HANDOFF OR FUMBLE? ARE DOD AND VA PROVIDING SEAMLESS HEALTH CARE COVERAGE TO TRANSITIONING VETERANS?

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

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HANDOFF OR FUMBLE? ARE DOD AND VA PROVIDING SEAMLESS HEALTH CARE COVERAGE TO TRANSITIONING VETERANS?

THURSDAY, OCTOBER 16, 2003

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

The committee met, pursuant to notice, at 10 a.m., in room 334, Cannon House Office Building, Hon. Christopher H. Smith (chairman of the committee) presiding.

Present: Representatives Smith, Evans, Bilirakis, Buyer, Brown of South Carolina, Snyder, Rodriquez, Michaud, Hooley, Simmons, Brown of Florida, Strickland, Miller, Boozman, Udall, Bradley, Davis, Ryan, and Brown-Waite.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. The committee will come to order. And good morning to everybody. For many years, this committee has been seeking to improve the procedures which separating servicemembers must follow to obtain post-service benefits. Thanks to efforts by VA and Defense officials, we have seen some notable improvements in those years. For instance, servicemembers with disabilities usually begin the VA benefits process before they leave service; physical examinations are performed to meet VA requirements, sometimes even by VA doctors; a complete record allows the VA to make a prompt initial decision concerning disability benefits, sometimes in less than 30 days.

Similarly, the administration will testify about its recent decision to place additional VA employees at military hospitals to help severely wounded veterans make a smoother transition to civilian life.

I believe these efforts are both commendable and necessary, but they do not go far enough. This is at least the sixth time since January of 2002 that this committee has called on administration officials to address administrative obstacles which confront persons leaving military service with health concerns. Each time, we learn of new efforts being made to overcome problems and address issues identified by physicians and caregivers.

However, in the end, veterans and their families do not care about policy manuals and regulations. What they want to know is whether there is a compassionate person available to help them, to assist them, who understands their particular pain and who has the resources to make sure their care is first rate.

Not all of the problems we will hear about today are new. Some of them take more time to solve than others. I want to be clear that by holding these hearings, we do not intend to question the dedication of caregivers on the front lines who are striving to daily to heal and console individuals who have been harmed defending our Nation. However, important decisions which could lead to more consistent and compassionate treatment and less bureaucracy and confusion continue to be deferred. Policies intended to make the health care handoff simpler are ignored by those who have been instructed to implement them.

For example, a recently completed Presidential task force recommended that the President direct the Department of Health and Human Services to declare the two departments to be a single health care system for purposes of privacy regulations. Failure to take this one step forces both departments to use cumbersome and inefficient mechanisms which directly impede the delivery of seamless health care.

Another example is the congressional mandate adopted in 1997 requiring the military services to document a servicemember's health before and after deployments. There is also unanimous agreement that this policy will improve the delivery of health care to servicemembers during and after service. However, GAO will testify that this mandate has been ignored in many instances and undermined in important respects. Battlefield treatment records, immunization records and mandatory health questionnaires, for example, are missing or nonexistent. Moreover, even when these records exist, some of them cannot be shared with VA after the servicemember becomes a veteran.

There are other examples. A shared electronic medical record is both vitally needed and feasible, but bickering and heedless administrators have delayed its deployment. Incentives for collaboration between the two departments, I am sad to say, is lacking, despite a congressional directive to establish them. Budget makers have not requested and Congress often belatedly supplies the necessary funding to care for an increasing workload at the VA treatment facilities.

Let me just say that I want to commend all of the witnesses who have prepared testimony for the committee for all of us to hear this morning. In particular, I want to thank each of the individuals who will appeal before us today who will relate how they or their family fared in making the transition from active service to civilian life. We understand and appreciate that they may never have testified before a congressional hearing, so the careful thought and detailed experiences reflected in their testimony is of enormous importance and assistance to this committee and by extension to the Congress.

Taken together, their testimony gives an indication of the serious challenges which hundreds of thousands of separating servicemembers have faced in the last 10 years. They also demonstrate what is possible when a government is focussed and dedicated to understanding and addressing these challenges. Regrettably, they also tell us how much more can and must be done.

A recent memorandum issued by two of the VA's Under Secretaries, Dr. Roswell and Admiral Cooper, said, and I quote: Our Na-

tion's newest veterans deserve to receive hassle-free services from the VA.

This is an admirable goal; let's figure out how to make that a reality.

[The prepared statement of Chairman Smith appears on p. 137.]

The CHAIRMAN. I would like to yield to the vice chairman, and I will delay an opening for my good friend and colleague, Mr. Evans, and ask if the vice chairman, Mr. Bilirakis, would like to make an opening statement.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Mr. Chairman, I thank you on behalf of all of us for holding this hearing. And I have a statement that I would like to put in the record. Very briefly, I would just like to say the transition from military to veteran status—from the top status to my way of thinking in our everyday life, which is the military, to the next top which is the veteran, and yet it is sometimes very difficult. Obviously, I have gone through it. So many of us have. Going from a lack of freedom, if you will, all of the sudden to freedom.

So it is important that we have an oversight here and it is important, I think, for the Veterans' Administration to be aware of any of the problems that seem to be developing. They should be aware to prevent them from developing in the first place. But God knows if they feel they do not have the resources to keep these things from happening, then they should be contacting us to try to help them get the resources they need. Because there is no excuse for not being available and doing a better job insofar as that transition is concerned. Thank you very much, Mr. Chairman.

[The prepared statement of Congressman Bilirakis appears on p. 138.]

The CHAIRMAN. Thank you. Mr. Michaud.

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you, Mr. Chairman. I want to thank you, Mr. Chairman, and Ranking Member Evans for holding this hearing. I don't think that it could be any timelier. We have significant forces committed overseas and we will need this assistance when they return. I look forward to hearing from each of our witnesses today on the successes and failures of our transition assistance. It is so important that we provide our military personnel with a seamless transition to life as veterans so that we may provide the care when they do return back home in the United States. So I am looking forward to hearing your testimony. Thank you, Mr. Chairman.

The CHAIRMAN. Chairman Buyer.

OPENING STATEMENT OF HON. STEVE BUYER, CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, COMMITTEE ON VETERANS' AFFAIRS

Mr. BUYER. Thank you, Mr. Chairman. This hearing provides us a better opportunity to evaluate whether or not DOD and VA are providing servicemembers with the proper health care as required, as well as access to important benefits when they return home from military service.

As Chairman Smith stated eloquently, the delivery of health care and other benefits has gotten better, but there is tremendous room for improvement. As we will hear today, too many veterans have received less than stellar treatment on their return home. I do not mean to sound cynical, but we have been down this road many times before. Ever since the Persian Gulf War, DOD and VA have talked about providing a seamless transition for our returning troops, yet after reading the GAO's testimony for today's hearing, it appears that we still have not gotten it right.

On July 8, 2003, the VA Subcommittee on Oversight and Investigations held a hearing to learn that Public Law 105–85 had not been implemented as stated in the statute. I wanted to find out if pre-and post-deployment medical examinations were now being conducted. We learned during the hearing that semantics played a major role in how the question was answered. DOD interpreted the actual writing—it is one thing when those of us as legislators write the law. When you take a pen and write on paper that you want physical exams to be done, and DOD then redefines "physical exams" only for the narrowly drawn purpose of providing these health assessments and screenings, is how they have defined them. Nowhere else in our health professions in our own country does anyone define a physical exam as a health assessment or a screening, except DOD.

It is stressful for legislators, if we are actually to draft statutes and use words from whom we know—have the common definition, but then someone else wants to participate in verbicide and destroy the meaning of words to interpret them for their own legitimate means.

Today, both the VA, and DOD have a golden opportunity to set the record straight. I would like to thank all the witnesses for being here today, and in particular, the brave servicemembers who will tell their personal stories. You will find their stories compelling and at times upsetting as they talk about their experiences and the traumas they incurred on and off the battlefield. We thank them for service to their country. And I also want to take the opportunity to thank Senior Master Sergeant Robert Halcomb of the 181st Fighter Wing from Indiana. I am proud to say that your service was well done. Not only yours, but the men and women who served along with you. And welcome home. I yield back.

The CHAIRMAN. Thank you.

Mr. EVANS. I would ask permission to enter my statement in the record.

[The prepared statement of Congressman Evans appears on p. 138.]

The CHAIRMAN. Without objection. Dr. Snyder.

Mr. SNYDER. I do not have a statement at this time. Thank you.

The CHAIRMAN. The Chair recognizes Chairman Brown.

OPENING STATEMENT OF HON. HENRY E. BROWN, CHAIRMAN, SUBCOMMITTEE ON BENEFITS, COMMITTEE ON VETERANS' AFFAIRS

Mr. BROWN of South Carolina. Thank you, Mr. Chairman. I thank you and Mr. Evans for holding this morning's hearing on providing seamless health care coverage to transitioning veterans

with respect to disability compensation, vocational rehabilitation and long-term sustained employment. This is vital to a successful transition.

