service organizations helping us get DBQs, fully developed claims, talking to veterans, doing the things that we need to do. So, they help us a lot and I will see what they can provide me.

Mr. LANGEVIN. That would be very helpful. I appreciate that. Thank you.

I yield back.

Chairman MILLER. Thank you very much, Mr. Langevin.

Thank you to the witnesses for being with us for a little over 2 hours. We certainly appreciate that.

I thank all the members that were here today to ask some very pertinent questions. I would ask unanimous consent that all members would have 5 legislative days with which to revise and extend their remarks and add any extraneous material, subject to the hearing topic today.

And without objection, so ordered.

And with that, this hearing is adjourned.

[Whereupon, at 12:11 p.m., the Committees were adjourned.]

A P P E N D I X

Prepared Statement of Hon. Jeff Miller, Chairman

Good morning. Welcome to this joint hearing of the Committees on Veterans' Affairs and Armed Services. I also welcome Chairman Buck McKeon and Ranking Member Adam Smith and, of course, my friend from Maine the Ranking Member of the Veterans' Affairs Committee, Mike Michaud.

This is the second time in two years that these two Committees on which I am proud to serve have met jointly to review the collaborative efforts of the Departments of Defense and Veterans Affairs in assisting servicemembers with their transition from active duty to civilian life.

A year ago we were privileged to have Secretaries Panetta and Shinseki at the witness table. Both of them testified at length regarding the progress VA and DoD were making in several key areas. I'd like to revisit two of those areas in my opening statement. First, the progress made in developing an integrated electronic health record. Second, the progress made in reducing the wait times associated with veterans' disability claims, which necessarily involves cooperation from DoD in the transfer of records.

I'll start with the electronic health record. In response to my direct question at last year's hearing Secretary Shinseki remarked that the two departments had finally, after 17 months of discussion, agreed on a way forward on a "single, joint, common Integrated Electronic Health Record" that would be completed by 2017. The Secretary told us that each of those words – single, joint, and common—meant something, and that finally we were breaking through the cultural issues between the two departments that had stifled progress in the past.

What a difference a year makes. Contrary to the Secretaries' testimony, the two departments are, once again, moving on their own tracks, with promises we've heard before about making two separate systems "interoperable." Pardon my frustration, but it seems the only thing interoperable we get are the litany of excuses flying across both departments every year as to why it's taking so long to get this done.

In response to this latest course correction, the House included an amendment to the National Defense Authorization bill, an amendment developed in collaboration with the leadership of the Armed Services, Veterans' Affairs, and Appropriations Committees, to direct the completion of an integrated health record by October 1, 2016. The message of the amendment is simple: No more excuses, get this done. I'm anxious to hear from our witnesses how they'll comply with the mandate of the amendment once it is enacted into law.

The second issue I'll briefly touch on is the disability claims backlog. It's interesting to note that the progress made in reducing the pending inventory of claims the last few months correlates with the heightened Congressional oversight and media scrutiny. Well, none of us up here are going to take our foot off the gas when it comes to ensuring progress on the backlog. And although progress has been made lately, VA is woefully short of its own goals for the year.

Going forward, ending the backlog necessarily requires a seamless records transfer from DoD. I look forward to hearing the status of those efforts and what more can be done. This problem of veterans waiting years for their disability claims to be decided must remain at the forefront of our consciences, especially as further troop draw downs occur over the next five years. It, too, is an issue where the excuses must end, and real, sustained progress must occur.

Very quickly, just a bit of housekeeping before we proceed. To accommodate such a large contingent of members we have agreed to last year's framework that limited to 2 minutes each member's time to ask questions of the witnesses. Therefore, I ask unanimous consent that each member have not more than 2 minutes to question the panel of witnesses, starting with my own questions. Without objection, so ordered.

Further, I ask unanimous consent to include all Member statements in today's hearing record. Without objection, so ordered.

I now recognize Chairman Buck McKeon for his opening remarks to be followed by Ranking Member Mike Michaud, and then Ranking Adam Smith for their opening remarks.

Prepared Statement of Hon. Michael H. Michaud

I want to thank the Chairs of the House Committee on Veterans' Affairs and Armed Services for holding this joint hearing today. Transition is a critical issue that greatly affects our servicemembers and veterans.

This hearing is the second joint hearing our two Committees have held concerning transition. The purpose of this hearing is to reiterate our joint oversight commitment, and ensure that VA and DoD work together on behalf of the men and women who are sent into harm's way.

At last year's joint hearing on this topic, the two Agency Secretaries appeared before us, sitting side by side. I am disappointed to see that neither is here today. I take this lack of personal engagement as a sign that they care less, that they are not as committed, that they have delegated – abdicated – ownership of this issue. My disappointment is solidified by receiving testimony in the eleventh hour. Clearly, this issue, and this hearing, is not a priority.

I would submit to you that the government has struggled to fulfill the "sacred trust" to care for those who have served and sacrificed in defense of our Nation. After twelve years of war, we know transition is the critical first step, and it requires the cooperation of many agencies to accomplish successfully. I do not believe we have made any measurable progress in getting the two agencies before us today to work more effectively together.

The Department of Defense has announced it will put out to bid for a new system to manage its health records. Such a decision appears to back an interoperable approach over an integrated one. An integrated – integrated, not interoperable - electronic health record is something that Congress mandated years ago. We have spent hundreds of millions of dollars. Delaying the delivery of an integrated – that is integrated, not interoperable - information sharing system runs directly against Congressional intent, and ultimately hurts our veterans.

Also, of particular importance to our Committees is the claims backlog. Let me be clear, both VA and DoD have a responsibility to end the backlog by 2015. The claims backlog is not a "VA issue". DoD must do a better job of transferring veteran and servicemember's records to VA in a timely and complete manner.

This includes the records of our National Guard and Reservists. It also includes late and loose records being sent to VA.

Because benefits and health care affect so many servicemembers and veterans, DoD and VA must put aside their parochial differences and work more effectively together to ensure an integrated – that's integrated, not interoperable - process addressing transition issues.

Over the course of the last several months we sent letters to the Secretaries, and the President, asking for their personal commitment and support. We requested concrete decisions be made in a timely manner. What we received in response is a no-show to this hearing, and a press conference that kicks the decisions down the road . . . again.

And, it would appear that leadership is lacking not just at this hearing. During a recent Roundtable on the iEHR, industry leaders told us progress is not due to a lack of available technology solutions, but rather a lack of leadership. When two divisions in their companies can't - or won't - agree, the CEO steps in and mandates a direction. Where is DoD and VA's "CEO"?

Just recently, in a bi-partisan effort and due to ongoing congressional concerns with the lack of a unified vision between VA and DoD electronic health record programs, language was included as part of the National Defense Authorization Act for 2014. This language created a deliberate approach in developing a joint electronic health record.

I am told that strategies have been modified and collaborative efforts are ongoing for both records transfer and iEHR. However, months continue to go by with seemingly no real progress.

I look forward to hearing from our panelists today just how far they have come, and to learn about the path ahead on the transition issues that are the focus of this hearing today.

Thank you and I yield back.

Prepared Statement of Hon. Corrine Brown

Thank you, Messrs. Chairmen and Messrs. Ranking Members, for calling this hearing today.

I believe it is our duty as Americans to provide proper care for our veterans and servicemen who have unselfishly put their lives on the line for our wellbeing. This starts with health care. Time has shown that we, as Members of Congress, and Senior Leadership of the Department of Defense, and Department of Veterans Affairs' have not been able to provide timely compensation for the work our servicemen and women did to defend this Nation from all enemies. While the VA has made incredible progress with its initiative to resolve all claims older than two years and now one year, there are still too many claims not being resolved in a timely manner.

Secretary Hagel has stated that with the majority of claims being made for those veterans who served previous to Iraq and Afghanistan both the DoD and VA need to:

- Certify service treatment records so that claims processors know not to hold up processing to request additional records.
- Hold data-sharing summits every six weeks to look for ways to improve DoD and VA practices.
- Conduct separation health assessments to establish baseline medical conditions, which will speed future disability benefits claims.
- Improve the format of DoD service treatment records so that they are portable and can be quickly scanned by other users.

I am concerned that while talking about pursuing these goals, the DoD is not fully behind the plan. Earlier this year, the DoD pulled out of joint program with the VA to develop one computer system that would be able to be used by both departments.

Just the other day, there was an article in the Washington Post regarding a company that created a back-end computer program to have 6 separate accounting programs be able to talk to each other. It cannot be that difficult to do what you each propose.

Both the DoD and VA have a full understanding of what needs to be done to fix this issue with the integrated electronic health record program (iEHR), but, efforts to progressively move this program forward have proven diligently slow. You must put forth a greater effort to ensure that these veterans are awarded their benefits in a timely manner and their health care is seamless. I am resolute in my commitment to ensure the DoD and VA work toward their shared goal of achieving full interoperability of health care records. It is imperative that the DoD and VA make progressive moves together to ensure an effective system is ran between both agencies that will produce consistent service for our current servicemen and veterans.

Prepared Statement of Hon. Frank Kendall

Chairman McKeon, Chairman Miller, Ranking Member Smith, Ranking Member Michaud, and distinguished members of the Committees, thank you for extending the invitation to discuss the recent actions that the Department of Defense (DoD) has taken to assist the Department of Veterans Affairs (VA) to eliminate the disability benefits claims backlog and our collaboration on the integrated Electronic Health Record (iEHR) program. Although DoD is currently operating under significant resource constraints as a result of sequestration, including civilian furloughs, DoD will continue to work in conjunction with VA to provide exceptional care and services for America's service members and veterans. Thank you for your attention to this issue and for your continued support of our active and reserve component military members, and their families who serve with distinction every day and who deserve the best medical care and treatment as both service members and as veterans.

BACKGROUND - VETERANS' DISABILITY BENEFIT CLAIM BACKLOG

Veterans' benefits are a vital extension of a holistic benefits package to sustain an all-volunteer force. DoD and VA are committed to working together to provide continuous, accessible, and quality health care for America's active duty military and veterans. When a service member completes his or her service obligation and separates from the military, DoD is responsible for ensuring that they are seamlessly, efficiently, and quickly transitioned to the care of Veterans Affairs – with all of their records.

DoD currently provides VA with electronic access to approximately 98 percent of the required personnel and administrative data for claims adjudication, including electronic "read-only" health records, and we meet together on a regular basis to close the gap on the remainder. We provide VA access to scanned images of all personnel records (including available DD Form 214) through a DoD data system web portal, and we are taking action to provide Veterans Benefits Administration employees with enhanced access to our electronic medical record data. DoD has electronically provided VA with the health data of more than 5.9 million servicemembers who have separated since 1989. The ability to access and view this data has existed between all DoD and VA medical facilities on 4.7 million shared patients since 2007. Building upon past successes in real-time data exchange, the Departments have sought to go beyond point-to-point interfaces between their systems and to establish full data interoperability. Achieving interoperability will mean the Departments will use a common taxonomy that provides access to human and machine-interpretable data by doctors and patients anywhere, anytime. Health care record transfer from DoD is not a major factor in VA's current backlog.

Over the last few months, both Secretary Hagel and Acting Under Secretary Wright have met with and listened carefully to the concerns and input from DoD's health care providers, leaders from the VA, and Veterans Service Organizations and Military Support Organizations. Their input has been vital to ensuring that our service members and veterans receive quality care, and their input has been very helpful in defining a path forward.

On May 22, 2013, the Secretary of Defense and the Secretary of Veterans Affairs met with Senator Mikulski and the Senate Appropriations Committee on Defense in a roundtable discussion regarding the disability benefits backlog and we provided an overview of our actions to support VA.

Most recently, on July 2, 2013, the Secretary of Defense, Under Secretary Kendall and Acting Under Secretary Wright met with Secretary Shinseki, Dr. Robert Petzel, the Director of the Veterans Health Administration and Ms. Maureen Coyle, the VA Deputy Chief Information Officer, to ensure that the efforts of both of our Departments are aligned and that appropriate progress is being made to address the backlog issue. Our meeting agenda specifically focused on our mutual efforts to help VA reduce the veteran disability benefit claim backlog, veteran homelessness, and our electronic health record systems.

