

HEARING TO EXAMINE THE IMPLEMENTATION OF WOUNDED WARRIOR POLICIES AND PROGRAMS

WEDNESDAY, APRIL 29, 2009

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:33 p.m. in room SH-216, Hart Senate Office Building, Senator E. Benjamin Nelson (chairman of the subcommittee) presiding.

Committee members present: Senators Ben Nelson, Hagan, Begich, Chambliss, Graham, Thune, and Wicker.

Committee staff member present: Leah C. Brewer, nominations and hearings clerk.

Majority staff members present: Jonathan D. Clark, counsel; Gabriella Eisen, counsel; and Gerald J. Leeling, counsel.

Minority staff members present: Paul C. Hutton IV, professional staff member; Daniel A. Lerner, professional staff member; Lucian L. Niemeyer, professional staff member; Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: Mary C. Holloway, Jessica L. Kingston, Brian F. Sebold, and Breon N. Wells.

Committee members' assistants present: Ann Premer, assistant to Senator Ben Nelson; Gordon I. Peterson, assistant to Senator Webb; Roger Pena, assistant to Senator Hagan; Clyde A. Taylor IV, assistant to Senator Chambliss; Adam G. Brake, assistant to Senator Graham; Erskine W. Wells III, assistant to Senator Wicker; and Rob Eppin, assistant to Senator Collins.

OPENING STATEMENT OF SENATOR E. BENJAMIN NELSON, CHAIRMAN

Senator BEN NELSON. Good afternoon. The subcommittee will come to order. The subcommittee meets today to discuss the implementation of wounded warrior programs, policies, and plans by the Department of Defense and Department of Veterans Affairs. This hearing was originally scheduled for April 1st, but, unfortunately, had to be postponed due to a series of stacked votes. I want to thank the members of our second and third panels, who were all present and accounted for, ready to testify, when the hearing was called off at the last minute. We thank you for your patience and understanding. But, actually, the delay produced a very positive result. On that same day, April 1st, Senator Graham and I were for-

tunate enough to meet with a group of wounded warriors and some of their family members, who were very—who very candidly shared with us the positive and negative experiences they'd gone through, and are still going through, on their journeys through treatment, the disability evaluation process, and transition to the next chapters of their lives. During that meeting, Senator Graham and I mentioned the possibility of the group testifying at a hearing on a future date, to which they all graciously agreed. Now, little did they know the day would come so soon, but, because of the hearing's postponement, we were able to create a new first panel and have invited them all to speak about their experiences as seriously wounded servicemembers and veterans and as spouses of wounded warriors.

We all remember February 18, 2007, the day the first in a series of articles appeared describing problems faced by our wounded warriors receiving care in an outpatient status. Many of these servicemembers, who were wounded or injured in service to our Nation, were living in substandard facilities, were unaccounted for, and were fighting their way through a bungled, adversarial administrative process to rate their disabilities. After they left DOD care, they had to start all over with the VA, and many fell through the cracks in the transition. And, as a result of these articles and various reports on wounded warrior transition policies and programs, Congress passed the Wounded Warrior Act, which was incorporated into the fiscal year 2008 National Defense Authorization Act. The Wounded Warrior Act, among many other things, required the Department of Defense and the Department of Veterans Affairs to work jointly to develop and implement a comprehensive set of policies to improve the care, management, and transition of recovering wounded, ill and injured servicemembers. The Act also required the Comptroller General to assess and report on the progress made by the two departments in this endeavor. This report is near completion, so on our second panel we have personnel from the Government Accountability Office to share their findings. On our third panel, we'll have several representatives from the Department of Defense and the Department of Veterans Affairs. They will discuss DOD and VA efforts to organize and resource wounded warrior program and policy improvements, as well as the accomplishments to date of the Senior Oversight Committee for the Wounded, Ill, and Injured, which has been in place for nearly 2 years and is comprised of several high-level DOD and VA officials. In fact, in a hearing earlier this year, Secretary Gates himself pledged to chair this oversight committee's meetings during this period of administration transition, along with Secretary Shinseki of the VA. This is evidence of the priority placed on helping wounded warriors and their families within the highest echelons of these Departments. I'll introduce our DOD and VA witnesses when the third panel convenes. Now, I'm very pleased to welcome our first panel. These men and women, who represent wounded or Active-Duty servicemembers and veterans and their families, are the reason we're all here today. We have with us Lieutenant Colonel Gregory D. Gadson, United States Army, Lieutenant Colonel Raymond T. Rivas, United States Army, his wife, Mrs. Colleen O. Rivas, Ms. Kimberly R. Noss, Ph.D., the spouse of a seriously wounded serv-

icemember, and First Lieutenant Andrew K. Kinard, United States Marine Corps. The wounded warrior legislation passed by Congress required the Department of Defense and Department of Veterans Affairs to collaborate on many levels. The Departments have tasked with great challenges, such as jointly developing a fully interoperable electronic health record, improving—process—improving the disability evaluation system, establishing centers of excellence for psychological health, traumatic brain injury, and eye and auditory trauma coordinating care, and much more. Collaboration on such a large scale was new ground for these two huge government agencies. The fact that these agencies have been able to work so closely on so many different levels is a sign of great commitment on their part to ensuring that our wounded, ill, and injured servicemembers and their families are given the best care management and support possible while navigating through these bureaucratic processes. But, with any undertaking of this magnitude, there are bound to be outstanding issues and problems to work out along the way. Now, I visited with many of our wounded warriors, including soldiers from Nebraska, at Walter Reed Army Medical Center. The servicemembers that I've spoken with lauded the treatment they were receiving at Walter Reed, and so, I commend the efforts of those who have worked to improve the outpatient care and treatment of our wounded warriors. However, I also learned of many issues that indicate there's still work to be done. We've heard of the shortage of healthcare professionals, but we still owe it to our troops and our country to adequately assess the medical condition of our servicemembers prior to their deployment. I recently learned of incomplete medical assessments, due to a shortage of time or manpower, which resulted, in one case, in the unnecessary exacerbation of a servicemember's medical condition. In another case, the incomplete medical assessment resulted in the deployment of a medically unfit servicemember whose condition quickly deteriorated in Afghanistan, causing him to collapse in the field. This servicemember consequently had to be medically evacuated from the forward deployment for a known medical condition. When our servicemembers return home with war wounds, it's imperative that we have the medical personnel and resources available to care for them. It's also essential that we make efforts to treat our servicemembers as close to home as possible. The ability to receive care near their home base provides a better network of support for the servicemember, and will likely speed recovery time. Ensuring we have the means and resources in place for medical assessments and adequate treatment facilities is why oversight hearings such as this are so very important. And as we reflect on the work done to date in improving these policies and programs for our servicemembers and their families, we must also identify any existing gaps or problems in the care, coordination, and transition process. Only after we identify problems can we work to find answers and provide the highest quality of care for our wounded, ill, and injured servicemembers and their families. But, this is far more than just a procedural issue. The purpose of these massive policy and program reforms is to care for our wounded warriors. And now it's my pleasure to welcome, just in time, Senator Graham. We're delighted to have you here with us today to discuss these critical

issues, and I ask if you would like to make an opening statement. I want to also welcome—[Laughter.]

Senator GRAHAM. He was just here. Senator BEN NELSON.—well, Senator Webb. I understand—is it possible that he might return? Okay. Well, Senator Graham, would you like to make an opening statement?

Senator GRAHAM. Very briefly, Mr. Chairman.

**STATEMENT OF HON. LINDSEY O. GRAHAM, U.S. SENATOR
FROM SOUTH CAROLINA**

Senator GRAHAM. I want to thank you for conducting the hearing. You've been terrific supporter of the Wounded Warrior Program and men and women in the military, in general. We got to meet with this group. We were going to have a hearing a couple of weeks ago, and we had a bunch of votes scheduled, but the Chairman was kind enough to come to my office, and I think we got a lot out of that meeting, meeting with our wounded warriors, here, and—you know, Andrew worked in my officer, and we learned a lot just about—one thing I learned is that I don't want these hearings to be taken by anybody—is that there's not a lack—there's a lack of caring. People care a lot. There's a lot of bureaucracy out there that cares a lot. We've just got to get it focused on doing the best job it can. Secretary Gates has put \$300 million in the budget, which will help us. It's a budgetary item now for the Wounded Warrior Program. And the purpose of these hearings is to learn how to do it better, and not to question anybody's motives. If the services are not being delivered well, it's not because people don't care, it's just not working right. Now, for these Warrior Transition Units, we hear some disturbing reports that people feel like the odd guy out. Family members feel like the command climate wasn't as responsive as it could be. That disturbs me. I'd just say this, if you're in charge of a Warrior Transition Unit, you—we're going to judge you by how you take care of those who have paid a real heavy price. And I hope that problem is—can be fixed and is not as bad as some people have said it was. So, we're here today to learn, and the best way to learn is from people who live it. And that's panel one. And the next panel are the people in charge of making sure it works. And we're going to be a team. Every American wants us to get this right. This has got nothing to do with party politics. This is the one thing that will bring this country together above all else, is taking care of the men and women who have been hurt. So, thank you, Mr. Chairman, for having the right tone and attitude about how to do this.

[The prepared statement of Senator Graham follows:]

[SUBCOMMITTEE INSERT]

Senator BEN NELSON. Well, thank you, Senator Graham. You have been steadfast in your support for this program, whether the roles were reversed and you were chairman and I was ranking member, or the current situation, and we will continue to make it bipartisan, nonpartisan, because there's nothing partisan about the need for care for our men and women and their families who serve our country in so many different ways. And now to our first panel. We welcome four frank assessments of the strengths and weaknesses of the systems supporting wounded warriors and their families, as well as any recommendations that you may have for improvements in the future. We'll begin by hearing opening statements, followed by some questions. And first, Lieutenant Colonel Gadson, if you would please start us off, and then we'll work our way down the table.

**STATEMENT OF LIEUTENANT COLONEL GREGORY D. GADSON,
UNITED STATES ARMY**

Colonel GADSON. Yes, sir. Chairman Nelson, Senator Graham, distinguished members—

Senator BEN NELSON. You might have to punch the button.

Colonel GADSON. It's pressed. It's red. Hello?

Senator BEN NELSON. There you go.

Colonel GADSON. Test. Test. Chairman Nelson and Senator Graham, distinguished members of this committee, thank you for this opportunity to testify today to share my experiences as a wounded warrior in the Army medical system. First and foremost, I cannot overstate how impressed I am with the treatment and care I have received since I was wounded, nearly 2 years ago. Walter Reed Army Medical Center and other service medical centers have treated unprecedented injuries and trauma, and not only successfully treated those injuries, but enabled those who have been injured to rejoin society and live productive lives. For that, I am truly grateful and humbled by those in the medical community who have dedicated their lives to making us well. Dealing with severe injury and trauma is not easy. When you consider the myriad of injuries, as well as the unfamiliarity of a typical—of typical families—a typical family has in dealing with an injured servicemember, it's easy to understand how difficult a task it is to recover. I can say, from my vantage point, that our medical system is up to the task. Over the past 23 months, I have seen tremendous improvements in the quality of care for injured servicemen and their families. However, that does not mean that there isn't room for improvement or gaps don't exist in the system. One such gap that I personally experienced involves support of—from a nonmedical attendant. Current policy allows nonmedical attendants to be reimbursed for meals and lodging. This nonmedical attendant—the nonmedical attendants' roles are to provide assistance to injured servicemembers in activities they cannot do for themselves—i.e., bathing and driving, et cetera. In my case, my wife was reimbursed as a nonmedical attendant while our household was at Fort Riley, Kansas. However, when we decided to relocate to the local area in proximity to Walter Reed Army Medical Center, her nonmedical attendant reimbursement was discontinued. What I want to illustrate to you is that we don't want to put families in a hardship situation when deciding how and who will assist the servicemember who needs assistance. The fact that per diem and lodging are paid to nonmedical attendants shows an inconsistency in rate, essentially paying nonmedical attendants based on location. I believe there should be a set rate for nonmedical attendants, as well as the per diem and lodging. The situation that family members often find themselves in is how to deal with the loss of income while the servicemember recovers. I have personally seen families remain apart while the serviceman recovers, because they cannot afford to remain together. This is a choice families should not be forced to make. I would like to emphasize the Army's dedication to our wounded warriors. Our purpose here is not—is to see continued improvement. Thank you for holding this hearing, and thank you for your continued support for warriors. I look forward to your questions.

Senator BEN NELSON. Dr. Noss?

STATEMENT OF KIMBERLY R. NOSS, PH.D.

