

Transition Report

Research Question 26: To what extent is the coordination between VA and DoD adequate to meet the needs of service members/veterans, particularly the need of service-connected disabled veterans?

Research Question 27: To what extent is the coordination for seriously injured and disabled service members/veterans adequate within VA between VHA and VBA and internally with each administration? What are the internal and external impediments, challenges, and gaps, and how might these barriers be overcome?

Research Question 28: To what extent is the coordination adequate within DOD between the Offices of the Secretary of Defense for Personnel and Readiness, Health Affairs and Force Management Policy, and the branches of Service? What are the internal and external impediments, challenges, and gaps and how might these barriers be overcome?

Research Question 29: To what extent do DoD and VA provide disabled members/veterans the means and the opportunity to succeed in their transition to civilian life? What are the adequacy, quality, and timeliness of the benefits provided by each agency?

Research Question 30: What policy and cultural shifts must be made to produce a common, shared, bi-directional data exchange between VA and DoD and within VA between VHA and VBA?

Research Question 31: To what extent are the training, education and outreach programs (of DoD, VA and DOL) adequate to ensure that the greatest number of active duty, Guard and Reserve personnel are informed of the full range of Federal government veterans benefits and services and provided the tools such as statement of education and military occupational specialties experiences adaptable to civilian job searches?

Issues:

There are several research questions before the Commission that have overarching implications for military service members as they transition to veteran status and the civilian sector. The following subjects are addressed jointly in a single paper in order to look at the policies and processes in place within the Departments of Defense (DoD), Veterans Affairs (VA), Labor (DOL), Health and Human Services (HHS), and the Social Security Administration (SSA) that effect military separation or retirement. Each of these entities plays a significant role in the readjustment of veterans and their families. Agency policies and procedures

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need to be efficient, effective, and well-coordinated internally and externally. Primarily, VA and DoD cooperation and communication are crucial for the successful transition of service members to veteran status, but as separate entities governed by two distinct statutory codes (DoD under title 10 United States Codes and VA under title 38 USC) and funding processes, true integration is very difficult. Transition strategic planning is one of the functions coordinated by the VA/DoD Joint Executive Council (JEC) and its supporting activities and task forces. These include Seamless Transition, Transition Assistance Program (TAP), Benefits Delivery at Discharge (BDD), information technology interoperability, joint ventures, sharing agreements and integrations, and health care delivery.

Other programs that specifically feed into seamless transition are those offered by the DoD Family Support Services, Military Severely Injured Programs, Tricare, Traumatic Servicemembers Group Life Insurance (TSGLI), and the Disability Evaluation System. At VA, the Medical Centers (including Compensation and Pension examiners), Regional Offices, and Vet Centers all have a role in transition. In assessing transition, these were the programs that appeared to have the foremost mission in reducing the risks of unsuccessful transition.

Background: Transition Risks:

Some of the best and the brightest serve in the Armed Forces of the United States. Recent recruits are more likely to have a high school diploma than those who do not join, and have scored in the upper half of standardized aptitude tests. These individuals are more likely to come from above average rather than lower income neighborhoods.¹ They enter career paths that demand intelligence, leadership, fortitude, courage, and conviction. They make great sacrifices in their personal comfort, family and community time, and earnings potential, while ready to risk life and limb for their country. They remain proud to serve, devoted and loyal to their comrades, corps, and flag. When they leave military service, they are recruited by Fortune 500 companies, educators, and the federal government. Those who understand the military structure and culture recognize their skills as leaders, managers, and effective employees. According to the National Leadership Index 2005, "Americans have significantly more confidence in military leaders than in leaders from any other sector of public life."²

¹ Russell Beland, Curtis Gilroy, *The Reality of Our All-Volunteer Military*. The Washington Post, November 25, 2006 p. A21

² Center for Public Leadership John F. Kennedy School of Government, Harvard University, *National Leadership Index 2005: A National Study of Confidence in Leadership*. Conducted by Yankelovich Inc. for US News and World Report. Cambridge, MA: 2005. p. 8.

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However, military separation or retirement is not without its pitfalls and engaging in such a major life change can be difficult for the most seasoned service member to say nothing of a disabled veteran. Therefore, carefully orchestrated transition services and programs are crucial for service members and their families and can be a determining factor between successful and unsuccessful transition. If transition and readjustment to civilian life are not properly facilitated or accomplished, the veteran may be at greater risk for homelessness, incarceration, unemployment, divorce, PTSD and other mental illnesses, substance abuse, and suicide. Limited information is available on the frequency of these problems among those recently separated from the military.

Homelessness

The extent of homelessness among veterans has been an issue for many years and there have been varied estimates of the number of homeless veterans. One recent estimate is that there are half-million homeless veterans in America with tens of thousands being Vietnam-era veterans and approximately 1,000 of the veterans returning from Iraq and Afghanistan having nowhere to go.³ In 2006, VA awarded 52 grants in 50 states, DC, and Puerto Rico totaling nearly \$11.6 million to programs assisting homeless veterans, which brings the number of community-based beds to more than 10,000.⁴ However, besides this being an inadequate number of beds, there are many other services that homeless veterans need. The level of care required is very involved and manpower intensive. A smooth transition from the military to civilian life that allows for relocation and employment planning and home loan assistance may reduce the risk of homelessness.

Incarceration

The most recently available information from the Department of Justice (DOJ) on incarcerated veterans is from a 2000 report. At that time, DOJ reported there were approximately 225,700 incarcerated veterans, which was a 46 percent increase over those held in 1985. 56,500 were Vietnam-era and 18,500 were Persian Gulf-era veterans. Twenty percent were reported as having seen combat. Over 12 percent had been homeless prior to their incarceration and 30 percent suffered from alcohol dependence, and 45 percent from drug addiction.⁵ (There is no available DOJ data for incarcerated OIF/OEF veterans at this time.) The reduction of VA inpatient capacity has been seen by the Veteran Service Organizations (VSO) community as a contributing factor to the number of

³ Libby Lewis. *An Evolving Government Approach to Homeless Veterans*. October 30, 2006 <http://www.npr.org/templates/story/story.php?storyId=6394180>. Accessed: October 30, 2006

⁴ VA Homepage. *Homeless Veterans Program Grants*. <http://www.va.gov/> Accessed: November 17, 2006.

⁵ Christopher Mumola. U.S. Department of Justice Bureau of Justice Statistics. *Veterans in Prison or Jail*. January 2000, NCJ 178888, Revised September 29, 2000. p.1

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homeless and incarcerated veterans in America. The American Legion documented their concerns in the Chicago area over the lack of [VA] mental health services. Thresholds Jail Program, a Chicago community-based organization that helps individuals transition from jail, reported that “as the Chicago VA hospitals closed their inpatient capabilities and have offered less aftercare, more veterans are ending up in the Cook County Correctional Facility.”⁶

Unemployment

Unemployment and under-employment have been encountered by veterans, particularly prior to WWII. In 1944, the GI Bill of Rights was designed to specifically stave off the influx of returning WWII GIs from flooding the unskilled work force by providing them with the resources to attend college and other training to create better opportunity for them in the marketplace in the long run.⁷ Since then, unemployment rates have fluctuated and veterans, like everyone else, are subject to economic vacillations. In the current market, Senator Craig noted that “the unemployment rate for all Americans is now 4.6 percent. Veterans are doing even better – their unemployment rate is 3.5 percent.”⁸ Additionally, OPM reported that veterans are holding 25 percent of all federal jobs.⁹

Yet, there are still concerns with the “lack of teeth” veterans’ preference has in the hiring process and in contracting. Furthermore, according to an AMVETS online study, 80 percent of all surveyed military veterans believe that more could be done to ensure a smoother transition to the civilian workforce. Thirty-eight percent of responding veterans in all age groups felt that they were underemployed with an additional two-thirds reporting difficulty accessing their disability benefits.¹⁰ AMVETS attributes this disconnect to the inability of transitioning service members and their families to identify and access the

⁶ Jacqueline Garrick, Deputy Director Health Care, The American Legion. *Mental Health, Substance Abuse, and Homelessness Programs* testimony before the House Veterans Affairs Committee, Subcommittee on Health. Washington, DC: June 20, 2001. p.3

⁷ *Findings and Recommendations: Veterans Benefits in the United States*. The President’s Commission on Veterans’ Pensions (“Bradley Commission”) Washington, DC: April 1956 p. 251.

⁸ The Honorable Larry Craig, (ID) Chairman Senate Committee on Veterans Affairs. *Strong Employment Numbers for Veterans*. Washington, DC, October 12, 2006.

⁹ Office of Personnel Management. *OPM Report Shows Veterans Continue Entering Federal Employment Ranks; Overall Gains Made by Veterans and Disabled Veteran*, Washington, DC: November 9, 2006. <http://www.opm.gov/news/opm-report-shows-veterans-continue-entering-federal-employment-ranks-overall-gains-made-by-veterans-and-disabled-veterans,1110.aspx> Accessed: November 28, 2006.

¹⁰ AMVETS. *80% of Veterans Say More Can be Done to Help Them Find Work After Completing their Military Service*. Chicago, IL: October 18, 2006.

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correct resources and to know how to translate their military skills and training into the civilian sector.¹¹

Veterans have had difficulty in translating their Military Occupational Specialty (MOS) to civilian certifications and licenses. For example, Army medics have had to re-qualify upon discharge for such professions as Emergency Medical Technician. In response to this difficulty, DoD created a website to provide access to the Verification of Military Experience and Training (VMET) document, which “provides descriptive summaries of the service members’ military work experience, training history, and language proficiencies” in addition to recommended college credits equivalent to military training and experiences.¹² Additionally, the Army created the Credentialing Opportunities On-Line (COOL) that “helps soldiers find civilian credentialing programs related to their MOS.”¹³ Navy COOL followed in 2006. These programs are good examples of services that assist service members with post-military employment. The Task Force on Returning Global War on Terror Heroes made several recommendations regarding improving employment awareness at job fairs, improving certification and credentialing opportunities for transitioning service members and spreading awareness regarding the Uniformed Services Employment and Reemployment Rights Act.¹⁴

Divorce

According to the National Center for PTSD, approximately 38 percent of Vietnam veterans’ marriages failed within six months after their return and their overall divorce rate is significantly higher than the general population along with more acts of family violence.¹⁵ With over 50 percent of today’s troops married, family issues are of greater importance. Many of these marriages are not surviving the stress of multiple deployments and long periods of separation. In 2004, the Army reported a spike of over 10,000 divorces or 6 percent among its troops,¹⁶ an

¹¹ AMVETS. *Voices for Action: A Focus on the Changing Needs of America’s Veterans*. National Symposium for the Needs of Young Veterans. Lanham, MD: November 9, 2006. p.21.

¹² The Honorable David S.C. Chu, Under Secretary of Defense for Personnel and Readiness, *DoD-VA Cooperation and Collaboration* before the U.S. Senate Committee on Veterans Affairs, Washington, DC, January 23, 2007. p.15.

¹³ *Ibid*, p. 16.

¹⁴ *The Task Force Report to the President: Returning Global War on Terror Heroes*. Washington, DC: April 19, 2007. p. 54-57.

¹⁵ Jennifer Price, Susan Stevens. *Partners of Veterans with PTSD: Caregiver Burden and Related problems*. National Center for PTSD Fact sheet.

http://www.ncptsd.va.gov/facts/specific/fs_partners_veterans.html Accessed: December 1, 2005.

¹⁶ Donna Miles, *Reducing the Military Divorce Rate*. American Forces Press Services June 13, 2005. <http://usmilitary.about.com/od/divorce/a/divorceprograms.htm>. Accessed: December 1, 2006.

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increase of 78 percent over 2003¹⁷. However, that rate dropped to about 2 percent after the Army began offering marriage support programs that included Deployment Cycle Support Programs, educations groups, Military OneSource information and referral clearinghouse, the Building Strong and Ready Families program, Battlemind Training, and a premarital program for single soldiers.¹⁸ The Navy and Marines have similar programs; the Air Force does not.

PTSD & Mental Health

Major contributing factors to the ill-adjustment of combat veterans are Posttraumatic Stress Disorder (PTSD), depression, anxiety, and substance abuse. According to Post-Deployment Health Assessments (PDHA) done by the Walter Reed Army Institute of Research, 15-17 percent of the OIF/OEF veterans have screened positive for PTSD, 20 percent for depression and 20-25 percent for alcohol abuse.¹⁹ Chronic and delayed PTSD is more difficult to treat and manage, which places an even greater demand for resources on the VA system, especially when co-morbid Traumatic Brain Injury (TBI) is involved.

The VA Office of the Inspector General found that among all service-connected disabled veterans, from FY 1999-2004 PTSD compensation rates grew by 79.5 percent. While veterans being compensated for PTSD represent only 8.7 percent of all compensation recipients, they receive 20.5 percent of all compensation payments.²⁰ In 2006, VA treated 345,713 veterans with PTSD, which was an increase of 27,099 over 2005. This included 34,000 OIF/OEF era veterans.²¹ As of FY2005, there were 244,876 veterans receiving compensation for PTSD.²²

If left unaddressed, PTSD and co-morbid disorders can have grave impacts on quality of life and even premature death. Unresolved, emotionally-charged issues can sometimes lead to suicide, homicide, or fatal accidents. Previous

¹⁷ Gregg Zoroya, Soldiers Divorce Rates Up Sharply, USA Today, June 6, 2005, http://www.usatoday.com/news/nation/2005-06-07-soldier-divorces_x.htm, Accessed: December 1, 2006.

¹⁸ Donna Miles, Army Divorce Rates Drop Significantly in 2005, American Forces Press Service. January 27, 2006. http://www.defenselink.mil/news/Jan2006/20060127_4034.html. Accessed: December 1, 2006.

¹⁹ Charles Hoge. *Mental Health, PTSD and Readjustment Issues* presented at the VA Update on Providing Care to a New Generation of Combat Veterans Symposium, Washington, DC: May 23, 2006.

²⁰ VA Office of the Inspector General. Review of State Variances on VA Disability Compensation Payments. Report No. 05-00765-137, Washington DC: May 19, 2005. p.vii.

²¹ The Honorable Gordon Mansfield, Deputy Secretary, Department of Veterans Affairs on *VA/DoD Cooperation and Collaboration* before the Senate Committee on Veterans' Affairs, Washington, DC: January 23, 2007.