DOD EFFORTS TO ASSIST VA WITH THE BACKLOG

The most important thing DoD does to help VA process claims is to provide VA with the information that it needs. DoD provides information to VA in both electronic and paper form. With the exception of some records from visits to private health care providers since 2004, medical records have been transferred as electronic records. DoD provides Service Treatment Records (STRs), personnel and administrative data within 45 days from when a Service member separates from the military.

The Department of Defense is working closely with VA to provide any information VA needs to enable them to complete the processing of disability claims. In collaboration with VA, we are also refining our processes by which we provide information to ensure future disability benefit claims can be processed by in a shorter time.

For example:

- DoD has agreed to provide VA with certifications that STRs are complete with all known information at the time they are sent to VA. VA claims processors, following established VBA claims processing protocols, will not have to delay processing to request additional medical records when the service members' claim is not substantiated in the record VA has received from DoD. This will reduce one source of additional claims from adding to the current backlog and reduce future processing time. Certification began in earnest in April 2013, and, with input from the Director of the Veterans Benefits Administration, we continue to refine this process.
- DoD provided a team of subject matter experts to the Veterans Benefits Administration in January 2013 to review the disability claims backlog to analyze cases where DoD has information that can assist VA in processing claims. The team has been assisting VA with the most difficult cases. The team has recently shifted to assist with the oldest claims, those that have been in process for over one year.
- Enhancing direct access to DoD electronic medical record data is extremely useful to VA in preparing claims for decisions. Enhanced access can increase VA production rates for any claims which are awaiting STR information – not just claims in the backlog, but at any stage in the process. We are fielding the Janus Joint Legacy Viewer, which will allow both DoD and VA to be able to access

and read the other Department's electronic health records. The Joint Legacy Viewer is in operation now and will be fully deployed by December 2013. On July 1, 2013, a DoD Liaison cell comprised of senior military personnel with medical, administrative and personnel expertise was placed at VA to assist in the reduction and elimination of the backlog. This cell was requested by the Secretary of Veterans Affairs and agreed to by the Secretary of Defense to operate for six months.

- DoD has provided VA with approximately 5,000 accounts giving direct access to the Defense Personnel Record Information System, which allows disability claims adjudicators access to Official Military Personnel Files. Additionally, VA also has been provided with access to 300 accounts giving direct access to the Defense Finance Accounting Service to validate pay and retirement information. This same pay and retirement information is also provided daily to the VA Data Information Repository system.
- DoD also provided 15 Service members to the VA Seattle, WA, Disability Rating Activity Site, in support of an Integrated Disability Evaluation System (IDES) backlog in May 2013. These service members provide administrative assistance, which frees up disability benefits claims processors to speed up the overall IDES process.
- DoD and VA convene an Information Sharing Summit (usually 80+ participants from all Services, Coast Guard, DoD and VA) every 6 to 8 weeks to further the electronic exchange of personnel, medical and administrative information between the two Departments. This summit has met 5 times since January 1, 2013, to monitor process improvement events and major system developments to ensure alignment of all efforts in support of reducing the disability claims backlog and evolving this interchange to a truly paperless environment.

The Department of Defense has also initiated the following actions to streamline processes for exchanging information, but these actions will assist with reducing the processing time for future claims, not claims in the current backlog:

- In January 2013, DoD initiated the establishment of a Separation Health Assessment (SHA) for all service members who do not request a disability claim upon their separation from the military. This assessment will provide VA with the ability to better assess the basis for a service connection on future disability benefits claims. VA will continue to conduct the assessment for those service members who do make a disability benefits claim at the time of separation. DoD will make the required policy changes associated with this action by the end of fiscal year (FY) 2013. We have begun to implement the SHA at some locations and we plan to complete implementation by the end of FY 2014.
- In January 2013, DoD committed to accelerate the deployment of the Health Artifact and Image Management Solution (HAIMS) in support of a move to a digital environment. Deployment is planned to be complete by December 2013. HAIMS will consolidate military and private sector treatment and medical images and artifacts and make them available for use by VA medical clinicians and VA disability claims processors, who will be provided with direct access. Once deployed, this will allow for electronic processing of information; lower storage, mailing requirements, and manual processing and facilities costs; and accelerate future claims processing.
- DoD and VA will conduct a pilot, beginning in September 2013, whereby a version of the STR will be sent to VA in an electronic document format at the time a service member attends mandatory Transition Assistance Program in addition to the certified copy which is sent within 45 days from when the Service member separates from the military. This will give VA an archived version of the STR, which VA believes may reduce the time required to process a future disability claim by as much as 50 days.

SERVICE MEMBER TRANSITION ASSISTANCE PROGRAM

In compliance with the Veterans Opportunity to Work (VOW) to Hire Heroes Act of 2011 (Public Law 112–526), and in accordance with the recommendations of the Veterans Employment Initiative Task Force, the Department of Defense, Military Departments and our interagency partners are successfully implementing the redesigned Transition Assistance Program (TAP). The redesigned TAP, including a new curriculum called Transition GPS (Goals, Plans, Success), is aligned with the VOW Act, as codified in in Chapter 58, title 10 United States Code, which requires all eligible Service members discharged or released from active duty after serving their first 180 continuous days or more (including National Guard and Reserves) to participate in Pre-separation Counseling, Department of Veterans Affairs (VA) Benefits Briefings and the Department of Labor (DOL) Employment Workshop. While some

Service members may be exempted from attending the DOL Employment Workshop, as allowed by Congress, every Service member will attend Pre-separation Counseling and the revised VA Benefits Briefings.

Additional components of the redesigned TAP include specialized tracks developed for Service members to tailor their transition program to correspond with their expressed interest in achieving their future employment goals through Higher Education, Career Technical Training, or Entrepreneurship. These specialized tracks are being piloted this summer and will be implemented across the Department of Defense by 1 October 2013. The cornerstone of the redesigned TAP is the concept of Career Readiness Standards. These standards correspond to deliverables that all Service members are to meet prior to separation. The value of the Career Readiness Standards is ensuring we equip our service members with the tools they need to become valued, productive and employed members of our labor workforce cannot be overstated. We are, and have been, fully engaged in implementing the redesigned program.

BACKGROUND - INTEGRATED ELECTRONIC HEALTHCARE RECORDS (iEHR)

In March 2009, President Obama directed the Department of Defense and the Department of Veterans Affairs to "work together to define and build a seamless system of integration with a simple goal: When a member of the Armed Forces separates from the military, he or she will no longer have to walk paperwork from a DoD duty station to a local VA health center; their electronic records will transition along with them and remain with them forever." This directive built on the Congressional requirement established in the National Defense Authorization Act for Fiscal Year 2008 for the two Departments to "jointly develop and implement electronic health record systems or capabilities that allow for full interoperability of personal health care information between the Department of Defense and the Department of Veterans Affairs." Our Service members, Veterans, retirees, and eligible family members deserve nothing less than the best possible care and service our two Departments can provide. Successfully achieving the goals articulated by Congress and the President is fundamental to delivering on our promise to them and we are fully committed to doing so.

In March 2011, DoD and VA agreed on a joint approach to develop a single longitudinal health record to be used by both Departments: the "integrated electronic health record" or "iEHR." This approach was intended to meld the Departments' ongoing efforts to improve their health information technology: firstly, by achieving interoperability of health data, as sought by the President and the Congress; secondly, by modernizing their respective healthcare management systems, which were each in need of replacement or upgrade (i.e., replacing the DoD's Armed Forces Health Longitudinal Technology Application (AHLTA) and replacing or upgrading the VA's Veterans Health Information Systems and Technology Architecture (VistA)). Acting on this decision, the Departments re-chartered the DoD–VA Interagency Program Office (IPO) –established by Congress in the FY2008 NDAA to oversee joint data interoperability efforts – to accomplish this expanded mission.

Together, the two Departments have made important steps toward achieving health data interoperability between DoD and VA and procuring the foundations of an underlying joint IT infrastructure. Specifically, we have:

- Made the DoD Health Data Dictionary (HDD), the common data model used by all DoD medical treatment facilities, openly available to the nation and initiated VA data mapping to ensure integrated, common data for all patient information across DoD and VA;
- Established the Development Test Center to provide a testing configuration that emulates the operational healthcare environment and infrastructure;
- Selected a joint DoD–VA Single Sign On / Context Management (SSO / CM) solution. "Single Sign-On" enables a user to access multiple applications after logging in only once. "Context Management" allows clinicians to choose a patient once during an encounter and ensure all required applications are able to present information on the patient being treated. This capability was successfully deployed to the Development Test Center and is now being deployed at San Antonio;
- Implemented a joint Graphical User Interface (GUI) pilot at North Chicago, Tripler, and San Antonio that displays information from both DoD and VA systems;
- Completed business process mapping for initial clinical capabilities;
- Developed integrated Program Level Requirements (iPLR), which detail the functional requirements for the program, e.g., laboratory, pharmacy, etc.;

- Developed and published the iEHR architecture and Technical Specifications Package that provide high-level technical and business requirements to enable a standardized and interoperable solution.; and
- Begun work on a number of data interoperability "accelerators."

A SHIFT IN STRATEGY FOR iEHR

In December of last year, Secretaries Panetta and Shinseki directed a joint review of the iEHR program to simplify and accelerate the achievement of data interoperability while reducing the cost and technical risk of what had proven to be a complex and expensive joint IT development program. This February, they agreed to specific actions for each Department; these agreements have since been reinforced by Secretary Hagel. While some may have interpreted this shift in strategy as backing away from our commitment to achieve an integrated electronic health record, that is not the case.

For the remainder of this calendar year, the two Departments are focused on achieving full interoperability of health data through a series of near-term "Accelerator" efforts. These efforts will result in each Service member and Veteran having a single, seamless, shared, integrated healthcare record. All patients, and the clinicians serving them, will be able to access all of their health data, whether the patient is currently a military member or Veteran and treated at a DoD or VA hospital. This interoperability will be achieved without replacing the healthcare management software system for either Department.

In 2012, DoD made its Health Data Dictionary data model openly available for use by VA and other interested parties including non-government healthcare providers. VA will map their data to this standard, thereby contributing to the establishment of an authoritative health data source for both Departments by January 2014. This will fully realize the health element of the President's vision for a Virtual Lifetime Electronic Record, incorporating all clinical care for Service members and Veterans into a common, computable and interoperable health record, accessible wherever care is provided.

For the DoD, achieving data interoperability is also the path forward to exchanging health information with private healthcare providers. Today, 65 percent of all Service members', dependents' and beneficiaries' healthcare is provided outside the military health network through private providers. Capturing this health information can only be accomplished through interoperability standards championed by the Department of Health and Human Services and being adopted by commercial health care providers. The use of open national standards to express the content and format of the information, not a single healthcare management software system, is the cornerstone of seamless exchange of health information.

Secretaries Panetta and Shinseki also announced that the two Departments were revising their strategy for modernizing their legacy healthcare management software systems to use existing EHR technologies rather than bearing the cost and risk of designing, building and implementing an entirely new system. The two Departments agreed instead to use a "core" set of applications from existing EHR technology. Based on this core concept, VA determined that its best course of action would be to evolve its legacy system, VistA, to serve their modernization purposes. This decision left DoD with the need to determine whether modernization based on VA's existing VistA system, DoD's legacy AHLTA system, or one of the several commercially available modern healthcare management systems was the best course of action for DoD.

DoD'S DECISION MAKING ON iEHR

In testimony before the House Appropriations Committee and the Senate Armed Services Committee on April 16–17, 2013, Secretary Hagel committed to provide Congress his decision on the Department's modernization strategy within thirty days. Under Secretary Kendall and Acting Under Secretary Wright commissioned a team of senior stakeholders and technical experts to review and assess the options and to recommend a course of action for modernization. After confirming that further evolving AHLTA, DoD's legacy healthcare IT system, was not a viable alternative, the group focused on two alternative courses of actions: (1) pursue an evolution of VistA as the DoD "core" capability or (2) compete a modernization solution from a broader field of options. This team reviewed existing artifacts, studies and analyses and received briefings from the IPO and from VA/VHA leadership.

The team concluded and recommended that the DoD and VA continue their ongoing near-term efforts to develop data federation, presentation and interoperability, particular through the completion of ongoing "accelerator" efforts. The team recommended that DoD select a core healthcare management system on a "best value" basis.