Dr. NOSS. First of all, I'd like to thank the committee for allowing me to speak today on behalf of my husband, Sergeant First Class Scott Noss, U.S. Army. Scott was severely injured in Afghanistan in 2007. He suffered a severe brain injury, with damage to his frontal lobes and brain stem. He had two broken ribs, his pelvic

fracture, three fractured vertebrae, and broken feet. So, he sustained a very polytraumatic injury. However, the brain injury was the worst, where he is currently minimally conscious, 2 years later, and is 100-percent dependent for daily living activities. The past 2 years have been very challenging, considering that we, as a country, were not prepared to take care of these severely injured soldiers. Men and women of the Armed Forces are surviving injuries that would not have survived other wars because of the medical technology available in theater and because of our excellent training from the medic, corpsmen, and from the para-rescuemen. However, there is a huge gap between that technology and training available in theater and what is available stateside for continued long-term healthcare and services for our severely wounded warriors. I come here today representing the minority of injured, the minimally conscious realm of injury, that represent the ones who need the majority of the long-term healthcare for the rest of their life. One issue that needs to be addressed is TRICARE's lack of coverage of cognitive rehabilitative therapies. Those on Active Duty are able to access this care, but are prohibited, once retired, which is why many families fight to stay in Active Duty service. Unfortunately, just recently at the Department of Defense Cognitive Rehabilitation Consensus Conference, DOD commissioned a formal ECRI Institute of Technology Assessment on the benefits of cognitive rehabilitation for combat-injured veterans. This report stated that the assessment, in quotation, found that the available evidence was of insufficient quantity nor quality to reach meaningful evidenced-based conclusion on the efficacy of cognitive rehabilitation for TBI. However, the Defense Center of Excellence of Psychological Health and Traumatic Brain Injury, a center created by this committee, recently issued a white paper supporting cognitive rehabilitation as a well-accepted and usual-customary component of comprehensive rehabilitation for persons with modern severe TBI. Unfortunately, for no other reasons, the conclusion of the report stated that, even though cognitive rehabilitation research shows promising results, they are now, at this time, not covering for veteran-status injured soldiers. If DOD will cover cognitive rehabilitation for Active Duty soldiers, why will they not cover it once he is a veteran? Why is it sound therapy for an Active Duty servicemember, but not a retiree? While I understand that this committee does not have jurisdiction over disability compensation, it is still important that you understand that compensation for men and women with mild to moderate functional traumatic brain injuries needs to be addressed. These men and women will not have the opportunity to have a career or retirement because of their limitations from their combat injuries. What will their future entail? These individuals fall short for benefit coverages that will ensure a healthy lifestyle, but they are not employable, because of their injuries. And what about the caregivers of the severely injured soldiers? The mean age of injured soldiers is 22 years old. If this individual requires 24-hour/7-days-a-week care or constant supervision for safety, how can their family, which most likely are the prime of their career, afford to quit their jobs and forego retirement benefits to take care of their loved one? What about the 18-year-old wife who did not have the opportunity for education and chose to take

care of her severely injured husband instead of putting him in a nursing home? This wife will not have means to income, and should be compensated for her caregiving capabilities and services. Nursing home is not an option for these young men and women coming back from overseas injured. The collaborative efforts of DOD and VA have been evident; however, there is still much work to be done. For example, it would be very helpful if a Veteran Benefit Administration employee were housing all of the wounded warrior advocacy offices. For example, the U.S. SOCOM Care Coalition, who has been my main source of information and advocacy. Due to the classified nature of SOCOM warriors, if the a VBA employee was located in their office, the transfer of veteran status would be smoother because of the initial and continual presence from the transition of veteran status. And finally, I'd like to say that we should not reinvent the wheel. If TBI rehabilitation and care is better in the private sector, that's where our men and women should go. This country alone has 1.5 million brain injuries a year, where the Armed Forces have only sustained 8,000 since 2001. The VA should have an open mind and a higher fee-based budget to provide the necessary care for these individuals, as well as TRICARE stepping up to the plate to provide such services as cognitive rehabilitation. These men and women of the Armed Forces have earned opportunities—or, excuse me, earned options and deserve the best in continued healthcare services for their entire life. And I would like to say that, even though these have been the negative aspects of our journey, I do thank the DOD, U.S. SOCOM, and the CARE Coalition. Scott was a proud Army Ranger, and he fought gallantly for his country. I'd also like to thank the VA. They kept my husband alive and has done superb. Thank you.

[The prepared statement of Dr. Noss follows:]

Senator BEN NELSON. Lieutenant Kinard?

**STATEMENT OF FIRST LIEUTENANT ANDREW K. KINARD,
UNITED STATES MARINE CORPS (RET.)**

Lieutenant KINARD. Yes, sir. Good afternoon, Chairman Nelson, Senator Graham, members of the subcommittee. I'm pleased to appear before you today to discuss my experiences as a warrior in transition. I hope that, by sharing some of these challenges with you that I've faced, and some of the successes that I've had, that we can sort of gain a collective understanding of the path forward from here. And what I'd like to focus on, really, are some common themes that unite a lot of the wounded warriors that are returning home. Is the microphone close enough? Can you all hear me okay?

Senator BEN NELSON. I think it is.

Lieutenant KINARD. All right. Now, although I've faced many challenges in the 2 and a half years of my recovery since being injured in Iraq, first of all let me say that I would not be here today were it not for the dedication and professionalism of our medical service personnel. Every breath that I take is a testimony to their service. I mean that. You know, I was injured, you know, like I said, 2½ years ago, and my subsequent medical evaluation and recovery consisted of over 60 surgeries and countless hours of physical therapy, occupational therapy—you name it, I went to just about every service except for gynecology. [Laughter.]

Lieutenant KINARD. I was an inpatient at Walter Reed when the Washington Post broke the stories, and remained there through all the changes that ensued during the fallout. And some of them have been pretty effective, and some of them we've got, you know, some way to go forward. If I might just make a quick comment on the GAO study that you will hear about in the next panel, I've had a chance to read that study, and their assessment, their overall assessment, shows that 60 out of 76 of the criteria have been met. My comment to that is that, although mathematically that sounds like a pretty good progress report, even the GAO itself admits that they did not actually study the effectiveness of each of those policies that had been met. So, all they did was check the box that there is a policy that was created; they didn't actually look at, Is this working, or not? And what I'd like to talk to you about today is, you know, How can we sort of look some of these policies that have been out there and say, Are they working or are they not? How can we reduce redundancies within the system? How can we sort of streamline things so that the net effect is a decrease in the amount of confusion amongst the wounded veterans and their families? You know, the biggest item that I could sort of sum up is case management. Case and care coordination. You know, the need for competent case management at all phases of transition cannot be overstated, but it's especially critical during the rehabilitation and reintegration phases of a person's transition. You know, if you can get the proper care identified, I think you're going to have a very successful chance of a good recovery. You know, I—when my doctors knew what was going on and when we are identified, you know, which specialty service did I need to go see, there's no question, I thought the care that I received at Walter Reed in Bethesda were excellent. However, the problem arises in an outpatient status, keeping track of the number of case managers alone can be overwhelming. I can count, on—you know, eight different case managers that I had to keep track of at any one time. The burden of responsibility fell on me to make sure that I knew which of my case managers to go to for which problem. And, in effect, you know, I was left with a handful of business cards. You know, they all said, "Hey, call me if you have any problems." And I said, "Well, I don't really know, you know, what to ask or not to ask." So, one of the things that has been great success, I think, has been the creation of the overall care coordination program within the DOD and the VA. The DOD has a coordination program called the Recovery Care Coordination Program, RCCs. The VA has, on the other hand, FRCs, Federal Recovery Coordinators. And what they simply do is bring together all the resources that we have available within the DOD and the VA, and, at a 30,000-level view, say, "How can we coordinate some of these things?" And it's a one-stop shop. But, what my concern is, is that, while the RCCs and the FRCs are really doing the same thing, and the only difference is what category of wounded person they're treating, FRCs typically treat—typically manage the care of the more seriously injured and more critically injured servicemembers, while RCCs are the less severely injured. But, the two systems are administered by two different departments. One's by the VA, one's by the DOD. And yet, they're supposed to be doing the same thing and bringing the same resources

to bear. So, my question is, you know, At what level are we going to be coordinating these two programs to make sure that we're getting the most effective treatment delivered to the servicemember and we're reducing redundant programs so that we can also make sure we're spending dollars on beans and bullets where we need to, and as well as maximizing our dollars spent on our wounded warriors? I'd also like to comment briefly on the Disability Evaluation System Pilot Program that was created directly as a response to some of the criticisms raised in the Walter Reed coverage by the Washington Post. In an effort to simplify and streamline the process, before the DES pilot was created, a recovering servicemember would have to be rated, their whole body rated by the DOD, found unfit to continue service, then transferred into the VA, rated again, and then receive disability compensation. And the VA would take quite a while, and there would be a many-month gap between receiving that critical compensation. And what we did was, we streamlined that process by eliminating one of those two medical examinations. But, at the same time, I think we still need to make sure and follow up that the Department of Defense and the VA are doing the handoff correctly and effectively. You know, for myself—and I don't want to get into specifics of my case; that's what I'm not—I'm not here for my specifics today—but, as an example, it took me roughly 9 months for the DOD and the VA to figure out that my legs were not growing back. So, you know, there's some efficiencies that I think we can still continue to enjoy and benefit from if we take hard looks and ask the second and third panel of witnesses how we can really make it work for us up here on the first level. Do, thank you, gentlemen and ma'am, for your time, and I appreciate to answer your questions.

[The prepared statement of Lieutenant Kinard follows:]

Senator BEN NELSON. We thank you very much, Lieutenant Kinard. We've had join us, since we began, Senator Hagan from North Carolina, Senator Begich from Alaska, Senator Chambliss from Georgia, and Senator Thune from South Dakota, a neighbor, and Senator Wicker from Mississippi. Why don't we ask if there are any comments that you'd like to make before we turn to questions. Okay, I guess we're ready to turn to some questions. Should we try to do it about 6 minutes, questions? Okay. And some of these questions will, in one way or another, be comparable to some of the testimony you've already made. But, perhaps it'll be a little bit different. For example, this one. Where you had care—care managers, and they were working with you, do you think they were effective in getting you better care? We'll start with you first, Lieutenant.

Senator GRAHAM. It's "Kin' ard."

Senator BEN NELSON. "Kin' ard." I'm sorry.

Lieutenant KINARD. Thank you, Senator Graham.

Senator BEN NELSON. I like to get names right.

Lieutenant KINARD. The question, sir, is—

Senator BEN NELSON. Were we effective—

Lieutenant KINARD.—were the case managers effective in delivering? Yes and no. I feel that the sheer volume alone of case managers, the number of case managers there are available, creates a diffusion of responsibility within the overall system. Having the

RCC program and the FRC program, which are relatively new—what they do is, they bring all those together to a—one person that I can call and say, “Let’s figure this out together.” I think that is certainly a great improvement that the Department of Defense and VA have made. And so, I can’t say, in every single case, that the case managers dropped the ball, but it certainly will make it easier having these programs in place with effective oversight and coordination between the two departments to allow us to achieve the maximum medical benefit.

Senator BEN NELSON. What we did see, though, is, in bringing a case manager in, at least it appears that we got over the hurdle that we had, where people were unaccounted for. Wounded warriors were unaccounted for. At least was—that part of it, was it effective in having you accounted for? Did we make any progress there?

Lieutenant KINARD. I think the individual services have made tremendous efforts in accountability. And, you know, at the end of the day, just looking at this issue through the lens of your average patient, 18- to 24-year old male, he’s going to trust that guy in uniform. He’s going to go to the sergeant, he’s going to go to the—his—you know, the NCO. I think we’ve done a tremendous job, and the services ought to be commended for how they’ve really stepped up to the plate with case management and with accountability.

Senator BEN NELSON. Thank you. Dr. Noss?

Dr. NOSS. I’ve—I was very fortunate to have the SOCOM Care Coalition manage Scott’s—and continue to manage Scott’s care and his Active Duty status, and know that he will be a part of the Care Coalition for life. And if we’re trying to have a system to be modeled by, I really do think it’s the Care Coalition. They have done a fabulous job ever since General Brown started the organization. So, I have not had any bad experiences when it comes to case management, because of the Care Coalition.

Senator BEN NELSON. Mrs. Rivas?

Mrs. RIVAS. We haven’t had any bad experiences, either. The case manager, in fact, saved us. When he first arrived at BAMC, he just sat there in a room, and, at that point, he didn’t have a case manager. And when they assigned him a case manager, that’s when things started moving along. And with the traumatic brain injury, he couldn’t remember anything. So, she coordinated everything and made sure that he got to where he needed to be and that all of his care was taken care of. So, we had a wonderful experience. And then, later on, SOCOM came in, the Care Coalition. At first, they didn’t realize he was there; he was kind of in limbo. And when they found him, that’s when the ball started rolling, too. And they have stayed with us afterwards and made sure that we are up on any new care issues that arise. They’ve both been wonderful. Well, the—I need to add this, too. The care manager, the case manager, she was the one that was able to get him outpatient farmed out to RIOSA. It’s an institute that helps with mild to severe brain injuries. And if it wasn’t for that, he wouldn’t be where he is today. This—that outpatient care has been wonderful.

Senator BEN NELSON. Such a simple concept, but once it’s—simple concept, but an essential part of the tracking and keeping care

appropriate and constant so that something doesn't just lose its momentum.

Mrs. RIVAS. Well, it's made all the difference in the world to us, to where he is today and to where he was. He couldn't do simple things. And—just getting dressed, just feeding himself. And he stuttered terribly, he couldn't carry on a conversation. And they worked with him on every aspect. And he is so much better today. And then, I have to say, even the VA, we have a wonderful VA vocational counselor that we've been put in touch with, and she got him involved in the Easter Seals program. So, it's just having that contact.

Senator BEN NELSON. Thank you. Colonel Gadson?

Colonel GADSON. Yes, sir. I would echo what Lieutenant Kinard, Andrew Kinard said. The multiple case managers can be a bit confusing, and I personally have raised a question as to why—in fact, in Andrew's and I's case, because we're amputees, we have a specific amputee case manager, and then we have—we have another case manager, and he may even have some additional ones. And so, I guess the frustration is, Where is the accountability? I—even to this point, I would say that I don't understand what the clear delineation between responsibility is, and so, there's a potential gap, not that I've had any personal issues with it. You know, you've got to be—you know, you've got to be on your game and understand what's going on, and make sure that doesn't happen. And so, I feel like I've been able to, for the most part, advocate for myself. So, I think there's room to streamline that. And I think they recognize that, but we haven't gotten there yet.

Senator BEN NELSON. Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman. I thank the panel for sharing your experiences with us. Make sure I get this right. You get wounded, you get back home, your Active Duty pay continues until you're medically discharged. Is that right?

Colonel GADSON. Correct.

Senator GRAHAM. Now, in terms of support for the spouse that's life has changed as much as yours has, there is no—there is a compensation stream, is that right, Colonel Gadson?

Colonel GADSON. Well, sir, first I'd like to say that there is—they have the TSG Alive, which is the traumatic insurance that you get, and that's—

Senator GRAHAM. Right.

Colonel GADSON.—that a family or that a—

Senator GRAHAM. How much is that?

Colonel GADSON. Well, it really depends on your injury. There's no—there's no set—

Senator GRAHAM. Okay.

Colonel GADSON. There's no set—

Senator GRAHAM. Gotcha.

Colonel GADSON.—amount.

Senator GRAHAM. But, you get a payment.

Colonel GADSON. You get a payment. And that can—that, in some case, can be used to offset that, but I'll—I can tell you certain circumstances where people have had to move and they haven't been able to sell their house, and it starts eating to those—you know, eating into money that wasn't necessarily designed for that.

Senator GRAHAM. But, my question is, A family member is going to, maybe, have to quit their job—

Colonel GADSON. Yes, sir.

Senator GRAHAM.—[inaudible] or certainly, you know, their life is affected dramatically. What income stream is available to them? Dr. Noss?

Dr. NOSS. Yes. Right now, through the VA benefits, they have a small portion—it's called aid and attendance—which is to utilize to pay for caregiving hours or to be utilized by the family member who's doing the caregiving.

Senator GRAHAM. How much money did that mean for you?

Dr. NOSS. \$580 a month.