²² Veterans Benefits Administration. *Annual Benefits Report: Fiscal Year 2005*. Washington, DC: September 2006. p.32

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DRAFT**

studies on Vietnam and Gulf War veterans have shown increased events of suicidal behavior and accidents over their peers. In 1999, IOM noted that increased mortality rates among Gulf War veterans attributed to accidents were similar to those of Vietnam veterans.²³ As of January 2007, "Since the 2003 invasion of Iraq, 96 troops have committed suicide in Iraq, according to the Department of Defense. Another 15 committed suicide in Afghanistan."²⁴

Transition Coordination

In order to minimize the risks associated with transition, VA, DoD, HHS, SSA, DOL and other entities, such as the VSO and state agencies have joined forces to assist with military separation and retirement. The primary responsibility for service member transition falls on DoD and VA. Even though there have been guidelines in place for VA/DoD health care resource sharing since July 1983 (38 U.S.C. §5011),²⁵ greater emphasis has been placed on sharing and transition since the inception of the Global War on Terrorism and the advent of the Joint Executive Council.

VA/DoD Joint Executive Council:

In 2003, Public Law 108-138 required that VA and DoD create a Joint Executive Council (JEC) to enhance coordination and resource sharing between the two organizations. JEC is co-chaired by the VA Deputy Secretary and the DoD Under Secretary for Personnel and Readiness. Reporting to the JEC are the Health Executive Council (HEC) and the Benefits Executive Council (BEC) that were created to ensure that resources and expertise are specifically directed to those crucial areas.²⁶ "The HEC is responsible for implementing a coordinated health care resource sharing program (between VA and DoD). The BEC is responsible for examining ways to expand and improve benefits information sharing, refining the process for records retrieval, and identifying procedures to improve the benefits claims process."²⁷ In the FY 2004 VA/DoD Annual Report,

²³ Lyla Hernandez, Jane Durch, Dan Blazer, Isabel Hoverman, Committee on Measuring the Health of Gulf War Veterans, Division of Health Promotion and Disease Prevention, Institute of Medicine, *Gulf War Veterans: Measuring Health*, Washington, DC: National Academy Press, 1991.

²⁴ Kimberly Hefling, *Military Creates Mental Health Hotline*, Associated Press. January 29, 2007. http://news.yahoo.com/s/ap/20070129/ap_on_he_me/troops_phoning_for_help&printer=1; ylt=Aukey0wZcW3bFqBgZ0k5Hhda24cA; ylu=X3oDMTA3MXN1bHE0BHNIYwN0bWE-. Accessed: January 30, 2007.

²⁵ *VA/DoD Joint Executive Council FY 2005 Annual Report*. Washington, DC: January 2006. p.B-1.

²⁶ VA Office of Policy, Planning, and Preparedness. *Issue Paper on VA/DoD Collaboration*. Washington, DC: August 11, 2006. p.1

²⁷ The Honorable David S.C. Chu, Under Secretary of Defense for Personnel and Readiness, *DoD-VA Cooperation and Collaboration* before the U.S. Senate Committee on Veterans Affairs, Washington, DC, January 23, 2007.

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DRAFT**

the JEC outlined a 2006-2008 strategic plan based on the guiding principles surrounding collaboration, stewardship, and leadership. In 2005, these goals, strategies, and performance measures were revised and published in an annual report. The main components of the strategic plan cover issues related to seamless transition, high quality health care, operational efficiencies, joint readiness, information technology interoperability, and other joint ventures and sharing agreements.

The need for a shared vision to overcome cultural barriers and for sustained leadership was previously recognized in other reports, such as those by the President's Task Force to Improve Health Care Delivery to Our Nation's Veterans (otherwise known as the PTF) in 2003, and the Congressional Commission on Servicemembers and Veterans Transition chaired by Anthony Principi (otherwise known as the Transition Commission) in 1999.

As part of the JEC, VA and DoD were authorized to establish a Joint Incentive Fund (JIF) held by the Treasury.²⁸ By the end of 2006, forty seven JIF projects accounting for \$88.8 million of the \$90 million in the fund had been approved by the HEC from a total of over 200 proposals.²⁹ This was a marked increase over the number of JIF projects that had been funded as of March 2006. At that time, Chairman Walsh, House Appropriations Committee, Subcommittee on Military Quality of Life and Veterans Affairs and Related Agencies, criticized VA and DoD for having only funded 33 projects in 15 states at a cost of \$58 million. He further noted that with both Departments having billions of health care dollars, the spending on sharing was a relatively low percentage.³⁰

The Congressional mandate for the JEC did not include other Departments, such as DOL, which is a major player in TAP and seamless transition. As service members move from being military personnel to the civilian sector job market, DOL provides briefings and job searches at military installations. When veterans return to their communities, they are entitled to special job services and placement opportunities along with veterans' preference that DOL handles at their local offices. Additionally, the Social Security Administration (SSA) grants Social Security Disability Insurance (SSDI) to severely injured active duty service members. Therefore, including DOL and SSA in the JEC may improve coordination even further.

²⁸ Public Law 107-772 § 721.

²⁹ The Honorable David S.C. Chu, Under Secretary of Defense for Personnel and Readiness, *DoD-VA Cooperation and Collaboration* before the U.S. Senate Committee on Veterans Affairs, Washington, DC, January 23, 2007.

³⁰ The Honorable James Walsh (R-NY) House Appropriations Committee, Subcommittee on Military Quality of Life and Veterans Affairs and Related Agencies remarks during a hearing on VA and DOD partnership concerning the Joint Initiative Fund (JIF), Washington, DC, March 28, 2006.

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DRAFT**

In reviewing the VA/DoD JEC FY 2005 Report, the Commission still has questions regarding immediacy, implementation plans, expansion to other facilities, and compatible capabilities that include inpatient records and imaging, funding and resource sharing, remaining obstacles, and projected milestones.

Seamless Transition

Seamless transition has become a familiar term in the VA/DoD lexicon and in the communities they serve, but a clear and consistent understanding of this concept has been elusive. Seamless transition has been defined by the JEC as “an approach to health care and benefits delivery whose goal is to ensure continuity of services through the coordination of benefits, with the intended result of improving the understanding of, and access to, the full continuum of benefits and services available to service members and veterans through each stage of life.”³¹ In essence, this means that a service member should be able to access VA health care and file for benefits prior to leaving active duty. The Commission saw positive examples of this during its site visit process when it met with an Army liaison at the Tampa VA Polytrauma Center and with BDD representatives at military bases and saw the integration taking place at Great Lakes. However, all too often this intention does not get transmitted to the field and severely injured veterans who have appeared before the Commission reported being denied access to VA health care while on leave because they were still on active duty, and did not have their DD 214³² yet. Others reported that they have had to wait months for disability compensation to be granted. To the veteran, who has to leave Tricare, submit a claim for disability compensation, enroll at a VA hospital, determine an eligibility priority group, and have a C&P exam, none of this seems seamless.³³

VA has created an Office of Seamless Transition with a director who reports to the Under Secretary for Health with a staff of coordinators and liaisons to work internally with VHA and VBA and externally with DoD’s active duty, National Guard and Reserves. This office is tasked with a huge responsibility and coordination is crucial. However, there are two major obstacles faced by this office. First, it is organizationally located within VHA, which requires extra effort to ensure collaboration and cooperation with VBA. Second, DoD, and other agencies, do not have similar single points of contact for transition. The PTF emphasized “the need to build organizational cultures and enduring leadership that support improved sharing and coordination of health care resources and

³¹ VA/DoD Joint Executive Council FY 2005 Annual Report. *Section 2.1-Seamless Transition*. Washington, DC: January 2006. P.2

³² Military discharge papers

³³ President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans. *Final Report 2003*. Arlington, VA: May 2003. p. 24

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services.”³⁴ For the Office of Seamless Transition to be successful, past barriers and territorialism need to be overcome.

There is also no counterpart to this office on the DoD side. Seamless transition is headed by the Deputy Director of Deployment Health Support Directorate and its functions are collateral duties and piecemealed within Health Affairs and Personnel and Readiness making internal communication and coordination difficult at times.

For military transition to be seamless the handoff between DoD and VA should not be as confusing and challenging as it is for the veteran or his/her family members. Severely injured service members, that the Commission has heard from admitted to being overwhelmed by the number of contacts and business cards they have collected. There is no single point of contact that coordinates all of their benefits and care. There are multiple case managers for DoD and VA programs, and often the veteran does not know who to contact to ask questions. For example, for a soldier with an amputation, there would typically be an Army Wounded Warrior Specialist, an amputee peer counselor, a Military OneSource contact, a Military Severely Injured Center representative, a social worker at Walter Reed and a different one at the local VA hospital, a VA voc rehab case manager, a VA benefits counselor, an OIF/OEF coordinator, and a DOL representative, not to mention a primary care provider and other specialists and therapists. There are also VSOs and other nonprofit organizations offering support and services. The Independent Review Group (IRG) found several problems with the DOD outpatient case management process, which included: an ill-defined process, differing treatment plans and medications, improper staffing to patient ratios, lack of centralized management of staff, lack of standards, qualifications and training of staff, unqualified contractors, and inconsistencies across the branches.³⁵ The Task Force on Returning Global War on Terror Heroes went a step further and identified that “there are no formal interagency agreements between DoD and VA to transfer case management responsibilities across the military services and VA” and recommended that a system of co-management be developed.³⁶ The identification of a lead-agent case manager by the Departments in this process would minimize confusion and alleviate the stress on transitioning service members and their families in tracking information and accessing services.

³⁴ Ibid. p.6

³⁵Independent Review Group on the Rehabilitative Care and Administration Processes at Walter Reed Army Medical Center and National naval Medical Center. *Rebuilding the Trust*. Arlington, VA: April 11, 2007. p.11-15.

³⁶ *The Task Force Report to the President: Returning Global War on Terror Heroes*. Washington, DC: April 19, 2007. p.20

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DRAFT**

The way in which transition functions are organized in each of the Departments leaves seamless transition as a varied priority for management, oversight, and information dissemination. Transition is not effectively set up to be seamless since counterparts are not easily identifiable, all of the players are not at the table (no DOL or SSA), and it has not consistently been given a high enough level of priority within the Departments.

Transition Assistance Program/Disabled (TAP/DTAP)

TAP/ DTAP classes are an important component of seamless transition and lead those intending to file claims for disability compensation to the BDD program. "TAP is offered at a critical juncture of the servicemembers' life at a time when he or she is getting ready to move from DoD jurisdiction to the jurisdiction of other departments and agencies, such as VA, DOL and the Small Business Administration."³⁷ Public Law 101-510 mandates DoD to offer TAP and DoD Instruction 1332.36 provides guidance to the branches. On implementation, Community Services or Family Support Centers are the lead entities within the branches. The Marine Corps is the only branch to mandate TAP classes. TAP is delivered in partnership by DOL and VA, which conduct the briefings at the military installations. DOL, under its Veterans' Employment and Training Services (VETS), has a lead role in the TAP process. DOL has operated the RealLifelines program for disabled veterans since 2004, and staffs offices at Military Treatment Facilities (MTFs) and within the Military Severely Injured Center.

TAP is offered to service members with between 180 days and 90 days of active duty service remaining. Classes provide information on employment and job searching, education options, counseling, and VA benefits. This information can also help service members know what their options are when a period of enlistment ends. It enables them to weigh their options for re-enlistment as a career choice against the civilian job sector market or schooling.

DTAP is provided to those who may have a service-connected disability or an illness or injury that was aggravated by service and can begin the Benefits Delivery at Discharge (BDD) process. At that time, applications for compensation, Vocational Rehabilitation and Education (VR&E), and health care can be made prior to the service member's discharge. Additionally, Social Security Disability Insurance (SSDI) can be awarded to severely injured service members even while they are still on active duty.

In FY 2005, 7,500 TAP/DTAP briefings were held for 310,000 service members and their families, which also included 119,000 National Guard members and

³⁷ Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance. Arlington, VA: January 14, 1999. p. 38.

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Reservists.³⁸ During FY 2005, 144,965 active duty service members were discharged.³⁹

The TAP process is the opportunity to prevent or deal with the transition risk issues previously identified, and provide veterans and their families with the information, support, and assistance that they will need as they plot a new course post-military service. Ongoing efforts are underway to make TAP more accessible to all separating military members, especially National Guard and Reserves, and to their families. There have been issues with mandating TAP/DTAP for all military personnel since DoD does not control all of the human or fiscal resources that support this activity. On September 19, 2006, a new memorandum of understand (MOU) was signed by DoD, VA, and DOL to redefine departmental roles and responsibilities for the TAP/DTAP, which should increase class availability.

Funding for TAP has remained fairly constant for the last decade with no increases for inflation. In FY 1997, the TAP allocation was \$40 million. The table below highlights the total FY 2007 allocation and the distribution by service branches.

TAP Allocations for FY 2007⁴⁰

Branch	Funding Percentage	Dollars (000)
Army	36%	\$13,287
Navy	28%	\$10,220
Marine Corps	11%	\$4,000
Air Force	25%	\$8,943
Total	100%	\$36,450

Benefits Delivery at Discharge

To expedite the claims process, VA and DoD jointly developed and implemented the Cooperative Separation Process/ Examination at Benefits Delivery at Discharge (BDD) sites. This initiative grew out of concerns for the growing backlog at the ROs as the number of pending claims increased from around 250,000 claims in 2003 to over 360,000 at the beginning of 2006.⁴¹ Veterans who do not file a claim through BDD, must then have their claims processed at a

³⁸ VA/DoD Joint Executive Council FY 2005 Annual Report. Washington, DC: January 2006. p.4

³⁹ Associated Press. *Numbers leaving the military goes up: drugs, parenthood among reasons.* www.Journalnow.com. January 16, 2006. (Accessed: March 29, 2007)

⁴⁰ LTC Applegate, Melissa, Military Personnel Policy, OUSD (P&R) (MPP)/COMP email transmission to Jacqueline Garrick, Veterans' Disability Benefits Commission on April 6, 2007. TAP funding as of March 11, 2007.

⁴¹ C&P Services, *Pending Workload FY 2003 through FY 2007*. Department of Veterans Affairs, Washington, DC: Accessed January 25, 2007

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DRAFT**

RO, which will increase their wait time for a decision because of the backlog. As of January 6, 2006, there were Memorandums of Understanding (MOU) at 111 BDD sites. However, in testimony before the Senate Veterans Affairs Committee on January 23, 2007, the VA Deputy Secretary reported that BDD has expanded to 140 locations while the backlog has grown to almost 400,000 pending claims. VA handles all BDD claims at two locations: Salt Lake City, UT and Winston Salem, NC Regional Offices (RO). The purpose of the BDD is to allow service members to file VA claims prior to separation. The MOU requires DoD to transmit pertinent medical information to VA in order to eliminate delays and errors and unburden the service members.⁴² For FY 2006, 40,600 transitioning service members went through the BDD process to file original compensation claims.⁴³ For a service member to go through the BDD process, they must have an established date of discharge and be within 180 days from that date. Those on medical hold or on the Temporarily Disabled Retired List (TDRL) are often precluded from entering BDD because they do not have established discharge dates.