With us in the audience is Mr. Christopher Reid, an inspiring Veterans Benefits Administration employee who personifies VA's mission. Mr. Reid served with distinction in the U.S. Army from 1989 to 1994. He was honorably discharged after being seriously injured while serving in Mogadishu, Somalia. Since April 2003, Mr. Reid has been the face of VA at Walter Reed Army Medical Center where he assists servicemembers injured in Operation Enduring Freedom and Operation Iraqi Freedom.

Mr. Reid provides benefits information, takes claims and manages individual cases. But he actually does more than that. Mr. Reid is an outstanding personal example of how our servicemembers, with help from dedicated VA and Department of Defense professionals, can overcome obstacles of severe injuries incurred in selfless service to our Nation.

Mr. Reid, we appreciate you and could I ask you to stand, please? (Applause.)

Mr. BROWN of South Carolina. I would also like to take a moment and congratulate the Secretary of Veterans Affairs, Anthony Principi, and Under Secretary for Benefits, Daniel Cooper, for making good on the President's pledge of reducing the backlog of compensation claims. The inventory dropped from a high of 432,000 to 253,000, a 41 percent reduction. It is also worth noting that the average wait time for a new claim has been drastically reduced. The folks who we are discussing today will be waiting a shorter period of time than those of a few years ago. Thank you, Mr. Chairman. I yield back the balance of my time.

[The prepared statement of Congressman Brown of South Carolina appears on p. 139.]

The CHAIRMAN. The Chair recognizes the gentlewoman from California, Mrs. Davis.

OPENING STATEMENT OF HON. SUSAN A. DAVIS

Mrs. DAVIS. Thank you, Mr. Chairman. I want to thank those of you who are here today who will share your stories with us because that is very, very important, I think, so that we do a lot of waving the flag. But those of you who salute the flag know that you need more than good words from us. And I think that we need to act on what you tell us.

One of the things when I first came into Congress, I heard from so many of people in my community of San Diego. We do not always hear the good stories, but people do come forward when they have difficulties that they have endured. And I think that this transition period for many is not a good experience. And so I appreciate the fact that those of you who are feeling free can be comfortable to share that. We also want to know when we have done the right thing. But we need to make sure that more of those opportunities are available to our servicemen and women. Thank you very much for being here.

The CHAIRMAN. The Chair recognizes the distinguished Chairman, Mr. Simmons of the Health Committee.

OPENING STATEMENT OF HON. ROB SIMMONS, CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON VETERANS' AFFAIRS

Mr. SIMMONS. Thank you, Mr. Chairman. And thank you to our witnesses for your service. And I include Mrs. Stiffler for her service. Being the mom of a serviceman and woman is not easy, so I thank you for what you do.

I am a Vietnam veteran, and serving in that conflict was no fun. But I will also tell you that coming home was no fun either. When I went over in 1967 there appeared to be support for the war. When I came back at the end of 1968, that support had evaporated. As a consequence of that, the U.S. Army had a policy that when you mustered out at the Oakland Army Base in California, you were required to change into civilian clothes to go home so you wouldn't get into trouble.

Nor did you have a medical exam. You were simply asked how you felt and they would review your medical records and off you went.

So based on that experience, I feel that it is critically important that our military services have a policy that deals specifically with how we deal with returning military members. And that we need a plan to implement that policy and we need oversight of that plan, which I believe is something that this committee and perhaps the Armed Services Committee as well on which I serve, can do.

I think homecoming is a critically important part of military service and we cannot simply leave it to chance. So I thank the chairman for holding this hearing today. I thank the members for attending. And I very much thank those who will be testifying on this very important issue. And I yield back.

The CHAIRMAN. The Chair recognitions Mr. Strickland.

Mr. STRICKLAND. No statement, Mr. Chairman, I am anxious hear what the witnesses have to say to us. Thank you.

The CHAIRMAN. Ms. Brown-Waite.

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. Thank you, Mr. Chairman. Many of us on this committee have visited Walter Reed and also Bethesda. And when you see the young men and women there who were receiving medical care, you realize the absolute need for good planning so that there is a seamless health care coverage as they transition from active members of the military to veterans. And making sure that that happens is something that I know that the Chairman of this committee is very, very committed to, as are all the members. And I just wanted to thank you all for being here today. And although all of the seats are not filled, many of the people are at other committee meetings being held simultaneously. There is not a lack of interest, but I know myself I have two other committee hearings that I will be heading in and out of, but I know that every member of this committee is very committed to assisting the chairman in making sure that there is a seamless health care system out there. Thank you for being here.

The CHAIRMAN. Mr. Miller.

Mr. MILLER. No statement.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. Mr. Chairman, I want to take this opportunity to commend three gentlemen who have joined us today. Their actions exemplify selfless service: Jim Mayer, Fred Downs and Chris Reid are VA employees and severely disabled veterans who devote their on-the-clock time and off-duty time to help veterans with their disabilities, visiting them at their bedside, counseling them, and simply being friends to them. These gentlemen, and the family members on our first panel, deserve our applause and highest accolades. Mr. Chairman, I yield back. (Applause.)

The CHAIRMAN. Thank you.

Let me introduce our first panel of witnesses. Mrs. Arvilla Stiffler is the Program Director for Trauma, Trauma Outreach, and Safe Communities at the University of North Carolina Health Care System in Chapel Hill, NC. She also serves on the faculty as a clinical instructor in the Department of Surgery at the University of North Carolina. She is also a Captain in the U.S. Army Reserves and received the Army commendation medals in 1999 and 2000.

Today she will testify as the mother of a former Army Private First Class Jason Stiffler, who served this Nation in Operation Enduring Freedom until becoming seriously injured in an accident in Afghanistan.

We will then hear from Colonel Robert Frame, the senior dentist in charge of the VA dental corps for the Department of Veterans Affairs. In this position, he is responsible for policy development and guidance for the Department of Veterans Affairs National Dentistry Program, which serves approximately 340,000 patients annually.

Colonel Frame is a graduate of the U.S. Army Command and general staff college and an active member of the U.S. Army Reserve. He is currently a member of the 352nd Civil Affairs Command, and serves as chief of the public health team. Most recently, he served in Operation Iraqi Freedom as chief of the public health team tasked with standing up the Iraqi ministry of health. He and his team were extremely successful in accomplishing the mission, but on April 27, 2003, Colonel Frame was seriously wounded by enemy action in an ambush in Baghdad. He received the Purple Heart for wounds received from hostile enemy action.

We will then hear from Nelson Villegas, a retired U.S. Army sergeant, who served our Nation for over 17 years, 10 of which were on active duty. Some of his occupations included combat medic, pharmacy technician and respiratory technician. He was awarded the expert field medical badge, airborne paratrooper badge, and instructor special skill identifier. He was also activated during Desert Storm.

On May 3, 2003, Nelson Villegas was medically evacuated from Germany to Walter Reed Army Medical Center for further management of a life-threatening condition. As a result, Mr. Villegas underwent a bilateral below-the-knee amputation on May 10, 2003. Since his retirement he has recovered remarkably and was discharged from the hospital 2 months after his admission. Currently, he is undergoing rehabilitation as an outpatient with the primary goal to return to his favorite sport of backpacking.

He was admitted to the University of Maryland where he is planning to further his education and receive a degree in information

systems management. His long-term goal is to become a systems analyst and serve as a role model to other disabled veterans. Even while continuing his own rehabilitation, Mr. Villegas continues to encourage and inspire fellow disabled soldiers.

We will then hear from Senior Master Sergeant Robbin Halcomb, who is the chief of management and systems for the 181st Logistics Readiness Squadron for the Air National Guard in Terre Haute, Indiana. He is responsible for providing training resources and systems required to support the efficient and effective operation of the logistics readiness squadron.

He has been a member of the Air National Guard for 29 years and works in the logistics field. On January 29, 2003, Sergeant Halcomb was called up to active duty and sent to Turkey to provide combat support in an operation referred to as Operation Northern Watch. It was while in Turkey that Sergeant Halcomb seriously injured his right arm in an accident, resulting in numerous treatments and surgeries. He was released from active duty in June and will share his experiences both before and after his release from active duty.

STATEMENTS OF ARVILLA STIFFLER, MOTHER OF JASON STIFFLER, U.S. ARMY VETERAN; COL. ROBERT T. FRAME, D.D.S., U.S. ARMY RESERVE; NELSON VILLEGAS, U.S. ARMY VETERAN; AND SENIOR MASTER SERGEANT ROBBIN HALCOMB, AIR NATIONAL GUARD

The CHAIRMAN. If you could begin, we would appreciate it.

STATEMENT OF ARVILLA STIFFLER

Mrs. STIFFLER. I would like to thank this committee for giving me the opportunity to speak. I submitted a very lengthy statement surrounding by son's hospital course and treatment, and today I will focus on the concerns and issues I feel contributed to the disruption in benefits, income, and care within the military and VA systems.