The DoD assessment characterized the alternatives based on estimates of life cycle cost, schedule, performance, risk and capacity for further modernization and growth. The assessment leveraged data from a formal Request for Information conducted by the OSD Cost Assessment and Program Evaluation (CAPE) organization. This market research identified a broad field of existing EHR capability providers, with exiting commercial products that spanned a range of maturity, capability, cost and implementation risk. The responses to the RFI included commercial offerings as well as vendors offering an evolved VISTA solution, as well as a VA proposal for an evolved VistA offering.

The assessment concluded that a competition provided the best opportunity for the Department to identify the best value solution – one that offered advanced clinical capabilities, low adoption risk, the potential to evolve further as new innovation enters the EHR marketplace and the potential for significant cost savings.

The Department recognizes that adopting and evolving VA's current VistA software was a reasonable and sound business decision for VA. The Department of Veterans Affairs already employs a substantial workforce and infrastructure supporting the VistA system; VA caregivers are already trained on the system and its processes reflect the VA's organization and business practices. Adopting VistA would require the Department to duplicate these "sunk cost" investments by the VA. While evolving and enhancing VistA was a logical business decision for VA, DoD faces a very different situation.

The DoD study confirmed that the Department requires a healthcare software management solution that can operate in its unique medical environment, interfacing with VA and private sector providers using open national standards and providing operational medicine capabilities in a variety of environments, often with limited or no connectivity. The Department will also require the capability to easily add specialized modules to address DoD needs, such as battlefield casualty care, in a timely manner. Given the options available to DoD, the best course of action for DoD is to conduct a "best value" competition acquisition of a core healthcare management software system.

THE DoD WAY AHEAD ON iEHR

The study team reported its findings and recommendations to Secretary Hagel in May. This was formalized on May 21, 2013, with a memo to the Department outlining the way ahead for integrated Electronic Health Records, and reinforcing DoD's commitment to providing high-quality healthcare for current Service members, their dependents and our nation's Veterans. The Department informed the Congress of the Secretary's decision on May 22, 2013. In his memo, the Secretary directed the USD(AT&L) to assume direct responsibility for DoD healthcare records related acquisition programs and to conduct a full and open competition for the core set of capabilities for DoD Healthcare Management System Modernization. USD(AT&L) was tasked to lead DoD coordination with VA on the technical and acquisition aspects of healthcare records and healthcare management systems.

USD(AT&L)'s first step was to restructure the Department's health care IT efforts. The former iEHR program is being refocused on two separate but related healthcare information technology efforts: the DoD Healthcare Management System Modernization (DHMSM) program, and the joint DoD/VA iEHR program. Both efforts will be conducted as highly tailored Major Automated Information System (MAIS) programs. USD(AT&L) will serve as the DoD Milestone Decision Authority (MDA) for both programs.

The revised iEHR program will remain focused on the near term goal of delivering the tools and supporting data infrastructure to ensure integrated health data can move seamlessly between VA, DoD, and commercial healthcare providers with initial fielding targeted for early CY 2014. The IPO is taking the following steps to deliver seamless, shared integrated health information on an accelerated basis:

- Developing and deploying a data management service to give DoD and VA clinicians access to integrated patient health record information by the beginning of CY 2014.
- Accessing data through a single integrated view to nine high priority sites by the beginning of CY 2014.
- Making standardized, integrated clinical record data broadly available to clinicians across the DoD and VA later in CY 2014.
- Enhancing "Blue Button" functionality, which will give patients the ability to download and share their own electronic medical record information, enabling them take greater control of their own healthcare.

The DoD Healthcare Management System Modernization program will focus on competitively acquiring a core set of capabilities to replace the DoD legacy Military

Health System (MHS) clinical software systems, including the Armed Forces Health Longitudinal Technology Application (AHLTA), Essentris, Composite Health Care System (CHCS), and Theater Medical Data Store (TMDS) systems. The objective is to field a modernized replacement for legacy systems by 2017.

The USD(AT&L) has designated a Program Executive Officer (PEO) to oversee both iEHR, which will continue to be executed by the Integrated Program Office (IPO), and DHMSM. A Program Manager (PM) has also been designated for the DHMSM program. The PEO will ensure that DHMSM works in close collaboration with iEHR to ensure compatibility and interoperability with the standardized healthcare data framework, infrastructure, and exchange standards being made available via the iEHR program.

The PM for DHMSM is initiating internal planning activities for release of a Request for Proposals (RFP) that supports an objective to achieve full fielding of core DHMSM capabilities. It is crucial to note that a seamlessly integrated and interoperable electronic health records with full data exchange and read/write capability can be achieved without DoD and VA operating a single healthcare management software system. Just as someone can send and receive the same e-mails from a range of different e-mail software clients, health record information can be made available to patients and physicians without every hospital in the nation moving to a single healthcare management software system. In fact, private sector experience shows using the same software does not guarantee information can be shared. By competitively selecting a core to replace its Legacy Systems, DoD will have an opportunity to evaluate a range of modern commercial alternatives in order to determine a best value approach.

FY14 LEGISLATIVE IMPACTS FOR iEHR

Current legislation passed by the House of Representatives addressing iEHR include Sections 713 and 726 of the National Defense Authorization Act (NDAA). The Department interprets Section 713 as requiring a report describing the Secretary's basis for selecting the preferred alternative. With this interpretation, the Department has no objection to Section 713 since it allows the flexibility to implement the Secretary's direction as outlined in his May 21, 2013, memo. Section 726, however, imposes extensive governance, design, schedule and reporting requirements and funding withholds that will impede the Department's ability to compete a full range of commercial solutions and significantly increase schedule risk and cost. In particular, the requirement to execute a joint iEHR development program per the Joint Strategic Plan is counter to the Department's competitive approach. Setting a deadline for deploying an integrated electronic health record could preclude a best-value solution. Overly restrictive criteria for meeting open architecture standards could also disqualify some effective, commercially developed solutions. The Department has similar concerns with the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act which constrains VA funding for electronic health records. The proposed language, as written, constrains the VA funding to agreements established prior to the Secretaries new direction. The Department seeks to work with the Congress to streamline the multiple reporting mechanisms, conditions and oversight and advisory functions directed in Sections 713, 726, and the MILCON/VA Appropriations Act.

CONCLUSION

Chairman McKeon, Ranking Member Smith, Chairman Miller, Ranking Member Michaud, and members of these distinguished Committees, again, thank you for the opportunity to testify today. The Secretary of Defense has taken very seriously the needs and responsibilities of the Department of Defense to provide first-class healthcare to our Service members and their dependents, and to enable the seamless sharing of integrated healthcare records between the Departments of Defense and Veterans Affairs. The Department is committed to ensure that our Service members receive the best service we can provide while in uniform. As importantly, we also have the responsibility to ensure that this same quality of health care and service is carried through to the end of a Service members' career when their status changes to civilian status as a Veteran.

The Secretary remains committed to fully cooperating with the Department of Veterans Affairs to continue ongoing efforts to create a seamless electronic health record integrating VA and DoD data in the near-term. In addition, the Secretary believes a competitive acquisition to acquire a healthcare software modernization solution will achieve the best value for the Department's Service members by evaluating all potential solutions and considering the costs and risks of the options that will be offered to the Department.

The Secretary and the Department greatly appreciate the Congress' continued interest and efforts to help us deliver the healthcare that our nation's Veterans, Service members, and their dependents deserve. Whether it is on the battlefield, at home with their families, or after they have faithfully concluded their military service, the Department of Defense and our colleagues at the Department of Veterans Affairs will continue to work closely together, in partnership with Congress, to deliver benefits and services to those who sacrifice so willingly for our Nation.

We look forward to your questions.

Prepared Statement of Stephen W. Warren

Chairman McKeon, Chairman Miller, Ranking Member Smith, Ranking Member Michaud, and Members of the Committees, we appreciate the opportunity to appear before you today to discuss the Department of Veterans Affairs' efforts to reduce the backlog of disability compensation claims and to develop an Electronic Health Record (EHR) with the Department of Defense (DoD).

Disability Compensation Claims Backlog

Today, many Veterans wait too long to receive benefits they have earned and deserve. That has never been acceptable to the Secretary, or the dedicated employees of the Veterans Benefits Administration (VBA); over half are Veterans themselves. VA is implementing a robust plan to ensure we achieve our goal of eliminating the claims backlog and improving decision accuracy to 98 percent in 2015.

Over the last 3 years, the claims backlog has grown from 180,000 at the end of fiscal year (FY) 2009, to approximately 530,000 claims as of June 19, 2013. To meet the goal of eliminating the backlog by 2015, we have set to transform VBA into a 21st century organization. VBA's transformation is demanded by a new era, emerging technologies, and the latest demographic realities

As background, it is important to note that over 60 percent of the pending claims are "supplemental" claims from Veterans seeking to address worsening conditions or file for new conditions ("issues"). Seventy-seven percent of these Veterans are already receiving disability compensation and are eligible for VA health care. Additionally, as VA does not limit claims submissions, Veterans can continue to apply for additional service-connected disabilities while their claims are pending.

There are several factors that have impacted on the volume of incoming claims. In 2009, based on all available scientific evidence and the Institute of Medicine's Veterans and Agent Orange: Update 2008, VA made the decision to add three presumptive conditions (Parkinson's disease, ischemic heart disease, and B-cell leukemias) for Veterans who served in the Republic of Vietnam or were otherwise exposed to the herbicide Agent Orange.

Due to this policy change, the number of compensation and pension claims received increased from 1 million in 2009 to 1.3 million in 2011 (a 30 percent increase). In addition, beginning in October 2010, VBA identified these claims for special handling to ensure compliance with the provisions in the Nehmer court decision that requires VA to re-adjudicate claims for these three conditions that were previously denied. VBA dedicated over 2,300 claims staff to re-adjudicating these complex claims, which required time-consuming and detailed review. Nehmer claims for all live Veterans were completed as of April 2012 and Nehmer survivor claims were completed in October 2012. The claims staff previously focused on these Agent Orange claims are now working on reducing the backlog. As of June 19, 2013, VA has processed approximately 280,000 claims and awarded over $4.5 billion in retroactive benefits for the three new Agent Orange presumptive conditions to more than 166,000 Veterans and survivors. Our focus on processing these complex claims contributed to a larger claims backlog, but it remains the right thing to do for our Vietnam Veterans, many of whom waited a long time for these benefits. In 2010, VA also made an important decision to simplify the process to file disability claims for combat Post-traumatic Stress Disorder. These decisions expanded access to benefits for hundreds of thousands of Veterans and brought significantly more claims into the system.

There are several other factors that have resulted in the submission of more disability claims and contributed to the backlog. These include VA initiatives to increase access and externally driven demand to address unmet disability compensation needs such as: increased use of technology and social media by Veterans, families, and survivors to self-inform about available benefits and resources; improved access to benefits through the joint VA and DoD Pre-Discharge programs; and increased outreach programs to inform more Veterans of their earned benefits, which

can include compensation claims. The demand for disability compensation has also been impacted by: ten years of war with increased survival rates for our wounded; an aging population of previous era Veterans such as Vietnam and Korea, whose conditions are worsening; a difficult economy, and the growth in the complexity of claims decisions as of result of the increase in the average number of medical conditions for which each claimant files.

The current composition of the inventory and backlog also includes claims from Veterans of all eras – from Veterans of the current conflicts to World War II Veterans who are just now filing a claim for the first time. The largest cohort of claims comes from our Vietnam-era Veterans who filed 448,000 claims in FY 2012, and made up 36 percent of the inventory and 37 percent of the backlog as of May 31, 2013. Gulf War Era Veterans make up 23 percent of the total inventory and 22 percent of the backlog. Veterans of Iraq and Afghanistan conflicts make up 20 percent of the total inventory and 22 percent of the backlog. Veterans of the Korean War, World War II and all other eras make up less than 10 percent of both total inventory and backlog. The remainder of the inventory and backlog is from peacetime era Veterans.

To meet the goal of eliminating the backlog, VBA is aggressively implementing its Transformation Plan, a series of tightly integrated people, process, and technology initiatives designed to achieve our goal of processing all claims within 125 days with 98 percent accuracy in 2015. VBA is retraining, reorganizing, streamlining business processes, and building and implementing technology solutions based on the newly redesigned processes in order to improve benefits delivery.