AMVETS has noted several issues with BDD. They recommend addressing issues surrounding a lack of integration or mandate for BDD policy, and a lack of collaboration between VA and DoD. AMVETS believes that BDD is understaffed, and is not currently codified, funded, mandated, standardized or flexible, and does not account for branch requirements.⁴⁴ A suggestion made during the Commission site visit to Florida was for an electronic DD214 to be sent by DoD to VA to expedite this process.

During its site visits, the Commission heard conflicting reports on BDD. For example, in Florida, there were concerns with having to send cases out of the state to the North Carolina RO for ratings, which might increase veteran's confusion and impede follow up. At the Boston RO, they were relieved to not have the added workload. Additionally, veterans at town hall meetings and on panels reported varied experiences in the field with BDD and reported inconsistency in assistance between VA and DoD. Anecdotally, most veterans were satisfied with the expeditious turn around in receiving VA awards; however others who had been found unfit for duty and separated from the service reported that they were denied VA compensation and attributed it to the BDD process being too rushed.

⁴² VA/DoD Joint Executive Council FY 2005 Annual Report. *Section 2.1-Seamless Transition*. Washington, DC: January 2006. P. 4.

⁴³ Department of Veterans Affairs FY 2006 Annual Performance and Accountability Report. Washington, DC: November 15, 2006. p. 1-2. <http://www.va.gov/budget/report/PartI.pdf>. Accessed: November 22, 2006.

⁴⁴ AMVETS. *Voices for Action: A Focus on the Changing Needs of America's Veterans*. National Symposium for the Needs of Young Veterans. Lanham, MD: November 9, 2006. p. 3-5.

Beyond the BDD process, VBA needs to address the backlog. The steady increase in pending claims at the ROs is unacceptable for veterans waiting on an initial claim or for an appeal to be processed. This delay puts some veterans at risk for the complications of an unsuccessful transition. VBA must improve its process by streamlining operations, reallocating staff, and better forecasting its operational/budgetary needs.

Information Technology (IT) Interoperability

Information technology interoperability is the cornerstone for successful transition between the Departments. It is the key ingredient to fostering communication, collaboration, coordination, and cooperation between the Departments. The PTF described such a system that would “flow easily across all components of care, geographic sites and discrete patient care incidents while protecting privacy and confidentiality...and would provide VA and DoD with insights about diseases or illnesses that could result from exposure to occupational hazards during military service and assist in epidemiological research.”⁴⁵ In order to achieve this level of functionality, VA and DoD have developed a Joint Electronic Health Records Interoperability (JEHRI) plan, which incorporates a series of separate initiatives for the DoD AHLTA and VA VistA information systems. This plan is overseen at the HEC level. Integrated Information Sharing Goal #4 in the JEC FY 2006 Annual Report states, “VA and DoD will utilize interoperable enterprise architectures and data management strategies to support timely and accurate delivery of benefits and services. The emphasis will be on working together to store, manage, and share data and streamline applications and procedures to make access to services and benefits easier, faster, and more secure.”⁴⁶

The JEHRI plan has included the development of the Federal Health Information Exchange (FHIE), which is a one-way transfer of military health data from DoD to VA’s Computerized Patient Record System (CPRS). Since 2002, 3.6 million patient records have been transferred and 2 million of these veterans have received care from VA. “The Compensation and Pension Records Initiative (CAPRI) electronic health records, including FHIE categories are available to VBA employees at 57 Regional Offices. Access to CAPRI helped accelerate the adjudication of compensation and pension benefit claims.”⁴⁷ Building on the FHIE capability, DoD transferred data for VA patients being treated in DoD facilities under local sharing agreements. As of September 2006, 1.8 million data transmissions have taken place.⁴⁸ In 2004, following the success of FHIE and building upon it, VA and DoD developed the Bidirectional Health Information

⁴⁵ President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans. *Final Report 2003*. Arlington, VA: May 2003. p.7.

⁴⁶ VA/DoD Joint Executive Council FY 2006 Annual Report. Washington, DC: January 2007. P. A-21.

⁴⁷ VA/DoD Joint Executive Council FY 2005 Annual Report. Washington, DC: January 2006. p. 12

⁴⁸ VA/DoD Joint Executive Council FY 2006 Annual Report. Washington, DC: January 2007. p. 17

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THE COMMISSION.
DRAFT**

Exchange (BHIE), which expanded access to patient information including pharmacy data, pathology/surgical reports, laboratory, radiology (no images) and other test results and allergy information. As of February 2006, VA is able to access data from nine military treatment facilities (MTF) (Madigan, Beaumont, Eisenhower, Great Lakes, San Diego, Nellis, Walter Reed, Dewitt, Bethesda, and O'Callaghan) and these MTFs can access VA records. This technology also allows for the transfer of pre- and post deployment health assessments, and as of March 2006, DoD transferred 475,000 assessments on 248,900 separated service members.⁴⁹

Continued expansion of bidirectional capabilities known as the Clinical Data Repository/Health Data Repository (CHDR) will be a bridge between the new DoD AHLTA system and VA's VistA system. Additionally, Laboratory Data Sharing and Interoperability (LDSI) software will continue to leverage the Departments' abilities to work together and create standardization across systems that ensure patient safety. However, at this time, AHLTA cannot transfer inpatient discharge summaries or radiological images to VistA without them first being scanned. VA and DoD plan to share patient encounters, clinical notes, problem lists, and theater data no later than December 2007.⁵⁰

DoD extended FHIE capabilities to include Pre- and Post-Deployment Health Assessments (PPDHA) for transitioning service members and demobilized Reservists and Guardsmen. As of September 2006, over 1.4 million PPDHAs on 604,000 individuals have been transferred. A historical data extraction was completed, and DoD will continue to transfer these assessments on a weekly basis once a referral to VA from a provider is recorded.⁵¹ Other military personnel data sharing plans are in process.⁵²

This level of interdepartmental cooperation has also given VA and DoD lead roles as co-chairs for the Department of Health and Human Services (HHS) Consolidated Health Informatics (CHI) initiative. When implemented, this initiative will allow all appropriate Federal health agencies to share data and information while protecting privacy and reducing medical errors as part of a Federal Health Architecture system. CHI also will connect to the Office of the National Coordinator for Health information Technology (ONCHIT) created by an Executive Order from President Bush.

⁴⁹ VA/DoD Joint Executive Council FY 2005 Annual Report. Washington, DC: January 2006 p.9.

⁵⁰ Cliff Freedman, VA/DoD Health Information Technology Sharing Program. Department of Veterans Affairs. *VA DoD Electronic Health Information Sharing* briefing before the Veterans' Disability Benefits Commission, Washington, DC: May 9, 2007

⁵¹ VA/DoD Joint Executive Council FY 2006 Annual Report. Washington, DC: January 2007. p. 17

⁵² Ibid. p.22

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

Initially, concerns over the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (PL 104-191) restrictions on sharing medical information were an issue for DoD and VA patient information exchanges. However, after review by the Departments, HIPAA is no longer considered a barrier to the Departments' ability to share information.

On January 24, 2007, VA and DoD announced an agreement to create a joint inpatient electronic health record. The purpose of this joint system will be to make inpatient medical records instantly accessible to clinicians in both Departments. VA clinicians will have immediate access to their patients' military health records, allowing doctors and others to make faster and better treatment decisions.

The April 2007 Task Force Report on the Returning Global War on Terror Heroes encouraged the Departments to expand their IT initiatives and enhance electronic health records for OIF/OEF veterans, improve patient tracking between systems and to track TBI patients, combat veterans, and poly-trauma patients. The Task Force also recommended that VA improve its electronic enrollment capabilities and to use DoD's Military Service Information as part of VA's enrollment process.⁵³ Furthermore, the report calls for VA to improve its IT interoperability with the Department of Health and Human Services (HHS) and Indian Health Service (IHS).⁵⁴

Paper Records

In spite of efforts to move VA and DoD to be totally electronic record systems, that goal is far from being realized and paper records will be in use well into the future. The DoD AHLTA system has only recently come on line and it will take time for those whose records are in a paper format to retire or separate from service, and for those records to transfer to VA. DoD also cannot transfer inpatient discharge summaries or images, and is looking at a 5 year time frame to implement that capability. This leaves huge gaps for service members seeking VA benefits. During its site visits, the Commission heard numerous accounts from veterans and VA employees regarding unassociated, lost, or missing personnel or medical record information. At the St. Louis Records Management Center visited by the Commission, there are reams of unidentifiable and unmatched records. These missing documents can have a grievous affect on a veteran's ability to document a claim for service connection. A joint VA/DoD task force has been established to address this situation, but resolution can take years while some veterans' claims cannot be documented.

⁵³ *The Task Force Report to the President: Returning Global War on Terror Heroes*. Washington, DC: April 19, 2007. p. 29-36.

⁵⁴ *Ibid.* p. 48

Other Joint Ventures, Sharing Agreements, and Integrations

According to the JEC Annual Report, Health Care Resource Sharing is a term used to describe a wide spectrum of collaboration between VA and DoD that includes: general and specialized patient care, education and training, research, and health care administration. VA and DoD coordinated health services through direct sharing agreements, Tricare contracts, joint contracting for pharmaceuticals and medical/surgical supplies, information technology collaboration, and joint facilities.⁵⁵ In FY 2006, each Department made available \$9 million for resource sharing⁵⁶ (from their combined \$50 billion healthcare budgets.) There are examples of these initiatives throughout the country. The initiatives most familiar to the Commission are the ones it saw during its site visits. In Florida, the Commission met with the Army Community Based Health Care Organization (CBHCO) allowing injured or ill Guardsmen and Reservists while still on active duty to receive treatment at VA or private sector facilities so that they can be closer to home. The VA rehabilitation center in Georgia cares for the active duty in addition to veterans. In Illinois, the team visited the Great Lakes Federal Healthcare Facility where VA and the Navy are now managing a single facility. In Texas, the VA/DoD Joint Incentive Fund is providing resources for a new primary care clinic. San Antonio is the site of the Intrepid Rehabilitation Center. The building of the center was funded by the private sector, but will require VA/DoD sharing to go a step further to figure out how to fund its future operations.

There are dozens of these projects underway and many more on the horizon. Many of these initiatives are locally driven and are done without “interference” by the Departments. Local managers see this as the best way to get things done. They want authority delegated to the field, and the freedom to negotiate MOUs, sharing agreements, and joint ventures as independently as possible. Standardization and guidance from the Departments can be an issue. These ventures maximize resource utilization, increase market penetration, and enhance buying power for all entities involved. However, it sometimes requires a change in leadership, cultural norms and bureaucratic processes to allow such a sea change to take place. The PTF found the main barriers to facility collaboration were: lack of a stable business environment; no standard process for submitting proposals; no local incentives for collaboration; and no process to address agreement risk.⁵⁷ In reviewing the JEC Annual Report, it is unclear if these barriers have been fully addressed.

⁵⁵ Ibid. p.24

⁵⁶ VA/DoD Joint Executive Council FY 2006 Annual Report. Washington, DC: January 2007. p.30

⁵⁷ President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans. *Final Report 2003*. Arlington, VA: May 2003. p. 46

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

The Transition Commission and the PTF both recommended that VA and DoD develop a joint formulary to take advantage of their economies of scale and increase their purchasing power. GAO also saw several advantages for the Departments and their beneficiaries in creating a joint national formulary. Additionally, the PTF went on to conclude that “establishing a uniform formulary would likely minimize problems for veterans in transition between DoD and VA.”⁵⁸ This would also be an advantage in continuity of care for beneficiaries who access care at multiple locations.⁵⁹ However, at this time, no joint formulary exists although there are joint contracting efforts for purchasing pharmaceuticals.

Family Support Services:

The Office of the Under Secretary of Defense for Personnel and Readiness ensures that family issues are overseen by the Military Community and Family Policy Office. This office includes the Quality of Life office and provides for family support policies and programs in such areas as family center operations, child care, youth programs, family advocacy, relocation, transition support services, and support during mobilization and deployment (including casualty affairs).⁶⁰ These functions are carried out at the local level by Community Services (i.e. Army Community Services) and the Family Centers (i.e. Airmen and Family Readiness Center), which provide a great deal of support, assistance, and training for the family members of the active duty, Guard, and Reserves. These family support programs include such services as job placements, parenting classes, Family Readiness Groups, post-deployment, and reunion and reintegration briefings. Behavioral Health (which falls under DoD Health Affairs and the Medical Commands) operates the Family Advocacy Program (FAP) and intercedes in cases of domestic violence and child abuse. As noted previously, many of these programs were instituted after a spike in divorce rates was noticed by the branches in 2004 and have been very successful at keeping families intact in spite of the continued stress of deployments. But vigilance in this area is vital as troops continue to experience multiple deployments.

Adequate funding and oversight of family programs can best protect the military family and the stability of the service member, which has been seen as a component in military retention. During the Commission site visits to Hanscom Air Force Base, these types of DoD family services and quality of life programs were seen as having a value-added benefit to service members when they are at a point where they can re-enlist or separate from the service and should be given consideration prior to transitioning as well.

⁵⁸ Ibid p. 49

⁵⁹ Ibid.

⁶⁰ Under Secretary of Defense Personnel and Readiness. Military Community and Family Policy <http://www.dod.mil/prhome/mcfpmission.html>. Accessed: November 20, 2006.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

DoD has a broad acceptance of the importance of family, which not only includes spouses and children, but also parents, siblings, extended family, and other significant partners. This broad definition comes into play when support is being provided to next of kin or survivors. DoD can provide significant financial assistance, travel, and housing near MTFs for these families.

A huge disconnect takes place when the service member leaves active duty and transfers to VA. Under title 38 USC, VA has no statutory authority to treat or assist veterans' family members, other than in some very limited capacities. There is no VA office that mirrors DoD's Military Community and Family Policy Office. There are no special programs or projects designed for the spouses, children, parents or siblings of disabled veterans. They do not have the travel and per diem benefits available from VA as they do when the injured service member recuperates while on active duty. Family support, which is often identified by DoD as a main component in successful transition, is something VA is not authorized to provide.