I do want to take this opportunity to thank my colleagues who rendered care to my son. They saved his life, and for this I am eternally grateful. Jason was injured in April of 2002 while on duty in Afghanistan. His diagnoses included a spinal cord injury with significant motor and sensory deficits, closed head injury with two subgaleal hematomas with memory loss, poor retention capability and post traumatic stress.

The health care workers who cared for Jason in the field in Afghanistan, in Germany, at Walter Reed and the VA hospitals are all dedicated staff. It is not the employees that make this process fail, it is the process itself.

The lack of integration of two very important establishments from the beginning of a soldier's hospital course must be changed. With respect to the the Army Medical Review Board, Jason received a 40 percent disability rating for his spinal cord injury. No rating for his head injury or constant pain, nor for the problems he was having mentally even though he had strong evidence in a report performed by a neuropsychologist, which indicated concern over his cognitive status prior to the board meeting.

I was disappointed and even more deflated to know that the medical board convened without a family member present, with this only to happen a second time when Jason signed a waiver to accept the VA benefits in lieu of military pay. In October of 2002, he was released with the understanding that the VA hospital would contact him. By November and with Jason's condition declining, I encouraged him to seek out emergency room treatment at the VA in Ft. Wayne, Indiana. The faculty at the hospital indicated they did not know about his case and no one from Walter Reed had ever contacted them. At the same time, his pay had been cut in half to $700 a month. He was unable to work. He tried, but collapsed several times.

His family had increasing financial problems. Their car was repossessed. They began to receive food stamps and lived in a trailer that was not accessible for a wheelchair until the owner himself, built a ramp.

After the first of the year, the VA medical center began the process to increase his rating, which could take up to 18 months. Jason's strength in his legs declined awaiting physical therapy from 3 plus to 1½. His appointments were sometimes canceled due to VA case overload, while others were canceled because they had no money or a car for the long drive.

As a Captain in the U.S. Army Reserves and after witnessing my son's journey, I feel, if recruiters would inform new recruits the consequences of becoming injured, may include, the expectation to become frustrated with a system that leaves you living below the poverty line, forces you on food stamps and into a welfare system, and lastly, will make you wait long periods of time to receive medical care, I ask you: Would you sign up?

As a health care professional, I can say I understand the lack of and the declining resources the VA system has with respect to nurses and physicians. The final burdens placed on health care systems in America is underscored only by the continual dilemma between an increasing patient population and a diminishing capability to serve their needs adequately. The problems I can clearly identify include the lack of an integrated system. Patients are and will continue to suffer. The lack of discharge planning. A soldier at a minimum deserves a care coordinator who can assist to educate the families, assure upon discharge the soldier has confirmed appointments, given full care instruction, and include a discussion on an assignment to a temporary disability retirement list and facilitate a smooth transition from the military into the VA system. This piece was lacking in all phases of his hospitalization.

As a health care professional, it is not responsible practice for patients who are on narcotics to legally sign papers, especially if they are diagnosed with a head injury. Waiting significant periods of time for medical care should not be an option.

My proposed recommendations are: Improved discharge planning, increase the number of health care professionals available to care for our veteran population, increase the support capabilities to assure soldiers who live miles from a VA Hospital can receive care locally, timeliness of care should be a priority, decrease the time it takes to increase a disability rating and give financial support to the VA Hospitals. The integration of these two systems is crucial

in eliminating many of the discrepancies and miscommunications currently being experienced by our soldiers today.

In closing, I truly hope that this committee understands the value of the commitment that my son and others gave. We owe it to the soldiers still in battle and those who return every day to make a concerted effort never to let another soldier who was injured, receive a second insult, because they felt abandoned by their country. I thank this committee for the honor of expressing my opinion and I thank you.

The CHAIRMAN. Thank you very much for your testimony and we will go to questions when all of our witnesses have concluded.

[The prepared statement of Mrs. Stiffler appears on p. 141.]

The CHAIRMAN. I would like to ask Colonel Frame if you would proceed.

STATEMENT OF COL. ROBERT FRAME

Col. FRAME. Good morning, Mr. Chairman, honorable members of this committee, I am Dr. Robert Frame, Reserve Officer with the 352nd Civil Affairs Command, and also Assistant Under Secretary of Health for Dentistry for the VA. I have been on active duty since October of 2001 serving in Pakistan, Afghanistan, and then had a short break and returned to the States and remobilized for Iraq. I am most proud of the ability to serve my country in both positions.

The comments I wish to offer today are my own and do not represent either organization that I belong to. Let me make that clear to the committee.

As an injured soldier with injuries that have left me with a disability—I have lost the use of a left hand and part of the use of my left arm. My clinical profession, I am a maxillofacial prosthodontist, a dentist, so I cannot practice my clinical skills again. So I think about the continuity of care available to me and my fellow soldiers as we share experiences at Walter Reed and throughout this process.

I have given a lot of thought of the transition away from the safety of the military care that I am receiving and my colleagues are receiving. On April 27th, my public health team was on the way to a ministry of public health. We were ambushed by five individuals on the high ground in the center of Baghdad. My left arm was basically blown off. I tied it to my gas mask and continued to fight for about 20 minutes and we were able to escape. All five members of my team were injured all five got out alive and are back to productive life.

I would like to note that within 90 minutes of being shot, I received a plastic shunt that rehabilitated the vascular system in my left arm and returned circulation to the arm. This forward surgical team did this and that is the reason I still have my arm. The army system at this level is outstanding. I was immediately medivacced to a combat support hospital. And within several hours, I had fixation of the arm and then a vascular graft was placed from a vein removed from my leg and continued restoration of vascular support. By May 22, I was at Walter Reed Medical Center in intensive care and I spent the next 60-plus days in a bed at Walter Reed receiving outstanding care.

Certainly, some of the comments that one of my colleagues' mother has made is very important to listen to. And I think if I were to focus on one of them, it is that it is not the individuals providing care, as all organizations we have systems issues to fix. And I am comfort that both—can have the that both organizations are working on them and it is something to know and important to note. The individual care that and I my colleagues received on the ward as we shared—and Nelson being one of them. We spent some time together on the ward—I would rate as outstanding.

As far as the commitment and as far as the quality of care. From the perspective of a patient with future needs for specialized care, I would like to offer two areas: I am aware that—my comments I think would reflect the feelings of many of the men and women that I have met over the last several month since I have been recuperating at Walter Reed Medical Center and we have shared a lot of these ideas. So I think the main thing is that we would like to feel assured that there is a seamless transition between DOD and VA care, uninterrupted and that quality of life for us and our families is impacted in as positive as way as can be possible. In this situation, one still has to seek out the positive sides.

I am aware because of my position in both organizations that both DOD and VA have been working extensively to assure this transition for quite a while. I have worked personally with Dr. Roswell for many years and than he is a formidable advocate for veterans and I am sure he will address this. There are two areas that I would like to comment on. One of them is the issue of the flow of information. Patient information from the ground level all the way through the system is essential. It is something that in my previous position in the VA we worked at, and we do have success stories to tell.

VA does have a dental electronic record that includes imaging capabilities and speaks to 209 clinics and we issue working with DOD to make that linkage as well. There are areas that I assure you is happening.

This flow of information is essential. At each stop, clinicians use this information starting out on the grounds when I was medivacced as a paper piece of information that came with me and moved along my travels. It tells the story and this is the information that will pass on to the VA for benefits disability ratings and continuing care. And if this record is not complete, then it will not help any of us. Neither clinician nor the patient.

The purpose of this en route care in the army process is to ensure that the same high standards of care are provided from the point of injury forward. Accurate and complete patient information is essential at every juncture of this process, and once at a fixed facility, these data should go into the electronic record and at that point, accurate documentation is critical, and we have commented that we would like to see the ability of those data to flow electronically, DOD and VA, as a critical factor. This seamless movement of patient medical information would give us a great deal of comfort and security and from the clinicians, I know that a great deal of security.

The second item, very quickly, is the question that arises continuously about VA's future capacity and the commitment of our

government to maintain that organization as a standing organization. It is important because of the uniqueness of veterans. The men and women that I've spoken to throughout these last several months always ask will the VA have the skills, will they have the staff, and will they have the ability for our health care needs over time, because as we age, those needs do become more complicated.

I'm 55. Most of my colleagues are in their 20s. I can tell you there is a significant difference. Many also ask if the VA will be around to care for us, and family members that I've spoken with are fearful of not being able to properly care for their loved ones without the support of such an organization. And my personal belief is that there is no other organization that can touch the uniquenesses of what veterans feel, not only physically from a health standpoint but emotionally. It is a support system.

In closing, the transition from VA to DOD care is extremely important to numerous soldiers, to the veterans, and to their families who do not have many times the recourses for this unique and very needed care if the VA did not exist.