VBA is deploying technology solutions that improve access, drive automation, reduce variance, and enable faster and more efficient operations. VBA's digital, paperless environment also enables greater exchange of information and increased transparency to Veterans, the workforce, and stakeholders. Our technology initiatives are designed to transform claims processing from the time the Servicemember first enrolls in the joint VA and DoD eBenefits system and submits an online application, to the issuance of the claims decision and receipt of compensation payments.

VBA's major technology initiative to reduce the backlog is the Veterans Benefit Management System (VBMS). VBMS is a powerful paperless, Web-based, and electronic claims processing solution complemented by improved business processes. It is assisting in eliminating the existing claims backlog and serves as the technology platform for quicker, more accurate claims processing.

National deployment of VBMS began in 2012, with 18 regional offices (RO) operational by the end of calendar year (CY) 2012. As of June 10, 2013, all 56 ROs and our Appeals Management Center have fielded the first generation of VBMS paperless processing capabilities. All new incoming claims are being established and processed using the new system, which will gradually eliminate paper processing of claims. We estimate that with the development of additional automated functionality in the future generations of VBMS, it will help improve VBA's production by at least 20 percent (in each of FYs 2014 and 2015) and accuracy by at least 8 percent.

There are over 12,400 users of VBMS to include Veterans Health Administration (VHA) staff and VSO representatives. VBMS has also successfully converted 133 million documents to images, which is the main mechanism for transitioning from paper-based claim folders to the new electronic environment. Veterans enrolled in the VA/DoD portal, eBenefits, receive electronic notification of changes in status of their disability claims, including notification of the claims decision and any benefit payments due.

In addition, through the Veterans Relationship Management (VRM) process VBA engages, empowers, and serves Veterans and other claimants with seamless, secure, and on-demand access to benefits and military service information. Veterans have access to benefits information through multiple VA sources or channels – on the phone, online, or through eBenefits. VRM provides multiple self-service options for Veterans and other stakeholders.

Also, as part of VBA's technology initiatives, the Veterans On-Line Application (VONAPP) Direct Connect (VDC) incorporates a complete redesign of the legacy Veterans On-line Application (VONAPP) system, leveraging the eBenefits portal. Claims filed through eBenefits use VDC to load information and data directly into the new VBMS application for paperless processing. Veterans can now file both original and supplemental compensation claims through VDC.

Support from our partners and stakeholders is critical to better serving our Veterans, Servicemembers, and their families. VA's claims transformation changes our interactions with employees, other Federal agencies, Veterans Service Organizations (VSO), and state and county service officers.

Fully Developed Claims (FDC) are critical to achieving VBA's goals and provide a method for our VSOs, DoD, and State and county partners to assist in gathering the necessary evidence to decide a claim. An FDC is a claim submitted to VA with all the material required for VA to make a decision, along with the Veteran's certification that nothing further will be provided. An FDC is critical to reducing "wait time" and "rework." VBA currently receives 9.5 percent of claims in fully developed form. When a qualified FDC is received, VBA is able to discharge its evidence-gathering responsibilities under the Veterans Claims Assistance Act much more efficiently than in traditional claims. VA currently completes FDCs in about average time to complete all other claims. VBA's target for FY 2013 is to receive 20 percent of claims in the fully developed format with the help of our DoD and VSO partners.

In addition, collaborative efforts are ongoing with DoD to allow VA to receive complete service treatment records (STR) – and to receive them electronically for faster and more efficient claims processing. In December 2012, VBA reached agreement with DoD to require the military services to certify a Servicemember's STRs as complete at the point of transfer to VA. The final medical treatment facility at each military service, including the National Guard and Reserve component, will certify the completeness of all STRs at the point of separation from military service. This will further increase the number of FDCs. This action has potential to cut as much as 60–90 days from the "awaiting evidence" portion of claims processing, and reduce the time needed to make a claim "ready for decision" from 133 days currently to 73 days for departing Servicemembers.

We are working with DoD to be able to view DoD electronic health records information, which will enable VBA to review any DoD records that VBA does not already possess in order to complete claims. We are also working with DoD on a capability to provide information in the Armed Forces Health Longitudinal Technology Application system (AHLTA) as a print-to-portable document format (PDF). A pilot of this capability will begin in September 2013 to provide VA electronic data (PDF) of information contained in AHLTA at the time a Service member separates from the military. DoD will deploy the Healthcare Artifact and Image Management Solution (HAIMS) to provide a mechanism for scanning and uploading paper documents to make them readily available to VA. Additionally, the technology could also be used to scan and upload paper medical record items received from private-sector providers. DoD has initiated an accelerated deployment schedule for HAIMS with a goal of stopping the flow of paper STRs to VA by December 2013.

On April 19, 2013, VA announced a new initiative to expedite compensation claims decisions for Veterans who have waited 1 year or longer. VA claims raters are making provisional decisions on the oldest claims in inventory, which allows Veterans to begin collecting compensation benefits more quickly, if eligible. Veterans are able to submit additional evidence for consideration a full year after the provisional rating, before VA issues a final decision. Provisional decisions are based on all evidence provided to date by the Veteran or obtained on their behalf by VA. If a VA medical examination is needed to decide the claim, it is ordered and expedited.

As a result of this initiative, more than 65,000 claims – or 97 percent of all claims over two years old in the inventory – have been eliminated from the backlog. VBA staff are now focusing their efforts on completing all disability claims of Veterans who have been waiting over one year for a decision.

It is important to understand that as a result of this initiative, metrics used to track the timeliness of benefit claim decisions will fluctuate. The focus on processing the oldest claims will cause the overall measure of the average length of time to complete a claim to rise in the near term because of the number of old claims that are being completed. VA's average time to complete claims will improve as the backlog of oldest claims is cleared and more of the incoming claims are processed electronically through VA's new paperless processing system. In addition, the average days pending metric – or the average age of a claim in the inventory – will decrease, since the oldest claims will no longer be part of the inventory.

The Department already prioritizes processing of some claims, including the claims of seriously injured and Servicemembers separating through IDES as well as those of Medal of Honor recipients, former prisoners of war, the homeless, terminally ill, and those experiencing extreme financial hardship. The Department also prioritizes FDCs.

VA has made huge strides in its journey to improve technology and provide all generations of Veterans the best possible health care and benefits that they earned through their selfless service. VA is committed to continue that journey, especially as the numbers of Veterans using VA services increase in the coming years.

Electronic Health Records

In April of 2009, President Obama directed the DoD and VA to, "work together to define and build a seamless system of integration with a simple goal: When a member of the Armed Forces separates from the military, he or she will no longer have to walk paperwork from a DoD duty station to a local VA health center; their electronic records will transition along with them and remain with them forever."

The mission of both Departments is to fundamentally and positively impact the health outcomes of active duty military, Veterans, and eligible beneficiaries. As a result, VA and DoD are committed to creating a seamless health record integrating VA and DoD data, while modernizing the software supporting VA and DoD clinicians in the most efficient and effective way possible.

Today, DoD and VA are already exchanging a significant amount of electronic information and are taking aggressive actions in 2013 to further expand these efforts. But, most of the information shared today is not standardized to support use in electronic clinical decisions. As an example, different names for "blood glucose" in the DoD and VA systems make it impossible to integrate and track blood sugar levels for diabetics across the two systems. Once this data is mapped to standard codes it will be possible to chart and track blood sugar levels across DoD and VA records. A key priority for both Departments is to standardize electronic health record data and make it immediately available for clinicians so they have the information they need to make informed medical decisions for our patients.

In December of 2012, when presented with the revised cost and schedule information, the Secretaries directed that the Interagency Program Office (IPO) Advisory Board Co-Chairs and the Health Executive Committee (HEC) Co-Chairs prepare and provide "quick win" recommendations to accelerate interoperability and recommend changes to the governance structure and budget impacts. As a result, the IPO Advisory Board Co-Chairs and HEC Co-Chairs provided a plan which the Secretaries approved that included:

Program Strategy: Adjusted the March 2011 iEHR acquisition business rules from "buy" commercially available solutions for joint use, "adopt" a Department-developed application if a modular commercial solution is not available and one Department has a solution, "create" a joint application on a case by case basis if neither a modular commercial or Department-developed solution are available, to "adopt, buy, create" to leverage existing capabilities for joint use. The Departments will also define a "core" set of iEHR capabilities that would allow us to evaluate the selection of existing EHR products to reduce program risks and costs while accelerating implementation.

Quick Wins: On February 5, 2013 VA and DoD agreed to four accelerators. First, VA and DoD clinical health data will be made interoperable and available in near real-time using translation mechanisms such as the Health Data Dictionary and DoD's adoption of Blue Button. This data interoperability work will be completed by January 2014. Second, we approved deployment of the presentation software called JANUS Graphical User Interface to five VA polytrauma rehabilitation centers and two associated Military Treatment Facilities. JANUS is the tool clinicians use to view VA and DoD health data simultaneously. Third, the Departments will create a VA–DoD Medical Community of Interest network and security infrastructure to enable the creation of a logical "single medical enclave" that meets both Departments' security requirements, provides equal access to iEHR services by both Departments, leverages existing DoD and VA existing infrastructure, and provides connectivity between DoD and VA medical networks. Fourth, the Departments will rapidly adopt an identity management solution to establish consistent methods for identifying patients across the two organizations.

Under this plan, VA has committed to deploying an iEHR "core" based on VistA while DoD committed to evaluating available alternatives in order to make a "core" technology selection that will best fit its needs. In order to achieve the desired data interoperability between both Departments, both "cores" will conform to an agreed-upon set of standards that enable the secure and interoperable exchange of information.

While the immediate focus is on accelerating data interoperability between the two Departments, the end goal remains the same – to make certain that VA and DoD are creating a seamless health record integrating VA and DoD data and modernizing the software supporting DoD and VA clinicians. As a result of a DoD review directed by Secretary Hagel to determine the best way forward for improvements in interoperability and EHR modernization, DoD has decided that they will use a competitive process in choosing their "core." This will allow DoD to consider commercial alternatives that may offer them reduced cost, reduced schedule, and

technical risk and access to increased current capability and future growth in capability by leveraging ongoing advances in the commercial marketplace.

In today's world that means that VA and DoD don't have to utilize the same EHR software. Health record data integration and exchange is possible regardless of the software systems. In fact, as private sector experience has shown, using the same system does not guarantee that information can be shared. The important thing is that both systems use national standards and a common language to express the content and format of the information they share.

To achieve the goal, the Departments are taking the following steps that will deliver seamless, integrated health information on an accelerated basis: We are creating a Data Management Service that will give DoD and VA clinicians access to integrated patient health record information. The service will retrieve data from across DoD and VA for a given patient in seven critical clinical areas— medications, problems, allergies, lab results, vitals, immunizations, and note titles—representing the vast majority of patients' clinical information. The data will be mapped to open national standards—the same as those being adopted by the private sector—making the data computable and supporting health information sharing not only across DoD and the VA, but also with private sector providers. The data will be available in near real-time, so clinicians can rely on it for urgent clinical decisions. The standardized, integrated data will fuel a variety of apps, tools and views supporting clinicians.

The Data Management Service will be developed and deployed by the beginning of CY 2014. Nine high priority sites will have access to these data through a single integrated view. DoD and VA intend to make standardized, integrated clinical record data broadly available to clinicians across DoD and VA later in CY 2014. We are also enhancing "Blue Button" functionality, giving patients the ability to download and share their own electronic medical record information (in structured and coded format), helping them take control of their own health.

Efforts to deliver the Data Management Service are currently funded through FY13 and are in the President's FY14 budget submission. This work leverages previous health data interoperability efforts funded through the Joint DoD/VA Interagency Program Office (IPO). The IPO's efforts to date to standardize data and provide the infrastructure to integrate and view electronic health information across the Departments are the foundation for the efforts to create a seamless health record by 2014.