During site visits, the Commission had briefings from Casualty Affairs Casualty Officers (CACO). Casualty Affairs is often an emotionally difficult task that is a collateral duty for a member of the decedent's unit. The CACO is often responsible for ensuring that the survivor(s) needs are being met and that they have all of the information regarding their VA and DoD benefits. They also make referrals to the Vet Centers or to the Tragedy Assistance Program for Survivors (TAPS) for peer support counseling. Training for the CACOs is crucial and their ability to network with VA and TAPS can be vital for grieving families.

Military Severely Injured:

As troops began being medevaced from Iraq and Afghanistan with complex and multiple injuries, DoD's Medical Commands needed to provide an efficient and effective response. Body armor, an improved evacuation system, and coagulants are allowing an estimated 90 percent of the troops to survive battle wounds, particularly blast injuries from Improvised Explosive Devices (IED). Serious injuries primarily center on amputation, traumatic brain injury, visual/hearing impairment, burns, other life-threatening conditions, and PTSD. However, the branches do not use the same definition of severely injured, so the reported level of injury and the eligibility for services may vary.

The Office of the Under Secretary of Defense for Personnel and Readiness oversees the Military Severely Injured Center (MSIC), which opened February 1, 2005. It supplements and supports the branch programs: Army Wounded Warrior, Navy Safe Harbor, Marines4Life, and Air Force Palace Heart, which all began at different times. The MSIC has been described as an "upside umbrella" for the severely injured and tension exists between the Center and the branches

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

since its existence implies that these service members were falling through the cracks. However, the branch programs provide a first line response and services to the needs of combat and other severely injured service members; the Center then responds to unmet needs and overall program and policy issues. The MSIC and the branch programs link injured service members and their families to: medical care and rehabilitation; education, training and job placement; personal mobility equipment; home, transportation and workplace accommodations; personal, couple and family issues counseling; and financial resources in order to return to duty or to integrate back to their home communities.⁶¹ The Center also has an MOU with The American Legion to operate the Heroes to Hometowns program that helps the severely injured transition back to communities throughout the nation.

When personnel from the Center testified before the Commission, they reported that as of March 2006, 2,064 of the OIF/OEF severely injured were being assisted by its case managers and advocates. The Army program reported assisting 909, the Marines 424, the Navy 165, and the Air Force 63.⁶² The extent of overlap between the MSIC and the branches is unknown. DoD provided a 2006 end of year update on these contacts and reported that the Army had increased its workload to 1,450, the Marines assisted 1,595 (from the inception of its program), the Navy had 102 cases, (a decrease), and the Air Force increased its caseload to 120.⁶³ The challenge with this data is that the branches each use their own definition of "severely injured" and calculate totals differently. There is no common database that tracks information on the military severely injured. The branches can each report their own performance data, but DoD cannot. Therefore, it is difficult to compare information or draw conclusions on overall program successes. There is also limited opportunity to identify lessons learned that could be shared across the branches or to develop strategic plans that target funding more effectively, which could be accomplished by the MSIC.

Furthermore, according to DoD over 11,365 troops have been wounded (not returned to duty) in Iraq and Afghanistan.⁶⁴ For FY 2005, over 23,000 were in the Medical and Physical Evaluation Board (MEB/PEB) process, which had grown

⁶¹ Military Home Front. Military Severely Injured Center. http://www.militaryhomefront.dod.mil/portal/page/itc/MHF/MHF_HOME_1?section_id=20.40.500.393.0.0.0.0.0. Accessed: November 20, 2006.

⁶² Military Severely Injured Center and Branch Program Panel before the Veterans' Disability Benefits Commission, Arlington, VA: March 17, 2006.

⁶³ Military Severely Injured Workload data for 2006 was obtained via emails from LTC Melissa Applegate, Assistant Director, Military Compensation, Personnel and Readiness transmitted to Jacqueline Garrick, Senior Policy Analyst, Veterans' Disability Benefits Commission, December 28, 2006 for Army, Marines, and Navy data and January 2, 2007 for Air Force data.

⁶⁴ Defenselink OIF/OEF U.S. Casualty Status As of May 17, 2007. <http://www.defenselink.mil/news/casualty.pdf>

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

from 15,000 in 2001.⁶⁵ According to VA, over 6,700 of the OIF/OEF severely injured have transferred from MTFs to VA Medical Centers (VAMC).⁶⁶ It is undeterminable how many of these service members meet the assistance criteria for the MSIC or branch programs. The inconsistencies in these statistics raise questions whether all injured or ill service members and their families are being assisted by these programs. In order to better understand the successes of the MSIC and the branch programs, a single definition for disability and severely injured is needed, and overall DoD accountability is necessary.

The Center also oversees the Military OneSource program, which is Internet and telephone based services that provide information and referral to active duty service members, Guard/Reserve, retirees and their families. According to DoD, Military OneSource averages 202,000 contacts a month. The website experiences 9.2 million hits and they counsel 51,000⁶⁷ (of the 9.2 million) beneficiaries. The cost of Military OneSource ranges from about \$9 to as much as \$20 per capita depending on the kind of service being provided to the Service member and or family member.⁶⁸ During its site visits, the Commission heard different opinions on the usefulness of Military OneSource, which ranged from seeing it as interference with local ability to track and refer cases, to it being of assistance when services, such as translators were needed to communicate with family members. Since these services are contracted, some DoD personnel saw the advantage to having those dollars spent on local military resources and activities as a better alternative.

SIMS Pilot Study

Additionally, the Commission has followed the activities of the Severely Injured Marines and Sailors (SIMS) Pilot Program through briefings and regular attendance at SIMS monthly meetings. The Assistant Secretary for the Navy Manpower and Reserve Affairs authorized the pilot program to determine if there were gaps in the Navy's support of injured sailors/Marines and their families, and if changes to internal and external policies are warranted. "The purpose of SIMS is to accelerate the retirement dates of the severely injured Marines/sailors who are unlikely to return to duty within 12 months of injury and enhance the compensation and benefits they are entitled to receive in order to reduce

⁶⁵ GAO. *Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members*. (GAO-06-362) Washington, DC March 2006. p. 11

⁶⁶ The Honorable Gordon Mansfield, Deputy Secretary, Department of Veterans Affairs on *VA/DoD Cooperation and Collaboration* before the Senate Committee on Veterans' Affairs, Washington, DC: January 23, 2007.

⁶⁷ LTC Melissa Applegate, Military Personnel Policy, OUSD (P&R) (MPP)/COMP email transmission to Jacqueline Garrick, Veterans' Disability Benefits Commission on April 27, 2007.

⁶⁸ LTC Melissa Applegate, Military Personnel Policy, OUSD (P&R) (MPP)/COMP email transmission to Jacqueline Garrick, Veterans' Disability Benefits Commission on June 18, 2007.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

economic stressors on the family, to reduce uncertainty and fear about the future and to increase the focus on getting better.”⁶⁹ The pilot program will study the outcomes of 25 severely injured individuals. The program identified the complexities and confusion of DoD, VA, DOL, and SSA benefit systems as key issues. A solution has been to improve coordination between these agencies, which has been achieved for the test subjects by the convening of an Interagency Working Group that is composed of over 50 agency representatives.⁷⁰

In summation, SIMS found that the use of VA Memo Ratings to get severely injured a VA rating prior to separation and the use of the Temporary Disability Retired List (TDRL) status are useful techniques to get benefits quicker. With the help of an interagency working group and the Armed Forces Services Corp, SIMS was able to provide the injured and their families with computations and statements from the various agencies on their estimated benefits, so that they had hard dollar figures to work with in preparing for the future.

Among the SIMS study findings and recommendations were:

- A comprehensive patient tracking system is needed across agencies
- A master case management component is critical that coordinates all case management activities
- Comprehensive treatment plans need to be developed before a patient is discharged that clearly delineates procedures, medications and responsibilities.
- An electronic health record is imperative. The patch between AHLTA and Vista is several years in the making.
- Information on SSDI and its availability to injured service members while they are still on active duty must be disseminated. (This provision of SSDI is not well-known and service members do not know to apply.)
- Further study is needed on Tricare. There is also a cost to the 100% retired disabled who are transferred under Tricare for Life to Medicare after 2 years and have to pay the \$100 per month premium that their contemporaries do not have to pay.
- There needs to be a review of the Invitational Travel Orders (ITO)/ Non-medical attendants under the Joint Federal Travel Regulations to return them to the MTFs for follow up care.
- Recommend a review of the combat stress control program and the lessons learned from OIF/OEF be applied.
- Track TBI patients for present and future symptoms.

⁶⁹ Severely Injured Marines and Sailors Pilot Study (SIMS) *Interim Report*, August 2006 p.1

⁷⁰ *Ibid*, p. 2

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

- There needs to be a comprehensive process to ensure families are provided services and support
- SIMS has supported legislation to allow prorated payments of retirement for severely injured whose service was interrupted by injury.
- Durable power of attorney should be executed by all deploying service members and 3 ITO persons be designated
- Severely injured service members should be able to receive support in the form of “gifts” from VSOs and other non-profits, such as Segs4Vets under certain circumstances and a task force be convened on this issue and a new ethics opinion rendered.
- Use the relationship VA already has with the states to transmit DoD information, especially in relation to PTSD and TBI treatment, and employment.
- Adaptive Housing grants change in law was endorsed to allowed injured service members to use this benefit more than once.
- OPM was asked to change its veteran’s preference regulation to allow active duty to use this status with a disability determination.
- Amend the Family and Medical Leave Act (FMLA) to include parents of injured troops over the age of 18.
- Pursue the Vets-to-Vocations (V2V) concept that would allow rehabilitating severely injured to attend Navy and Marine schools to obtain certification and training in higher demanded occupation that translate more readily in the civilian sector than did their military occupational specialty.⁷¹

TSGLI:

Traumatic Service members’ Group Life Insurance (TSGLI) is a traumatic injury protection rider under Servicemembers’ Group Life Insurance (SGLI) that provides a lump sum payment to any member of the uniformed services covered by SGLI who sustains a traumatic injury that results in certain severe losses. TSGLI coverage will pay a benefit between \$25,000 and \$100,000 depending on the severity of the loss directly resulting from the traumatic injury. Every member who has SGLI also has TSGLI effective December 1, 2005. There is a 44 item list of disabilities and the respective payment amounts on the VA website.⁷²

To be eligible for payment of TSGLI, a service member must meet all of the following requirements:

⁷¹ Severely Injured Marines and Sailors (SIMS) Pilot Program Final Report, Prepared for the Secretary of the Navy, April 10, 2007.

⁷² Department of Veterans Affairs. Traumatic Injury Protection Under Servicemembers' Group Life Insurance (TSGLI) Schedule of Payments for Traumatic Losses Accessed: January 23, 2006 <http://www.insurance.va.gov/sgliSite/TSGLI/TSGLI.htm>

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

- Insured by SGLI.
- Incur a scheduled loss and that loss must be a direct result of a traumatic injury.
- Must have suffered the traumatic injury prior to midnight of the day that they separate from the uniformed services.
- Must suffer a scheduled loss within 365 days of the traumatic injury.
- Must survive for a period of not less than seven full days from the date of the traumatic injury. (*The 7-day period begins on the date and time of the traumatic injury, as measured by Zulu [Greenwich Meridian] time and ends 168 full hours later*).

Congress directed that TSGLI would be retroactive to October 7, 2001, for members who incur a qualifying loss as a direct result of injuries incurred on or after October 7, 2001, through and including November 30, 2005, in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF). For the purposes of TSGLI only, “incurred in Operation Enduring Freedom or Operation Iraqi Freedom” means that the member must have been deployed outside the United States (OCONUS) on orders in support of OEF or OIF or serving in a geographic location that qualified the service member for the Combat Zone Tax Exclusion under the Internal Revenue Service Code. This retroactive directive does not apply to those injured elsewhere. However, all service members injured after December 1, 2005, who and have not opted out of SGLI, are eligible for coverage based on the established criteria outlined above.

A consideration brought before the Commission was regarding the difference in benefit between OIF/OEF disabled service members and non-deployed service members during the retroactive benefit eligibility time frame. There were also troops in harms way in other operations (i.e. covert or peacekeeping) around the globe who could also be eligible for TSGLI. At this time, there is proposed legislation in both the House and Senate to provide coverage to everyone injured since October 7, 2001.

Additionally, the Commission heard a great deal of testimony from the VSOs regarding lump sum payments in lieu of on-going monthly disability compensation. One concern that the VSOs expressed was that veterans would “squander” a lump sum payment.⁷³ Although a significantly different benefit package than TSGLI, the concerns the VSO voiced regarding how a lump sum payment would be spent by disabled veterans might be applicable to those receiving a TSGLI lump sum payment.

⁷³ Joseph Violante, National Legislative Director, Disabled American Veterans statement on *Lump Sum Analysis* before the Veterans Disability Benefits Commission, Washington, DC: October 19, 2006. p.8.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

The Commission heard from veterans and their families that some of this money has been spent on extravagant products, but it is also a necessary supplement to health care coverage and family support. When the Commission inquired about TSGLI spending patterns, there was no data available. It would be useful to evaluate the effectiveness of TSGLI in achieving its intended outcomes and determine if there are gaps in their other benefit packages. It would also seem advisable for VA and DoD to offer financial counseling to these veterans and their families in order to teach financial management principles and investment practices.

Additionally, during the Commission's deliberations regarding the Apportionment and Garnishment issue, it voted to tentatively "*Recommend that VA disability benefits (including TSGLI), except VA compensation benefits received in lieu of military retired pay, should not be considered in state-court proceedings on spousal support.*" Although this issue was not discussed initially as a Transition issue that vote has implications for the Commission's overall position regarding TSGLI, therefore is noted here as well.

Health Care:

Although the delivery of health care was not a primary focus of this Commission, issues regarding various aspects of the way in which transitioning service members access health care entered into many of the public comment sessions and meetings held with VA and DoD staff. Furthermore, defining and assessing disability compensation and the processes by which DoD and VA make those determinations, have been pivotal points for the Commission. The Commission is aware that VA and DoD have a combined healthcare budget of \$51.5 billion, 1,982 care sites, 333,000 staff, and 16.9 million beneficiaries (not unique users).⁷⁴ With this many national resources at stake, certain aspects of VA and DoD healthcare policies and delivery procedures warrant the attention of this Commission.