In addition to the unique care, VA also provides an environment in an atmosphere of security and familiarity for veterans, and for those of you that have been in combat, I think that will follow us for a long time.

VA also has provided a center of gravity and balance. Very important to us. As unique members of society and certainly not—I think at least myself—not expecting special attention from other parts of my society I hope to return to be a productive member and pay my dues and be evaluated at the same standard as everybody else. However, to have a center of balance for us during the times that we need the special care, is extremely important. I can't emphasize that enough.

VA does have a number of centers of excellence, and if there were one issue that I would comment in closing is the fact that it's not only the center of excellences like spinal-cord injury, like prosthetics, and rehab, like mental health, dentistry, audiology, podiatry, speech pathology, but it's the ability to have a clinical service that brings it all together. One-stop shopping would be a slang word that would describe what most of us would like to see, at least, have be available to us.

I appreciate the opportunity to share these thoughts and feelings, and I know that these are shared by many of the men and women that have served their country and given their all to the service of this great country. We still are the best country in—coming from somebody that's traveled a lot of the world through my years in the Army—and this is part of it.

In Bosnia—in closing—we worked with the Bosnian government to try to help them form a veterans' service organization system to take care of veterans, because they recognize that importance, even with their fragmentation. So I appreciate the opportunity to comment. Thank you.

[The prepared statement of Dr. Frame appears on p. 149.]

The CHAIRMAN. Dr. Frame, thank you very much for your testimony.

And Mr. Villegas, if you would proceed.

STATEMENT OF NELSON J. VILLEGAS

Mr. VILLEGAS. Good morning, Mr. Chairman, Ranking Member, and distinguished members of the committee. First of all, I would like to take the opportunity to express my sincere appreciation for allowing me the honor to appear before you today. I would like to praise the committee members for conducting an oversight hearing on such a significant issue.

My name is Nelson Juan Villegas, U.S. Army, sergeant retired. And it is, indeed, a privilege for me to share my experience as I transition from the Department of Defense to the Department of Veterans Affairs Health Care Services. As I look back, I ask myself the following question. Was I provided with seamless health care coverage during my transition? The answer is absolutely.

On May 3rd, 2003, I was medically evacuated from Germany to Walter Reed Army Medical Center for further management of severe rhabdomyolysis and lactic acidosis with subsequent compartment syndrome. Furthermore, my hospital course was complicated by blood loss, renal and respiratory failure. As a result, I underwent a bilateral below-the-knee amputation just before Mother's Day.

My prognosis was tenuous at best and expected to expire within 72 hours. An expeditious medical retirement took place based on death being imminent. This would secure my retired status and greater benefits for the next of kin. Therefore, I was medically retired from active duty on May 7th. I gained consciousness a week later and suddenly became aware of my condition.

My new status as a retired—excuse me—as a retiree presented me with unthinkable personal challenges that needed to me met. These include pay issues, living arrangements, property management, and transportation.

The procurement of durable medical equipment and prosthetic care was also of great concern. All of these obstacles were surpassed thanks to the coordinating efforts between the Department of Defense and the Department of Veterans Affairs staff.

Currently, I receive care interchangeably from both departments without any complications. All of my physical rehabilitation, prosthetic fittings, and medical follow ups take place at Walter Reed Army Medical Center. I seek dental care, driving rehabilitation, and the acquisition of medical equipment from the Department of Veterans Affairs.

I have scheduled several appointments with both institutions and have been seen shortly after. Also, medical equipment order has arrived at reasonable time. Evidently, an aggressive effort has been made on their part in order to provide me with the best care possible. The high level of concern expressed by both hospitals regarding my disability bears witness to their joint commitment to care for veterans just like myself.

Furthermore, to my relief, the existence of the Foreign Medical Program has reassured me that the future care of conditions related to my disability will be properly covered overseas. Also, the Vocational Rehabilitation Program has made possible for me to continue pursuing my educational and employment goals. Also, disability compensation payments provide me with means of subsistence otherwise unable to attain.

Whether I was an active-duty soldier or retiree, either an outpatient or inpatient, the continuum of care that I received at both hospitals has been nothing other than excellent. I have been treated with the utmost professionalism and respect. Therefore, my transition before and after my medical discharge was completely seamless and transparent regardless of my unique situation.

In closing, I would like to thank the Committee of Veterans' Affairs for granting me the opportunity to share my testimony before such an honorable group of our society.

[The prepared statement of Mr. Villegas appears on p. 151.]

The CHAIRMAN. Thank you very much, Mr. Villegas.

I'd like to now ask Mr. Halcomb if he would proceed.

STATEMENT OF SENIOR MASTER SERGEANT ROBBIN D. HALCOMB

Sgt. HALCOMB. Good morning, Mr. Chairman. Ladies and gentleman. My name is Robbin Halcomb, and I'm a Senior Master Sergeant with the Indiana Air National Guard, the 181st Fighter Wing in Terre Haute, Indiana, and I've been in the Air Force National Guard for almost 29 years.

During that time I've deployed to Italy, Norway, Germany, Macedonia, Bahrain, Guatemala, and most recently to Turkey, participating in Operation Northern Watch, Operation Noble Eagle, and Operation Enduring Freedom. I would like to thank you for the opportunity to tell my story and the story of thousands just like me who have had the greatest honor to serve in the armed forces of this great Nation as a member of the reserve component.

On March 8th, 2003, I was injured while stationed at Incirlik Air Force Base, Turkey. I had 7 hours of surgery to repair a shattered elbow. After 3 days in the hospital, I was released and continued by duties with the 39th Air Expeditionary Wing.

After returning home the 22nd of April, I made an appointment to see my family physician for follow-up treatment, as I've been told to do so as I need to correct the range of motion in my right arm that I'd lost because of the injury. Because of the extent of my injury, the Commander of the 181st Medical Group, Col. John P. McGoff, requested that I remain on active duty. The National Guard Bureau denied that request, along with several others from our unit. I was released from active duty on the 15th of June 2003.

On the 16th of June of this year, I applied for veterans' benefits at my local courthouse. The first words spoken to me "You're in the Guard. What makes you eligible?" I promptly showed him my DD 214, and their attitude immediately changed to a more professional one.

I was told that the process would take up to 9 months before a final review of my case would be determined. I received notification about the 15th of July to report to the Roudebush VA Medical Center in Indianapolis for a medical appointment on the 16th of August for testing and evaluation. I am sill awaiting word of that approval. The medical evaluation at the Veterans Hospital in Indianapolis was the very best treatment I've received in any medical facility.

I have been around for many years and have many good friends retire from active duty, and they were the ones who advised me

about the possible benefits to which I may be entitled. The problem is I would never have any idea, even after 29 years, that I could apply for veterans' medical benefits had they not told me, you know, being on active duty and still in the Guard.

I still have pins and wires in my right arm that need to be removed, but who is going to pay for those medical follow-up treatments now that I'm off active duty. Will my own personal Blue Cross/Blue Shield pay for it since I was on active duty when injured? They have in the past been paying for some of my stuff. Will the VA cover the cost of my medical claim as approved? Or will TRICARE pay for it because of the line-of-duty determination that was accomplished? These questions remained unanswered until September.

I am personally saddened by the fact that several Guardsmen from my unit, who have been injured on active duty, have been discharged or some are even pending discharge right now and some have lost their full-time jobs, because they were unable to perform their duties due to the injuries that occurred to them while on active duty.

Six members of the 181st Fighter Wing requested to stay on active duty, pending medical recovery, and they were denied that entitlement. This type of action in the Guard is known as Operation Deny Entitlement.

Federal agencies also need to be made aware of who and what is a veteran. It shouldn't matter if the veteran holding the DD 214 is a Guardsman or a Reservist. And I'm not here to whine nor complain about the medical treatment that I received while on active duty or any other place. The medical care given to all of us has been second to none.

I'm here today because there's a disconnect between what happens to an active-duty member when they are injured or retire and what happens to a member of the reserve component when the same thing happens. It seems like there's no equity, and you can ask T. Sgt. James Wilson, M. Sgt. Dave Roberts, or T. Sgt. Marty Lathrop. I had an opportunity to take care of some his problems yesterday with the Congressman. All of these men have legitimate military-related injuries, and to me, all of them have been denied equity.

When a member of the active-duty force retires, they're afforded an opportunity to attend a retirement school. Then 60 to 90 days prior to their discharge he or she was given a physical. There's always a VA representative there to take their claim and process it if they so desire.

The members of the reserve component are not afforded the same opportunity, and many go throughout retirement years without ever knowing about or applying for veterans' benefits that they have earned. We also need to receive a retirement physical and retirement counseling.

I have worked side by side with my active-duty counterparts every day, and have done so for almost three decades. There are thousands more just like me, and I'm very proud to serve with them all.

Only they do not know about what benefits they may be entitled. There needs to be an equitable process so when you return from

defending our Nation's freedom on active duty you, as a Guardsman or a woman, have the opportunity to seek VA benefits without trying to track down what their benefits are on your own. I cannot stress enough that need for equity.