Senator GRAHAM. Okay. Andrew, you're not married, I know. What—your dad's a doctor, and your mom—are fairly well off, but there are a lot of guys your age that don't have that—what do single guys get?

Lieutenant KINARD. Single guys, with the family members coming to—

Senator GRAHAM. right

Lieutenant KINARD.—take care of them? I am not familiar with the compensation, sir.

Colonel GADSON. Senator Graham, I believe, right in the D.C. area, the per diem for a caregiver—or nonmedical attendant would have been about \$30 a day.

Senator GRAHAM. Okay. Now, and your concern is, it shouldn't be based on where you're located, it should be a flat rate, where they bump up based on location, right?

Colonel GADSON. Plus per diem, yes, sir.

Senator GRAHAM. Ms. Rivas, did you get any income support?

Mrs. RIVAS. I'm not aware of any of this. We lived off his retirement pay and savings and—so, this is new information to me.

Senator GRAHAM. All right. Well, that's why we have these hearings. Now, the point that I'm trying to make is that the country needs to come to grips with the fact that the moment the person is catastrophically, devastatingly injured, the family changes, and I think most Americans would like an income stream available to family members who provide that support that otherwise would be given by the Government. But, the one thing highly unlikely, the Government caretaker's not going to live with you 24 hours a day, maybe, like a family, so that's something, Mr. Chairman, I think we can look at, is finding a revenue stream. Now, Dr. Noss, you—how old are you?

Dr. NOSS. I'm 28 years old.

Senator GRAHAM. Okay. What's your educational background?

Dr. NOSS. I have a doctorate in chemical engineering. I actually just graduated, this past semester.

Senator GRAHAM. Most of the people in your husband's—how old is your husband?

Dr. NOSS. He's 31.

Senator GRAHAM. Okay. So, is—

Dr. NOSS. He's at E-7.

Senator GRAHAM. But, as Andrew said, most of these young people—wounded people are young people right?

Dr. NOSS. Yes.

Senator GRAHAM. What have you found, in terms of their spouses' capability or family members' capability to survive these injuries, financially?

Dr. NOSS. Actually, the 2 years that I have been inpatient with my husband, because Scott is still inpatient at the VA in Tampa, a lot of—majority of the families are very young. Most of the wives who come with their injured husbands don't have a job. They were stay-at-home mothers, they are 17-, 18-, 19-year-old high-school-educated young women.

Senator GRAHAM. Andrew, what would you have done if you didn't have the family you have?

Lieutenant KINARD. Sir, I would have been by myself. You know, my dad, he left his practice for 2 months, came up to Washington,

DC, moved up there. My mom lived up with me for over 7 months. And it wasn't until I was discharged from the hospital and able to sort of take care of myself.

Senator GRAHAM. Colonel Gadson?

Colonel GADSON. Senator, the tough task is that, as you're saying and alluding to, is that these are young families. I was a senior officer, and, you know, I had the revenue to be able to withstand my wife not being at work. But, still, even that, that took about a third of our income away from us, you know, as a professional school-teacher.

Senator GRAHAM. Well, I think this is something the committee can work on. And the final inquiry—now, you're still on Active Duty is that right, Colonel?

Colonel GADSON. Yes, sir.

Senator GRAHAM. They're going to let you stay on Active Duty, it looks like?

Colonel GADSON. They are.

Senator GRAHAM. Well, I want to congratulate the service for doing that. Andrew, I know you're going to Harvard Law School. So, you know, to those that helped Andrew, you know, look what you've done. I mean, he's going to Harvard and has a great life ahead of him. How long did it—it took you 9 months for the—to get from one medical evaluation to the other? Tell me about that again. What's the 9 months?

Lieutenant KINARD. Sir, I actually did most of that when I was a fellow in your office.

Senator GRAHAM. Yeah, I know. [Laughter.]

Senator GRAHAM. You've gone Hollywood on me, now, I see you on TV all the time. [Laughter.]

Lieutenant KINARD. No comment. [Laughter.]

Lieutenant KINARD. Well, sir, the—that was one of the big issues that was highlighted, you know, was the inadequacies with the flexibility and the speed—

Senator GRAHAM. Now, you're medically discharged from the Marine Corps, about a month ago, is that right?

Lieutenant KINARD. That's right.

Senator GRAHAM. Okay. Now, you're 100-percent disabled by the—

Lieutenant KINARD. Yes, sir.

Senator GRAHAM.—VA? What took 9 months to figure out that your legs weren't going to grow back? Tell me what you mean by that.

Lieutenant KINARD. Well, the—there were actually two different boards that I went through. There's the Medical Evaluation Board, which is the—

Senator GRAHAM. Right.

Lieutenant KINARD.—Department of Defense evaluation of your fitness to continue service in the military in the job in which you were assigned, or they can find you another job. Then, once they determine that you are no longer fit to continue serving, they refer you over to the VA to a Physical Evaluation Board that then rates the amount of compensation that you are owed, you know, for your injuries. And so, it's going from that one board, where they have

to prepare all the materials, hand it to the next board; if there's anything wrong, it gets sent back. And then, that other board sits on it and they—

Senator GRAHAM. Is that still the case today?

Lieutenant KINARD. It is. And, you know, I hate to say that, you know, every case is 9 months, but I think I fell within about an average period of time for the disability evaluation system.

Senator GRAHAM. Thank you.

Colonel RIVAS. Senator, if I can make a comment?

Senator BEN NELSON. Yes.

Colonel RIVAS. My situation is a little different, where—from the other individuals here. I was retired at 100 percent from the military, 100 percent from the VA. I was a civilian engineer with the Department of Defense, with the Army. I was medically retired from that, at a significantly reduced income. Also, I was a licensed law enforcement peace officer in the State of Texas, was retired from that, with no retirement income. So, we've seen significantly reduced income from my retirement. And the issue that I have is with the—what the—the concurrent receipt law is, the way it's currently written, that, even though I've got 35—almost 35—had 35 years of military service, both Active and Reserve, I'm not—what I do is, I lose all my VA to get my military retirement. I think that's a real injustice, because if I had 20 years, the way the law is written, I would receive both of those. I didn't choose to get blown up before I'd made sure and had 20 years of Active Duty so I could get both of those. So, we have to wait til I'm age 60. I've—most recently, have come down with some secondary—

Senator GRAHAM. You were injured when you were a Guard member or a Reserve—

Colonel RIVAS. Reserve. Reserve. And I've—since then, I've come down with some secondary issues with kidney failure and some other issues. My concern—my family's concern is, I may not live long enough to see my concurrent receipt.

Senator GRAHAM. Thank you.

Senator BEN NELSON. We've been working on that program since we got here, making some improvements, but we still have a long way to go to get that fair and equitable. Thank you.

Senator Hagan.

Senator HAGAN. Thank you, Mr. Chairman. First, I want to thank each and every one of you for all of your service, and the wives, you, too, to be complimented for all of your extended care that you've been giving. Dr. Noss, I have question for you. Your husband is currently—I think you said, is in Tampa; so, he's still in the—in care.

Dr. NOSS. Yes. He's still—he is still inpatient at the Tampa VA, the Polytrauma Unit.

Senator HAGAN. And what do you—when he—will he leave? Will he be sent someplace else? What's his laughing prognosis, as far as where he might go?

Dr. NOSS. He's going home with me. I—

Senator HAGAN. He'll be able to come home.

Dr. NOSS. Well, we're going to make it where he can come home. I don't believe in putting him in a nursing facility for long term.

Senator HAGAN. Well, then, from a—the standpoint of any sort of financial help to you at that point in time, what has the VA established for that?

Dr. NOSS. They do have a benefit package that Scott will receive every month, and it is a substantial amount of money. However, the net income will be small, because you have to take in consideration our bills that will incur in the month. For example, I know of a family who has a quadriplegic—he's quadriplegic and he's on a vent. And because of the 24-hour having power source, the ventilator, and his bed—has to have a special type of bed that's hooked up to power, their power bill is over \$1,000 a month. And because of that, the special care that Scott's going to have to receive because of his injuries, even though the substantial amount of benefit money that will come in per month, what we're going to have to pay for bills is going to be large, so the net is going to be small.

Senator HAGAN. You mentioned one other comment. I believe it was the cognitive rehabilitative therapy, that if—as long as he was considered active military, he would receive that, but then, once he went—became on a—the veteran status, it was not funded.

Dr. NOSS. Yes, ma'am, that's correct.

Senator HAGAN. But, is he currently getting that?

Dr. NOSS. Yes, he is receiving cognitive therapy at the VA, the Polytrauma Unit, which I have to say is absolutely fabulous. I just love them down there. However, my concern is if we need to take him to a private-sector rehabilitative center. TRICARE, as it is stated right now, will not pull from the supplemental fund that they have set aside for Active Duty soldiers to pay for cognitive rehab for veteran status.

Senator HAGAN. I see.

Dr. NOSS. So, right now they are not covered—

Senator HAGAN. It feels like—

Dr. NOSS.—for cognitive rehab.

Senator HAGAN.—we ought to be doing something about that, too.

Dr. NOSS. Right. I really hope you can.

Senator HAGAN. Lieutenant Colonel Rivas, I hear, all the time, your concern on the concurrent pay issues, and that's something I'm glad to hear Senator Nelson say we've been working on for a long time, but it seems like we certainly need to be moving forward, because it doesn't make a lot of sense to me at all. But—Thank you, Mr. Chairman.

Senator BEN NELSON. Thank you, Senator.

Senator THUNE.

Senator THUNE. Thank you, Mr. Chairman. And let me also add my deep appreciation to all of you for your great service to our country and the sacrifices that you and your families have made. We are, as a nation, enormously grateful. So, please know how much we appreciate that. In his prepared testimony, Major General Meurlin outlined several improvements that the DOD and VA have made to the Disability Evaluation System through the pilot program. He also says that more should be done and we need to, and I quote, “shift away from a focus on pay entitlements to one of recovery, rehabilitation, transition, and making the servicemember a viable member of society,” end quote. And I guess what I would ask

any member of the panel to answer is, In your opinion, what steps can the DOD or the VA and this committee take to improve the system and focus more on recovery, rehab, and transition? Colonel?

Colonel GADSON. Yes, sir. I'd like to just—I've got a few suggestions. And the first is—and I know we're working toward that—is getting the VA and the DOD together at the highest levels. The Army—I was fortunate enough to allow the Army to send me graduate school, and I'm almost—I'm finishing up my graduate degree at Georgetown now, while I was recovering. But, to illustrate this, in terms of VA benefits, there are some—there are some VA benefits that I don't have access to unless I retire. By staying on Active Duty, I'm only authorized a one-time \$11,000 vehicle grant, and that's because I lost my legs, and that's to get a new vehicle and modify that vehicle. And then there is a \$60,000 housing grant—again, for modification of an existing home or to apply toward—to apply toward a home. Other than those two benefits, I cannot access my education benefits for voc rehab. I have—for instance, my daughter's a junior in high school, and so, I will not be able to use any of my veterans benefits toward her college, which I would be able to do if I were to retire. I think we need to just look—I think we need to take a comprehensive look at those benefits, and merge that, because those benefits were built under the assumption that, when a servicemember was severely injured, he was going to be out. And, you know, as we look at our force, as an all-volunteer force, many people still opt to continue to serve, or would like to continue to serve, and they should be allowed to have access to a benefit. This is not—this is not a benefit to double any kind of compensation or get something that you're not authorized, but just giving you access to it when you need to. And so, I think that's a discussion or a dialogue that needs to take place as we look at these two things holistically.

Senator THUNE. Good. Dr. Noss?

Dr. NOSS. About the rehabilitation for minimally conscious patients, I really do think that integration into a civilian-sector rehab would benefit these men and women greatly, because there are four polytrauma centers in the country right now, a fifth one being built in San Antonio. There's one located in Tampa, where I'm located now, which I'm so gracious that the Fisher House was built on campus, because I have been staying at the Fisher House for a year and a half now. There's one in Richmond, in Minnesota, and Palo Alto. So, now you're having an issue of families having to relocate from their strong support from their family in order to be close to the polytrauma center. That shouldn't be an issue. The family should be able to relocate to their desire and have some sort of rehabilitation in the private sector. As well, my husband is still Active Duty, and I'm fighting to keep him Active Duty. And it's not about the money. I've been hearing for 2 years now, "Now, Mrs. Noss, if you retire him, you'll be getting more money every month." I don't care about the money. What I'm caring about is the fact that when he retires, he will lose some of his coverage for his therapies. And I really am fighting to keep him in, actually. And I'm so appreciative of the DOD for actually understanding my reasons for wanting to keep him Active Duty, and they've been very helpful. So, for the cases, as my husband, the minimally conscious

patients that are still Active Duty and have retired since, really need to work on how we can better improve the healthcare after the veteran status is achieved.

Senator THUNE. Anybody else?

Lieutenant KINARD. Senator Thune, very briefly, you know, if we're shifting away from a focus on pay and entitlements, where are we shifting to? And I think the word is reintegration. Becoming productive members of our society is essential. Picking back up our—you know, getting back up on our feet, moving forward. You know, we got injured, but, hey, we've got, still—we still have value and we can be productive. I think we need to take a look at some of the employment opportunities available while servicemembers are recovering in the Warrior Transition Units. There's a program here in the National Capitol region called Operational Warfighter. I think it's a fantastic program. It allows guys at Walter Reed and Bethesda to go intern in any of the Federal agencies in the D.C. area. But, the downside is, it's only in the D.C. area, that I know of. So, if you're at Bragg, if you're at BAMC, if you're at any of the other medical military treatment facilities, I don't know what programs there are available to get guys into some sort of internship, especially for the ones that know that they're going to be transitioning out of the service. And also, in a way, you know, as the old saying goes, "Idle hands make for the devil's work." You know, having gainful employment, in whatever capacity, even looking at perhaps doing something within the private sector for those that are in more remote locations that don't have Federal or State agencies right there, I think that could be a great step forward and towards reintegration.

Dr. NOSS. May I add one more thing, as well? With the integration to society for the mild to moderate brain injured who fall beneath the realm of the benefits to compensate a healthy lifestyle for them, the employment rate is drastically lower because of their combat injury. For example, I have befriended a family whose son was in an IED blast in 2003, and, because of his injuries, is not able to have a very high-stressful job. And so, he is able to do produce at a grocery store, but that's a very healthy transition into society for him, because he feels a part of the society again, he doesn't feel like he's lost any type of integrity, and he's really proud of that job. So, helping these mild to moderate brain-injured men and women be able to find something to help them become a productive citizen is very important for them for long-term recovery.