At its open public meetings, the Commission heard testimony from VA and DoD expert witnesses on the programs and operating procedures in place to facilitate evaluating the needs and providing benefits to disabled service members, veterans, and their families. It also heard testimony from VSOs and veterans during public comment sessions and on panels to discuss health-related issues. During its site visits, the Commission visited Centers for Poly-Trauma, Blindness, Spinal Cord Injury, Burns, Amputee Care, Traumatic Brain Injury (TBI), and PTSD. The Commissioners also met with VHA and QTC C&P examiners and

⁷⁴ Data was compiled from the DoD AHLTA Briefing provided to the Veterans' Disability Benefits Commission on November 17, 2006, and from VA's *Organizational Briefing Book*, May 2006 and the VA *FY 2006 Performance and Accountability Report*.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

with DoD DES branch board members. The discussion in this section will begin with DoD Health Affairs, and will include Tricare and DES as issues and then will examine VHA and its ability to conduct C&P exams and provide services in specialty areas.

Women's Health

The Commission is specifically concerned with women's health issues. As of 2004, women comprised 15 percent of the active duty armed forces and were 6 percent of the veteran population.⁷⁵ However, DoD projects the number of women in the military to increase at greater rate than men, especially among African American women. VA projects women veterans will be 10 percent of its patient population by 2020.⁷⁶ Women veterans tend to be younger, on average, than their male counterparts and are more likely to have served during later war periods,⁷⁷ which means they are seeking health care at younger ages. The top three diagnostic categories VA treated female veterans for in 2004 were hypertension, depression, and hyperlipidemia.⁷⁸

Additionally, VA has created a few inpatient programs to specifically deal with Military Sexual Assault (MSA) and PTSD, and Vet Centers employ MSA counselors. Several epidemiological studies suggest that women are likely to develop PTSD at a greater rate than males, even though males are more likely to be exposed to traumatic events.⁷⁹ IOM noted that combat exposure was an even greater precipitant to the development of PTSD and "women veterans were nine times more likely to develop PTSD if they had a history of MSA".⁸⁰ With an increasing number of women serving in Iraq and Afghanistan, their chances of being exposed to combat, witness death, be assaulted, or wounded are also growing and can lead to life-long aftereffects. Research studies, diagnostic tools, and interventions, which are predominantly designed for a male cohort, need to be designed to account for the unique experiences of women veterans to ensure a more seamless transition from military to civilian life for them as well.

The Defense Advisory Committee on Women in the Services (DACOWITS) and the VA Center for Women Veterans have each followed the issues pertinent to women whether it be related to physical/emotional trauma, family and child care, gynecological health and pregnancy, educational and career opportunities or

⁷⁵ Robert Klein, Office of the Actuary, Office of Policy, Planning and Preparedness, *Women Veterans: Past, Present and Future*. Department of Veterans Affairs, Washington, DC: May 2005. p.7-8

⁷⁶ *Ibid.* p.9.

⁷⁷ *Ibid.*

⁷⁸ *Ibid.* p.23

⁷⁹ Edna Foa, Terence Keane, Matthew Friedman. *Effective Treatments for PTSD*. The Guilford Press, New York, 2000, p. 20.

⁸⁰ Institute of Medicine. *Posttraumatic Stress Disorder: Diagnosis and Assessment*. The National Academies Press, Washington, DC: 2006, p. 39-41.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

disability compensation. These issues are complex and the Commission supports efforts to ensure equality in the treatment of our nations' women in uniform, and her veterans.

DoD Health Affairs

The mission of DoD Health Affairs is "to provide, and to maintain readiness to provide, healthcare services and support to members of the Armed Forces during military operations. In addition, the Department's healthcare mission provides healthcare services and support to members of the Armed Forces, their family members, and others entitled to DoD healthcare. The Assistant Secretary of Defense for Health Affairs (ASD/HA), is the principal staff assistant and advisor to the Secretary and Deputy Secretary of Defense and the Under Secretary of Defense for Personnel and Readiness for all DoD health policies, programs, and activities."⁸¹ The military health system is comprised of 70 MTFs, over 800 clinics and the Tricare network. There are 9.2 million beneficiaries, and a \$20 billion budget.⁸² A full discussion of DoD Health Affairs would be too broad a discussion for this paper, therefore comments will be limited to areas of concern for the Commission, which are directly associated with the issue of transition.

Tricare

Tricare is the DoD health care coverage program for active duty and retired uniformed services and their families. Tricare brings together the health care resources of the Army, Navy, Air Force, and Coast Guard with a network of civilian health care professionals. Tricare consists of:

- Tricare Prime, a managed care option;
- Tricare Extra, a preferred provider option;
- Tricare Standard, a fee-for-service option.
- Tricare For Life, a Medicare-eligible beneficiary's option.⁸³

Tricare Prime offers less out-of-pocket cost than any other Tricare plan. Active duty members and their families do not pay enrollment fees, annual deductibles or co-payments for care in the Tricare network. Retired service members pay an annual enrollment fee of \$230 for an individual or \$460 for a family, and minimal co-pays apply for care in the Tricare network. Tricare Prime enrollees receive most of their care from military providers or from civilian providers who belong to the Tricare Prime network. All referrals for specialty care must be arranged by the primary care manager to avoid point-of-service charges.

⁸¹ Health Affairs Organization. Responsibilities and Functions. <http://www.ha.osd.mil/about/default.cfm> Accessed: November 22, 2006.

⁸² Tricare Management Activity, *AHLTA Briefing and Demonstration* before the Veterans' Disability Benefits Commission, Falls Church, VA, November 17, 2006.

⁸³ Tricare Beneficiaries <http://tricare.osd.mil/mhshome.aspx> Accessed: November 14, 2006

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

Tricare Extra or Standard do not have annual enrollment fees. Beneficiaries are responsible for annual deductibles and cost-shares. Beneficiaries may see any Tricare authorized provider they choose, and the government will share the cost after deductibles.

Tricare Standard is a fee-for-service option with availability of an authorized Tricare provider. This flexibility means care costs more. Tricare Extra cost share after deductibles is 15 percent for active duty families and 20 percent for retirees and their families. Tricare Standard cost share after deductibles is 20 percent for active duty families and 25 percent for retirees and their families; non-participating providers may also “balance bill” up to 15 percent above Tricare allowable charges.⁸⁴

Tricare divides the states into 3 regions and the 4th region is OCONUS. Each of the regions are covered by different insurance contractors, which does little to foster collaboration and cooperation between the regions since these contracts come up for bid every few years and are competitive. When a service member retires and stays with Tricare, this lack of cooperation can make re-locating to other regions difficult, especially in rural areas where the Tricare network is limited and there are no MTFs.

In areas where Tricare has MTFs and an extensive network, access and quality is not as much of an issue. However in locations where that is not the case, its beneficiaries feel the gaps in Tricare. In the course of its open public meetings, site visits, and through emails, the Commission heard various complaints regarding Tricare. First, many wounded soldiers who have returned from Iraq or Afghanistan have had to pay the costs associated with Tricare as outlined above for their combat-related wounds, which has been described as “adding insult to injury.” Additionally, the provider networks are often limited and in remote or rural areas where this can mean difficulty finding a provider who will accept Tricare patients and is competent in dealing with military-related health issues. There are also serious concerns within The Military Coalition with DoD proposals to cost shift more of the financial burden to the beneficiaries through higher premiums, which are already seen as prohibitive by medically retired lower enlisted. In March 2006, the Senate Armed Services Subcommittee on Personnel held two hearings on the *Defensive Health Program Initiatives to Control Costs*, but no further action has been taken as of this date to change the fee structures.

As previously noted, the SIMS study has also raised concerns regarding Tricare and suggested it needed further study because of the costs to injured retirees.

⁸⁴ Ibid

DoD Disability Evaluation System

The Disability Evaluation System (DES) is the process by which each of the military branches determines whether or not a service member is fit to perform the duties of his/her office, grade, rank, or rating because of disease or injury.⁸⁵ The process begins with a Medical Evaluation Board (MEB) that reviews the service member's impairment and makes a fitness for duty determination. If the service member is not returned to duty, the process continues with a Physical Evaluation Board (PEB). The PEB convenes with a 3-member board (one or 2 medical officers and one or 2 line officers) who will decide if the service member can perform his/her military duty, and if not, determines a level of disability using the VA Schedule for Rating Disabilities (VASRD). The DES process is governed under 10 USC Chapter 61 and by DoD Instruction 1332.39.⁸⁶ The Army, Navy/Marines, and Air Force each have their own directives governing the application of the DoD instruction and convene MEB/PEBs that are different, based on the needs of the branch. The Commission heard criticism regarding inconsistencies in these ratings between VA, the branches and among the Guard and Reserve and is assessing the consistency of ratings between VA and DoD.

In March 2006, the Government Accountability Office (GAO) reported on the DES and found that the Army, Navy/Marines, and Air Force's policies and procedures for disability evaluations and determinations are different. GAO attributed these dissimilarities to the lack of DoD direct implementation of its policies and guidelines. According to the GAO, "DoD has explicitly given the services the responsibility to set up their own processes for certain aspects of the Disability Evaluation System."⁸⁷ This freedom has led to the independent and somewhat different interpretation and application of the DES in each of the service branches.⁸⁸ Although DoD is providing guidance to help promote consistent, efficient, and timely disability decisions for both the active duty and Reservists' disability cases, it is not monitoring compliance, accountability, effectiveness, or accuracy in the decision-making process. There is no DoD-wide database, and this prevents standardization among the branches.

GAO found that there were serious problems and inconsistencies in the electronic data and the actual date that a report was filed by a doctor and the

⁸⁵ Noel Howard. *DoD DES Exam Process*. Presentation to the Veterans Disability Benefits Commission, Washington, DC: June 21, 2006.

⁸⁶ Ibid.

⁸⁷ GAO. *Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for the Reserve and Active Duty Service Members*, (GAO/HRD-06-362). Washington, DC. March 2006, page 1.

⁸⁸ GAO report on *Military Disability System* for a detailed description of the Medical and Physical Evaluation Boards stages of the disability process.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

addenda. GAO attributed this disparity to the lack of systematic training and oversight by DoD, and an inadequate system for adding additional information from medical tests to the narrative summary.

This also has implications in the development of a VA/DoD medical data sharing system since it precludes the determination of accurate, useful, medical data, which would be required for expeditious and objective disability decisions. The inaccuracies of the DoD data also raises concerns over disability information sharing with VA since both Departments' disability compensation evaluation systems still need significant and relevant modifications (as indicated by multiple GAO reports).⁸⁹ For example, in the March 2006 GAO study, an assessment of the disability processing time could not be conducted because the data in the Army's electronic databases needed to calculate processing time for both reserve and active duty members were deemed unreliable.⁹⁰ This is just one of the problems of the entire disability assessment and compensation decision-making process. If DoD information technology cannot effectively communicate internally, how is it to export electronic information accurately to VA?

According to presentations to the Commission on the DES, DoD has established policies that require a systematic and accurate disability decision-making process, which includes the standard use of the VASRD for the assessment of the severity or percentage of disability. However, each branch then applies the policies differently.

GAO also found that disability ratings for Reservists with comparable injuries or illness to those of the active duty were not the same, and that the level of compensation was less. Reservists were less likely to receive disability benefits similar to the ones received by active duty members with the same disability. The reasons why these disparities were found are not clear because of limited and unreliable information that impedes an assessment of this issue.

There were several observations and recommendations that came from the March 2006 GAO report that could be further explored and implemented to improve the DES:

⁸⁹ GAO. *{Veteran's Disability Benefits: VA Should Improve its Management of Individual Unemployability Benefits by Strengthening Criteria, Guidance, and Procedures}*, GAO, 06-309 (Washington, D.C.: May 2006). See GAO. *Veterans Benefits: VA Needs Plan for Assessing Consistency of Decisions*, GAO-05-99 (Washington, D.C.: Nov. 19, 2004) and GAO. *VA Disability Benefits: Routine Monitoring of Disability Decisions Could Improve Consistency*, GAO-06-120T (Washington, D.C.: Oct. 20, 2005).}

⁹⁰ GAO. *Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for the Reserve and Active Duty Service Members*, (GAO/HRD-06-362). Washington, DC. March 2006, page 1.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

- 1) Council meetings: DoD periodically convenes a Disability Advisory Council (DAC) comprised of branch officials to review and update disability policy and discuss current issues. However, neither DoD nor the branches systematically analyze the consistency of decision making. The time and effort put forth in these council meetings produces limited results because the branches are unwilling to change policies. However, if they were better aligned, a more objective analysis of the DES could be conducted. GAO indicated that, "such an analysis of data should be one key component of quality assurance."⁹¹ GAO further noted, "DoD is not collecting available information on disability evaluation processing time from the services to determine compliance, nor are they ensuring these data are reliable."⁹² Consequently, inefficiencies and errors in data collection, such as missing information and the inaccuracy of data entered need to be corrected. Therefore, GAO concluded that increasing DAC meetings in frequency and duration would allow DoD to correct some of the limitations in the current DES. This would require having personnel from all parties involved (DoD, the branches, and VA) in the DES working as fulltime members on the DAC.

- 2) Misinformation of functions and responsibilities: Internal communication and understanding is a significant concern. GAO stated, "Despite a regulation requiring DoD's Office of Health Affairs to develop relevant training for disability staff, DoD is not exercising oversight over training for staff in the disability system."⁹³ The Office of Health Affairs indicated that "They were unaware that they had the responsibility to develop a training program."⁹⁴ In addition, this issue is heighten by the high turnover rate of military disability evaluation staff, plus the branches do not have a comprehensive or well developed plan to ensure that all staff are properly trained. A clearer delineation of responsibility and communication of duties for each DoD office is required to eliminate any confusion in these areas.

- 3) DoD lack of oversight and consistent guidance: There is a heightened concern with the consistency of the DES across the branches. For example, lack of oversight of military DES only adds to the inconsistency and differential experience between branches, and also between active duty members and Reservists. Furthermore, during GAO interviews, military officials at some DES sites noted that in some cases the current time processing goals were unrealistic. Consequently, an assessment of the realistic time lines for processing disability cases needs to be carefully

⁹¹ Ibid. p 3.

⁹² Ibid.

⁹³ Ibid. p 4.

⁹⁴ Ibid. p 22.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

reevaluated. There is a need to increase DoD involvement in the development of training programs for all branches' disability processing personnel. More specifically, the Office of Health Affairs needs to take charge of this function by developing, implementing, and evaluating training for all the branches.