We need the awareness for our veterans' rights while we serve and when we retire, but, most of all, we need equity with our active-duty counterparts.

Thank you for your time and your service to this committee.

[The prepared statement of Sergeant Halcomb appears on p. 154.]

The CHAIRMAN. Thank you very much, Sergeant, for that testimony, and, you know, your words concerning the disparate treatment between Guard and Reserve and the active force needs to be taken very seriously. We have a total-force concept. We know that especially with the deployment now to Iraq that our military could not be sustained; our projection of power and force could not be sustained without the integration of the two, and it seems to me that you've made a very strong statement concerning the importance that the treatment during and afterwards be equal. And the word equal seems not to have been followed with regards to yourself and some of your friends.

So I thank you for bringing that to our attention, and I hope that it's taken back, as well, by our friends—the good people at DOD and VA who are here and who we will in follow up to this hearing be pressing for additional reforms. We're all on the same side, and I think we're all on the same page. We just all need to do it a heck a lot of better than we have heretofore. So I want to thank you for that.

I do want to note, Dr. Frame, you talked about the outstanding care that is a systems' issue to fix, and I think you put your finger on it really well. That the care provided by the Department of Defense, starting with the actual treatment on the battlefield and right through, was second to none, but there seems to be glitches in spades all over when it comes to the hand off of the baton. And I thank you for highlighting that for us.

I would ask, if Mrs. Stiffler could comment; as you have pointed out, you served as a trauma coordinator at a major teaching hospital. Did your son have written instructions following him as he went through his ordeal? Did he have a case manager that insured that his interests and the totality of his need for care were followed as he went through the system or was that lacking, and what would be your recommendation along those lines?

Ms. STIFFLER. We had spoken to a social worker on several occasions when my husband and I were there at Walter Reed. So those were the contacts—we had to ask specific questions related to his disability, related to health insurance, those types of things, were able to be answered. So that's how we received the information.

As to how the transition would occur with the Veterans Affairs, Veterans' Administration; the VA Hospital would contact Jason to render his care in the future, we asked questions, there were conversations, but there wasn't a specific assigned case manager to my knowledge, otherwise I would be able to call them directly.

I had a contact there, Col. Truelove at Walter Reed, and he was a wonderful Social Worker, he was the Department Head for the

Social Services Department at Walter Reed, and he tried to answer as many questions as he could. But upon discharge when Jason had questions, he had to go through the transition center there, which he had to leave several messages, and many of those went unanswered or couldn't be answered.

And when he would call the inpatient clinical side of the rehab department there at Walter Reed, the inpatient clinicians couldn't answer his questions, because he was no longer part of their system.

So there's a real, you know, transition problem from going from an inpatient clinical piece to going into the VA system when there's no contact or no liaison between those two establishments taking place at the time Jason was in the hospital.

The CHAIRMAN. Let me ask, Dr. Frame, in your testimony you focused on what needs to be done in keeping track of care. Were there gaps or omissions in your record that led to you coming forward as you have, or did you pretty much pick it up from other people who had gaps?

Col. FRAME. Most of it has been from other people. I do have the benefit of being a doctor also, so I was able to be aware of many of the things that were going on. So my testimony is probably one sided in that sense.

I was always very vigilant. On the other side I could also, I think, more confidently attest to the positive side to the flow of information. My comment was more to emphasize the importance of the flow of information during in-route time.

I think, as I look back at the paperwork that I have in my hands in my folder at home, most of what happened was documented, and the real key will be when that starts to be consolidated into an electronic format that will then transition to VA, and I have not—that has not—I'm not at that stage that.

The CHAIRMAN. Mr. Villegas, you were complimentary to the both the DOD and VA departments for the care that they provided to you. And I think it's important that, in your case they seem to have gotten it right throughout, and it was seamless, as you pointed out.

As far as you know, did the VA and DOD use a common medical record in your case? You got everything you needed and there were no gaps?

Mr. VILLEGAS. As far as I'm concerned, the only thing that I have not received as of yet is my medical records from Germany, but my inpatient medical records at Walter Reed I have a copy of those and I submit those to Veteran Administration. So that's basically what I know so far as far as my records.

The CHAIRMAN. Okay. And, Mr. Halcomb, you mentioned several other NCO's whom you believed were denied services for injuries they received while on active duty. Can you just elaborate on that a bit, if you would.

Sgt. HALCOMB. Yes, sir.

The CHAIRMAN. Was that anecdotal?

Sgt. HALCOMB. No, sir. The individuals I spoke of one of them works directly for me, T. Sgt. Marty Lathrop, who's in his final stages of his medical evaluation board and stuff, and it seems to me all three of these people have suffered injuries, and the Air

Force says they are pre-existing conditions. Yet, his medical records are set in Terre Haute, Indiana, and the board being held in Texas, and they've never looked at his medical records, other than the fact of the time that he was injured in Turkey.

And he's been on active duty for almost 2 years, pending surgery. It's a pretty complicated thing. He injured his back and they fused his back. At the same time they found cancer in his back in a different area. So it's kind of a—obviously, half the problem was the—half the problem has been his injury that he sustained while on active duty, and the other half was a pre-existing condition. And every one of them seems like—we have had I know five people who have gone before boards on active duty, and every time it's pre-existing.

So if something was happening to me, you know, my medical records, even after 30 years wearing a uniform, it's going to be pre-existing, but if you count the number of points and stuff that I had, you know, it's been like 10 years of active duty, you know, and after 30 years, one out of every 3 days, I've been on active duty. So which one of those 3 days did I—did it not become a pre-existing condition.

The CHAIRMAN. Thank you. Have they appealed?

Sgt. HALCOMB. They are in the process of appealing, and I met—I can't remember the Congressman's name—Shimmel or something—from Illinois.

The CHAIRMAN. Shinkis?

Sgt. HALCOMB. Shinkis. I met with him yesterday and took his appeal package up to him. Martin is in severe pain, and he's doing a lot of—problems with the drugs and stuff like that. So he's in the process of working that. But he also has an attorney that's working it. So there's some client issues that the Congressman is going to try and work out and stuff.

So I really do appreciate him taking the time yesterday to see me for—about one of his constituents.

The CHAIRMAN. Well, for the record, because I know Mr. Shinkis very well. He's a very effective lawmaker, but if our committee can be helpful, as well, we'd like to be engaged, so thank you. So, please, share that with us, as well.

Mr. BILIRAKIS. Mr. Evans, Lane Evans.

Mr. EVANS. Thank you, Mr. Chairman. This has been an excellent hearing. I think it's important for all of us, not even those that are on the committee, to understand what these individuals have been going through in the last few months.

Mr. Halcomb, have you attempted to seek care from the VA, and if so, what was the result?

Sgt. HALCOMB. Yes. I've been awaiting the evaluation. You have to go through an initial evaluation. They said they take up to 9 months, but thanks to this committee calling me up to testify I called the VA to find out my status and—I called them. That was before I found out I was coming, and then I called Friday and I mentioned that I was coming up here to testify and the person on the phone within 10 seconds was able to tell me that they're going to give me a 10-percent disability for the arm that I can't move anymore. So for that I appreciate.

Mr. EVANS. Mr. Chairman.

The CHAIRMAN. Mr. Bilirakis.

Mr. BILIRAKIS. I just, you know, thank you, Mrs. Stiffler, and Mr. Simmons certainly said it correctly. What the moms must be going through when their sons and daughters are in the military. My mother had three of us in the service all at the same time, and what she must have gone through. I guess have everybody appreciate it, and you guys are our heroes.

The testimony by Mr. Halcomb, I mean all of it is so very critical, but the fact that he's in the Air National Guard and how the reserve—the role of the reserves in the National Guard play in today's world and today's military is sort of really impacting. Out of the 29, 30 years about a third of that—about 10 years is spent on active duty, right?

Sgt. HALCOMB. Well, I'm a full-time technician, and so they count the points when we do our drill weekends. So I've—as a full-time Air technician, I've had an opportunity to travel to other countries and stuff. So, probably, for about 3 years but for points in retirement it's about 10 years' worth of points; of active-duty points.

Mr. BILIRAKIS. I see. But about actual 3 years on deployment so to speak?

Sgt. HALCOMB. Yes, sir.

Mr. BILIRAKIS. Well, the thing is is that I think we all, including DOD, has just realized the significance of the Reserves and the Guard, and, as I said earlier, today's military society and today's world. I know we're doing concurrent receipt right now, and as you may know, we had the special pay in the legislation that was signed into law last year.

But the—somebody made the decision apparently in DOD that Air National Guard and the Reserves were not to be included when, in fact, that was our intent all along that they be included, and there will be a piece of legislation coming down the pike in just a few days that will include the Air National Guard and the Reserves, and we should always keep that in mind. Thank you very much, Mr. Chairman. It's been very illuminating.