Mrs. RIVAS. I'd like to add something to that, too. Our VA counselor got us involved in—with the Easter Seals, and they've been working with Ray on a daily basis on cognitive skills and such thing as job skills and job training. So, outsourcing to the Easter Seals and other programs like that have been a big help.

Senator THUNE. Well, I, Mr. Chairman, appreciate very much the perspective offered here, and I hope that we can use the insights in—as we shape policies, to deal with these very important issues. So, thank you. And thank you all very much for your—for being here today and for your testimony.

Senator BEN NELSON. Thank you.

Senator Begich.

Senator BEGICH. Thank you very much, Mr. Chairman. And thank you for holding this hearing. Thank you all for your testimony, and I have learned a great deal, listening. And it sounds you have also learned something about a program that exists, which I think is part of the process of this hearing. I just want to make sure I understand how that works and how the nonmedical attendants receive pay or don't receive pay. I want to make sure I understand that clearly. And if—whoever can walk through that with me. Lieutenant Colonel?

Colonel GADSON. Yes, sir. First of all, the—

Senator BEGICH. If you can walk me from the point of—the injury occurs. What next?

Colonel GADSON. Okay. A soldier is injured, and typically they will remain in a hospital, in an inpatient status, until their medical—until their medical condition gets to a point—

Senator BEGICH. Okay.

Colonel GADSON.—that they can transfer or transition to an outpatient status. And in the case of these—

Senator BEGICH. And both of these—I'm sorry to interrupt you—both these facilities, so far, are all military-operated facilities.

Colonel GADSON. I would—I can't speak for anything outside of Walter Reed, but typically Walter Reed and Fort Sam Houston—not Sam Houston, but Brook and Palo Alto, out in California, have them—and Bethesda—have the most severely injured.

Senator BEGICH. Okay.

Colonel GADSON. And the nonmedical attendant is typically tied to that. Now, we have traumatic brain injury, and there are some other situations wherein—when a soldier is in an outpatient status, but they cannot perform all the things that they need to do—I couldn't drive, I couldn't get in and out of a vehicle, I couldn't wash without assistance. And so, my wife became that attendant for me, she became that person that did those things for me, and she couldn't—she had to quit her job. We had to relocate our family to this area, and she was no longer working. Right now, all the—

Senator BEGICH. Can I interrupt you for a second? So, during that process, she did receive, or did not receive—

Colonel GADSON. Well, when my house was at Fort Riley, Kansas, which is where I was stationed at when I got hurt, she received nonmedical attendant—

Senator BEGICH. Because she was at the location—

Colonel GADSON. She was here with me.

Senator BEGICH. Understood.

Colonel GADSON. And then, when we moved here to be—to consolidate our family, it stopped, because she was in the local area. It really doesn't make any sense. In other words—another way of describing the situation would be, if I was stationed at—in this local area, and I was stationed at Fort Belvoir, and gotten hurt, and—

Senator BEGICH. You'd be okay.

Colonel GADSON.—the exact same thing happened to me, she would have never gotten nonmedical attendant, and she had—

Senator BEGICH. Oh, really?

Colonel GADSON. Right. Because she's in the local area. So—

Senator BEGICH. Ah.

Colonel GADSON.—the rule or regulation or policy doesn't—it doesn't—

Senator BEGICH. Doesn't make sense.

Colonel GADSON.—doesn't make sense. And then, my point about—it pays lodging and per diem for the local area, so someone in San Antonio probably gets paid less than

Washington, D.C., because of the difference in the—

Senator BEGICH. Sure, the housing costs.

Colonel GADSON.—the cost of living. And that was why my recommendation about—there should be a flat, regardless of wherever it's taking place. And then, of course, you cover the per diem and lodging also.

Senator BEGICH. Anyone else want to add to that? Dr. Noss?

Dr. NOSS. The transition from your acute military facility, postinjury, to your acute rehabilitation facility—I'm going to have to use myself as the—or, our—

Senator BEGICH. Sure.

Dr. NOSS.—our experience. When Scott was injured, he was taken to Bethesda, and we were there for 8 weeks, and then we transitioned to the VA in Tampa. The nonmedical attendee status remained with me, and still is, in Tampa, because—I'll tell you what, we earn that money whenever we are receiving that nonmedical attendee, because it is very hard. Being a caregiver to 100-percent dependent loved one is the hardest thing I ever had thought—or could never imagine I'm doing. But, I love him very much, and that's why I do it. But, that nonmedical attendee pay will be drastically reduced whenever he is in veteran status. It actually goes away. But, what everyone continues to tell me is that, "Well, his benefits will counteract the nonmedical attendee's pay, and you will receive more." Well, however, I think people forget that, because of Scott's status, I had to file for guardianship for him. Now I have to account for every cent that I pay for his benefit from his benefit money. And when I have no income coming in, because I'm his 100-percent caregiver, but I also have to have accountability for every cent that's spent out of his benefit money, it's going to be very stressful. And I know I'm not the only family out there that this is happening to, and it especially is worse when a soldier's parents receive guardianship of him. They are watched like a hawk with his—their money. And it is very unfair, in some circumstances.

Senator BEGICH. Thank you.

Colonel GADSON. Senator—and I would—I failed to mention—and the Doctor reminded me, and my wife would say this if she were here—is, that is now a person that is no longer productive in society. My wife was a full-time teacher. She was working, being productive, and she's no longer working and being productive, working toward a retirement, and all those other things. So, it's not—so, it's really kind of a double whammy, in terms of, you know, your ability to produce. And so, I'm not advocating that all that has—you know, that you've got to cover all—we've got to—the Government should cover all that. But, you have to understand the scope is not just someone quitting their job and being compensated, but they're no longer producing money towards the household and retirement and all those other kinds of things.

Senator BEGICH. Thank you very much. My time is expired, but I want to say, again, thank you very much. I'm actually very familiar with this from the Medicaid end. I have a nephew that has been spina bifida from birth, and he's now in late 20s, and I clearly understand the non—you know, the nonmedical attendant and what that means, and the stress that does that to the family, and the cost, and the economic costs. So, again, I thank you for being here. The information is very helpful, and it's helped me think of some ways that maybe we, as a committee—subcommittee, can move forward. But, thank you very much.

Senator BEN NELSON. Thank you, Senator.

Senator Chambliss.

Senator CHAMBLISS. Thank you very much, Mr. Chairman. And let me thank our witnesses for really excellent testimony. And thank you for your frankness, too. And I want to particularly say to you spouses how much we appreciate you. Commitment to the military is a family commitment, we understand that. And we just thank you for your service, in addition to the service of your spouses. And, Andrew, I know, as a marine lieutenant, you feel—you've got to feel like you're still in combat every day you work for Graham. I'm sorry you have to put up with him like you do, but—
[Laughter.]

Senator CHAMBLISS. I just have one question, and it kind of goes to exactly what you were talking about, Andrew, with respect to the coordination of all of these services that you receive. We've got a unique situation down in Augusta that I hope I can stick around and talk to the next couple of panels on with respect to the Eisenhower Medical Hospital and the VA and the Medical College of Georgia, all of which are participating in care for our wounded warriors. And case management is a key aspect of what they're doing there. And I noted with interest what you talked about. You've got all these business cards, and you didn't know who to call, although you knew they were all going to help you, but trying to figure out who you need for the particular service. I want you to talk a little bit more about that, as to how that is working today, versus how it was 2 years ago, a year ago, or whatever, when you had somewhat of a state of confusion as to who you should call. And if anybody else has any experience in that same regard, I wish you'd comment on that. Andrew?

Colonel RIVAS. Yes, sir. Interestingly enough, the one single point of contact that I have is based out of Eisenhower in Augusta. Because I'm from South Carolina, she's the closest point of contact to me. She is what's known as a Federal recovery coordinator, an FRC, and this program was created in response to some legislation that we passed in Title 16 of the bill, 2 years ago. And I'd say that my experience with her has been very positive. I was referred into this program, just in January of this year, after struggling through—and, Senator Nelson, part of what I was talking with Senator Graham about, the 9 months that it took them to evaluate me—I had reached some walls there. I called her on the phone. I was referred to the program. Literally the next day, she had options e-mailed to me, said, "If you want to do it this way, we can do this; if you want to do it this way, we do that." I said, "Well, I'll take option B." She took care of it, it was done. And I said,

“Wow, this, for the first time, feels great,” knowing that there’s somebody that I can call that I can hold their feet to the fire, saying, “Why isn’t this done?” or, you know, “Let’s get some answers here.” A couple concerns of mine are how the FRC program is coordinated with the RCC program. I don’t have any suggestions for that. I’m—I just merely want to highlight that perhaps that merits some taking a looking at. And also, does the FRC program, which was designed to take care of the very seriously injured servicemembers, do they have the right authorities that they need? Do they have enough authority to take care of the problems? Because I—Senator Nelson, I appreciate what you said in your opening statement, sir, that—and, as Senator Graham echoed, as well—that nobody is arguing, here, about what servicemembers deserve: the best of the best that our Nation can provide. And I applaud you for that recognition. The question is, How do we provide that best of the best? And I think the FRC program is a great start. Dr. Guice, from whom you will hear on the second or third panel, I believe, she is the program director of this FRC program. She’ll be testifying here today. And I recommend you ask her some questions about how she feels that the authorities that have been provided to her, if they can meet the needs of the servicemembers.

Senator CHAMBLISS. Yes.

Dr. NOSS. I’d like to also make another comment. And I know throughout this whole hearing you’ve heard Care Coalition, Care Coalition the whole entire time, coming from me and the Rivases, as well. The Care Coalition is the advocacy group from the SOCOM Care—excuse me—from the Special Operation Command. And, as Andrew was talking about the many business cards that he received, he did not know who to call first. From day one, the Care Coalition was my one point of contact. They have been able to organize my life when I was not able to organize my life. They were able to itemize the pros and cons of staying Active Duty versus retirement. They have been there the whole entire way and have made my life easier. And I can honestly say that I have never been told no by that Care Coalition. They’ve—I’ve been told “maybe” a couple of times on some little sticky issues, but I really do feel like the way that they have modeled—or, they should be modeled after, because they were—they have been able to take me from the most traumatic day of my life and have carried me through to where I was able to graduate with my dissertation and my Ph.D. I do accredit them for doing that for me. And so, that one point of contact has always been there for me from day one, and that was from the U.S. SOCOM Care Coalition.

Senator CHAMBLISS. Okay.

Mrs. RIVAS. It’s the same for us, the Care Coalition. And then, we have the VA, too. But, it’s the Care Coalition that has helped us the most.

Lieutenant KINARD. Senator Chambliss, if I might jump in here and bring one point.

Senator CHAMBLISS. Sure.

Lieutenant KINARD. The SOCOM Care Coalition is a separate entity in the same scheme as the—each of the services have their own service-oriented and service-specific Warrior Transition Unit. Army has the Army Wounded Warrior Program. Marine Corps has

the Wounded Warrior Regiment. SOCOM has their own. When they show up to Walter Reed, the Special Forces guys, they just disappear, and they're taking care of. And from these two witnesses here, they've received the highest marks, I think, out of the any service-specific transition units. However, what a concern mine is, is the net effect when we've got DOD-mandated programs and then we've got each of the service-specific programs. So, if you're in the Navy, you have a different one than the Army or your Marine Corps associates. You know, where are these being coordinated? Who's taking care of making sure that we're eliminating redundancies that can be—the net effect is felt by the families, who will sort of get lost.

Dr. NOSS. And I also would like to make a comment. Even though Scott is being taken care of by the Care Coalition in SOCOM, his Wounded Warrior project manager from the Army is involved in his care as a—Active Duty and as a veteran status. They actually work hand in hand at—they even have him at the SOCOM Care Coalition office. So, I do accredit the U.S. Army by—as well, for taking really good care of my husband.

Senator CHAMBLISS. Thank you.

Colonel GADSON. Senator, just one last comment. It has a—it has improved greatly over the last 2 years. And I think DOD is working toward making it more efficient. There is definitely room for improvement. If—I think all of us would echo this sentiment, that there is a whole lot of folks that are out there trying to do the right thing and trying to do some good. And sometimes they're just stepping on each other. And when you put that in light of you're dealing with these traumatic and difficult times, it's really—a lot of times it gets drowned out, and it's too much for folks to manage. And I would say that probably SOCOM, again, does it the best; and that's generically, regardless of the service. But, they're smaller, in a much tighter community. And so, I think it's—that's why they're more efficient.

Senator CHAMBLISS. Well, thank you very much, all of you, for your excellent testimony today. Thanks, Mr. Chairman.

Senator BEN NELSON. Thank you, Senator. And I, too, want to add my thanks for your willingness to come and tell us, as you've seen it and experienced it, and are continuing to experience it. We want you to know that we're very interested, not only in what you have to say, but in finding solutions to the areas that need further work. And you can be sure that we're going to do everything we can to try to plug those holes and make it work the way Americans want it to work or our men and women and their families who serve our country in so many important ways. So, thank you, and may God bless you all. Thank you. Let's give them a round of applause, shall we? [Applause.]

[The prepared statements of Colonel and Mrs. Rivas follow:]

Senator BEN NELSON. The second panel is comprised, if you'll come forward, of GAO subject-matter experts, Mr. Randall B. Williamson, who is the director for Health Care. We welcome you. Ms. Valerie C. Melvin, director for Human Capital and Management Information Systems Issues. We welcome you. And Mr. Daniel Bertoni, director of Education, Workforce, and Income Security. We welcome you. We look forward to hearing your assessment of

the progress made by the departments, thus far, as well as identification of areas where work remains to be done. You've had the benefit of hearing some of our servicemembers and family members express their concerns, as well as their experiences. And, with that in mind, Mr. Williamson, we'll ask you if you have any opening statements—an opening statement.