Based on these findings, GAO made five recommendations:

- 1) Require the Army, Navy, and Air Force to take action to ensure that data needed to assess consistency and timeliness of military disability ratings and benefit decisions are reliable.
- 2) Require the branches to track and regularly report these data including comparisons of processing times, ratings, and benefit decisions for Reservists and active duty members to the Under Secretary of Personnel and Readiness and the Surgeons General.
- 3) Determine if ratings and benefit decisions are consistent and timely across the branches and between Reservists and active duty members and institute improvements to address any deficiencies that might be found.
- 4) Evaluate the appropriateness of current timeliness goals for the disability process and make any necessary changes and take appropriate actions.
- 5) Assess the adequacy of training for MEB and PEB disability evaluation examiners.⁹⁵

An issue relevant to the coordination between DoD and VA is the application of the VASRD. According to the GAO report, "to encourage consistent decision making DoD requires all services to use multiple reviews to evaluate disability cases. Furthermore, federal law requires that reviewers use a standardized disability rating system to classify the severity of the medical impairment."⁹⁶ Therefore, DoD is required to use the VASRD when rating disability. Nevertheless, "each of the services administers its own disability evaluation system and assigns a standardized severity rating from 0 to 100 percent, to each disability condition, which along with years of service and other factors, determines compensation."⁹⁷ However, "despite this policy guidance and the presence of the disability council, DoD and the three service branches lack quality assurance mechanisms to ensure that decisions are consistent."⁹⁸ Furthermore, each military branch has developed its own instruction on how to use the VASRD.⁹⁹

⁹⁵ Ibid. p. 27-28

⁹⁶ Ibid. p. 1.

⁹⁷ Ibid. page 1.

⁹⁸ Ibid. page 19.

⁹⁹ See, DoD Instruction 1332.39, Air Force Instruction 36-3212, Army Regulation 635-40, and Navy SECNAVIST 1850.4D.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

DoD and VA need to assess the differences in the application of the VASRD. The 1999 report from the Transition Commission documented that “the two systems apply different standards because they make determinations for different purposes.”¹⁰⁰ The report went on to recommend that, “a combined DoD/VA Disability Evaluation Rating Board would avoid redundancy.”¹⁰¹ This coordination of efforts could make sure that both military service members and veterans are receiving a consistent disability rating and compensation as well. At the SIMS meetings, it has been suggested that this process could include SSA for SSDI determinations as well.

The Commission contracted with the Center for Naval Analyses (CNA) to analyze disability ratings by DoD during the period of 2000-2006 and compare ratings with those of VA for the same individual. Overall, CNA found that only 19 percent of those rated by DoD are in the 30-100 percent range. The percentage rated 30 percent or higher ranges from 13 percent for the Army to 36 percent for the Navy.

The Army data contained 13,646 records (27%) out of the total of 50,676 soldiers who were found unfit for duty, yet assigned zero percent ratings. Navy, Marine Corps, and Air Force assigned zero percent ratings to about 400 individuals or less each. When CNA matched the Army zero percent ratings with VA records, the average VA rating was 56 percent for those with 20 or more years of service and 28 percent for those receiving severance.

The service branches are required to rate the condition or conditions that makes the service member unfit for duty. VA rates all conditions found as service connected. For those rated by both agencies, DoD rated only one condition 83 percent of the time. For cases in which DoD rated one condition, VA rated an average of 3.7 conditions.

There are significant variances between DoD ratings and VA ratings. Inconsistency in ratings between VA and DoD can largely be explained by two factors. First, DoD only rates the disability or disabilities that DoD determines makes the service member unfit. Second, DoD does not use the VA Rating Schedule in the same way that VA does. Variance in ratings among the Services and between VA and the Services can also be partially explained by the differences in mission between the branches and the disability determination standards they set. It is also apparent that DoD has strong incentive to assign

¹⁰⁰ Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance. Arlington, VA: January 14, 1999. p.139.

¹⁰¹ Ibid.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

ratings less than 30 percent so that only separation pay is required and pensions and continuing family health care are not provided.

GAO found that DoD does not directly implement its own policies and guidelines, nor does it maintain accountability or monitor compliance over the DES, largely because it delegates to the services and does not require them to report back. Also, there is no standard database that tracks disabled service members. GAO also found that there is no consistency in MEB/PEB training, or in the use of counselors.

In a 2002 RAND report, recommendations were also made for training tailored to each level of personnel involved with the DES with an emphasis on the creation of a Web-based training program that complemented traditional classroom style training programs.¹⁰² Furthermore, the Commission notes that if there were an extension of VA training programs to include DoD DES personnel, it could greatly reduce the variability in application between the Departments and across the branches. This could be done by having VA, DoD, and the branches coordinate efforts to develop standardized training.

DoD should address the revisions recommended by GAO reports, the RAND study, and other sources in order to improve its DES. These corrections to the DES need to take place in order to subsequently develop a medical data sharing system, which may better serve disabled service members.

Furthermore, in April 2007, the Independent Review Group (IRG) supported the findings of several GAO studies and the President's Task Force, and observed that "there are serious difficulties in administering the Physical Disability Evaluation System (PDES) due to a significant variance in policy and guidelines within the military health system. There is much disparity among the Services in the application of the PDES that stems from ambiguous interpretation and implementation of a Byzantine and complex disability process."¹⁰³ The IRG concluded that titles 10 and 38 should be amended to allow "the fitness for duty determination to be adjudicated by DoD and the disability rating be adjudicated by VA,"¹⁰⁴ and that the Departments should implement the single physical exam process as described by GAO.¹⁰⁵ The IRG also recommended that the Disability Advisory Council be expanded.

¹⁰² RAND. *Methods and actions for improving performance of the Department of Defense Disability Evaluation System*, (ISBN 0-8330-3010-8). Arlington, VA. 2002. p. 85-89.

¹⁰³ Independent Review Group on the Rehabilitative Care and Administration Processes at Walter Reed Army Medical Center and National naval Medical Center. *Rebuilding the Trust*. Arlington, VA: April 11, 2007. p.28.

¹⁰⁴ Ibid. p.30.

¹⁰⁵ Ibid. p. 34

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

In addition, the Task Force on Returning Global War on Terror Heroes also recommended that “VA and Do D develop a joint process for disability determinations.”¹⁰⁶ The task force described a similar process by which the Departments would cooperate in assigning a disability evaluation that would be used to determine fitness for retention, level of military retirement, and VA compensation that could be undertaken as an expansion of the BDD process for all MEB/PEB service members.¹⁰⁷

The Commission has observed that there are some obstacles to overcome to improve DES determinations for injured or ill service members and to better facilitate their transition to VA. These observations are as follows:

1. Congress should mandate DoD oversight of the DES. There should be consistency in disability determinations and use of the VASRD among the VA and the branches to include the Guard and Reserves.
2. There should be a comprehensive VA/DoD data sharing system. Disability compensation and medical evaluation procedures still need significant and relevant modifications and re-structuring as indicated by other reports.¹⁰⁸ This needs to go beyond the current AHLTA/VistA levels of interoperability.
3. In order to have an effective data sharing system between DoD and VA, both agencies need to update their current data processing and disability evaluation systems. If GAO recommendations to DoD and prior recommendations made by RAND, and other GAO recommendations to VA on their evaluation procedures and systems were implemented, services to disabled veterans could be vastly enhanced.
4. The IRG, GWOT Heroes Task Force, GAO, RAND, the PTF, and the Transition Commission have all made recommendations for the implementation of a single exam for VA and DoD disability compensation, examiner certification, and disability assessment training, especially on the use of the VASRD. A single exam process would entail the service branches determining fitness for duty while the VA assigns disability ratings. This single exam process could also be exported to SSA and applied to SSDI determinations for veterans if there were a Federal database of properly supervised, trained, and certified examiners. A Transition Czar or board could be established for this purpose.

¹⁰⁶ *The Task Force Report to the President: Returning Global War on Terror Heroes*. Washington, DC: April 19, 2007 p. 21.

¹⁰⁷ *Ibid.* p. 23

¹⁰⁸ GAO. *Veteran's Disability Benefits: VA Should Improve its Management of Unemployability Benefits by Strengthening Criteria, Guidance, and Procedures*, May 2006.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

Collaboration could further benefit both Departments in obtaining uniformity in rule applications, procedures, and in VASRD utilization. The Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation recommended that the VASRD criteria should be updated to reflect medically accepted diagnostic categories from the International Classification of Diseases (ICD) and the Diagnostic Statistical Manual (DSM)¹⁰⁹ and reflect functional and quality of life impairments.¹¹⁰

If VA and DoD shared a definition of disability and determinations were made using an agreement whereby fitness for duty was an issue left to the branches and VA made disability determinations, perhaps more consistency would be found.

The commencement date of disability compensation payments should be revised to ensure the financial stability of transitioning service members. Current law prohibits the commencement of disability compensation payments from the effective date of entitlement. Instead, payments are required to be delayed until the first day of the second month after the disabled service member is first entitled to receive payments as a disabled veteran. This is true even for those filing a claim within one year of discharge whose entitlement date is the day after the date of discharge. This requirement was enacted as a budget saving provision in the Omnibus Budget Reconciliation Act of 1982.¹¹¹ While this restriction might seem reasonable from a cost savings standpoint, it means that service members do not receive any disability benefits for up to two months after discharge. For example, a veteran discharged on August 2, 2006, could not be paid disability benefits for the partial month of August and could not be paid September benefits until October 1. When a panel of severely injured testified before the Commission in January 2006, this was a primary issue of concern. Before this statutory change, the veteran would have received payment from the effective date which was August 3.

Veterans Health Administration (VHA)

VHA delivers healthcare to service-connected disabled, poor, and other categories of veterans through its 21 Veterans Integrated Service Networks (VISN) that are comprised of 156 hospitals, over 800 Community Based Outpatient Clinics, 136 nursing homes, 43 residential facilities, and 209 Vet

¹⁰⁹ Institute of Medicine. *A 21st Century System for Evaluating Veterans for Disability Benefits*. Committee on Medical Evaluation of Veterans for Disability Compensation, Board on Military and Veterans Health. National Academy Press, Washington, DC: 2007. p. 11.

¹¹⁰ *Ibid*, p. 3

¹¹¹ Public Law 97-253, § 401, 96 Stat. 763, 801, now 38 USC § 5111.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

Centers. The number of unique patients treated has risen from 3.8 million in FY 2000 to 5.5 million in FY2006. Of the unique patients treated in FY 2006, 184,500 were OIF/OEF veterans¹¹² of the 631,174 who have left active duty and became eligible for VA since FY 2002.¹¹³ There are over 7 million enrollees. The VA medical care and research funding obligation was over \$34 billion.¹¹⁴

Veterans are eligible to enroll in VA health care by Priority Group. These Groups are:

1. Veterans with service-connected disabilities rated 50% or more disabling. Veterans determined by VA to be unemployable due to service-connected conditions
2. Veterans with service-connected disabilities rated 30% or 40% disabling
3. Veterans who are Former Prisoners of War (POWs); Veterans awarded a Purple Heart medal; Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty; Veterans with service-connected disabilities rated 10% or 20% disabling; Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"
4. Veterans who are receiving aid and attendance or housebound benefits from VA; Veterans who have been determined by VA to be catastrophically disabled
5. Non service-connected veterans and non-compensable service-connected veterans rated 0% disabled whose annual income and net worth are below the VA established thresholds; Veterans receiving VA pension benefits ; Veterans eligible for Medicaid programs
6. World War I veterans; Mexican Border War veterans; Compensable 0% service-connected veterans; Veterans solely seeking care for disorders associated with: Exposure to herbicides while serving in Vietnam, Exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki, Service in the Gulf War, Illness possibly related to participation in Project 112/SHAD; Service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998 are eligible for VA health care for two years following discharge from military service for combat related conditions
7. Veterans with income and/or net worth above the VA established threshold and income below the HUD geographic index who agree to pay co-pays: **Sub**

¹¹² Department of Veterans Affairs FY 2006 Annual Performance and Accountability Report. Washington, DC: November 15, 2006. p. 1-2. <http://www.va.gov/budget/report/PartI.pdf>. Accessed: November 22, 2006.

¹¹³ VHA Office of Public Health and Environmental Hazards, *Analysis of VA Health Care Utilization Among Southwest Asian War Veterans*. Department of Veterans Affairs. Washington, DC: November 2006. p.4.

¹¹⁴ *Ibid.* p.15

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

priority a: Non-compensable 0% service-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date; **Sub priority c:** Non service-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date; **Sub priority e:** Non-compensable 0% service-connected veterans not included in Sub priority a above; **Sub priority g:** Non service-connected veterans not included in Sub priority c above

8. Veterans with income and/or net worth above the VA established threshold and the HUD geographic index who agree to pay co-pays: **Sub priority a:** Non-compensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date; **Sub priority c:** Non service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date; **Sub priority e**:** Non-compensable 0% service-connected veterans applying for enrollment after January 16, 2003; **Sub priority g**:** Non service-connected veterans applying for enrollment after January 16, 2003.¹¹⁵

Veterans assigned to Priority Groups 8e or 8g are not eligible for enrollment as a result of the enrollment restriction, which suspended enrolling new high-income veterans (with incomes above \$27,000) who apply for care after January 16, 2003. Veterans enrolled in Priority Groups 8a or 8c will remain enrolled and eligible for the full-range of VA health care benefits.¹¹⁶ Enrollment in VA health care therefore is not automatic for all separating service members. They must first make an application to the nearest VA facility where they will relocate and have their eligibility determined. OIF/OEF veterans have two years of open enrollment. There has been proposed legislation to extent this period to five years.

Priority Group Workload for FY 2005¹¹⁷

National Total	Priority Group	Patients	Costs	Mean Cost	% of Total Patients	% of Total Costs	% of SC Veterans
SC 50% or more disabling	1	726,451	\$ 7,455,414,728	\$10,263			84%
SC 30-40% disabling	2	331,372	\$ 1,486,654,545	\$4,486			58%

¹¹⁵ Department of Veterans Affairs, *Health Care Eligibility: Enrollment Priority Groups*. <http://www.va.gov/healtheligibility/Library/pubs/EPG/>. Accessed: November 30, 2006.

¹¹⁶ Ibid.

¹¹⁷ VHA, *FY2005 Workload Data with Service Connection Spreadsheet*, Department of Veterans Affairs, Washington, DC provided to the Veterans Disability Benefits Commission, January 30, 2007.