In the mid-term, both VA and DoD have identified the need to update their respective healthcare management systems, replacing or enhancing existing legacy systems to give clinicians and patients the best healthcare software support, including state-of-the-art clinical decision support and analytics, to provide our Servicemembers, their dependents and our Veterans with the best healthcare possible. VA with its large installed base, trained workforce and in-house development and support capacity has chosen to enhance its healthcare management system core capability based on an evolved VistA. This is a logical choice and a sound business decision for VA. But, the Departments will ensure that the acquisition of their respective healthcare management systems will deliver the capabilities needed to meet each Department's clinical requirements, while delivering the best value to the American taxpayer.

The Departments intend to jointly determine and then leverage open standards, open architecture, and open published application programming interfaces (API), while still ensuring accessibility for users with disabilities, that will provide a strong shared foundation for both healthcare management systems. The Departments will also use mature solution approaches and will apply acquisition best practices (to include maximum use of competition) to efficiently address clinical needs. Where appropriate, VA and DoD will jointly acquire capabilities.

To meet its need for modernized software to support clinicians and Veterans VA chose the "core" technology of VistA to reduce the costs and risks associated with the selection and implementation of a different technology. Most importantly, while we are engaged in continuously improving VistA, it is still one of the best electronic health record systems available worldwide. Because the source code to VistA is available via Open Source, we know that we will be able to achieve competitive pricing for any changes we need to make. The basis of the decision to utilize an evolved VistA as the iEHR core include: VistA satisfactorily meets the majority of the core criteria; VistA has an enormous investment of clinical and business knowledge imbedded into the system; VistA is able to be progressively modernize the system module by module with less risk; and a thriving and growing Open Source community exists to engage in evolving VistA to meet future needs.

Through the President's leadership and the strong support of Congress, VA has made huge strides in providing all generations of Veterans the best possible health

care and benefits through improved technology. VA in concert with its DoD partners is committed to creating a seamless record and to modernizing its health record software, in order to realize the President's vision of healthcare records that can be used across the range of national healthcare providers, including Defense, Veterans Affairs and commercial providers. This course of action will also ensure that we meet our commitment to providing our active duty military, Veterans, and beneficiaries with the healthcare they deserve now and in the future.

VA and DoD are committed to our collaborations, and we continue to look for ways to improve our decision-making, achieve greater efficiencies, and accelerate the transition process for Servicemembers and Veterans. Thank you again for your support to our Servicemembers, Veterans, and their families and your interest in the ongoing collaboration and cooperation between our Departments. We appreciate the opportunity to appear before you today, and we are prepared to respond to any questions you may have.

Materials Submitted For The Record

Letter To: Hon. Dan Beniskek, From: Eric Shinseki, (VA)

THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON

JANUARY 4, 2014

The Honorable Dan Benishek
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Benishek:

Thank you for your cosigned letter regarding the Department of Defense (DoD) Centers of Excellence (CoE) for Vision and Hearing, and the Department of Veterans Affairs (VA)/DoD Extremity Trauma and Amputation Center of Excellence.

Congressionally-directed CoEs work collaboratively to address the needs of Servicemembers and Veterans. The three CoEs you write about each receive guidance and direction through a joi nt DoDNA CoE Oversight Board. The Board consists of members from each of the military services, DoD Health Affairs, VA, the Joint Staff, and the Uniformed Services University of Health Services. This Board helps to ensure that the missions and goals of the CoEs are well-defined and create value by achieving improvement in outcomes through clinical, educational, and research activities.

For fiscal year (FY) 201O through 2014, VA allocated $6.9 million to the Vision CoE. For FY 2012 through 2014, VA allocated $1.65 million to the Extremity Trauma and Amputati on CoE, and $1.74 million to the Hearing CoE. VA funding requirements for FY 2015 through FY 2018 are currently under review and planning.

VA has contributed 6.6 full-time equivalent employees (FTEE) for the Vision CoE; 2.6 FTEE are currently filled, and four FTEE are in the hiring process. VA provides four FTEE for the Extremity Trauma and Amputation CoE, for which two positions are presently filled and individuals have been selected for the other two positions. VA staffing for the Hearing CoE is four FTEE for which one position is currently filled, and three FTEE are in the hiring process.

The current governance agreements are Memorandums of Agreement (MOA) signed by the Acting Assistant Secretary of Defense (Health Affairs) and the VA Under Secretary for Health for the Vision CoE (signed October 2009), and for the Extremity Trauma and Amputation CoE (signed August 2010).

There are 17,375 Servicemember records entered in the Defense and Veterans Eye Injury and Vision Registry as of August 28, 2013 . .Development of the joint military Hearing Loss and Auditory System Injury Registry by DoD is underway and should be completed in FY 2015. VA will provide data, in accordance with existing data sharing agreements between VA and DoD, to help populate this registry once it is completed by DoD. Although the Extremity Trauma and Amputation CoE does not have a requirement for a patient registry, this Center has used an online database to track all DoD amputee patients from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND) since 2003. There have been a reported total of 1,626 amputee patients from the OEF/OIF/OND cohort

treated in all military treatment facilities. As of April 2013, a total of 1,265 OEF/OIF/OND amputees have been provided some level of prosthetic services and health care by VA. Not all injuries to these patients were necessarily combat related; some are due to motor vehicle accidents, training accidents, and other causes.

VA remains committed to partnering with DoD to provide comprehensive high-quality care and services to Servicemembers, and to our Nation's Veterans. If you have additional questions, please have a member of your staff contact Mr. Omara Boulware, Congressional Relations Officer, at (202) 461–6468 or by e-mail at Omara.Boulware@va.gov. A similar letter has been sent to the other cosigners of your letter.

Thank you for your continued support of our mission.

Sincerely,

Eric K. Shinseki

Questions For The Record

QFR submitted by Thornberry, Mac

House Committee on Armed Services

Question for: Honorable Frank Kendall

1) Please describe the process that led to SECDEF's electronic health record (EHR) procurement decision. What steps is DOD taking, both internally and jointly with VA, to improve oversight and management to support the effective implementation for this decision?

The Secretary of Defense convened an internal Department of Defense (DoD) review following his April 2013 budget hearings to examine the current state of the iEHR program and identify a way ahead for future EHR development and deployment. Based on the results of this internal review, which included inputs from previous analyses performed by the Director, Cost Analysis and Program Evaluation, as well as an assessment of the current Department of Veterans Affairs (VA) internal information technology, the Secretary of Defense issued a memorandum on May 21, 2013, reinforcing DoD's commitment to working with VA to establish healthcare data interoperability and directing the Under Secretary of Defense for Acquisition, Technology, and Logistics (USD(AT&L)) to oversee a competitive acquisition to modernize DoD healthcare management systems.

Following the issuance of the memorandum, USD(AT&L) restructured DoD's health care information technology (IT) efforts to focus on both the DoD Healthcare Management System Modernization program and the joint DoD/VA iEHR program. By pursuing these efforts separately, the Interagency Program Office is able to focus near-term efforts to establish standards-based healthcare data interoperability between DoD and VA. Concurrently, DoD can pursue a competitive acquisition, consistent with sound acquisition business practices, to obtain the most capable clinical support system for our Service Members at the best value to American taxpayers.

QFR submitted by Thornberry, Mac

House Committee on Armed Services

Question for: Mr. Stephen Warren

2) Please describe the decision-making process the VA used to determine that maintaining the existing Veterans Health Information Systems and Technology Architecture, or VistA, was the best approach for your organization.

See attachment

QFR submitted by Langevin, James R.

House Committee on Armed Services

Question for: Honorable Robert Petzel

3) I want to focus on the path through the DoD and VA system for our veterans suffering from neurological traumas, such as TBI and spinal cord

injury. Can you describe for us how their treatment and benefit trajectory varies from the baseline, and what supplemental assistance is available other than normal benefits for those no longer able to move around comfortably in their homes?

Outcomes data collected in the VA Spinal Cord Injury/Disorders (SCI/D) and Polytrauma/Traumatic Brain Injury (TBI) Systems of Care show that Veterans with SCI/D and TBI that receive rehabilitation in VA medical centers meet or exceed external non-Veteran benchmarks in functioning, community participation, and satisfaction with life. These outcomes reflect the outstanding rehabilitative care, prosthetic services, benefits, and adaptive modifications to the home and automobile that help Veterans with these severe disabilities to overcome common obstacles to achieve personal independence, positive life adjustment, and opportunities in meaningful areas of life. VA provides a wide variety of mobility aids for eligible Veterans with functional limitations due to neurological traumas and other health conditions. Mobility aids, like all other prosthetic devices and sensory aids, are made available based on a treatment plan developed by health care providers to address the specific needs of the Veteran to optimize independent mobility and home and community accessibility, and assist with other activities of daily living. Mobility aids provided by VA range from simple items, such as transfer boards and canes, to complex devices and installations, such as wheeled mobility and overhead lift systems that can help maneuver Veterans with severe mobility limitations around the home. Mobility aids are often augmented by devices that support activities of daily living such as environmental controls for activating home mechanisms and appliances, adaptive bathroom equipment to support self-care, and alternative communication devices and adaptive computer access for persons with communication challenges. Supplemental adaptations and specialized devices are provided for Veterans with cognitive difficulties such as memory lapses due to TBI. The Veteran and caregivers receive comprehensive education and training from VA clinical providers to ensure the provided equipment is used effectively and safely. Additionally, VA has a robust Housing Adaptation program that serves to modify certain Veterans or Servicemembers residences to accommodate their disabilities. Such adaptations afford individuals with functional limitations the capability to live at home in a barrier-free environment.

Disability compensation claims for neurological conditions such as TBI and spinal cord injury receive expedited processing for seriously injured and very seriously injured Veterans. A large portion of these claims are handled through the joint VA/DoD Integrated Disability Evaluation System, resulting in disability compensation awards for separating Servicemembers at the time of discharge from military service. In addition to compensation, Servicemembers with a traumatic brain or spinal cord injury who meet certain criteria may be eligible for additional assistance for home adaptations and modifications, automobile allowances and adaptations, and statutorily-authorized special monthly compensation.

QFR submitted by Langevin, James R.

House Committee on Armed Services
Question for: Mr. Danny Pummill

4) I want to focus on the path through the DoD and VA system for our veterans suffering from neurological traumas, such as TBI and spinal cord injury. Can you describe for us how their treatment and benefit trajectory varies from the baseline, and what supplemental assistance is available other than normal benefits for those no longer able to move around comfortably in their homes?

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Claims for neurological conditions such as TBI and spinal cord injury receive expedited processing for seriously injured and very seriously injured Veterans. A large portion of these claims are handled through the joint VA/DoD Integrated Disability Evaluation System, resulting in disability compensation awards for separating Servicemembers at the time of discharge from military service. In addition to compensation, Servicemembers with a traumatic brain or spinal cord injury who meet certain criteria may be eligible for additional assistance for home adaptations and modifications, automobile allowances and adaptations, and statutorily-authorized special monthly compensation.

The Veterans Benefits Administration (VBA) and Veterans Health Administration are also working together to revise the sections of the VA rating schedule for disabilities pertaining to neurological conditions. As part of the upcoming revisions to the schedule, VBA is considering how best to address the issue of neurological traumas.

QFR submitted by Langevin, James R.

House Committee on Armed Services

Question for: Honorable Robert Petzel

5) In response to unmet needs that veterans organizations brought to my attention, I introduced the Veterans Homebuyer Accessibility Act last Congress to aid our injured servicemembers modify their homes to ensure they are accessible, and I plan to introduce it again this Congress. Has there been an examination of benefit shortfalls specific to neurological traumas, particularly with regard to adaptive modifications to homes?

The Veterans Health Administration (VHA) has a number of housing adaptation programs that serve to adapt and/or modify a Veteran's/Servicemember's residence to accommodate their disability or disabilities. These programs are managed under the Home Improvements and Structural Alterations grant; or the Veterans Benefits Administration (VBA) under the Specially Adapted Housing (SAH), Special Housing Adaptation, Temporary Residence Adaptation; or Vocational Rehabilitation & Employment Independent Living program.

Adaptations and/or modifications are individually determined based on the medical feasibility for the Veteran/Servicemember to reside in their home, continuation with medical treatment and rehabilitation, and capability to live independently in a barrier-free environment. VBA's SAH program may assist with the purchase of a home to accommodate a Veteran's/Servicemember's disability or disabilities. VBA routinely reviews the program to ensure the program is meeting the needs of eligible Veterans. VBA also works closely with Veterans Service Organizations to incorporate their feedback.