STATEMENT OF RANDALL B. WILLIAMSON, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; ACCOMPANIED BY DANIEL BERTONI, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY ISSUES, AND VALERIE C. MELVIN, DIRECTOR, HUMAN CAPITAL AND MANAGEMENT INFORMATION SYSTEMS ISSUES

Mr. WILLIAMSON. Thank you, Mr. Chairman and members of the subcommittee. We are pleased to be here today to discuss action VA and DOD are taking to transition our Nation's recovering servicemembers back to Active Duty or to a veteran status. Beyond adjusting to their injuries, recovering servicemembers may face additional challenges, including difficulties managing their outpatient recovery process, navigating the military's Disability Evaluation System, and transitioning between care provided by DOD and VA. Our testimony today will discuss the progress made by DOD and VA to jointly develop policies on improvement to the care, management, and transition of recovering servicemembers, as mandated by the National Defense Authorization Act of 2008. We'll also address challenges both agencies face as they develop and implement policies on these issues. With me today are Dan Bertoni, a director overseeing our work on DOD and VA Disability Evaluation Systems, and Valerie Melvin, a director who heads up our work on issues related to information sharing and DOD and VA health records. NDAA 2008 required DOD and VA to jointly develop and implement comprehensive policies in four areas: care and management, medical and disability evaluation, return of servicemembers to Active Duty, and the transition of the recovering servicemembers from DOD to VA. Within these four areas, we identified 76 individual requirements contained in the act. DOD and VA are addressing these areas and requirements through its Wounded, Ill, and Injured Senior Oversight Committee, referred to as a SOC, which was established in May 2007 as a vehicle for jointly addressing issues for recovering servicemembers. It is staffed with both DOD and VA employees. Overall, DOD and VA have made good progress in developing policies spelled out in NDAA 2008. They have completed joint policy development for 60 of the 76 requirements. The remaining 16 requirements are in progress, and VA and DOD officials expect to complete policy development for these requirements by midyear. In developing policies to address NDAA 2008 requirements, DOD and VA have faced numerous challenges, and will continue to do so as they further develop policies and oversee policy implementation. For example, improving the disability evaluation process for recovering servicemembers poses a major challenge. Numerous studies have highlighted long delays and confusion that ill or injured servicemembers face as they navigate the military disability evaluation system. To help remedy these problems, VA and DOD initiated a Disability Evaluation System Pilot

Program as a test for consolidating the two departments' Disability Evaluation Systems. Both agencies have indicated that decisions on the feasibility of consolidating their disability systems will be made after the pilot project is completed. Possible expansion of this pilot is currently being considered. However, from our perspective, it is unclear what specific criteria DOD and VA will use to evaluate the pilot and whether they will have complete information needed for this evaluation. Another daunting challenge involved DOD and VA efforts to share electronic health records, an effort that has been underway for over a decade. While the departments are making progress towards increased information sharing, they face further challenges in managing initiatives required to achieve this goal. GAO has recently reported that the two departments' plans to further increase their electronic sharing capabilities do not consistently identify results-oriented performance measures to accurately assess progress toward the delivery of that capability, nor have the departments completed all necessary activities to fully set up their interagency program office, including hiring a permanent director and deputy director. Until these challenges are further—fully addressed, the departments and their stakeholders may lack the comprehensive understanding they need to effectively manage their progress toward achieving increased sharing of information between the departments. Finally, recent staff changes and working relationships within the SOC could also pose a future challenge. Since January, the SOC has experienced turnover in leadership and changes in policy development responsibilities. Also, DOD established two new organizations as a means to establish a permanent structure to support the SOC. Some DOD officials consider the changes to be positive developments that will enhance the SOC's effectiveness. In contrast, others are concerned with issues related to communication and interaction among SOC members. Given the recent organizational changes that have occurred in support of the SOC. How this plays out in the future is unknown. Mr. Chairman, this concludes my remarks. We'll be happy to answer any questions you have.

[The prepared statement of Mr. Williamson follows:]

Senator BEN NELSON. Ms. Melvin?

Mr. WILLIAMSON. We just had one statement.

Senator BEN NELSON. Well, thank you very much, Mr. Williamson. As you look at trying to develop an intercooperative arrangement between two distinct agencies, did you get a sense that maybe the tendency of an agency to create a silo for protection for their own agency—or stovepiping, as it's sometimes called—did you see an indication that that might be broken down to where there truly could be a bridge built between the two agencies to smooth the transition? Obviously, there is a transition in place today, it's just not smooth. Is it possible really to smooth it to the level we need and want it to be smooth?

Mr. WILLIAMSON. Well, as you know, Mr. Chairman, the SOC was created to deal with a crisis situation, and it was created to overcome the silos that might have existed in both agencies. And I think it enjoyed some relative success. I think the question now is, with the new organizations on the DOD side that have been created to support the SOC, and with certain other changes, whether

that smoothness will continue. Indications that we have so far is that the changes—and granted, the changes have only been in place for 4 months—that things are being accomplished. Again, I think a large part of the success of the SOC has occurred due to personality-driven kinds of considerations. The people who have been there have gotten along, they've communicated well up to this point. I think, now, with future changes looming, in terms of top-level people who are going to be leaving and others taking their place, it remains to be seen just how smooth things work out.

Senator BEN NELSON. Any comments from either of the other panelists?

Mr. BERTONI. Sure, I could add something from a disability determination perspective. I have seen—we've followed this pilot from the tabletop—or, initial tabletop exercise through the initial pilot phase with just three locations, to now it's up to 14 locations. And I can't say both DOD and VA—it's a partnership. They have—they're sharing information, they're trying to flatten the process and the handoff. So, I mean, I do see an effort to do that, to make it sort of a seamless process, to view this as a continuum of care from the battlefield injury to the stabilization of the person, and then ultimately making a decision on where—what is—what will we do with this person's future, whether to be—to go back into the service and have the appropriate supports in play, or to transfer that person into the civilian world, or—and perhaps VA—and there's coordination there between the board liaisons and the military service represents. So, there is an effort to do that, certainly. You know, there's always room for improvement, and we can talk about that.

Senator BEN NELSON. Ms. Melvin, I know that a lot of people think that information technology is just something that's essentially mechanical, and if you come up with the same system, it—everything will transfer. Is that a misnomer here, as well?

Ms. MELVIN. Yes, it is, sir. There's a big issue, relative to interoperability, and that's the critical aspect that has to be into play for VA and DOD to share their electronic health information. Getting to interoperability requires a lot of agreement, relative to standards, and those standards relate to medical terminology, data transfer, just a complex host of issues that have to be considered. So, it's not a matter of just having systems developed. It is a matter of really being able to understand the requirements that each of those departments has. What are the priorities, relative to their needs, and how do you build those systems, and build the interoperable capabilities that will allow the necessary data to be exchanged?

Senator BEN NELSON. Mr. Williamson, is it possible to get the two agencies to determine the same level and interest and need for the same criteria for determination of status of health and whether you're partially incapacitated or grossly incapacitated? Are their interests so different that you can't bring this together with a single set of criteria, or are you hopeful that it's possible to establish a single set of criteria, which would mean coming up with the same language, the same approach, which would make the transfer of records clearly more doable?

Mr. WILLIAMSON. Well, clearly, Mr. Chairman, the two agencies are distinctly different, even though they share many of the same issues. Again, I think, through the SOC and through the Joint Executive Committee, which is—or, Council—which is another body—they have taken steps, I think, to come together. As you saw in our written statement, there are issues over definitions.

Senator BEN NELSON. Right.

Mr. WILLIAMSON. Definitions—one of the ones that's still out there being decided is, What is "mental health"? What does it encompass? And certainly, the scope and eligibility and other issues regarding servicemembers depends on a common understanding of those things. So, they have worked their way through about three-quarters of the definitions. And I think, you know, that they're working on the others. But, it's not easy, and certainly they're working on it. I think, again, the SOC provides a good vehicle for doing that.

Senator BEN NELSON. Well, I was taken by what Mr. Bertoni said about their willingness to cooperate, and people of goodwill who desire to cooperate typically find a way to make things happen. Those who don't, don't. And so, I might ask, Do you think that, in the process, there is a senior partner here and a junior partner, or do we have coequal senior partners between the two agencies?

Mr. WILLIAMSON. I think they would like to view themselves as equal. You know, there are probably situations where one takes precedence when you're talking about issues that—some issues relate more to DOD than they do VA, in terms of Wounded Warrior Units and so on. So, naturally, you're going to have DOD taking the lead in those. Other issues, you know, really, VA might take a lead on. But, I think when you're talking about transition, I think they both try to play full partners.

Senator BEN NELSON. Well, I'm encouraged to hear your assurances that it appears that there's a cooperative spirit and a sincere and significant effort to make happen what everybody wants to have happen, a smooth transition for our members and their families.

Mr. WILLIAMSON. One notable thing is that the Secretaries of both DOD and VA have come together and have been real participants in this debate, have participated in SOC meetings, have participated in JEC meetings. I think that says a lot for what the agencies are trying to do.

Senator BEN NELSON. It certainly sends the right message and lends the credibility that's necessary for this to happen. Thank you.

Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. Did—Mr. Williamson, did you hear the testimony of Lieutenant Kinard, when he was talking about the GAO report said that a program existed, but that you really didn't evaluate the quality of the program. Is that a fair criticism?

Mr. WILLIAMSON. Well, we looked at policy. I mean, the first step in this process is, Do they have policies that are in place? And I think we said they're doing a pretty good job. And I was listening to that testimony, and I thought I would get a question on this.

Senator GRAHAM. You're [inaudible]—

Mr. WILLIAMSON. I think that the proofs in the pudding, in terms of implementation. And I think that has to play out in many of these, you know, 76 requirements. A couple of things we're going to be embarking on in the near future, we're going to be looking at the FRC/RCC process. We're going to be undertaking a review of that, which is very much akin to implementation. We're going to be looking at how that's been implemented. Also, we're going to be looking at the Defense Centers of Excellence for Psychological Health and TBI, which, again, the SOC has been involved in, in the TBI/PTSD issue. So, we're going to be looking at those from the standpoint of implementation. To look at all 76 requirements, in terms of implementation, is a big task. We're going to try to zero in on those that we think are very important and that need to be addressed soon.

Senator GRAHAM. Fair enough. One thing I'd like to just bring to the committee's attention, and to the public and our panel members, is that General—Colonel Gadson's a good example of how this war is different. He is going to remain on Active Duty, it looks like. Well, that just shows you how far we've come, in terms of medical technology and, you know, the desire of our soldiers to stay connected to their units and to the military. So, there'll always be two decisions to be made. And the one thing I don't want to do is rush a decision, because I think if it's up to Andrew, in many ways, he'd still be on Active Duty, but he's made the decision to move forward. We have some young men and women serving on Active Duty. I think there's a blind captain who's an instructor at West Point. And there are some amputees that are serving. So, I think that's good. So, just to let my colleagues up here know that there's always going to be some delay in making decisions, because the first decision, as to whether or not you can stay to Active Duty, is an important decision. And more times than not, most of the people hurt, that's their goal, is not to be discharged. So, I want to make sure that we have a system that looks closely at the ability to continue to serve, and think outside the box, and make places for people like Colonel Gadson and others. Now, once that decision has been made that you're not going to be able to stay on Active Duty, I do believe that we can do a lot better and just, you know,—the two agencies involved have two different missions. Department of Defense mission is to take care of soldiers, their families, fight and win this war. Department of Veterans Affairs is to take care of those who have served. And the interim period of time between medical discharge and evaluation and rehabilitation is always going to be complex, but this idea of having standard definitions, that mental health services and rehabilitative services, for an Active Duty member, should not be materially different than somebody that goes into the VA. And that's what Dr. Noss was telling us, that—and that's what Colonel Gadson was telling us, that, "When I was an Active Duty person, or I lived in this region, I wanted to—you know, I had certain services available. When I went into this new system—the VA—all of a sudden, my access to outpatient services was limited." Did y'all look at that?

Mr. BERTONI. I can talk a bit about that. I've done a lot of work across a lot of different programs, and I can say in many respects, the policies and procedures that pertain to Reserve and guardsmen

often do put them potentially at a disadvantage. At least there's a belief in many respects, and in some cases, we've identified that. And the issue here is when you look at the disability evaluation system, one in four folks come into that system are either a guard or Reserve Force member. A larger portion of our standing military is guard or Reserve. And I've brought this up in other testimonies, and it might be time to start looking at our policies. We have policies—

Senator GRAHAM. Colonel Rivas was telling us about compensation. He's a reservist. Not 20 years retirement eligible. He has to wait until 60. And yes, exactly—

Mr. BERTONI. There are many issues relating to say preexisting conditions and how many guardsmen can get caught in that situation and be aced out of benefits. So I think—and we have policies that were set up when we had this traditional army from many years ago, and we're moving to a new force.

Senator GRAHAM. Do you think both organizations are sensitive to the Guard and Reserve dilemma?

Mr. BERTONI. Yes, I think they are, and in the case of the disability evaluation pilot, which we have been able to get behind, versus just saying there's a policy.

Senator GRAHAM. One final area, and I'll yield here. She was talking about—Dr. Noss was talking about I think her husband was active duty, that when he got out of the active duty system, there was a limitation on therapy, access to therapy. Did you find that when you were looking at it, that going from one system to the other all of the sudden changed the menu you had to choose from, in terms of therapies?

Mr. BERTONI. No, we didn't look at that specifically. Again, we were following the pilot.

Senator GRAHAM. I think that's what she said. I think—that when her husband got discharged, that some of the therapies that were available on active duty were not available through the VA system. So thank you very much.

Senator BEN NELSON. Thank you, Senator.

Senator Begich.

Senator BEGICH. Thank you very much, Mr. Chairman. I want to follow up on the comment from the Lieutenant regarding the 76 policies. That's the magic number, and they've done 60, 70 of these, and that you just confirmed that they have the policies in place. Are you planning, or will you be doing kind of a measurement of the success of these policies, and have you, or is there a baseline to measure against? In other words, I'm going to speak for a moment as a former mayor. When we got audited at times by our internal auditor, we'd write a policy. Satisfied, you check the box and move on. It's when they came back and said, "What did you do?" that was more important. So what's the plan? Or is there a plan? And if there's no plan, do we need to help you get a plan on that?

Mr. WILLIAMSON. I mentioned two of the things we're going to be doing.

Senator BEGICH. I heard those, but on these specific—and here's why. I'm kind of walking through the steps. Seventy-six new policies. Now, of those 76 new policies, I'm following up—what Senator Graham I think was getting at, and that is now, there should be

some measurable method to determine if those polices are working or not. And in order to determine that, you have to have a baseline to where they are on every one of those policies and where they hope to go and if they achieve that. So I understand the other two you mentioned, but specifically about these 76, who wants to answer? I see Mr. Bertoni.