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DRAFT**

SC 10-20%	3	488,944	\$ 2,124,431,811	\$4,345			41%
subtotal SC		1,546,767	\$ 11,066,501,084	\$7,155	32%	42%	59%
Non SC Patients in Priority Group 3 NSC A&A, Housebound + Catastrophic	3	63,722	\$ 228,952,851	\$3,593			
	4	179,630	\$ 3,096,392,056	\$17,238			
NSC Means Tested WWI, GW, SC 0%	5	1,622,660	\$ 8,794,726,334	\$5,420			
Compensable >VA Means Test but <HUD Geo	6	99,549	\$ 226,360,395	\$2,274			
>VA Means Test & >HUD Geo	7	175,969	\$ 592,930,804	\$3,370			
	8	1,117,673	\$ 2,500,122,456	\$2,237			
subtotal NSC		3,259,203	\$ 15,439,484,896	\$4,737	68%	58%	
Total		4,805,970	\$ 26,505,985,980	\$5,515			
Number of SC Veterans		2,636,979					
SC 50-100%		863,714					
SC 30-40%		573,994					
SC 10-20%		1,184,521					

The table above provides the workload distribution for service-connected and nonservice-connected users of VA healthcare by priority group and the associated cost of that care. A greater level of disability severity, as seen in Priority Group 1, leads to a greater reliance (84 percent) on VA health care and an almost doubling of the cost per patient (\$10,263) over the average (\$5,515). In spite of the higher cost per patient among the service-connected population, the majority of VA healthcare expenditures (58 percent) are on nonservice-connected veterans. It is also noteworthy that the service connected population makes up 32 percent of all patients treated, while the nonservice-connected users represent 68 percent. This indicates the high degree of reliance on VA by other groups of veterans who are primarily indigent, and perhaps uninsured.

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THE COMMISSION.
DRAFT**

In a 2002 study, VA projected enrollment to grow to 8.9 million by 2012 in spite of the decline in the overall veteran population.¹¹⁸ VA projects that their over age 85 enrolled population will increase until 2012.¹¹⁹ With almost 200,000 of the 600,000 discharged OIF/OEF veterans seeking VA healthcare in FY 2006, one recent prediction places the number of OIF/OEF veterans accessing VA care in 2014 at over 730,000 (of 1.5 million assumed discharges). This would also result in a projected increase in cost from \$1 billion to \$6.8 billion during that same time period.¹²⁰ Financial stresses will continue to be placed on the system as it has to provide quality long-term care, mental health, and poly-trauma rehabilitation to several generations of veterans with varying needs. When veterans are not able to obtain health care because of budget shortfalls and waiting lists then, “such veterans are at high risk for unemployment, homelessness, family violence, crime, alcoholism, and drug abuse, all of which impose an additional human and financial burden on the nation.”¹²¹ Therefore, accurately projecting workload demand and business planning are crucial factors to reducing transition risks for future generations of veterans.

VAMC C&P Exams

A major function of the VA Medical Centers is conducting Compensation & Pension (C&P) exams. VHA receives approximately 400,000 exam requests per year from VBA and conducts almost double that amount of exams since many requests are for multiple body systems.¹²² VHA is performing exams at 135 locations nationwide and is using 57 templates developed thus far to complete this task. The national timeliness standard for requested exams to be completed and returned to the RO is 35 days, which is the responsibility of the hospital-based physician/examiners.¹²³ Discussions on C&P exams were a key component of the Commission site visits.

Much of the site visit discussions with the examiners focused on the use of the 57 electronic templates and the *Best Practice Manual for Posttraumatic Stress Disorder (PTSD) for Compensation and Pension Examinations*. Examiners made several suggestions for making templates more user-friendly, and some

¹¹⁸ VHA Office of Policy Planning and Preparedness, *Veterans Health Care Enrollment and Expenditure Projections: FY 2002-2012 From the Baseline Healthcare Demand Model*, Department of Veterans Affairs, Washington, DC: September 2002.

<http://www1.va.gov/vhareorg/enroll02/Fnl925Doc.pdf> Accessed: February 7, 2007.

¹¹⁹ Department of Veterans Affairs FY 2006 Annual Performance and Accountability Report. Washington, DC: November 15, 2006. p. 13

¹²⁰ Linda Bilmes, *Soldiers Returning from Iraq and Afghanistan: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits*. John F. Kennedy School of Government, Harvard University: January 2007. p.14.

¹²¹ Ibid. p13

¹²² Steven Brown presentation, *CPEP Overview* before the Veterans' Disability Benefits Commission. Washington, DC: June 21, 2006.

¹²³ Ibid.

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THE COMMISSION.
DRAFT**

locations had adopted their own formats. The templates are not currently mandated since many of the templates are still under refinement. However, the intent is for the templates to be refined, standardized, and eventually mandated. Most examiners seemed to see this as a favorable move and thought the more the examination process was done utilizing decision support software, the more accurate and consistent the results would be. Many examiners felt that electronic templates would increase processing timeliness since it would allow for “real time” ratings of severity of disability if the medical criteria in the Rating Schedule could be applied as they filled out the exam templates. Examiners felt that this capability could reduce man-hour requirements, improve productivity, protect quality, and greatly enhance veteran satisfaction.

Examiners also offered to be more involved with the rating process, assist raters with understanding the exam results, and to train them to write up more accurate requests. They also saw the need for better checks to ensure that requests are not sent to the examiners with missing documents. The examiners also discussed certification and specialization as a means of a single exam between VA and DoD. Most were in favor of certification as a means of ensuring that those doing the exams were properly trained and supervised since these types of exams are different from other types of assessments physicians conduct. DoD could adopt the same standards and training as VA to ensure consistent application of the VASRD during the DES process.

VHA is in compliance with its 35 day standard. However, it can still take the ROs months to rate a claim. At times, this renders the exam out of date and requires an additional exam. During town hall meetings, veterans complained about being called in for a second exam because the rater found the previous one to have been completed too long ago.

QTC C&P Exams

Exam requests that exceed the capacity of VA medical center examiners are being contracted out by some Regional Offices to QTC Management Inc. In general, QTC has pioneered software and technology to facilitate the examination process. They have produced over 25 million exams and reports with 460 employees at 31 facilities and a network of 12,000 medical professionals.¹²⁴ When QTC presented on their work for VA to the Commission in June 2006, they reported that “QTC has met or exceeded current VA contract quality performance requirements 92 percent (or higher) in 11 out of 12

¹²⁴ Lay Kay presentation, *QTC Exam Process and Demo* before the Veterans’ Disability Benefits Commission. Washington, DC: June 21, 2006.

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THE COMMISSION.
DRAFT**

quarters.”¹²⁵ They also reported that they have met their timeliness requirement of 38 days in 11 out of 12 quarters.¹²⁶

During site visits, the Commission found a mixed reaction to QTC. The team that met with QTC in San Antonio was very impressed with their operation, but in Seattle, Atlanta, Chicago, and Boston there were various complaints about QTC. In Boston, in particular, the RO Director stated he would not use QTC if the VAMC could handle the workload on its own because the VAMC produced a better product. At the other ROs, QTC exams also were reported as less efficient or effective as VHA exams. In general, veterans at town hall meetings and VHA examiners felt that veterans were not treated as well by QTC examiners as they were by VA hospital-based practitioners who veterans felt better understood them and military service.

Vet Centers

Instituted in 1979, the Vet Centers provide readjustment counseling at 209 community-based locations nationwide with over 400 mental health providers. Readjustment counseling provides a wide-range of services to all eras of combat veterans and their families to facilitate transition from military to civilian life. Services include individual, group, marital, family, and bereavement counseling. Counselors also provide medical referrals, assistance in applying for VA benefits, employment counseling, alcohol/drug assessments, information and referrals to other community resources, military sexual trauma counseling and referral, outreach, and community education.¹²⁷ Vet Centers are known for their expertise in treating PTSD. In FY 2005, Vet Centers provided services to 125,737 veterans (67.4 percent being from the Vietnam era) who made over a million visits.¹²⁸

On April 1, 2003, the VA Secretary extended Vet Center eligibility to OEF veterans and to OIF veterans on June 23, 2003. Subsequently, the Vet Centers hired 100 additional Global War on Terror (GWOT) outreach coordinators to encourage OIF/OEF veterans to come into the Vet Centers and to network with the National Guard, Reserves and their families. Counselors and GWOT Outreach Coordinators are making extra efforts to provide post-deployment briefings at military installations and with National Guard and Reserve units in their areas that are returning from Iraq and Afghanistan. Since 2003, they have provided services to a total of 156,787 OIF/OEF veterans, have had outreach

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Vet Center Services. http://www.vetcenter.va.gov/RCS/Vet_Center_Services.asp. Accessed: October 26, 2006.

¹²⁸ Alfonso Batres, Chief Readjustment Counseling Services Interview with Jacqueline Garrick, Veterans' Disability Benefits Commission, Washington, DC: May 15, 2006.

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THE COMMISSION.
DRAFT**

contact with 115,708, and 41,079 are engaged in treatment.¹²⁹ Vet Centers are also tasked with providing transitioning service members with benefits information and making referrals for claims, educational benefits, and healthcare enrollment. The Vet Centers have provided grief counseling to 1,213 family members of approximately 800 service members killed on active duty since 2003.¹³⁰

Vet Center staff members have been cross-training with DoD mental health providers, especially with the Battle Mind training project to improve intervention strategies with this new era of veteran.

Early intervention by the Vet Centers can address the difficult issues previously outlined as transition risks and mitigate the long-term impacts of the life-changes that military transition brings. Since Vet Centers are strategically located in communities close to where veterans live, they are positioned to be VA's first-line of intervention and transition risk prevention. One person suggested increasing Vet Center staff instead of Regional Office staff and said, "a better idea would be to expand the Vet Centers to offer some assistance in helping veterans figure out their disability claims. The 1,000 claims experts could be placed inside Vet Centers, thus enabling veterans and their families to obtain quicker assistance for many routine claims."¹³¹ There has been no commentary from VA regarding this suggestion.

Rehabilitation

As already noted, the Commission listened to testimony on treatment and rehabilitation and visited Centers for Poly-Trauma, Blindness, Spinal Cord Injury, Burns, Amputee Care, Traumatic Brain Injury (TBI), and PTSD. The complex nature of the injuries and multiple body system damage being seen in Iraq and Afghanistan veterans are leading VA and DoD to provide levels of care that are unprecedented and revolutionary. These programs are crucial to successful readjustment post military injury or illness. They are also very resource intensive and require a full multidisciplinary approach - with active involvement by VA and DoD case managers and liaisons.

Additionally, VHA is in the difficult position of having to balance the needs of a younger, sometimes severely injured population with that of its pre-existing and aging patient population. This diversity places an even greater demand on VHA

¹²⁹ Alfonso Batres, Chief, Readjustment Counseling Services presentation, *Treatment of PTSD in VA Facilities and Programs* before the Institute of Medicine, Washington, DC: January 16, 2007.

¹³⁰ Ibid.

¹³¹ Linda Bilmes, *Soldiers Returning from Iraq and Afghanistan: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits*. John F. Kennedy School of Government, Harvard University: January 2007. p.18.

**THIS IS A WORK IN PROGRESS PAPER ONLY. NO FINAL DECISION HAS BEEN MADE BY
THE COMMISSION.
DRAFT**

resources in areas that already are resource intensive and requires staff to expand their expertise and perspective in treatment planning and program design. Adequate funding is required for the cutting-edge medical science needed by OIF/OEF veterans, while maintaining the accessibility and stability of quality health care for previous generations of veterans. Future veterans will need to continue to depend upon this diversity of care.

Findings and Recommendations:

Transition has been described as needing to be seamless, integrated, and transparent to the service member/veteran and family. But these concepts are elusive since the Departments and agencies that support the transition process have very different missions and statutory authorities. Successful readjustment boils down to the veteran needing services that are coordinated, complementary, and well-communicated. The transition issues that are identified in relation to the Commission research questions are addressed in the following sections.

RQ 26: VA/DoD Coordination

Interagency participation that is replicated at all levels is the key to success. This has been demonstrated by the accomplishments of the JEC and its sub councils and working groups. Under the auspices of this council, various levels of sharing, integration, and other joint ventures have taken place. Issues related to HIPAA were resolved. Transition activities surrounding the TAP/DTAP and BDD have matured and efforts to increase briefings at military installations and with the Guard and Reserve are on-going.

However, there are still areas for improvement between VA and DoD coordination. The JEC Report should include a more detailed description of implementation plans, timelines for expansions to other facilities, IT capabilities for inpatient records and imaging, funding and resource sharing forecasts, identification of remaining obstacles, and projected milestones. There is a primary need for intensive case management for severely injured service members with an easily identifiable lead agent who oversees all transition issues. BDD needs to extend to the National Guard, Reserves, medical holdovers and other injured/ill service members who are currently unable to participate in this program.

DOL and SSA should be included in the JEC, at the minimum as liaisons. VA and DoD need to enhance their collaborative efforts in providing health care and increase their JIF sharing and create a joint formulary. Furthermore, communication from the Departments to the field needs to improve, so for example VA facilities understand that health care can be provided to injured active duty service members.

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THE COMMISSION.
DRAFT**

A wide variety of health care and benefits are needed to assist disabled veterans and their families to transition from military to civilian life. These services include medical and psychiatric care, housing, rehabilitation, employment services, compensation, education, and family support. Particularly for the severely injured, services must be well coordinated to provide bed capacities, clinical expertise, intensive case management, advanced technologies and pharmaceuticals, TSGLI financial planning, women's health and integrated networks and support systems. Effective service delivery must be well-coordinated to ensure gaps are closed and duplication of effort is avoided. The SIMS Interagency Working Group can be a model for this type of an approach where outreach is the responsibility of each of the partner/players. The barriers identified by the SIMS study need to be further addressed by the Departments.

Finally, there needs to be improvement in the way VA and DoD record transfers take place back and forth between the Departments, including addressing issues of lost, missing & unassociated paper records. All DoD records are not electronically available to VA and there is continuing reliance on paper records. When paper records are missing or lost, it limits veteran's ability to develop the evidence necessary for his/her claim to be adjudicated. So, maintaining and managing paper records is still a priority in this electronic age and VA must work with DoD to ensure this capability is not lost while focusing on the electronic capabilities.

RQ 27: VHA/VBA Coordination

When VA officials briefed the Commission on VA transition activities within the Department, they demonstrated a commitment to improving the quality of the claims process and transmitting information across Administrations. The "One VA" concept was clear in such efforts as the CPEP, and in Regional Offices access to VA medical center records for claims processing. The OIF/OEF coordinators are in place to guide this generation of veterans through the process of filing claims and establishing eligibility for care.

In spite of these accomplishments at the VA Central Office level, additional direction and standardization could vastly improve operations. As a result of the IOM recommendations regarding the VASRD, it should be updated and maintained to reflect medical research and advances. Templates for C&P exams are in the process of being developed and refined, but are not currently mandated, nor is the *Best Practice Manual for Posttraumatic Stress Disorder (PTSD) for Compensation and Pension Examinations*. These tools should be mandated. Claims processing could be improved and the backlog reduced by using decision support software. The process could also be improved and reduce

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THE COMMISSION.
DRAFT**

the backlog if there was more open dialogue between raters and examiners, improved VASRD training available to all, and rater and examiner certification. Vet Center documentation should be available and used in rating decisions.