Veterans with neurological traumas such as traumatic brain injuries or spinal cord injuries may be eligible for SAH grants if they meet the statutorily defined medical eligibility criteria. Specifically, the SAH grant is available to Veterans and Servicemembers who are entitled to disability compensation for a service-connected, permanent and total disability due to: • Loss or loss of use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair; • Blindness in both eyes, plus loss or loss of use of one lower extremity; • Loss or loss of use of one lower extremity together with: 1) residuals of organic disease or injury, or 2) the loss or loss of use of one upper extremity, affecting balance and propulsion as to preclude locomotion without the aid of braces, crutches, cases, or a wheelchair; • Loss or loss of use of both upper extremities at or above the elbows; or • A severe burn injury.

Additionally, Public Law 112–154 authorized a temporary expansion of eligibility for a Veteran or Servicemember who served after September 11, 2001, and is entitled to compensation for permanent service-connected disability that was incurred on or after September 11, 2001, and that is due to the loss or loss of use of one or more lower extremities which so affects the functions of balance or propulsion as to preclude ambulating without the aid of braces, crutches, canes, or a wheelchair. This expansion is set to expire on September 30, 2014, and VA may not approve more than 30 applications for assistance in fiscal year 2014.

QFR submitted by Langevin, James R.

House Committee on Armed Services

Question for: Mr. Danny Pummill

6) In response to unmet needs that veterans organizations brought to my attention, I introduced the Veterans Homebuyer Accessibility Act last Congress to aid our injured servicemembers modify their homes to ensure they are accessible, and I plan to introduce it again this Congress. Has there been an examination of benefit shortfalls specific to neurological traumas, particularly with regard to adaptive modifications to homes?

The Veterans Benefits Administration's Specially Adapted Housing (SAH) staff routinely review the program to ensure the program is meeting the needs of eligible Veterans. SAH staff also work closely with Veterans Service Organizations to incorporate their feedback.

Veterans and Servicemembers with neurological traumas such as traumatic brain injuries or spinal cord injuries may be eligible for SAH grants if they meet the statutorily defined medical eligibility criteria. Specifically, the SAH grant is available to Veterans and Servicemembers who are entitled to disability compensation for a service-connected, permanent and total disability due to: • Loss or loss of use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair; • Blindness in both eyes, plus loss or loss of use of one lower extremity; • Loss or loss of use of one lower extremity together with: 1) residuals of organic disease or injury, or 2) the loss or loss of use of one upper extremity, affecting balance or propulsion as to preclude locomotion without the aid of braces, crutches, cases, or a wheelchair; • Loss or loss of use of both upper extremities at or above the elbows; or • A severe burn injury.

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QFR submitted by Coffman, Mike

House Committee on Armed Services

Question for: Mr. Stephen Warren

7) What are VA unique requirements for the electronic health record that you don't feel a commercial solution addresses and requires continued investment in a VA-specific solution?

VA's rich history and success with its internally-developed electronic health record (EHR) can be attributed to the outstanding collaboration that has, and continues to, exist between our clinical users and the software developers. VA clinicians play a pivotal role in defining and prioritizing the EHR enhancements that most directly impact delivery of care to the Veterans we are proud to serve. Our VA system intentionally and necessarily contains software specific to the eligibility of our unique patient population. For example, VA providers document in the EHR whether care is related to a Veteran's service-connected condition and this information then determines whether the Veteran pays a co-pay for the visit and whether we send a bill to a third party insurance company. The EHR contains VA-specific determinations related to exposures such as ionizing radiation or Agent Orange and is currently being expanded to capture care for health conditions that may be related to time on the Camp Lejeune Base. VA's EHR has also been modified over time to capture and continually improve treatment for military sexual trauma, posttraumatic stress

disorder, traumatic brain injury, amputations, and an evolving list of conditions that our Veteran population faces based on their military service. By having an internally-developed core, we are able to rapidly implement additional VA-specific changes when needed to meet internal or external demands and we are able to rapidly share treatment best practices in new and evolving areas in order to improve care for our Veterans. Such modifications would not be made quickly, if at all, by a commercial vendor. VA's EHR is published in the open source and is used by many non-VA health facilities. Those non-VA facilities, in turn, enhance the software to meet industry-wide evolving health management needs and contribute those changes back to the open source community. By using an open Source EHR, VA is able to integrate enhancements made by others immediately without the significant planning and financial investments that would have to be made to have such enhancements made by a commercial vendor.

Having core EHR functionality built and maintained by VA enables us to continue to rapidly expand our health data exchanges with private health care providers to expand the amount of health care data used in clinical decision-making. In an environment of rapidly evolving health IT solutions, having a VA-specific EHR core allows VA to integrate with best-of-breed components rather than purchasing a single, commercial EHR solution which may excel in some capabilities, but fall far short in others. VA feels strongly that a continued investment in a VA-specific EHR core with integration of appropriate open source and commercial products provides the best solution for our patients, our providers, and the taxpayers. VA is committed to developing an EHR record that can exploit the value of a service-based architecture (SOA). SOA will enable us to modify clinical decision support in near-real time, improve care coordination, and facilitate the integration of new software applications into our health information technology stack.

QFR submitted by Maffei, Daniel B.

House Committee on Armed Services

Question for: Honorable Frank Kendall

8) The DoD and VA are now working to implement a Service-Oriented Architectures (SoA) suite to achieve interoperability. Can you speak to the progress of this effort and why a SoA suite is the best solution for interoperability? What issues stand in the way for interoperability?

An SOA can facilitate the delivery and use of healthcare data services by the Department of Defense (DoD) and the Department of Veterans Affairs (VA) by "transporting" messages between any DoD and VA electronic health record systems implemented in the future and the numerous information management systems used by private providers. Because of the complexities of medical record exchanges, such as mediating terminologies, simply transmitting messages is insufficient to provide interoperability between applications or even within the same application. To overcome these challenges, an SOA is envisioned to provide messaging services that ensure access for applications via standard protocols and support interoperability and data sharing.

The SOA suite efforts completed to date include design, testing, engineering demonstration (proof of concept), security certification, and accreditation. Key milestones achieved include:

- Award of an SOA suite acquisition contract in March 2012; • Establishment of commercial and Government development test environments to allow DoD and VA product developers and other approved users an opportunity to develop trial integrations with the SOA suite (the Government test site is in the Pacific-Joint Information Technology Center; the commercial test site is located in a contractor facility in Melbourne, Florida); and, • Implementation of the SOA suite at DoD sites in Hampton Roads and San Antonio.

There are two challenges associated with achieving this level of interoperability. First, there is a technical challenge to ensure all Government and commercial capabilities adhere to the same data exchange standards required for interoperability. Second, the business process engineering efforts required of both parties must ensure the successful integration of standardized data.

QFR submitted by Maffei, Daniel B.

House Committee on Armed Services

Question for: Honorable Frank Kendall

9) As DoD and VA continue to address health records interoperability, it would seem that a modular approach that allows the departments to choose and integrate the best of each electronic health records provider would be ideal - delivering the best product at the best price. Have your offices studied this approach?

Yes, the Interagency Program Office has considered modular development, as highlighted in the February 2013 Request for Information. The Department of Defense will continue to consider the appropriate degree of system modularity and its inherent trade-offs in the forthcoming competitive source selection process. It is important to note that there are significant benefits to acquiring a more tightly coupled group of key capabilities that will have been developed and tested to be both secure and fully integrated. Conversely, increased modularity brings with it increased development and integration risks which may introduce patient safety risks in addition to measured costs that would be borne by the Government.

QFR submitted by Scott, Austin

House Committee on Armed Services

Question for: Honorable Jonathan Woodson

10) A recent GAO report sites that acceptance of TRICARE by civilian physicians has declined to an estimated 70% between 2008 and 2011. In some areas of the nation, TRICARE acceptance is under 50% for doctors accepting new TRICARE patients.

There is also a disparity between Medicare and TRICARE reimbursement rates, and fourteen percent of civilian physicians in the GAO study said they do not take TRICARE because of the low reimbursement rates.

What factors do you attribute to the declining acceptance of TRICARE?

What factors account for the disparity between TRICARE and Medicare reimbursement rates?

The number of TRICARE participating providers has actually risen slightly. In Fiscal Year 2012, the number of participating providers increased to a total of 415,500 providers. This followed a similar increase in Fiscal Year 2011, when there were 399,200 participating providers. The total number of participating providers increased by 15% in areas near military bases and by 2% in areas not near military bases.

About 90% of the 9.6 million Uniformed Services beneficiaries enjoy access to a contracted provider network near where they work or live. However, we remain concerned with access for our beneficiaries and have submitted a legislative proposal to require providers who participate with Medicare to also participate with TRICARE. By law, TRICARE is required to follow Medicare's reimbursement fee schedule. Although we have not experienced any significant issues with contracting for sufficient numbers of providers to meet the health care needs of beneficiaries that live or work near our contracted networks (military bases or base closure sites), the intent of the legislative proposal is to improve access for our TRICARE Standard beneficiaries who live outside of the network areas.

Our surveys indicate that, on average, only three to seven percent of a provider's practice in the United States, particularly those practices not located near military installations, is dedicated to treating TRICARE beneficiaries. We believe survey results indicating that seven of ten physicians are accepting TRICARE patients, if they are accepting new patients at all, is actually a good news story considering the small percentage of TRICARE patients seen in any typical provider practice. Beneficiaries may easily find providers who have accepted TRICARE patients in the recent past by using the online TRICARE Provider Search Tool, maintained by TRICARE contractors, that lists non-network providers who have submitted one or more TRICARE claims during the previous 14 months.

QFR submitted by Barber, Ron

House Committee on Armed Services

Question for: Honorable Jonathan Woodson

11) Secretary Woodson, I wanted to ask a question about TRICARE and our beneficiaries in the Philippines. For years, the Department of Defense has said there has been a problem of fraud by providers to TRICARE Management Activity in that country. TMA has implemented a number of policies that has had the result of reducing access to care, yet failing to combat

fraud. At this time, TMA is six months into a new demonstration project, and a constituent of mine has kept me well informed on how it is proceeding. Mr. Secretary, I must say I am dismayed to report that the demonstration program has seen many flaws and I am quite concerned that beneficiaries are being limited to a number of providers, for example, one authorized hospital in a city larger than New York City. Many have seen their fees doubled or have had to pay up front for office visits. What is the Department's response to this situation? Can you please provide me a detailed report on the implementation of TMA's demonstration program since January 2013, how much fraud DoD has found in TMA's work with Philippine providers, and how this new demonstration program is combating this fraud? Thank you for your timely consideration to these questions.

(1) Providers have a choice to participate as approved providers, which may result in an insufficient mix of primary and specialty providers. The TRICARE Management Activity has approved specialty waivers in designated demonstration areas for beneficiaries to receive inpatient services at hospitals that are approved providers for outpatient services only. As of July 2013, there are 8 institutional providers and 151 professional providers delivering health care in designated demonstration areas for Phase I. Beneficiaries can still seek care from certified providers, professional and institutional, outside designated demonstration areas.

TRICARE reimburses health care costs based on the lesser of billed charges or the Philippine fee schedule located online at http://www.tricare.mil/CMAC/ProcedurePricing/SearchResults.aspx. To participate in the TRICARE Department of Defense Philippine Demonstration Project, providers have agreed to bill at the lesser of the billed charges or the Philippine Foreign Fee Schedule. Approved providers have agreed to collect only the appropriate deductible and cost-shares from TRICARE Standard under the Demonstration Project. According to TRICARE policy, beneficiaries who use TRICARE Standard, whether they reside overseas or in the United States may be required to pay their deductible and cost-shares up front when receiving medical services.

(2) In response to your request for a detailed report on the implementation of TMA's demonstration program, we have enclosed a document outlining the Philippine Demonstration Project.

(3) In 2008, the Department's aggressive action resulted in seventeen individuals convicted of defrauding the TRICARE program of more than $100 million. The Department's health care antifraud initiatives have resulted in a cost avoidance of approximately $255 million from 2006 through the end of Fiscal Year 2011.