Mr. BERTONI. I could talk again about this in terms of the disability program. Right now, we have a disability system that is the current system that most—nearly all folks are going through. We have a pilot that we're looking at right now, 14 locations, on its way up to 21 by June. Potential to roll that out worldwide, so that is potentially what will be. We have been able to look at that pilot. We've been tracking that for over a year, looking at many aspects of what DOD and VA are trying to do there. And in many respects, the baseline is, is what is now? What is the current system? What is broke? What are they trying to do? How is the pilot comparing against that existing system. So that at least in this example, that's a baseline in many of the policies that Randy referred to. Modifications of the existing system, and sort of many of the policies that are being folded into the pilot. So in some ways, we had looked at, got behind the implementation and effectiveness of some of these policies, at least from the disability standpoint.

Senator BEGICH. Can I—I'm assuming I at least will be one of the members that would like to see—what I would like to see is graphically, what happens? In other words, if the person used to take this much time going through the process, how much time does it take him now? He used to receive this much service. Now they're receiving this much services. That's something that you could share at some point, even though it's at a pilot status, of how that is?

Mr. BERTONI. Certainly. I mean, the pilot's ongoing, but we issued two testimonies and one report on this. Certainly DOD and VA are tracking timeliness, transparency, customer satisfaction, and measuring it against the existing system. With 14 sites, there is some data coming in, and I could say if you looked at that data, it tends to be trending pretty well. But our concern is that they're fairly early on. Some of the more high-risk, more difficult sites won't be rolled out until around the time they have to cut off data analysis to begin writing the final report. So I don't know if you all will have the data you're looking for, in terms of the effectiveness of this pilot relative to the other system as of August 2009.

Senator BEGICH. Let me follow up on the definition issue. You mentioned about—I don't know who mentioned it—about three-quarters of the definitions were kind of agreed to, or there's an understanding. I'm guessing the last quarter is the tougher group. What's the timetable that you think you'll see unification of these definitions?

Mr. WILLIAMSON. In terms of when they'll be—

Senator BEGICH. When they have agreed on it?

Mr. WILLIAMSON. I don't know. I think that's a good question for the next panel. They're the ones doing it.

Mr. BERTONI. Next panel, be ready. That's the question. You might just include it in your opening comments so we get—dispense with it. One other idea I'll just put on the table. And, again,

I don't know all the technical terms, so I apologize, and you could clarify them for me. But as described by the lieutenant, there's a process that the—as you're being discharged, there's a process of termination, and then there's a process with the VA. Why not have one board meeting? Why not just combine them together and have one review at the same time, even though there may be differences in some of the questioning, allow that to occur, and then you're done?

Mr. BERTONI. Again, it is the disability evaluation system. That's exactly what the pilot is trying to do. Right now, we have a Medical Evaluation Board, an informal Physical Evaluation Board, then the formal Physical Evaluation Board, the DOD rating, the decision on fitness and unfitness.

Senator BEGICH. All at the same time?

Mr. BERTONI. Well, this is DOD system. Once that occurs, and if the person is found unfit, they'll transition into the civilian world. And they'll go through another set of reviews for VA. What the pilot is trying to do is to move the person through concurrently in these two systems, have the MEB, Medical Evaluation Board, the Physical Evaluation Board, have the VA in there early at the same time doing a comprehensive physical exam, issuing a rating the DOD can use to make the fit/unfit decision and VA will use to ultimately assign a disability rating to the service member. In this situation, the service member's going to know pretty much what he or she will receive as soon as he leaves the service. That's the idea, is to try to compress this and make separate situations, processes concurrent.

Senator BEGICH. Last question on that. Based on the pilot—and, again, because I'm new here, I don't know what the timetable was. If the pilot's—using just my thinking, it sounds like it's much better than the existing system, no matter how you cut it. There's jurisdictional issues, but if the goal is to deal with the service person as the priority, then the jurisdictional issues should go by the side. But putting that aside for a second, have you or has someone—and maybe it's the next panel—laid out a strategy or timetable, assuming—and that's what I would assume here for a moment—pilots are working, when do we see them all up and operational, so the old system is gone? Is that the next panel?

Mr. BERTONI. We've got some information on that. I think—I don't know that we would say it's much better. I think that the jury's out. We have 14 sites. There's limited data that is coming in. They haven't stressed the pilot under a range of scenarios that they could stress it at. There are a number of different bases with different characteristics, and I think they're working towards farther down the line. I do know they'll be up to 21, I believe, sites by June 2009. They have to issue a final report in August. I don't know if they're going to say that at that time, that this is ready for further expansion. I think there are another seven sites they might roll out in the fall. But a timeline for worldwide implementation, I haven't seen anything to that effect. My concern is that they have all the data, and that this be a data-driven decision that can crank back into any system that is proposed.

Senator BEGICH. Thank you very much. My time is up. Thank you all for your testimony.

Senator BEN NELSON. Thank you, Senator.
Senator Hagan?

Senator HAGAN. Mr. Chairman, I'm going to wait for the next panel, thank you.

Senator BEN NELSON. Thank you. We thank the panel for your appearance here today, for providing us an update and analysis of progress, and that that remains—we hope that this partnership that you're a part of, as well, will continue into the future. Time is important, but getting it right is also important. So we thank you. Thank you very much. On our third panel, we welcome Ms. Gail H. McGinn, Deputy Under Secretary of Defense for Plans; Ms. Ellen P. Embrey, Acting Principal Deputy assistant Secretary of Defense for Health Affairs; Mr. Roger Dimsdale, Executive Director, Department of Veterans Affairs/Department of Defense Collaboration, Office of Policy and Planning for the Department of Veterans Affairs; Major General Keith W. Meurlin, United States Air Force, Acting Director of the Office of Transition Policy and Care Coordination; Rear Admiral Gregory A. Timberlake, United States Navy, Acting Director of the joint DOD/VA Interagency Program Office; and Dr. Karen Guice, Executive Director of the Federal recovery coordinator for the Department of Veterans Affairs. We have many actings here today because of the change in administrations. We're very fortunate to have your testimony, because each of you has played an integral role in developing and implementing these wounded warrior policies. We're obviously counting on you to give us your honest assessment of the work that the departments have completed, as well as areas where problems remain, and work also remains. So we look forward to your statements. Ms. McGinn, if you would like to begin.

**STATEMENT OF GAIL H. MCGINN, DEPUTY UNDER SECRETARY
OF DEFENSE FOR PLANS, DEPARTMENT OF DEFENSE**

Ms. MCGINN. Thank you, Mr. Chairman, Senator Graham, members of the subcommittee. I'm pleased to be with you today to discuss the Department's ongoing effort in collaboration with the Department of Veterans Affairs to support America's wounded warriors and their families. I will be addressing the organization DOD has put in place to continue and build on the partnership between our two agencies. The Department of Defense has made, in my estimation, an extraordinary organizational commitment to sustaining and enhancing our structures for continued progress on this front. Two years ago, when events brought to light the need for focus on wounded warrior support, the departments moved quickly to put organizational structure in place to staff the Senior Oversight Committee in its decision-making and oversight role. Because we needed to move quickly, the structure was of necessity ad hoc, comprised of borrowed executives, civilian detailees, borrowed military manpower, and contractors. DOD is now replacing this ad hoc staff with permanent employees, including the dedication of three senior executive resources, and over 50 permanent traditional positions. These are in addition to the resources dedicated to the Interagency Program Office program office. Our new structure creates a Director of Transition Policy and Care Coordination in Meurlin and an Office of Strategic Planning and Performance Management, encom-

passing an executive secretariat for managing Senior Oversight Committee and Joint Executive Council matters. This structure continues the work of the prior organization. The lines of action continue. Transferred to permanent executives and the functions of a previous senior oversight staff office transferred to the executive secretariat. This organization has several important features. First, it creates an organizational issue. There was previously no senior executive charged exclusively with working with the Department of Veterans Affairs to achieve a seamless transition for our service members, and now there will be. And it enhances our role with the Joint Executive Council and the development of the joint strategic plan to drive the improvement and benefits and healthcare for all veterans, in addition to continuing the extraordinary efforts in support of the wounded warrior. These offices of DOD are co-located with the VA office, a VA/DOD collaboration to ensure day-to-day collaboration. And, in fact, they recently moved to new permanent office space. I've worked for the Department of Defense for decades, and I've never seen faster and more committed progress than that embodied in the accomplishments of the Senior Oversight Committee as it addressed the various recommendations of numerous studies and commissions and the challenges given to us by your congressional action. The disability evaluation system pilot, the revolution in care coordination and customer care, advances in responding to traumatic brain injury and post-traumatic stress disorder, and progress and sharing of electronic information. This is not all of it, but it is impressive. My colleagues will speak to these and other accomplishments in more detail. But as you've heard in the first panel, our work on behalf of the wounded warrior is not done. And as the GAO representative noted, we are creating new organizations. We are completing our hires and we will ensure that our processes, their collaboration with VA, and for integration into the priority work of the Department are accomplished. We will establish metrics and evaluation processes to make sure our focus is steady and to make sure that we can see where our policies and practices may break down now that we've started to implement them so that we can find the gaps and fix them. We will continuously review program implementation to find those policy and program gaps. We will integrate the strategic planning for support of the wounded warrior into the overall plans of the Under Secretary of Defense for Personnel and Readiness so that all of these plans are embedded in the essence of what we do every day in Personnel and Readiness. We will continue to review the support systems for the wounded and also importantly, for the families and loved ones, and continue our focus on customer care. And we will continue our emphasis on mental health and the need for psychological fitness. The commitment of our leadership is unwavering. As noted, Secretary Gates and Secretary Shinseki chaired the SOC during the transition so that we could continue the momentum. Yesterday, Deputy Secretary Lynn and Deputy Secretary Gould from the VA co-chaired the first SOC and made a commitment to go forward on behalf of wounded warriors. Mr. Chairman and members of this subcommittee, we thank you for your continuing support as we strive to work with you to provide the best possible care and oppor-

tunities for our heroic wounded warriors and their families. Thank you.

[The prepared statement of Ms. McGinn follows:]
Senator BEN NELSON. Thank you. Ms. Embrey?

STATEMENT OF ELLEN P. EMBREY

Ms. EMBREY. Mr. Chairman, Senator Graham, members of the committee, thank you again for the opportunity to discuss what the Department of Defense is doing to improve the quality of care for our wounded warriors with respect to psychological health needs and traumatic brain injuries. I'm very pleased to be here. It has been my great honor and responsibility over the last two years to be the Department of Defense lead in partnership with my counterparts in the VA, with Dr. Lou Beck and Dr. Ira Katz, to address the work of Line of Action 2, which focuses on achieving improvements and help outcomes associated with psychological health, post-traumatic stress disorder, and traumatic brain injury. Today I also briefly discussed the role of my office in overseeing the health-related aspects of Line of Action 4, which focused over the last two years on DOD/VA sharing of information technology and information. Regarding Line of Action 2, the Department is committed to ensuring that all service members, especially those with mental health and traumatic brain injuries, receive consistently excellent care across the entire care continuum. For both psychological health and TBI, our focus has been on building and sustaining physical and mental resilience and improving the quality and consistency of prevention, protection, diagnosis, treatment, recovery, and transition programs for both DOD and VA. For traumatic brain injury, this also includes a significant emphasis on research to clarify and improve clinical diagnostic treatment and rehabilitation technologies and therapies, especially for mild TBI, known as concussion, but also moderate, severe, and penetrating traumatic brain injuries. While the Department has been actively expanding and implementing programs on psychological health and TBI, we also have been working to evolve and expand the sharing of medical and beneficiary data as directed by Line of Action 4. This collaboration has ensured that information is viewable, accessible, and understandable through secure and interoperable information systems and greatly advanced the electronic sharing of benefit, personnel, and health information between the two agencies over the last several years. Details of these efforts have been included in my submitted testimony for the record. But I would also like to add that recently, we have refocused our efforts to commit to build a virtual lifetime electronic record to ensure health and benefit information is available in either system to support the service member, veteran, and their families at any time, from the point of accession to burial. Mr. Chairman, the Department of Defense greatly appreciates the Committee's strong support and the concern that you have shown for their health and well-being. I stand ready to answer your questions.

[Statement follows:]

STATEMENT OF ROGER DIMSDALE

Mr. DIMSDALE. Good afternoon, Chairman Nelson, Ranking Member Graham, Senator Hagan. I want to thank you for inviting the VA to participate in this hearing. My name is Roger Dimsdale and I'm pinch-hitting for Karen Pane, who's the acting assistant Secretary for Policy and Planning. She had a family emergency and was not able to attend. I also—before I start with my oral statement, I would like to thank the members of the first panel. I learned a lot by listening to what they had to say. It's obvious that we have a ways to go. We're heading in the right direction, but we obviously have more emphasis on care and case management to do. I would also appreciate that my written statement be entered into the record.

Senator BEN NELSON. It will be.

Mr. DIMSDALE. Mr. Chairman, I want to assure you and the committee that Secretary Shinseki is fully committed to supporting America's wounded warriors and veterans. As a sign of that commitment, Secretary Shinseki has already met with Secretary Gates four times to discuss wounded warrior issues. And as Ms. McGinn brought up today, they co-chaired a SOC, a Senior Oversight Committee, meeting during the transition. They have recently agreed to establish a joint virtual lifetime electronic record. The latest acronym is VLER, so I'll use the term VLER as we continue through the testimony here. As you know, the President, on April 9, added support to the VLER. He and the two Secretaries announced the establishment of a joint virtual electronic record. The VLER will be for all current and future service members, veterans, and eligible family members, and will contain all data to uniquely identify them and ensure the delivery of care and benefits for which they're eligible. The VLER will begin when an individual enters the service and will continue throughout the period of time he or she is in the service, into the veteran status, and throughout their life. It will contain health and administrative data, so the idea is this will be one single record, one single virtual electronic record which will track men and women throughout their life span of their service. VA and DOD, of course, have been working for years on this issue and recently have started to see some progress. As you know, electronic records are a priority of the administration. Secretary Shinseki intends to do more than talk about it, and he holds our department accountable to accomplish this task. Another important example of an area in which DOD and VA have accomplished joint activity, is the Disability Evaluation System, or the DES pilot. The DES pilot is a demonstration project initially, but then in the National capitol region, to resolve the confusing aspects of the existing system, and to shorten the overall time required to complete the process. The pilot is intended for those service members who are being medically separated or retired. The processing time for those currently enrolled in the pilot has been reduced by greater than 50 percent. Our business rule is that service members departing active duty will receive their VA disability benefit check the month after they leave active duty. The pilot is currently conducted at 14 sites, with plans to expand and enhance DES process to another six by August 31. DOD and VA will submit a report to Congress on the lessons learned from the pilot, along with the recommendations as

to the way ahead. As a result of what we've seen so far, VA and DOD would like to extend the policies and lessons learned from the pilot program to additional installations, taking this phased approach to wider implementation of the enhanced process. We'll help ensure success by making sure that we have the right processes in place. The VA's also very proud of the success of the joint DOD/VA Federal Recovery Care program. Dr. Karen Guice, the Executive Director of the FRC for VA, is here with me to share with you details about the successes of the FRC program. We also believe that the successes we have seen in these joint efforts, as well as others, I've listed in my written testimony, is the direct result of a structure that allowed us an open dialogue, encourage collaboration, and focused on results. We have not changed our level of support for the Senior Oversight Committee since it was started in May of 2007 and will continue to do so. As you're aware, the 2009 NDAA Section 726 requires that both departments write Congress on the way ahead for the SOC and the JEC, and we fully intend to work with DOD to submit a joint report. While we were pleased with the joint efforts and progress made, there's a good deal more to do. The VA is committed to providing support for our Nation's wounded warriors and veterans. And as such, we believe that continued partnership with DOD is critical. The comment was made earlier in the GAO testimony that working harmoniously is the way ahead, and we are working harmoniously. DOD and VA are hand in hand. And certainly there are issues that take one department's tack versus another. But overall, the cooperation has been great and will continue to be so. Thank you, Mr. Chairman and committee members, for the opportunity. And I look forward to answering any questions.