The CHAIRMAN. Thank you very much. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Thank you for holding this hearing. I don't think that—I'm on both this committee and Armed Services Committee, and in my view the Armed Services Committee is not doing a good job in providing oversight in a whole lot of areas, and I appreciate your diligence in putting together this hearing.

Ms. Stiffler, I was a family doctor before I did this line of work, and your comment about inadequate discharge planning is really concerning, particularly, for a complicated patient like your son has been and is. And I hope that's something, Mr. Chairman, that we'll take a look at. If it's a personnel problem or a money problem or whatever it is, but that's the kind of very specific way—a very specific way of helping these folks get through a system when you've got geography and they may be in areas where they don't have any family members around.

Col. Frame, in your—you're a dentist; is that correct?

Col. FRAME. Yes, sir.

Dr. SNYDER. And also been in involved in public health. One of the things that has really surprised me in the GAO report is their

statistic that 36 percent of people did not receive two or more immunizations. Did you see any of those numbers?

Col. FRAME. I'm not sure what your——

Dr. SNYDER. Well, the GAO is going to testify, and they have this report, that by their account 36 percent—when they reviewed health records, 36 percent were missing two or more required immunizations. I found that shocking. I mean, we can talk about quality assurance and discharge planning, but every once in a while you've got a statistic that's a canary in the mind, and this is the most basic thing about sending people overseas. Do they have their immunizations or not?

I think it must be so difficult for the health care providers when you have a service person come in if they've got—if they're febrile or upset stomachs or whatever it is if you realize that, gee, maybe a third of them or over a third of them don't even have adequate immunizations. Do I have to look and try and figure out if I'm dealing with something that we thought everybody was immunized against. Do you have any comments about that?

Col. FRAME. I understand your question. I can only comment within my Civil Affairs Command.

Dr. SNYDER. Fine.

Col. FRAME. I know in our special operations community that is not a great problem. Everybody is very—all of my colleagues were anxious to be vaccinated. In my own unit I know that we review that on a regular basis, as new members come in. That's one of the jobs that I do myself for my command, my unit. So that has not been a problem for us.

Once in a while something may escape us, but other than that, nobody in our Civil Affairs Command that I'm aware of deploys in that condition of being under prepared from a vaccination standpoint.

Dr. SNYDER. I guess being Civil Affairs and a public health team you probably have a very positive bias. My guess is, though, if we talk to these unit commanders they will all say—we say is it important to you? And they absolutely having immunizations is important. That's just a shocking figure. Such a basic part of preparation for going overseas.

Thank you all for your service and for your time here today. It's very helpful.

The CHAIRMAN. Thank you, Doctor. Chairman Buyer.

Mr. BUYER. Mr. Halcomb, we're trying to figure this out. Post-Gulf War this committee, along with the Armed Services Committee, put a lot of time and effort into solving these issues with regard to Guardsmen and Reservists when they serve and then they come back off active duty.

In your particular case it's hard for me to comprehend and understand why the Guard Bureau didn't keep you on active duty. I think it would be very hard for even General Peake or anybody to even defend that judgment.

So give that aside. Number one, that's where the system failed you there. Now, that you go back home and you have injuries now even as I look in our own committee's statutes that we passed referenced to the Persian Gulf War, and trying to interpret then what we've, even as a committee, had drafted. We talk about injuries

when you served within a theatre of combat operations. Well, you know, we're all thinking about the things that occurred post-Persian Gulf War. This is one of these things, though, that, you know, we come in and we want individuals to be taken care of. That's what we learned about from the first Gulf War, and I don't understand why the VA, though, even following the spirit of this intent—even though we ended up in Gulf War II—would not have cared for you.

Here's where I'm caught. You had testified that you were pleased with the medical care you received at Roudebush, but then you also went to your private doctor for medical services. Why did you do that and not stay at Roudebush?

Sgt. HALCOMB. Because my medical care—my doctor was immediately following coming back from active duty. We do not have—in Terre Haute, Indiana we do not have, you know, an active-duty base around or doctors, other than the local doctors. So TRICARE, my insurance, paid for my physical therapy and the orthopedic person in Terre Haute, Indiana.

When I come off active duty, because I did not have a DD form 214 until July the 15th—until June the 15th when I come off of active duty—on June the 16th after I'd already been doing physical therapy and stuff, is when I went and then—I just filled the paperwork out. Then it takes a month—you know, they did it pretty fast. A month later they give you a schedule to come in a month later on a Saturday just for an initial evaluation to look at your paperwork.

You have to be, you know, accepted into the VA system in order to get treatment there.

Mr. BUYER. As a full-time tech, you access TRICARE?

Sgt. HALCOMB. No, sir. I have Blue Cross/Blue Shield.

Mr. BUYER. How did you gain access to TRICARE?

Sgt. HALCOMB. When you go on active duty.

Mr. BUYER. Yes, but you got off active duty. How did you gain access to TRICARE? You went to a private doctor of whom then Blue Cross/Blue Shield sought a sublimation against TRICARE?

Sgt. HALCOMB. No. After you come off active duty for a 60-day period, you get—you have coverage for 60 days with TRICARE following your active duty. They give you a continuous, which is a grey thing.

Mr. BUYER. The hard thing—here is what I'm trying to figure out, because we have overlapping systems——

Sgt. HALCOMB. Yes.

Mr. BUYER. And our intent—I think the intent of the committee and, I believe—I sure wish Dr. Snyder were here. He serves on the Personnel Committee—the intent is to make sure that these soldiers are taken care of.

And we're throwing around the word "seamless," but there really are two systems here, and the Guardsmen and Reservists do make it complicated. And if it's hard for someone, such as yourself, who's a full-time technician, can you imagine what it would be like for someone who doesn't work with these systems.

Sgt. HALCOMB. Yes, it is a nightmare for the traditionals.

Mr. BUYER. So I can't wait for Secretary Ed Wyatt to testify. Really, I can't, Ed. I'm not picking on you, but because we sat down

and tried to figure this stuff out beforehand, and now I feel awkward that as hard as we worked to try to make sure that all of you would be taken care of somehow it has failed itself.

Secretary Principi came before this committee and also provided testimony that when someone is discharged that we're going to take care of them for 2 years. I don't understand why you were—when you were discharged you weren't informed that the VA would be there for you. Did anybody inform you?

Sgt. HALCOMB. No. In the last week I have spent time, including this morning before I came here, spoke to an Army sergeant standing outside of the JP One who is retiring from active duty next month, and I asked her if she had ever had in her entire military career a briefing about her veterans' benefits, and she says, "Well, I've been a Guard Person." She said, "What kind of benefits can I get?" And I told her you need to look them up.

And, I think, it's an easy fix. I think when we deploy—when we come back, part of our deployment checklist is at the very end of it, hey, can we have a VA rep come in and speak to us, our county reps. You know, it doesn't have to be a VA rep. It could be myself. Someone who has learned the system to stand up before our people and say this is what you're entitled to, and give them the web sites. Your web site at the VA has an unbelievable amount of information.

Mr. BUYER. So as part of your out processing, that was done?

Sgt. HALCOMB. No, it's nowhere on the out-processing checklist at all.

Mr. BUYER. Well, the good thing your testimony before us today is you have—the surgeons general are here today from all three services, listening to your testimony, and they can address that issue hopefully——

Sgt. HALCOMB. I can feel the stares in my back.

Mr. BUYER. Actually, I want you to know that they deeply care about you.

Sgt. HALCOMB. Yes, I know they do, sir.

Mr. BUYER. So out of the four of you as you testified and you were thankful and appreciative for the medical services of all of those teams, you know that's what they are in charge of. But they also are going to be attentive listeners, because they want to make sure all of you are taken care of. That's what they're in the job for.

So I want you to—when you leave here today, I want you to know that you're making a difference in your testimony, and I appreciate it and yield back.

The CHAIRMAN. Thank you, Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman. I'll just be very brief, because I appreciate your testimony very much, and we have some others that we want to hear from, as well.

Part of what you're suggesting, however, is this—whether it's an information educational piece, which is not costly.

Sgt. HALCOMB. It's free.

Mrs. DAVIS. And, you know, so it always amazes me that we don't do a very good job at that. And where—you know, you suggested some of the points that we need to do that. I know that serving from—you know, in San Diego and I know that they are doing much more in the way of educating families and

servicemembers about what their entitlements really are under this, but we still miss a great deal of that, and so I know we've done some of that even up on our web site in trying to get that information out.

But where else—I mean, are there other ways that you feel that we miss it in terms of providing that information?

Sgt. HALCOMB. You know, I have been absolutely amazed about how much information was out there for veterans, and the information was there, and for some reason I just never—I personally never took the opportunity to seek it until one of my friends, who's retired, became a veterans' county rep—every county in the State of Indiana has a veterans' rep, representative there.

So when he started telling me about some of the benefits and I started checking into them, I was like, well, can I still do it and remain in the Guard and they said, "Sure."