(4) To combat fraud under the Demonstration Project, the establishment of an approved provider network allows the TOP contractor to screen out providers under prepayment review because of the providers' historical fraudulent claims activity before they become approved demonstration providers for TRICARE. Approved providers must comply with the on-site verification, certification, and credentialing requirements. The TOP contractor provides one-to-one education to approved providers to ensure the approved providers understand how to submit accurate claims. To date, there have been no identified fraudulent billing activities under the Demonstration Project.

QFR submitted by Tsongas, Niki

House Committee on Armed Services

Question for: Honorable Robert Petzel

12) How many disability claims is the VA processing annually which were filed by sexual assault victims? Of those, what percentage is submitted by male victims?

VA tracks "sexual assault" claims as posttraumatic stress disorder (PTSD) disability claims based on military sexual trauma (MST). The number of PTSD/MST claims processed varies. However, from August 2012 through July 2013, VA processed approximately 5,060 PTSD/MST claims. Male Veterans filed approximately 1,480 (29 percent) of these claims.

QFR submitted by Tsongas, Niki

House Committee on Armed Services

Question for: Mr. Danny Pummill

13) How many disability claims is the VA processing annually which were filed by sexual assault victims? Of those, what percentage is submitted by male victims?

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QFR submitted by Tsongas, Niki

House Committee on Armed Services

Question for: Honorable Frank Kendall

14) We are hearing a lot about musculoskeletal injuries that come as a result of long term wear of body armor and/or other equipment. How many disability claims are you processing annually that involve musculoskeletal injuries incurred as a result of the wear of heavy body armor and/or equipment? What are some of the most common ailments cited by veterans?

The Department of Defense (DoD) continues to look for ways to reduce the load weight carried by its troops. More specifically, the Army is leveraging new material construction and design approaches to reduce the weight of the Improved Outer Tactical Vest (IOTV) and Soldier Plate Carrier System (SPCS). The current Generation III IOTV, which weighs 31 pounds (lbs) (with plates) for a size medium, is four percent lighter than the previous IOTV variant. These same approaches are applied to the SPCS, which weighs 23 lbs (with plates) for a size medium, to reduce the weight by three percent. As newer weight saving technologies become available, DoD will incorporate them to lessen the burden on the troops. DoD defers to the Department of Veterans Affairs for specifics regarding disability claims processing and common ailments cited by veterans.

QFR submitted by Tsongas, Niki

House Committee on Armed Services

Question for: Honorable Robert Petzel

15) We are hearing a lot about musculoskeletal injuries that come as a result of long term wear of body armor and/or other equipment. How many disability claims are you processing annually that involve musculoskeletal injuries incurred as a result of the wear of heavy body armor and/or equipment? What are some of the most common ailments cited by veterans?

VA does not track musculoskeletal injuries that are caused specifically by the wearing of heavy body armor and/or equipment, only these injuries generally. For all Veterans, the most common ailments are: 1. Tinnitus, recurring; 2. Hearing loss; 3. Post-traumatic stress disorder; 4. Scars, other; 5. Diabetes mellitus; 6. Lumbosacral or cervical strain; 7. Hypertensive vascular disease; 8. Limitation of the flexion of the leg; 9. Degenerative arthritis of the spine; and 10. Limited motion of the ankle.

QFR submitted by Tsongas, Niki

House Committee on Armed Services

Question for: Mr. Danny Pummill

16) We are hearing a lot about musculoskeletal injuries that come as a result of long term wear of body armor and/or other equipment. How many disability claims are you processing annually that involve musculoskeletal injuries incurred as a result of the wear of heavy body armor and/or equipment? What are some of the most common ailments cited by veterans?

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QFR submitted by Tsongas, Niki

House Committee on Armed Services

Question for: Honorable Robert Petzel

17) Information technology is critical to helping tackle the backlog of disability claims. What percentage of veterans are currently able to retrieve their Official Military Personnel File through the eBenefits online portal? What is the timeline and strategy to make this an option for all veterans (going back to Vietnam, Korea, World War II)?

The Official Military Personnel File (OMPF) records are maintained in each of the military service's records management systems. Active duty Servicemembers and Veterans (including Reserve and National Guard members) who separated or retired from their respective branch of service on or after the dates specified below may access their OMPFs through the eBenefits online portal: • Army - Since October 1994, 4.2 million OMPF records have been uploaded in its Interactive Personnel Electronic Records Management System. • Air Force - Since October 2004, 1.6 million OMPF records have been uploaded in its Automated Records Management System. • Navy - Since January 1995, 1.6 million OMPF records have been uploaded in its Electronic Military Personnel Record System. • Marine Corps - Since January 1999, nearly 900 thousand OMPF records have been uploaded in its Optical Digital Imaging-Records Management System. • Coast Guard – The Personnel Data Record (PDR), the Coast Guard's equivalent to DoD's OMPF, is unavailable electronically. The PDR is still maintained in paper format and is sent to National Personnel Records Center upon separation or retirement.

As of July 22, 2013, 8.3 million OMPF records were available through the eBenefits online portal. VA does not have any information as to whether the Department of Defense plans on making this option available to all Veterans. If a Veteran's OMPF is not available electronically through eBenefits due to his or her military service ending prior to the date when his or her service branch digitalized its OMPF records, the records are maintained in paper form at the National Archives and Records Administration's National Personnel Records Center (NPRC) in St. Louis, Missouri. In these instances, eBenefits provides the Veteran with links to the request form (SF 180) and to the NPRC Web site.

QFR submitted by Tsongas, Niki

House Committee on Armed Services

Question for: Mr. Danny Pummill

18) Information technology is critical to helping tackle the backlog of disability claims. What percentage of veterans are currently able to retrieve their Official Military Personnel File through the eBenefits online portal? What is the timeline and strategy to make this an option for all veterans (going back to Vietnam, Korea, World War II)?

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Missouri. In these instances, eBenefits provides the Veteran with links to the request form (SF 180) and to the NPRC Web site.

QFR submitted by Tsongas, Niki

House Committee on Armed Services

Question for: Mr. Stephen Warren

19) Information technology is critical to helping tackle the backlog of disability claims. What percentage of veterans are currently able to retrieve their Official Military Personnel File through the eBenefits online portal? What is the timeline and strategy to make this an option for all veterans (going back to Vietnam, Korea, World War II)?

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QFR submitted by Kilmer, Derek

House Committee on Armed Services

Question for: Mr. Danny Pummill

20) Please outline the difficulties in replacing staff in field offices. I have been told it takes as many as nine months. Specifically: a. How long does it take to replace a staff member? Are there any particular obstacles that make it more difficult to staff field offices? b. During that length of time, what happens to the caseload and the referrals that the vacant field staff position would normally work on?

A) According to the Office of Personnel Management, a position should be filled within 80 days of being announced. The Veterans Benefits Administration is in-line with this guidance and typically fills positions at regional offices within 2–3 months of being announced. A number of factors may impact the time required to fill these positions. For example, bargaining unit positions must be posted for a specific length of time. Also, labor markets greatly vary from one geographic location to the next. Regional offices in large cities may face challenges recruiting and retaining qualified employees based on a higher cost of living. Regional offices in rural areas may be an employer of choice but have fewer applicants with necessary skill sets.

B) During periods of time when field positions are vacant, the caseloads are redistributed to other employees who continue to work on them until new staff are hired and fully trained. Management takes necessary steps to adjust workload and help staff keep up with increased demands.

QFR submitted by Kilmer, Derek

House Committee on Armed Services

Question for: Mr. Danny Pummill

21) I have heard from a number of stakeholders concern over how HUD–VASH vouchers are allocated and the data that both HUD and the VA use to make these determinations. In order to help promote better understanding of how decisions are made, please explain: a. how the VA uses state point-in-time data to determine number of homeless veterans who need vouchers, b. the method used by the VA to allocate this data to regions, and c. how the regions are ranked within the VA to determine need.

The Department of Housing and Urban Development – Veterans Affairs Supportive Housing (HUD–VASH) program is an interagency effort to end Veteran homelessness, where HUD provides Section 8 Housing Choice Vouchers and VA provides wrap around case management and supportive services to promote Veteran participants' sustainment in permanent housing. Although the HUD–VASH program has been a notable success in the Administration's efforts to end Veteran homelessness, HUD–VASH vouchers are a finite resource that must be allocated in areas where the most need is identified, and these vouchers must be targeted to the most vulnerable and chronically homeless Veterans. VA and HUD work collaboratively to fairly and objectively determine the location of HUD–VASH vouchers based on the best data presently available to HUD and VA.

A) It is clear that in order to end Veteran homelessness, the finite and limited number of HUD–VASH vouchers must be targeted towards those Veterans who are chronically homeless and/or especially vulnerable. Thus, to determine the location of fiscal year (FY) 2013 HUD–VASH vouchers, HUD and VA formulated data methodology to target these valuable HUD–VASH resources towards the chronically homeless and/or especially vulnerable homeless Veteran population. HUD uses a formula to assess relative need for HUD–VASH vouchers throughout the United States. HUD runs the point-in-time (PIT) data, VA data related to contacts with homeless Veterans, and PHA and VAMC performance data through the formula to determine the proportional allocation of relative need for each HUD continuum of care (CoC). Because HUD distributes HUD–VASH vouchers through local Public Housing Authorities (PHA), it is critical that the proportionate allocation of relative need is determined for each CoC. To better target chronically homeless and vulnerable homeless Veterans, the FY 2013 allocation of the HUD–VASH vouchers had greater weight applied to the local PIT number of unsheltered homeless Veterans and the percent of chronically homeless Veterans served in the VA medical centers (VAMC).

B)HUD and VA use applicable data resources to determine the proportional allocation of relative need by each CoC. The CoCs are then matched with VAMC and Community-Based Outpatient Clinics (CBOC) that serve Veterans in the CoCs' geographic area. It is through this matching process that HUD determines that a CoC within a particular VAMC or CBOC catchment area should be allocated HUD–VASH vouchers. Once the CoC allocations are determined, HUD begins the process of identifying PHAs that cover each CoC location to be invited to participate in the HUD–VASH program by administering the voucher allocations

C)During the collaborative allocation process, VA and HUD do not rank regions to determine need. VA and HUD process data to determine the locations with the highest relative need. Vouchers are allocated proportionally through the data formula that HUD and VA use. This allows locations with the highest relative need to get a proportionally higher number of HUD–VASH vouchers than a location with fewer chronically homeless Veterans and less relative need.

QFR submitted by Wittman, Robert J.

House Committee on Armed Services

Question for: Mr. Danny Pummill

22) Is a recently discharged, combat wounded, amputee prioritized or triaged in a way that his/her claim is reviewed and processed before, for example, a 45 year old vet discharged 20 years ago claiming a service connected disability for knee pain?

Servicemembers who are separated due to wounds, injuries, or illness are evaluated in the Integrated Disability Evaluation System (IDES). This system started in 2007 when DoD and VA collaborated to design a more seamless transition for

Servicemembers who could no longer continue their military careers for medical reasons. Claims for VA benefits from Servicemembers enrolled in IDES are adjudicated by staff solely dedicated to this mission. For Servicemembers enrolled in IDES and identified as seriously injured or very seriously injured, VA prioritizes their claims at all stages of processing to ensure benefits decisions are issued as quickly as possible.

QFR submitted by Wittman, Robert J.

House Committee on Armed Services

Question for: Honorable Robert Petzel

23) Is there an administrative triage process in place to service our combat wounded or members seriously injured in training accident claims first?

Servicemembers who are separated due to wounds, injuries, or illness are evaluated in the Integrated Disability Evaluation System (IDES). This system started in 2007 when DoD and VA collaborated to design a more seamless transition for Servicemembers who could no longer continue their military careers for medical reasons. Claims for VA benefits from Servicemembers enrolled in IDES are adjudicated by staff solely dedicated to this mission. For Servicemembers enrolled in IDES and identified as seriously injured or very seriously injured, VA prioritizes their claims at all stages of processing to ensure benefits decisions are issued as quickly as possible.

QFR submitted by Wittman, Robert J.

House Committee on Armed Services

Question for: Mr. Danny Pummill

24) Are you looking at sleep apnea as a disability, which may be treated with a CPAP machine and yet still rates a 50% disability?