[Statement follows:]

Senator BEN NELSON. Thank you.

General Meurlin.

General MEURLIN. Chairman Nelson, Senator Graham, thank you for the opportunity to represent the Defense Department and the Office of Transition Care—Transition Policy and Care Coordination this afternoon. I would like to briefly mention a few major areas where my office is currently engaged. The Physical Disability Board of Review has been established and is up and running. Although we encountered some challenges getting the program started, we're currently making very good progress. We're in the process of reevaluating our approach in two areas and expect significant modifications to be announced in the near future. The first area pertains to the scope of the review. It is our current intention to review all findings of the Physical Evaluation Board, those fitting and unfitting conditions, along with the ratings assigned to those conditions. The second is the service specific DOD guidance that conflicts with the VA's Schedule for Rating Disabilities, the VASRD, will be disregarded, and the conditions and rating will be evaluated only with the VASRD in effect at the time the initial findings and determinations were made. We believe both of these changes are consistent with Congressional intent and understand making these changes as soon as possible is a matter of great concern to the Committee. The Recovery Care Coordination program is up and running, with the initial cadre of 31 recovery care coordi-

nators, or RCCs, deployed to 13 military sites. My staff is training an additional 100-plus Army AW2 advocates as RCCs using the standard DOD curriculum, which includes standard assessment tools and a comprehensive recovery plan for recovering service members assigned an RCC. The Navy, Marine Corps, and Air Force are assessing how many more RCCs will be needed to ensure our recovering service members are supported. We have issued interim recovery coordination program policy and the DOD instruction to establish uniform policy—uniform policy for the program implementation and deployment of RCCs and the development of a comprehensive recovery plan. Ongoing site visits, analysis of the standard assessment tools, and customer satisfaction surveys will allow us to evaluate the program, to assess the population served, and placement of additional RCCs. Recent discussions with the services indicate that they are on board with these requirements. The third thing I'd like to mention is the progress we've made in regards to the Disability Evaluation System pilot program. There will be a total of 21 sites participating in the program by June and anticipate starting an evaluation in the near future. The pilot is due to report to the SOC this coming August, and it's imperative to note, however, that the Disability Evaluation System pilot is not an end-all solution, but rather a bridge, with the ultimate goal being in integrating DOD and VA systems at logical nodes. Ultimately, it is time for a national dialogue on how America supports its wounded, ill, and injured. We need to break down more barriers to trust and transparency and shift away from a focus on paying entitlements to one of recovery, rehabilitation, transition, and making the service member a viable member of society. The Secretary of Defense put in place a voluntary program that provides the ability to expedite a service member through the Disability Evaluation System. The expedited DES process a special benefit for those service members who sustain catastrophic injuries or illnesses from combat or combat-related operations, as defined in the policy. The establishment of the policy supports the department's belief that there must be a special process for those members who sustain catastrophic disabilities while participating in combat or combat-related operations, in contrast with those disabled otherwise. We are excited about this program because it allows the early identification of a full range of benefits, compensation, and specialty care offered by the Department of Veterans Affairs. Finally, in the area of personnel pay, financial support, I'd like to bring your attention to the concept of caregiver compensation. The Center for Naval Analysis is completing a study of wounded warrior caregivers, identifying that mothers and spouses spend on average up to a year, and in severe cases, much longer, providing physical and emotional support to their recovering service members. The final report from the CNA will be published shortly. Based on CNA's preliminary findings which were released in December, the Department proposed legislation for fiscal year 2010 to provide catastrophically wounded service members with a special monthly compensation for their caregivers. The amount of the compensation would be based on the monthly income of a home health care aide and would continue until the catastrophically wounded service member transitions to Veterans Affairs. My bottom line is that America's families turned

over their loved ones to us. We're returning some of them wounded, ill, and injured. The service members and their families earned and deserve to have the best that we have to offer. Pledge to continue the work with your staff, the VA and Department of Labor and others, to make that happen. Thank you for this opportunity. I look forward to your questions.

[Statement follows:]

Senator BEN NELSON. Thank you, General. Admiral Timberlake?

**STATEMENT OF REAR ADMIRAL GREGORY A. TIMBERLAKE,
USN**

Admiral TIMBERLAKE. Senator Nelson, Senator Graham, thank you for this opportunity to address you on the status of our, by which I mean DOD and VA, efforts to achieve full interoperability between the electronic healthcare records and those departments by September of this year. Let me begin with some background on the DOD/VA Interagency Program Office, which had its genesis in the language of Section 1635, the National Defense Authorization Act of 2008, which mandated that DOD and VA achieve fully interoperable electronic health record capabilities by September 2009 and establish the IPO to oversee and help coordinate this effort. On April 17th of 2008, the VA and DOD officially formed the IPO. Within the VA, the IPO was set up to report to the Deputy Secretary. Within DOD, the IPO coordinates most of its activities through the Defense Human Resource Activity and the Office of the Under Secretary of Defense for Personnel and Readiness. The IPO receives strategic guidance from the Secretaries of the DOD and VA, as well as from the Joint Executive Council, which you've heard described earlier, the Health Executive Council for health-related data sharing, and the Benefits Executive Council for personnel and benefits data sharing. In the early months, the IPO was focused on the basics of acquiring office space, equipment, determining appropriate staffing levels, and beginning the process in advertising for personnel. Today, just under half of the permanent professional government staff have been hired. Standard operating procedures are in place, and a formal charter has been signed by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness, which specifies the scope of the IPO's oversight responsibilities and further clarifies the relationship of the IPO to the two departments. The current mission of our office is to provide management oversight of joint activities, to accelerate that exchange of the electronic healthcare information between the departments. In this capacity, the IPO's responsible for working with the departments on issues like supporting the definition of DOD and VA data-sharing requirements and showing that DOD and VA, schedules are coordinated for the technical execution of the initiatives, assisting in the coordination of funding considerations, and assisting on obtaining input and concurrence of the multiple stakeholders. Originally, we expected to focus our efforts on the electronic healthcare record systems and other healthcare data-sharing initiatives between DOD and VA. However, the scope was later expanded at the suggestion of the wounded, ill, and injured Senior Oversight Committee to include personnel and benefits electronic data-sharing as well. Responsibility

for development of their requirements and the execution of information technology solutions still remained with the respective DOD and VA organizations. Technical execution also remains in the appropriate departmental offices, using the Department's established statutory and regulatory processes for acquisition funding, management control, information sharing, and other execution actions, which are significantly different in each department. For the immediate term, the IPO has centered its energies on ensuring that by September of this year, the systems are in place to allow for that full interoperability of the electronic personnel health information required for clinical care between the DOD and VA. A key to that has been the adoption of a shared DOD and VA understanding of the meaning of the phrase "full interoperability". In our view, that phrase is best defined by the people who are using the systems day to day to deliver care. With this in mind, we turn to the DOD/VA Interagency Clinical Informatics Board, or referred to in the future as ICIB, which is composed of clinicians from both the DOD and VA. It is headed by the Deputy assistant Secretary of Defense for Clinical and Program Policy and the Chief Patient Care Services Officer of the Veterans Health Administration. This group was given the responsibility for identifying and prioritizing the types and format of electronic medical information which clinicians need in order to provide the highest levels of care. In July of '08, the ICIB delivered these recommendations to the IPO and the Health Executive Committee, information management, information technology, working group. The recommendations were subsequently approved at the HEC and then passed down to our DOD and VA information technology teams as they developed the tools and applications to put these requirements into operation. By leveraging these prior accomplishments, many prior accomplishments to the departments towards the development of interoperable bidirectional electronic health records, the IPO and the Department were able to formulate a plan to achieve full interoperability for clinical care by the September 2009 target date. As a part of this plan, VA's and DOD's ability to utilize well known interoperability systems, like the Federal Health Information Exchange and the Bidirectional Health Information Exchange, has been greatly expanded. At the same time, new systems have been added to the Data Repository/Health Data Repository, CHDR, to allow even more medical data to be transferred between your two departments. And new pilot programs, such as the DHI energy project, were developed. This pilot is now deployed and operational at a number of major military and VA medical centers across the country. Today, I'm pleased to report that I feel we are on target to achieve full interoperability of electronic health records for the delivery of clinical care by September 2009 as defined by the ICIB. But information technology is not static. As new systems for capturing, storing, archiving, and retrieving patient data are developed, we need to make sure that those systems are built in such a way that they allow the data to be fully shared between DOD, VA, and authorized private sector providers, such as our TRICARE network and the VA contract care network. As I've previously mentioned, on April 9, 2009, the President announced a new vision for how this would be achieved, centering on the development of a vir-

tual lifetime electronic record, which Mr. Dimsdale has already alluded to. This virtual lifetime record will leverage investments already made in the existing DOD and VA electronic record systems, as well as industry best practices, to provide a system that will network with new and legacy applications. Right now, we believe it will be based on a common services approach that focuses on the development of standardized software applications to provide links between healthcare and benefits databases across the two departments. Timing is still in the early stages, but the way ahead looks promising, and I personally would look forward to briefing you on the progress, our progress on meeting the President's new initiative in the future. Thank you, sir. That concludes my statement, and I look forward to your questions.

[Statement follows:]

Senator BEN NELSON. Thank you, Admiral. Dr. Guice?

STATEMENT OF KAREN S. GUICE, M.D., M.P.P., EXECUTIVE DIRECTOR FOR THE FEDERAL RECOVERY COORDINATION PROGRAM, DEPARTMENT OF VETERANS AFFAIRS

Dr. GUICE. Good afternoon, Chairman Nelson, Ranking Member Graham, and Senator Hagen, Lieutenant Colonel Gadson, Lieutenant Colonel Rivas, Mrs. Rivas, Dr. Noss, and Lieutenant Kinard. Your strength and perseverance is a standard for all of us. Sixteen months ago, the Federal Recovery Coordination program was created to address services and benefits coordination problems across two large, complex systems of care and benefits. The Federal Recovery Coordination program is a joint program of the DOD and VA, with the VA serving as its administrative home. It is designed to provide oversight and coordination for very seriously or catastrophically wounded, ill, or injured service members, veterans, and their families. To do so, the Federal Recovery Coordinator, or FRC, develops a customized individual recovery plan that is used to monitor and track the services, benefits, and resources needed to accomplish the identified goals. The goals were those of the service member or veteran with input from their family or a caregiver and members of the multidisciplinary team. The number and types of goals are related to the medical problems, the stage of recovery, and the holistic needs of the family and client. Developing goals is a methodical process that begins with evaluation. FRCs review the relevant records and discusses specific challenges with the various healthcare providers and case managers. This appropriation allows for a structured dialogue with the client in developing the plan. The FRC and the relevant case manager determine responsibility and the timeline for implementing the steps necessary to reach a goal. The FRC then monitors progress with the case manager and the client, providing support and additional resources to both until the goal is reached. FRCs frequently organize meetings with providers, case managers, and clients to make sure objectives and expectations are clear. The plan and the goals change as the client progresses through the stages of recovery, rehabilitation, and reintegration. The FRC provides a single consistent point of coordination throughout this progression. Accountability for the plan rests with the FRC. Today, 14 FRCs are located at six military treatment facilities and two VA medical centers. All have a clinical

background, with most being nurses or social workers. One is a vision rehabilitation specialist. All have prior experience in either the military or VA healthcare system. Collectively, they have over 200 years of professional experience, all at a Master's level, and many have advanced practice degrees. All have specialized knowledge in either one or more clinical areas. They frequently consult each other, bringing their collective knowledge and experience to bear for their clients. Currently, 257 clients are enrolled in the program. Seventy-five percent of these are still active duty. Generally, these clients are very seriously or catastrophically ill or injured and require a complex array of specialists, multiple interfacility transfers, and lengthy rehabilitation. Individuals are either referred to the program or identified by FRCs from daily census lists and during attendance at specialty team care meetings or downrange video conferences. On the back of our newly designed brochures is the new toll-free number to make it easier to refer potential clients or get additional information about the program. A description of the program is on the National Resource Directory's website and the VA's OIF website. The program has a strategy to reach out to those who went through the system prior to its inception and who might still benefit from a recovery plan and care coordination. Care coordination improves service integration among different delivery systems and eases transition from one system of care to another. It's not a band-aid or an indication of failing systems. Instead, it is another step in the evolution toward a fully integrated system where care and benefits are organized around the multiple needs of individuals across the care continuum. FRCs, in keeping with this concept, coordinate the delivery of services and resources for service members, veterans, and their families, in accordance with the goals identified in the plan. They work with military services, RCCs, TRICARE, VHA, VBA, other governmental resources, including state and local agencies, as well as the private sector. For those service members and veterans not enrolled in the program, there are a variety of other programs, services, and resources designed to meet their needs through the Departments of Defense and VA. I appreciate your input and collaboration as the program matures, and I particularly appreciate your support, and I look forward to your questions. Thank you.

[The prepared statement of Dr. Guice follows:]

Senator BEN NELSON. Thank you. You were all here and heard my comments about stove piping and the silo effect of agencies. Based on everything that you've heard thus far, the GAO report, are you all of the opinion that we're breaking that down here so we can have a fully integrated system to smooth the transition and have it for every step along the way, including every aspect of the service member's life, as well as his or her family's? Is that fair to say, that what might have been there in the past is not there today?