So the word is starting to get around at our unit, and I spoke to a sergeant major yesterday from Louisiana Army National Guard, and he said that they've been given briefings every couple of years on—that they took it on themselves to do that about VA changes and stuff like that.

So, I think, it's an easy, free fix, and, you know, we can do it—each organization can just say, hey, you're going to be the VA rep and learn all there is about the VA and put together a death-by-PowerPoint slide and give people the information they need. I think it would be a fairly easy fix for us to let us know what our benefits are once you leave the service and while you serve.

Mrs. DAVIS. Did you want to comment on that?

Ms. STIFFLER. I guess from my point of view, I think, there's several areas that it can be introduced, Obviously, as the new recruits come in to their troop-program units as a Reservist, the education can begin there. It should be given before deployment, as a readiness package and after they come back and return.

A lot of times information is given to the individual when they're in high-stress mode. So it's better to either do it before versus when they come back, because they're so anxious to get the uniform off and get back to their families.

Discharge planning to me doesn't begin when the soldier is ready to be discharged, it begins on admission. That is educating, preparing the families, preparing the soldiers for the life changes, and so it can be done as a steady process, especially, for the most severely injured patients.

Obviously, you can't do a lot of education in an ICU for the soldier, but you can begin with the family. So as the trauma starts to subside, it can be more articulated to them and they absorb more.

I mean, when you're in a high-anxiety situation, you're not going to take on the information as much as if you waited a little bit and start articulating to the patients then.

Mrs. DAVIS. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Chairman Brown.

Mr. BROWN of South Carolina. Mr. Chairman, I'll pass.

The CHAIRMAN. Okay. Mr. Strickland has left. Ms. Brown.

Ms. BROWN of Florida. Thank you, Mr. Chairman, and I want to thank you all for your testimony. It was very, very informative.

Yesterday I was at Walter Reed, and everybody was very pleased with the service that they had received out there. They thought it was the best, the very best. And the families was there.

My question is that in the transition—I liked the way, Chairman Smith, you mentioned passing out the baton. It seems as if the breakdown is with the passing off of the baton. Is the family members involved in the discussion about the benefits that the service person receive?

Ms. STIFFLER. I guess I'll answer that first. The family members are in need of education, a lot of times it requires you (family members) to ask the question. So to me, that's why I'm indicating, you know, and recommending discharge planning, so that they (the military) can make a checklist of the things that need to be discussed with those family members.

And, yes, it is transition. It's the time that's spent finding out where your resources are that if they were just given to you in advance you wouldn't have to try and climb back a ladder that you were hoping you'd already climbed.

Ms. BROWN of Florida. Does anyone else want to respond to that?

Sgt. HALCOMB. Yes. The Air National Guard does a great job of family support. We have—every base has an organization to help with transitions and stuff before and afterwards. And the Air National Guard—I can speak from Indiana—everything I've seen from the national level to the Guard Bureau does an outstanding job of family support.

Mrs. DAVIS. Sir, let me just ask you one question. But you was not given in writing your benefits as it pertains to the VA?

Sgt. HALCOMB. No, ma'am.

Mrs. DAVIS. And so this is something that we're not doing in the transition; is that what I'm hearing?

Sgt. HALCOMB. Well, it's something that—maybe it's me not doing. Me not going out and finding the information that's available and passing it on to my troops. You know, we just need—you know, now that I'm aware of what is out there I take it on as my responsibility to serve my people that work for me at our unit, and I'll take that information back.

And we just need a point of contact in each unit who can become the expert in Veterans and pass that information on to the families or to the individual members who are serving this great Nation.

Ms. BROWN of Florida. I agree with you but I have National Guard units in my area in Jacksonville in Florida, and so it's not an organized program assisting to get the information out?

Sgt. HALCOMB. No, ma'am. It is not organized, but it could be. From the National Guards, the directors are sitting here. I mean, they could just say, okay, from now on when anyone deploys, we add that to the bottom of the checklist to someone do a VA—and we initial it off. It's a done deal. We can say that we honestly served our people. We gave them every benefit that they were entitled to.

Ms. BROWN of Florida. Is there money involved in this, or it's just passing the responsibility down?

Sgt. HALCOMB. No, there should be no money involved in this at all. It should be basically someone putting together a PowerPoint

or just, you know—it doesn't have to be a big leaflet. It could just be someone giving the briefing.

Ms. BROWN of Florida. Well, thank you.

Mr. BUYER. Ms. Brown.

Ms. BROWN of Florida. Yes, sir.

Mr. BUYER. Would you yield for a second?

Ms. BROWN of Florida. Yes, sir.

Mr. BUYER. I think your inquiry is very good, and could we find out from your other witnesses that you're asking your question whether or not they had received any information from VA out processing?

Ms. BROWN of Florida. Yes, sir. The other two gentlemen, please.

Mr. VILLEGAS. Well, in my personal experience I would like to thank Mr. Christopher Reed, who is the liaison representative at Walter Reed, who just very recently after I gained consciousness he went personally to my room and we did the paperwork required for me to receive my benefits.

So in my case—in my individual case I had a very positive flow as far as the applications and everything that I needed to take care of.

Ms. BROWN of Florida. You, sir.

Col. FRAME. In my experiences this current deployment, again, I echo the comments about Mr. Reed. He was within 3 or 4 days of my being in the intensive care ward. He talked to my brother, because I was not in condition to talk so my brother kept all the papers for me.

And then he followed up. He also advised me that I had other recourses, which is my state veterans' system, and I used that just for convenience sake. In all three of my most recent deployments, which were all 9, 10, 12 months worth each time, I did get at the time of redeployment a significant packet from the VA, listing benefits—and my whole unit did—and significant mailing follow ups, as well.

So I think what was stated previously also in the Reserve and Guard I think a lot of times we don't pay as much attention to these issues, because it's not part of our primary life. I find that even myself being a VA employee and a reservist we sometimes don't pay attention to a lot of this paperwork we receive, because it doesn't have any obvious significance initially to us. So that's been my experience.

Mr. BUYER. I think the—is that these two gentlemen, who were in a VA hospital that had veteran's benefit advisors, and we have the gentleman from the Air Force who came directly from the field and was discharged would not have received that benefit.

So what you're pointing out, Ms. Brown, is that there's tremendous gaps here in the system of these overlaps and I appreciate your questions.

Ms. BROWN of Florida. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. The chair recognizes Chairman Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman, and I thank the participants for the dialogue that just took place. It illustrates the point that the dissemination of information is a command responsibility under certain commands and certain situations that takes place, but under other situations, it does not take place.

That in and of itself is a problem from my perspective, and I will have to say that Command Master Sergeant Halcomb's testimony spoke to me and to my experience as a Reservist after active duty serving for over 30 years in the reserves. And that when members of my unit and then my unit itself were deployed there was not a push of information that you might find in an active-component unit. You know, it has to be pushed, and the command has to take responsibility for it.

Dr. Snyder, I think, has pointed out that the Armed Services Committee, on which we both serve, has some responsibility for some of these issues. You can't have a seamless transition if there are gaps between the oversight committees and the agencies that are responsible.

So that's the challenge that we face, and, I guess, my own feeling is that when somebody in the Guard and the Reserve is activated and injured or disabled in some fashion that the system has to push a benefits package at them, so that they know what their rights are.

And that, in essence, may be what we are looking at—a situation where we need to frame a bill of rights for people who fall into this category, so that we're sure the system pushes it out, not just to the individual, because as we know, the individual can be severely injured and, perhaps, not in a perfect situation to make these decisions.

But, also, the person with power of attorney, the caretaker, the family, the loved one is brought into the process. I just simply want to say that I think this has been a very useful interaction with the panel, and I think that it will be very interesting to hear what some of the others have to say later this morning.

Sgt. HALCOMB. May I say something for a second?

Mr. SIMMONS. Please.

Sgt. HALCOMB. The VA put out these pamphlets. They just handed me one. And I just received these, and I handed them out to my troops October 4th and 5th when we had our unit train assembly.

So the VA is getting the information out there, but I got it after I'd already had my testimony and everything ready. But they have these pamphlets put out, and I have insured that all the people at my unit that I'm responsible for have received these, these pamphlets and stuff. It's very good information, but I still think we need to have a program where we actually—somebody reads this to them.

Mr. SIMMONS. Well, recovering my time—and if anyone else wishes to comment, I welcome it. The VA has it but the question is who's pushing it and at what level should it be pushed.

As Mrs. Stiffler pointed out, there's a transition out, even when you're wounded—when you're injured or ill, there's a transition process out, and should that be something that shows up after you've gone through the process, or should it show up at the very beginning?

If you're in a hospital, I suspect that you get it early on, but if you're in another location and another status, that may not occur. And, I think, culturally, it's important to understand that for many years the Guard and the Reserve were strength and reserve. They were not necessarily deployed in the late 1970s and the early

1980s. My unit was not deployed for 38 years of its history, and then for the last 10 years they've either had members deployed or the unit deployed four times in 10 years.