: The rating criteria for sleep apnea were published in the Federal Register as a Final Rule on September 5, 1996, and have remained unchanged since that time. However, significant medical advances regarding the diagnosis, classification, and management of this disability have occurred since the initial introduction of the diagnostic code. VA has established a Respiratory Workgroup for the purpose of evaluating all diagnostic codes and rating criteria in the Respiratory System under the Schedule for Rating Disabilities (38 Code of Federal Regulations, Part 4), to include sleep apnea. The references relied upon by the Respiratory Workgroup for proposed revisions to the rating schedule criteria comprise a reflection of the current medical standards for the diagnosis, measurement of severity, and response to treatment of sleep apnea.

QFR submitted by Wittman, Robert J.

House Committee on Armed Services

Question for: Mr. Danny Pummill

25) Would you please expand on what a "buddy statement" is and the process for validating this type of statement?

A "buddy statement" is lay testimony from any person who knows facts relevant to a claimant's claim. They most often relate to a sickness, disease, injury, or event in service which may support a Veteran's claim for service-connected disability compensation benefits. A "buddy statement" can serve as a secondary or alternative source of evidence to corroborate certain elements of a Veteran's claim when considered in light of all available evidence, such as corroborating an in-service stressor, establishing proof of service in the Republic of Vietnam, supporting involvement in combat, or establishing that service treatment records (STR) have been destroyed. Most often they are submitted by, but not restricted to, fellow Servicemembers who can corroborate the Veteran's claim. Under VA regulations, a lay person is competent to testify to issues that do not require specialized education, training, or experience, so long as the person providing the testimony has knowledge of the facts or circumstances of the matter at hand and the matter can be observed and described by a lay person. While each statement is evaluated on a case-by-case basis in accordance with individual facts, "buddy statements" in general are accepted if

the statement is consistent with the times, places, and circumstances of the service of both the Veteran and the "buddy." If the evidence available calls into question the qualifications of the "buddy" to make such a statement, the "buddy" is asked to submit his or her DD Form 214, or other evidence of service with the claimant.

QFR submitted by Wittman, Robert J.

House Committee on Armed Services

Question for: Mr. Danny Pummill

26) You indicated your willingness to work with pro-bono law clinics such as the Lewis B. Puller, Jr. Veterans Benefit Clinic at William and Mary's Law School. At this point pro-bono law clinics are able to help veterans compile their claims and could significantly assist the VA's efforts to process claims. Are you willing, with appropriate privacy release forms, to have regional offices interact with pro-bono law clinics regarding specific cases both for initial claims and for appeal claims to help work through specific details on claims as they are being processed through the system? What are your thoughts on developing a pilot program to work on a Fully Developed Claims type program for appeal cases? Have you considered working to establish Centers of Excellence to disseminate information and training on how pro-bono clinics might best work with the VA to support out nation's veterans?

VA appreciates the assistance of organizations like William and Mary's Puller Veterans Benefits Law Clinic in helping Veterans complete their claims. This assistance also helps reduce the claims backlog. Although our primary focus is currently on eliminating the backlog, we are also actively seeking ways to expedite the appeals process. We are evaluating several proposals submitted by the Puller Clinic, which include establishing a Center of Excellence as well as developing an integrated training program that could be used as a model for improving collaboration between VA and law school clinics. Although VA shares your interest in having law schools serve Veterans nationwide, we are also mindful of constraints to entering a formal partnership with a private entity. As such, we are carefully considering the various options available. In the meantime, we have established a Community of Practice, which is a partnership between VA and organizations that commit to submitting claims as Fully Developed Claims (FDC). On August 22, 2013, the Puller Clinic was welcomed to the FDC Community of Practice. The Puller Clinic joins The American Legion and Disabled American Veterans, both Veterans Service Organizations who are charter members of the community.

IFR submitted by Forbes, J. Randy

House Committee on Armed Services

Question for: Ms. Jessica Wright
1) Page 47 Line 1116

The Department of Defense and the Department (DoD) of Veterans Affairs (VA) agreed on 22 February 2013 to certify that Service Treatment Records (STR) are complete with all known medical record information at the time they are transferred to VA, within 45 days of Service member's separation from the military. VA previously measured DoD compliance based on the percentage of Complete STRs—those containing both medical and dental components—that also contained a Certification Letter. Between April and June 2013, DoD improved from 26% the first week the metric was tracked, to over 99%.

The VA introduced a new metric on 24 June 2013. DoD and VA agreed to use a more stringent metric for certifying STRs and have developed the new DD Form 2963 to attach to all STRs sent to VA from DoD. This will verify that the STR is complete, and will ensure that VA has all proper documents to process STRs. This new metric is effective as of 1 August 2013 and it is our intent to be 100% by 1 Nov 2013.

IFR submitted by Conaway, K. Michael

House Committee on Armed Services

Question for: Mr. Stephen Warren
2) page 64 line 1522

VA Performance Rating FY2012 Total On Board at VA GS Employees Rated Outstanding 89,456 204,142 SES Employees Rated Outstanding 111 459

IFR submitted by Conaway, K. Michael

House Committee on Armed Services

Question for: Mr. Stephen Warren
3) Page 64 Line 1531

VA Performance Rating FY2012 Total On Board at VA GS Employees Rated Outstanding 89,456 204,142 SES Employees Rated Outstanding 111 459

IFR submitted by Wenstrup, Brad R.

House Committee on Armed Services

Question for: Honorable Jonathan Woodson
4) Page 73 Line 1754

A narrated, close captioned online demonstration of the Joint Legacy Viewer (JLV) can be viewed at the following link: http://www.pacifichui.org/hui/ext/JLV—Demo/JLV—demo.html JLV provides an integrated, read-only view of health data from DoD and VA sources in a common viewer.

An important stepping stone toward modernizing our VA and DoD health information systems, JLV supports care of our Wounded Warriors and Veterans by improving access to electronic patient records and reducing the need to transfer information by fax, mail or CD.

The JLV will be accessible to DoD and VA clinicians at nine sites using their DoD or VA credentials by the end of this month.

IFR submitted by Duckworth, Tammy

House Committee on Armed Services

Question for: Mr. Stephen Warren
5) Page 93 Line 2246

As Mr. Frank Kendall stated in testimony, VA and DoD seek help on this issue in the following ways: "If I may, Mr. Chairman, what I would ask from you is that you not over-constrain us. So I am very concerned, as I mentioned in my opening statement, about some of the language in various bills right now... For example, tying us to a strategic plan that was written last fall, which is very much overcome by events now, is not particularly helpful ... It was only submitted to Congress relatively recently, but that plan does not really reflect some very fundamental changes that have been made since it was initially written. So there are things like that ... tie our hands. There are also a lot of reporting requirements. We have no problem with keeping the committees informed. We are happy to do that. The withholds that are in some of the language ... are becoming increasingly problematic for us. And particularly, right now for VA, that is a concern we have that is somewhat imminent. So [we are] very happy to work with the committees, very happy to work with the members and their staffs, and to be very transparent about what we are doing, but we ask that, in return, you relieve some of the constraints that you have in mind right now and allow us to take the best path forward and give us the opportunity to explain that to you."

IFR submitted by Gibson, Christopher P.

House Committee on Armed Services

Question for: Honorable Frank Kendall
6) Page 96 Line 2318

No Answer

IFR submitted by Johnson, Henry C. "Hank"

House Committee on Armed Services

Question for: Honorable Robert Petzel
7) Page 98 Line 2373

Please see attached list of SES and SES–Equivalent FY 2012 Performance Awards for the Department of Veterans Affairs. (Attachment B).

IFR submitted by Johnson, Henry C. "Hank"

House Committee on Armed Services

Question for: Honorable Robert Petzel
8) Page 98 Line 2381

Please see attached list of SES and SES–Equivalent FY 2012 Performance Awards for the Department of Veterans Affairs. (Attachment B).

IFR submitted by Wittman, Robert J.

House Committee on Armed Services

Question for: Mr. Stephen Warren
10) Page 99 Line 2413

The timeline outlined in the hearing transcript only applies to service treatment record (STR) requests for Veterans currently serving in the National Guard and Reserves. National Guard and Reserve STRs are maintained at the unit level, and the 60/30-day timeframe was established to allow unit record custodians adequate time to gather records and appropriately reply to requests. VA's duty to assist claimants, an obligation created by 38 U.S.C. § 5103A, requires VA to undertake certain efforts to obtain Federal records as outlined in paragraph (c)(2):

Whenever the Secretary attempts to obtain records from a Federal department or agency under this subsection, the efforts to obtain those records shall continue until the records are obtained unless it is reasonably certain that such records do not exist or that further efforts to obtain those records would be futile.

To obtain National Guard and Reserve STRs VA takes the following steps: 1. The VA regional office mails a letter to the Veteran's assigned National Guard State Adjutant General's Office or Reserve Unit requesting the military records necessary to process the claim. An internal 60-day suspense is set in VA claim processing records. 2. If no response is received after 60 days, VA phones the National Guard or Reserve Unit to request the records again, and the call is documented in VA systems. An internal 30-day suspense is set in VA claim processing records. 3. If no response is received, or if the response is not legally adequate, VA phones the Veteran and asks him/her to contact the National Guard or Reserve Unit to request that the unit send the records to VA for processing. An internal 30-day suspense is set in VA claim processing records. 4. To satisfy VA's duty-to-assist obligations, VA must continue to request records from all Federal agencies until the records or a negative response from the Federal record custodian is received. VA conducts follow-up requests to the National Guard, Reserve Unit, and Veteran every 30 days until the duty-to-assist obligation is satisfied.

As service department records are being digitized, VA can build and update systems and revise its procedures to take advantage of digital-to-digital transfer capabilities. While VA continues to rely on paper service records (the only records available in many cases), current procedures must be continued.

IFR submitted by Langevin, James R.

House Committee on Armed Services

Question for: Honorable Robert Petzel
11) Page 102 Line 2483

Outcomes data collected in the VA Spinal Cord Injury/Disorders (SCI/D) and Polytrauma/Traumatic Brain Injury (TBI) Systems of Care show that Veterans with SCI/D and TBI that receive rehabilitation in VA medical centers meet or exceed external non-Veteran benchmarks in functioning, community participation, and satisfaction with life. These outcomes reflect the outstanding rehabilitative care, prosthetic services, benefits, and adaptive modifications to the home and automobile that help Veterans with these severe disabilities to overcome common obstacles to achieve personal independence, positive life adjustment, and opportunities in meaningful areas of life. VA provides a wide variety of mobility aids for Veterans with functional limitations due to neurological traumas and other health conditions. Mobility aids, like all other prosthetic devices and sensory aids, are made available based on a treatment plan developed by health care providers to address the specific

needs of the Veteran to optimize independent mobility and home and community accessibility, and assist with other activities of daily living. Mobility aids provided by VA range from simple items, such as transfer boards and canes, to complex devices and installations, such as wheeled mobility and overhead lift systems that can help maneuver Veterans with severe mobility limitations around the home. Mobility aids are often augmented by devices that support activities of daily living such as environmental controls for activating home mechanisms and appliances, adaptive bathroom equipment to support self-care, and alternative communication devices and adaptive computer access for persons with communication challenges. Supplemental adaptations and specialized devices are provided for Veterans with cognitive difficulties such as memory lapses due to TBI. The Veteran and caregivers receive comprehensive education and training from VA clinical providers to ensure the provided equipment is used effectively and safely.

Additionally, VA has a robust Housing Adaptation program that serves to modify a Veteran's or Servicemember's residence to accommodate their disability. Such adaptations afford individuals with functional limitations the capability to live at home in a barrier-free environment.

IFR submitted by Langevin, James R.

House Committee on Armed Services

Question for: Mr. Danny Pummill
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The Veterans Benefits Administration's Specially Adapted Housing (SAH) staff routinely review the program to ensure the program is meeting the needs of eligible Veterans. SAH staff also work closely with Veterans Service Organizations to incorporate their feedback.

Veterans and Servicemembers with neurological traumas such as traumatic brain injuries or spinal cord injuries may be eligible for SAH grants if they meet the statutorily defined medical eligibility criteria. Specifically, the SAH grant is available to Veterans and Servicemembers who are entitled to disability compensation for a service-connected, permanent and total disability due to:

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