RQ 28: DoD Internal Coordination

As the Global War on Terror has continued, DoD has needed to tailor its response based on the unique injuries and levels of care the severely injured demand. The survivability rates of multiple trauma injuries due to improved technology and medicine has resulted in DoD's crafting new programs at the Office of the Secretary of Defense (OSD) and at the branch levels. DoD is not a singular integrated entity. The branches exercise a great deal of autonomy over their own personnel and operational policies, which have led to inconsistencies in the application of the VASRD during the DES process and for each branch to have its own unique program for the severely injured. OSD operates the MSIC as a safety-net for the severely injured that the branch program might have missed. There is merit to this approach as the branches can provide services at the closest level, while DoD provides back-up and manages other outreach initiatives.

Congress should enact legislation that mandates DoD to provide oversight and standardization between the service branches. DoD needs common definitions and data bases to assist in quality control and program evaluation. Plus, it cannot effectively share information with VA if it has not coordinate efforts internally first. Specifically, DoD should develop a single definition of "severely injured" among the branches. The MSIC can expand its scope and cover the additional wounded/ill service members transitioning from active duty. This "upside umbrella" can be catching more of the disabled veterans that are falling through the cracks using the intensive network it has already developed through Military OneSource and the Heroes to Hometown programs. The effectiveness and efficiency of these programs should also be monitored. Furthermore, DoD should develop an integrated data base for all service persons considered for disability separation with special focus on the severely injured. DoD should ensure consistent quality in disability decisions by monitoring outcomes across the branches and better utilize the DAC . This information would help develop best practices and lessons learned that could be shared among the branches and with VA.

DoD needs to have an office similar to VA's Seamless Transition Office, so that there are those with full time responsibility for this activity and an easily identifiable point of contact for VA.

Although Tricare can be a great resource for health care, its costs and limited network availability have made it a less than optimal benefit for some retirees.

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THE COMMISSION.
DRAFT**

The associated expenses and the travel required to a provider for combat severely injured has caused them concern and an inability to rely on it completely for coverage.

Additionally, DoD should assess TSGLI effectiveness and achievement of intended outcomes. DoD should provide financial planning to the families for effective use of this lump sum payment. Legislation should expand TSGLI eligibility to all severely injured service members regardless of location of injury retroactive to October 7, 2001.

RQ 29: VA/DoD Adequacy, Quality and Timeliness

Criticism of inconsistencies in disability ratings between the branches and between the Departments have been made. CNA's analysis of this issue for the Commission has shown there is considerable variation between DoD and VA ratings.

Recommendations on solving the problems with the DES and the VASRD made by the IRG, GWOT Heroes Task Force, GAO, RAND, and other Commissions should be considered by DoD and VA. The deficiencies noted in these reports regarding disability ratings, timeliness, accountability, and training are worthy of further attention. A single disability exam and rating process should be the ultimate goal whereby the branches make fitness for duty determinations and VA renders rating decisions. There should be a single medical exam that can be used by DoD, VA, and SSA, which is conducted by a certified and trained examiner using the VASRD.

VA needs the legislative authority and funding to provide family services to those family members of the severely injured similar to the existing DoD authority. VA also needs the authority to expand health care access to five years after discharge.

RQ 30: IT Interoperability

IT interoperability is improving rapidly. VA and DoD efforts in this regard have created several mechanisms that allow for direct record transfers. Under the JERHI, the Departments were able to create the FHIE, LDSI, BHIE and the CHDR as steps towards integration. The CHI will enable VA and DoD to work more closely with HHS. These electronic steps are paramount in the provision of patient care and critical to future success in medical record sharing.

There has been some criticism that with Congressional support and the resources expended by the Departments, these capabilities should be further along than they are and a 5 year strategic plan has been viewed as too broad

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THE COMMISSION.
DRAFT**

given the demands of the current level of combat casualties. A more time-specific plan with milestones is needed immediately.

BHIE is limited to nine locations. Images, inpatient discharge summaries, and bar code capability are not readily available in AHLTA. Vet Center's records are not included in VistA, although reportedly, that is projected to change. VA and DoD announced in January 2007 that they have entered into a plan to create a uniform inpatient record. This should be an over-arching priority for both Departments.

DoD also needs to transmit an electronic a valid DD 214 to VA to ensure veterans are able to access their benefits and healthcare services in a timely manner.

RQ 31: Training, Education & Outreach Programs

TAP/DTAP classes are the primary source of information for transitioning service members. It is during this process that a service member is introduced to VA and DOL and learns about all available benefits. However, as previously discussed, there are still limitations on classes being provided at all levels. Often, the Guard, Reserve and Medical Hold patients miss out on TAP. Only the Marine Corps mandates TAP briefings when all of them should.

The Army and Navy have created websites to assist transitioning service members with translating their MOS training and experiences into marketable skills in the civilian workforce. The military is trying to assist these service members navigate state and professional licensure and credentialing requirements as well compare them to college credits. DoD, VA, and DOL can be of greater assistance in this area by providing individual counseling and coaching rather than just websites.

Transition activities need to be reported to Congress on an annual basis to ensure proper focus, oversight and funding.

Conclusion:

Seamless transition is an excellent concept but it does not fully exist at the present time. Successful transition from the military to veteran status will need the continuing involvement and commitment of the White House, Congress, VA, DoD, DOL, HHS, and other governmental agencies. Internal and external coordination is a key element. Transition must also continue to involve the VSOs and other non-profits to step up to the plate in every community across America. The ultimate vision of transition should be the continuation and fulfillment of a

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THE COMMISSION.
DRAFT**

quality life for our nation's veterans, especially for those disabled while on active duty.

Options:

<p>RQ 26 (VA/DoD Coordination)</p> <ul style="list-style-type: none">• Enhance the JEC strategic plan to include specific milestones• Intensive case management for severely disabled with identifiable lead agents• Expand BDD locations & extend BDD availability to Guard, Reserve, Med Hold• DOL & SSA be included in the JEC to improve transition process• Increase joint incentive fund spending on health care sharing• Create a Joint Formulary• Improve headquarters communication on collaborative efforts to the field• Improve interagency coordination of benefits using SIMS as a model• Improve record transfers including addressing issues of lost, missing & unassociated paper records
<p>RQ 27 (VBA/VHA Coordination)</p> <ul style="list-style-type: none">• Update and maintain the VASRD (IOM)• Refine and mandate C&P exam templates (IOM)• Mandate PTSD Best Practices Manual• Consider use of Automated Decision Support System in the claims process to help reduce the backlog• Increase rater/clinician dialogue (IOM)• Train and certify C&P disability examiners and raters (IOM)• Utilize Vet Center patient information in the claims process
<p>RQ 28 (DoD Internal)</p> <ul style="list-style-type: none">• Congress should mandate DoD DES oversight and standardization between the Services• Standardize definitions of disability & severely injured between the Services• Create a common DoD database of disabled service members• Expand Disability Advisory Council role and function• Create an Office of Seamless Transition in DoD• Disseminate Best Practices & Lessons Learned to the field• Consider SIMS findings and recommendations• Address Tricare limitations, especially for severely injured• Evaluate TSGLI to assess achievement of intended outcomes

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THE COMMISSION.
DRAFT**

RQ 29 (VA/DoD Adequacy, Quality, & Timeliness)

- Consider recommendations by the IRG, GWOT Task Force, GAO studies, RAND, the PTF, and the Transition Commission to improve disability ratings process and institute a single system
- Single DoD/VA Disability system & exam: DoD makes “unfit” decision and VA determines rating
- Legislation for VA Severely Injured Family Services that mirrors DoD
- Expand VA health care access to 5 years after discharge

RQ 30 (IT Interoperability)

- Develop plan with milestones to implement compatible IT capabilities
- Create one compatible patient record for VA & DoD
- Provide electronic DD 214 to VA

RQ 31 (Training, Education, & Outreach)

- Mandate and adequately fund TAP to ensure that all service members are knowledgeable about benefits before leaving the service
- Offer employment services to families of severely injured
- Provide military occupational skills and experience translation for civilian employment counseling
- Require DoD annual report including all components on transition to Congress.

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ADDENDUM 1:

Transition Report Matrix

Research Question	Identified Programs	Responsible Agency	Findings
RQ#26: VA/DoD Coordination & Outreach	JEC, BEC, HEC, TAP, BDD, SIMS	VA, DoD, SSA, Congress	<ul style="list-style-type: none"> • Enhance the JEC strategic plan to include specific milestones • Intensive case management for severely disabled with identifiable lead agents • Expand BDD locations & extend BDD availability to Guard, Reserve, Med Hold • DOL & SSA be included in the JEC to improve transition process • Increase joint incentive fund spending on health care sharing • Create a Joint Formulary • Improve headquarters communication on collaborative efforts to the field • Improve interagency coordination of benefits using SIMS as a model • Improve record transfers including addressing issues of lost, missing & unassociated paper records
RQ#27: VBA/VHA Coordination	BDD, C&P, Healthcare	VBA, VHA, RCS	<ul style="list-style-type: none"> • Update and maintain the VASRD (IOM) • Refine and mandate C&P exam templates (IOM) • Mandate PTSD Best Practices Manual • Consider use of Automated Decision Support System in the claims process to help reduce the backlog • Increase rater/clinician

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			<p>dialogue (IOM)</p> <ul style="list-style-type: none"> • Train and certify C&P disability examiners and raters (IOM) • Utilize Vet Center patient information in the claims process
RQ#28: DoD Internal Communication	DES, Military Severely Injured Center & Branch Programs, Tricare, TSGLI, Healthcare	Health Affairs, Personnel & Readiness, Force Management	<ul style="list-style-type: none"> • Congress should mandate DoD DES oversight and standardization between the Services • Standardize definitions of disability & severely injured between the Services • Create a common DoD database of disabled service members • Expand Disability Advisory Council role and function • Create an Office of Seamless Transition in DoD • Disseminate Best Practices & Lessons Learned to the field • Consider SIMS findings and recommendations • Address Tricare limitations, especially for severely injured <p>Evaluate TSGLI to assess achievement of intended outcomes</p>
RQ#29: VA/DoD Adequacy, Quality & Timeliness	TAP, DES, C&P, healthcare	VBA, Health Affairs, VHA, Congress	<ul style="list-style-type: none"> • Consider recommendations by the IRG, GWOT Task Force, GAO studies, RAND, the PTF, and the Transition Commission to improve disability ratings process and institute a single system • Single DoD/VA Disability system & exam: DoD makes “unfit” decision and VA determines rating • Legislation for VA Severely Injured Family Services that

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			<p>mirrors DoD</p> <ul style="list-style-type: none"> Expand VA health care access to 5 years after discharge
RQ#30: IT Interoperability	AHLTA, VistA	DoD, VA	<ul style="list-style-type: none"> Develop plan with milestones to implement compatible IT capabilities Create one compatible patient record for VA & DoD Provide electronic DD 214 to VA
RQ#31: Training, Education & Outreach	TAP/DTAP, Realifelines, MOS compatibility, SSDI	DoD, VA, DOL, SSA, Congress	<ul style="list-style-type: none"> Mandate and adequately fund TAP to ensure that all service members are knowledgeable about benefits before leaving the service Offer employment services to families of severely injured Provide military occupational skills and experience translation for civilian employment counseling Require DoD annual report including all components on transition to Congress.

ADDENDUM 2

Transition Report Glossary

AHLTA – DoD’s information technology architecture system
BDD – Benefits Delivery at Discharge conducted by VA at 140 DoD facilities
BEC – VA/DOD JEC Benefits Executive Council
CACO - Casualty Affairs Casualty Officer
CAPRI – VBA’s Compensation and Pension Records Initiative is available at 57 ROs.
CBHCO – Army Community Based Health Care Organization program for injured/ill Guard or Reserve to receive treatment closer to home
CHDR – Clinical Data Health/Health Data Repository is a bridge between AHLTA and VistA.
CPRS – VA’s Computerized Patient Record System
DES – DoD Disability Evaluation System mandated by the Department, but implemented differently by the branches to determine fitness for duty and disability ratings
DoD – Department of Defense
DOL – Department of Labor
FHIE – Federal Health Information Exchange is a one way data transfer from DoD to VA
GWOT – Global War on Terror
HEC - VA/DOD JEC Health Executive Council
HIPAA – Health Insurance Portability & Accountability Act of 1996 (PL 104-191)
IOM – Institute of Medicine
IRG – Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center
JEC - VA/DoD Joint Executive Council
JEHRI – Joint Electronic Health Records Interoperability Plan between VA and DoD
JIF – VA/DoD Joint Incentive Fund, which requires VA and DoD to contribute \$15 million each
LDSI – Laboratory Data Sharing and Interoperability software
MEB – Medical Evaluation Board – Determines fitness for Duty, each branch has their own criteria, if unfitness is found, service member is referred to PEB
MSIC – Military Severely Injured Center run at the OSD level
OEF – Operation Enduring Freedom (refers to troops returning from Afghanistan)
OIF – Operation Iraqi Freedom (refers to troops returning from Iraq)
OSD – Office of the Secretary of Defense
PDRL – Permanently Disabled Retired List

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PEB – Physical Evaluation Board that determines if a service member can perform their job, if not a disability rating is assigned and a service member is discharged with severance (30% or below) or medically retired

PDHA – Post-Deployment Health Assessments (conducted by DoD)

PTSD – Post Traumatic Stress Disorder

RCS – Readjustment Counseling Services oversees the Vet Centers nationwide

RO – VBA Regional Offices located in 57 cities

SCI - Spinal Cord Injury

SIMS – Severely Injured Marines and Sailors pilot study of 25 severely injured

TAP- Transition Assistance Program offered by DoD with VA, DOL, and SSA speakers

TBI – Traumatic Brain Injury

TDRL – Temporarily Retired Disabled List

TSGLI – Traumatic Servicemembers Group Life Insurance paid to 44 categories of severely injured in rates from \$25,000 to \$100,000 in a lump sum

VA – Department of Veterans Affairs

VASRD – VA Schedule for Rating Disabilities ranges from 0% - 100% in 10% increments and covers major body systems

VBA – Veterans Benefits Administration – the component of VA that delivers compensation and pension benefits

VETS – Veterans Employment and Training Services offered by DOL

VHA – Veterans Health Administration – the component of VA that delivers medical, surgical, and psychiatric services

VistA - VA information technology architecture system