Ms. MCGINN. Senator Nelson, I think we have to be constantly vigilant because of the nature of our organizations. I do think in the last two years, watching the collaboration between DOD and VA, at the highest level, not at the patient care level, has been extraordinary, and I think one of the indications of that is the development of this Federal Recovery Coordinator, where the SOC de-

cided they wanted there to be one definitive person, and that person was decided that they would be administratively done by the Department of Veterans Affairs. I think that at our organizational high level, the co-location of the offices, the people that we have put in place in an acting capacity, building relationships, continuing to build relationships with the Department of Veterans Affairs office. And going forward, we not only have SOC issues that we work together on, but also JEC issues, which are the issues that cover all of the matters between the Department of Defense and Department of Veterans Affairs, and we need to strengthen those relationships. And the Department of Defense is leading forward to do that and avoid having the kinds of silos that we've had in the past. As I said in opening remarks, we never really had a senior executive dedicated to breaking down those silos before, in terms of collaboration with VA, and now we will, so I'm hopeful for that.

Senator BEN NELSON. Is that generally shared?

Mr. DIMSDALE. Sir, I would like to add my comments. It's not Kumbaya. Nothing is Kumbaya, but we talk daily. We sit side-by-side and work daily, and so the silos are breaking down. But there's a lot of work to continue. But I want to assure you that it's an ongoing effort, and we're doing everything we can to move the ball in the right direction.

Senator BEN NELSON. Are you in a position where if you run into a question of legal authorities, that you could bring back to us any kind of statutory change that might be necessary to further break it down or to establish this integrated system?

Mr. DIMSDALE. I believe so, sir.

General MEURLIN. Mr. Chairman, if I might even—

Senator BEN NELSON. Sure.

General MEURLIN. To bring it down a little—a lower level from what Ms. McGinn was talking about, we recently invited the Medical Director of the Richmond Polytrauma Unit VA to go over on a C-17—go over to Landstuhl, look at the operation there, collaborate with the DOD physicians at the receiving point from the AOR, and then come back in that operation. We're going to expand that program to the other VA Polytrauma Units. So we're planning those forces together, which I think will help out in easing the transition and acceptance of patients as they come back. Also yesterday at the SOC that was mentioned earlier in reviewing a way ahead for the DES system, the larger look at it, we saw both Deputy Secretaries, really, I think, in quite agreement and accord, which set a tone for the rest of the organization. So as Roger said, we have offices together in the palatial Hoffman Building down in the south end of Alexandria, and we're working together with staffs and mixing them. I think we're making great progress on that.

Senator BEN NELSON. You mentioned on the Federal Recovery Coordination program, that a decision was made as to which agency would probably be in the best position to administer this. Are you finding other areas where assigning one of the agencies the responsibility makes more sense than both agencies trying to coordinate work together on it, some other areas?

General MEURLIN. Well, sir, since Karen, Dr. Guice and I—Dr. Guice and I have been working quite closely and commiserating on

the two different bits of law, one that established the FRCs and then, later on, the NDAA that established the RCCs. Really pretty parallel programs. The question is, as we work through this, since they are so parallel, why not bring them both together? I think probably the initial intent was to have one program cover all notches, the FRCs or the ones that are most seriously injured and destined to depart from the Department of Defense and move into VA. But also, the Category 2, the middle level, that really are sort of up in the air whether they will progress medically to return to duty, or then depart. And so I think there's a lot of questions there. I know that was the number-one priority or the number-one recommendation of the Dole-Shalala Commission. It's one that I think we need to—we're making progress in that area. I think it's going to be absolutely significant to the success of the recovery and reintegration of our soldiers, sailors, airmen, and marines.

Senator BEN NELSON. Dr. Guice?

Dr. GUICE. I'd just agree with him.

Senator BEN NELSON. Other comments that you might want to make about this progress?

Ms. EMBREY. Sir, I think that the VA has long been a source of expertise for PTSD and for severe traumatic brain injuries within the Federal Government, and the DOD has learned from its expertise and has been partnering with them on a whole variety of protocols and standards and guidelines. And we believe so strongly that when we set up our Center of Excellence within the Department of Defense, we made our deputy for that center a VA employee who retains their employment with the VA to ensure close integration of the programs of care for both DOD and VA through that Center of Excellence.

Senator BEN NELSON. Well, if the military can have joint commands, it would seem to me the agencies can find a way to do some of this jointly as well, recognizing how important it is, but also how common it can be to have both agencies having similar responsibilities because of the needs. Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman. This has been a very informative hearing, I think. And to all who attended, thank you. This has helped the committee a lot, and we appreciate your time. And I think we are making progress. And I guess from the 30,000-foot view of things, number one, you get injured, I want to make sure that you get a fair evaluation as to whether or not you're fit for duty. Right, General? First thing is, can this service member, admiral, return back to service. Do you agree with that?

General MEURLIN. Absolutely.

Senator GRAHAM. Is that kind of a hope and dream of most people that are injured?

General MEURLIN. It is. Most people that are injured, the different hospitals and patients that I've visited with, that's their ultimate objective. Now, the question which was brought up in the first panel, is is that in their best interest, which is one that goes. And even in the expedited process, we made sure that it was a provision that even though if they're catastrophically wounded, hit that category, we expedite the DES process, and they leave the service, that if they do retain a level that they can come back, that we allow for that provision to petition to come back.

Senator GRAHAM. The only reason I mentioned that is the Colonel Gadsons of the world. There's no other time in American history that someone like him would be able to serve. So the one thing you want to do is to have a system that can capture people like him, but realize that a lot of these young men and women are going to have to move on to civilian life. All of them can't be integrated back into the military, so, one, let's not lose sight of that. One of the goals is to make sure that the Colonel Gadsons of the world and others have a chance to continue to serve. Now, once the decision's been made that you're not going to be able to go to stay on active duty, I think that the goal here, between the two of you all, is the same, is that when you leave DOD, I just want to make sure that when you go into the VA system, that whatever rehabilitative services you had as an active duty member, you're not lost because your status changes. But here's the real problem. Most of these services are provided by very—centers that are exceptional. The guard member, the reservist, or the person being discharged, may go back to a home area that's not nearly as robust as what Walter Reed provides. That is what Dr. Noss is trying to tell us. Let's make sure that—and you could go back to Allendale, South Carolina for the medical requirement, where you're a guardsman or reservist. I mean, there's just going to be limitations as to the rehabilitation services available to you. What I want to do is make sure that whatever is available, that it's available as soon as possible, and we think outside the box, because the goal is to reintegrate people in society. And to come up with—I don't know if it's a voucher plan. I don't know exactly what it is. But the moment you hit medical retirement, the moment you go back into the civilian community, whether you're a guardsman or a reservist or medical retired active duty person, you go to a rural area, we want to do as much far as you can, understanding there's limitations. And apparently, there are some areas of improvement there. The second problem is, General, you were talking about a report coming out in December, how the Nation can help care providers, family members who are going to provide care, income-wise. That is coming out in December. Is that right?

General MEURLIN. The preliminary study that CNA did, their preliminary results came out in December. The final results are going to be coming up very shortly.

Senator GRAHAM. And the final results will suggest to the Congress that we creative a revenue stream grater than we have today?

General MEURLIN. Yes, sir. What we're looking at is—and there's proposed legislation coming forward for compensation for caregivers, that will provide for a benefit for caregivers equal and approximate to what a caregiver commercially would be earning.

Senator GRAHAM. And that would last for how long?

General MEURLIN. As long as the individual requires.

Senator GRAHAM. Okay. Well, I think that is a great idea, because, you know, we focus on the wounded warrior and their family member. They have to drop most of their hopes and dreams. That's just the way it is, and we want to help them where we can. And, finally, Mr. Dimsdale, you were talking about standardized definitions. Mental health services available through the Department of

Defense should be the same as the Veterans Administration when somebody falls into these programs. Whatever rehabilitative services, whatever definitions we have, are we moving down the road to getting standardization?

Mr. DIMSDALE. Yes, sir, but it is not easy.

Senator GRAHAM. I know it would be hard.

Mr. DIMSDALE. This is anecdotal, but like 45 definitions we were working on, and I think we got agreement on about 35 out of the 45. There are policies, as far as benefits are concerned, based on the definitions. We are continuing to wicker this thing down, but we've got a ways to go.

Senator GRAHAM. But the category of somebody who's medically retired, not fit for duty, that, to me, is your first evaluation to make. Once that happens, what's the problem after that?

Mr. DIMSDALE. Well, I'll give you an example. When you asked the question, I was writing notes and trying to get some answers. And I'll give you an example. The definition of catastrophically injured entitles people to different things. So if we say—Senator GRAHAM. Based on what organization you're in, DOD versus VA?

Mr. DIMSDALE. As far as the determination of what is catastrophic? So Joe or Jane get injured, and we call them catastrophically injured. Well, one agency may say one thing. Another may say another. And what the individual gets based on the definitional acceptance.

Senator GRAHAM. Is there differences within the services, or just VA/DOD?

Mr. DIMSDALE. I cannot answer that, sir. I would have to get back—Senator GRAHAM. But you know that is a definitional problem?

Mr. DIMSDALE. Yes, sir.

Ms. EMBREY. My sense is that it's a difference between DOD and VA. The authorization and the way the defense health program is set out and the benefits and whether we have prime and basic and different other kinds.

Senator GRAHAM. You're on to the problem. Just kind of keep us informed. The more standardization, the easier it is for the case manager and the troops and their family to get through this thing. And I know it's hard, but like Senator Nelson said, we're joining everybody else. And it was hard. I never thought I'd be in an office. I went to—did some Reserve duty in Iraq, and there was a Coast Guard guy. That's the first guy I met, and said, "What the hell are you doing here?" But we had people from everywhere, every branch of the service guarding the service. And you couldn't tell the difference. This stuff does work. So thank you, Mr. Chairman.

Mr. DIMSDALE. Sir, let me do my homework, and we will get back to you for the record.

Senator GRAHAM. Sure. No, that's good.

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Mr. DIMSDALE. I don't want to send you a woof ticket. I want to get something straight.

Senator GRAHAM. I got you. Thank you for participating and serving our Nation.

Mr. DIMSDALE. Thank you.

Senator BEN NELSON. Thank you, Senator. Senator Hagan?

Senator HAGAN. Thank you, Mr. Chairman. I can understand how confusing this would be for the men and women in the service who obviously, once they're veterans, they've all been in the Department of Defense or the Reserves or the National Guard. And then it seems like they're in a different language and a different world going into the VA. So I think this Committee is excellent, and I certainly think it is time that we try to mesh the two in a seamless fashion. And, Dr. Guice, I think you were talking a little bit, too, about some of the case manager aspects, and I know that Lieutenant Colonel Kinard said that he had eight different case managers. So these pilot programs you're doing now, is that actually going to solve those issues?

Dr. GUICE. The term "case manager" is a fairly ubiquitous term and pretty generic. It is a term to describe any organization service delivery system. You have case managers in the legal system. You have case managers in public assistance programs. You have case managers in healthcare. In healthcare, case managers are usually aligned with a service line or a specialty, but they exist within a single facility; for example, in a hospital or in an outpatient unit of a hospital. They are very key in actually organizing the individual's care in that facility. When the individual moves to another facility—for example, if you're at Walter Reed and you go down to the Polytrauma Unit in Tampa, you would have another set of case managers similarly aligned because of your constellation of injuries. Having a care coordinator eases that transition somewhat so the care coordinator in the Federal Recovery Coordination program, for example, will stay with that service member and family when they transition over to the VA Polytrauma, and then when they transition back, and however many transitions they need to make through the medical system because of the way we specialized care in a variety of different places. So they can kind of help connect the dots for the individual, make sure that all the case managers are aware of any particular needs of that individual or family, and make sure it is as comfortable as it can be a transition. They are always difficult, but the coordination effort is part of making that better.

Senator HAGAN. Do we have enough personnel to do the care coordinated model?

Dr. GUICE. I believe we do. I think that's under continuous evaluation, in terms of it may change tomorrow, depending upon what happens. It's always something that we are constantly looking at, recalibrating, and adjusting.

Senator HAGAN. Great. And then this is sort of a follow-up on Senator Graham's question, but I really think that keeping our wounded warriors employed is critical, if they can be. Obviously, if it's a catastrophic injury, in many cases, they cannot. But I encourage the services to devise road maps to enable our wounded warriors with additional skill sets, with the transition into civilian life, or perhaps the services could utilize them in another capacity, keeping them on duty, and these wounded warriors, if they could be trained to serve as administrative personnel, be assigned as case managers, be assigned as mentors to other wounded warriors. But

I was just curious as to what are your thoughts on this, and is this being done?

General MEURLIN. It is. On the first point that Senator Graham mentioned on Lieutenant Colonel Gadson being retained in the service as a double entity. In the Air Force, we had a number of years ago the first amputee above the knee who's flying. He's a pilot with the 89th and back on flying status. So we've made a huge change in how we look at injuries. Part of the Recovery Care Coordination program, this is a group that's administered by DOD that does the care management that Dr. Guice was talking about, and developing the comprehensive recovery plan for the individual looks at where that individual wants to go, what his ultimate destination is, or hers, and then programs it along. We work with the Department of Labor. We work with the Veterans Administration. We work with the different—with the services to see how they can be retained if they want to or how they want to transition. There are a number of programs out there. We've been working with one in the very infant stages now of training people to work within the Civil Service, actually leading them and training them while they're in that recuperative time to ultimately be employable. So all of this, and this larger package gets taken care of or help coordinated by the Recovery Care Coordinator or the Federal Recovery Care Coordinator to facilitate that smooth transition.

Senator HAGAN. Thank you. Thank you, Mr. Chairman.

Senator BEN NELSON. Thank you, Senator. Thank you to all the panels for your candid and heartfelt testimony today. The journey has thus far been a long one, but we recognize that we're not at the conclusion of it yet. And even when we get to the conclusion, there will be a need to continue to work together to make certain that the integrated system continues to work forward. So thank you very much. And my regret to Senator Webb for not understanding, but I should have had him go before my lengthy opening statement. So we certainly would invite the good Senator to submit a written statement for the record.

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Senator BEN NELSON. The written testimony submitted by all witnesses today will be included in the record, without objection. Additionally, we received a statement from the Blind Veterans Association, and without objection. It too will be included in the record of this hearing.

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Senator BEN NELSON. This hearing is adjourned. Thank you.

[Whereupon, at 5:07 p.m., the hearing was adjourned.]