So the role of the Guard and Reserve has changed dramatically, but some of the attitudes have not changed. That's what has to change coincident to the change in role, or members who serve in the Guard and Reserve are just going to get out. They're going to see what happens to others—to their friends and colleagues. They're going to say we don't want that for us. Thank God we're not injured or wounded yet. We're just going to get out.

And the current numbers coming out of Iraq show, as I recall from the Stars and Stripes study, a 37-percent group of people indicating that they will either get out or they're thinking of getting out.

So—but we have a serious problem here that involves this committee and the Armed Services Committee, and I really thank the witnesses for bringing it up. If you have any comments, I'd be happy to hear them, but I think I've run out of time. I yield back.

The CHAIRMAN. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman, for bringing this panel, and I want to thank all the panelists and also thank you for your service.

I know that—Col. Frame, I think you talked a little bit about the importance of continuity of care, and I was just curious in terms have you ever seeked out any data or information in terms of medical records from the Department of Defense and, if so, how difficult is it or did you encounter some problems or——

Col. FRAME. I have—at this point, other than at Walter Reed, and they've given me copies of everything that I've gone through to include the packet that followed me during the medivac process. So I have not had any problems to this point.

Mr. RODRIGUEZ. Do we know—I'm throwing it out to everybody—do we know—I think as we go from hospital to hospital, region to region, as to how it varies, getting that data—the medical records from the Department of Defense for the VA for the purposes of following up on veterans?

Sgt. HALCOMB. I don't see—everybody that I've talked to has seen that their medical records followed them, you know, seamlessly through the system. And I can only speak on the people that I know of that I've spoke with.

Mr. RODRIGUEZ. So that doesn't seem to be one of the difficulties then?

Sgt. HALCOMB. No, sir, it has not.

Mr. RODRIGUEZ. And, you know, I just personally also want to thank you for—and, you know, I am what Chairman Simmons just talked about the importance of the fact that the Reserves now is a very different Reserve, and somehow we need to come to grips with that and try to standardize the services that they're provided, since they're also out there. And so somehow we got to see if we can streamline that process.

And just that—I know that we—in the past we've passed legislation to try to correct some of these problems, but there seems to be—there's still some gaps there that, even though it's not sup-

posed to occur, in some cases we still have those problems in terms of the lack of information that's either—that our veterans receive.

And I was just hearing, for example, right now we have another 1500 or so that have been injured in Iraq. And so how that—and I had read that article that young lady that got injured in Iraq and then got—and then found herself having difficulties getting access to service. So we need to streamline that process as much as possible. And thank you very much for providing the testimony. Thank you.

Mr. BUYER (presiding). Ms. Hooley, you are now recognized.

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you. Chairman, those that put this together thank you very much for having this hearing. A couple of things. One is we had an oversight hearing on the importance of having—before you go into the service, before you're deployed—making sure that you've had a physical. That you've had your dental work all done, so that we know what kind of condition you go in as you go into service or you're deployed.

Do you have to ask for the records, or do the records automatically go from the Department of Defense to the VA? Your medical records do they automatically when you have—when you're discharged, do those records go from the Department of Defense to the VA, or do you have to ask for your records and you take them to the VA?

Col. FRAME. Generally, as a soldier, one tries to carry copies of everything that you own that represents your situation, and most of us will walk out with hard copies of what we have. Having been away for a couple of years, I'm not sure what the status of the electronic transfer of data is.

Ms. HOOLEY. But you want your own copy, but you don't know if that automatically happens through——

Col. FRAME. I do not know how that process works, other than the fact that we carry our own, and that's one thing that we all try to do.

Ms. HOOLEY. Okay.

Sgt. HALCOMB. I had to make copies of my medical records and took them to the VA when we filled out the initial paperwork.

Ms. HOOLEY. Did the VA have them, as well?

Sgt. HALCOMB. No, ma'am.

Ms. HOOLEY. So you carried them?

Ms. STIFFLER. As far as my son's case was concerned, because his medical record was so thick, he didn't have copies of everything. And so when he entered into the VA system, they didn't have any of his records. So they did have to submit to Walter Reed to get his records. So, they were not already there.

Mr. VILLEGAS. It's my personal experience that the VA went and asked for my medical records at outpatient section. Like the Colonel here, being in the military, I carried all my copies of everything that I have. So, basically, I have medical records for myself, another copy for the VA, and one extra copy that I keep with my family.

Ms. HOOLEY. I have just one other question for all of you. First of all, thank you all for serving and for your sacrifice.

If there's one thing that you could do differently to make the system work better, what would it be? Any one of you. I don't mean to put you on the spot, but, you know, what we're trying to do here is figure out how to make this better. We want to make sure that all of the people that serve have the best health care and the best treatment.

Col. FRAME. I think we have on both sides of—of both organizations some of the most stellar clinicians and health care people in the country. I think our ability to attract the best still exists because of many reasons.

I think our ability to—if I were to change one thing, it would be to put our systems on more similar tracks where possible, and that's dangerous ground to tread on, because our missions are different, our types of patients are different, there are significant differences that we need to protect on each side.

But the ability for flow of electronic information. The ability to talk and share on both sides from both organizations in both directions. A systems' organization of that sort where, not at a high level, but at a functional operational level we were able to interact more without having different types of systems. That would include using same electronic systems. That would include using similar educational processes, a number of things that would bring clinical and administrative people closer together.

Sgt. HALCOMB. I guess if I would change one thing it would be, just like I said, is to notify the Reservists or the Guardsmen of what benefits that they are entitled to before something happens. And that would probably be the only thing that I would change, and that's what I plan on changing. The VA has already helped me out by providing us with a summary of our benefits to the National Guard.

Ms. HOOLEY. Okay. Thank you.

Ms. STIFFLER. Systems are great but if people don't know how to utilize the system, it does no one any good. So for me, the systems that are put in place, if they're to work, we need to educate and train the soldiers, not only from a Reservist standpoint, but active duty, because those kids are so young going in, as young as 18 years old. How many of them are really concerned that they're really going to get injured over there. A lot of them are just ready to go.

So we need to educate and train them as to how the system works and the resources that are allocated to them if and when they need to use them.

Mr. VILLEGAS. In my case I think that a liaison in each hospital. That basically did a great difference in my case. Also, the great staff for social work program at Walter Reed is absolutely excellent and mentorship like—mentorship like Mr. Jim Mayer make a great difference in my case, too. Thanks.

Ms. HOOLEY. Thank you so much all of you for your testimony. I really appreciate it.

Mr. BUYER. Mr. Boozman.

Mr. BOOZMAN. No questions.

Mr. BUYER. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman, and thank you all for your service and I apologize. I may be repeating a little ground here. I wasn't able to be here from the beginning.

But I wanted to ask Mrs. Stiffler. I see in your statement you talk about Jason suffering from depression and having mental problems. And you talk about the disability that was given by the Army Medical Board being 40 percent.

My question to you, I guess, is it seems to me that sometimes mental problems can be completely disabling. I mean, they can be fully a hundred percent just on their own, and when you look at Jason's problems, his physical pain, his head injury, the disability that he's received, I mean, does this look to you like a fair disability rating in terms of what they've come out with?

Ms. STIFFLER. I do not think it was a fair disability rating, and that's why I mentioned it in my statement. I think it really just concentrated on his paraplegia, to his lower extremities, and they didn't really look at the holistic picture of the soldier.

So, you know, to me, not only was he having signs of post-traumatic stress, the depression that goes along with losing, you know, losing the use of both of your lower extremities, but also just being in a traumatic injury and all of those things that one must go through when they're injured.

So I didn't feel that it was fair, but it wasn't until I spoke to a Col. Fred Brown in the Air Force Reserves several months later that he indicated that we could have appealed it, and Jason had already signed the waiver to waive his rights to go into the VA system.

So I can articulate to you the same as he did as far as a Reservist. As a captain in the Army Reserves, I did not know what the rights were of my son as a full-time, active-duty soldier. Somehow there was miscommunication. There was no communication as to what we could have done. If they articulated it to him with a head injury, with memory loss—I mean, he still has episodes where he doesn't remember things.

So to me, it should have been given to family members so we clearly understood what the rights were. They may have told him that he could have appealed it, but it was never indicated to any of us that that could have happened.

Mr. UDALL. And by signing that waiver, then he no longer has the right to an appeal?

Ms. STIFFLER. He gives up his military pay, my understanding is he gives up his military pay and benefits and transitions over at that point into the VA system, and then you have to then go into the VA system, once you're discharged, because he signed the waiver previous to being discharged from Walter Reed. Then you have to go through the VA system to get an increase.

So you're left with—because they don't go on the 40 percent—the 40 percent doesn't articulate as pay. They have to increase it to 50 percent. So you have 50 percent of his pay. So it automatically decreased him to below the poverty line for a family of three, and then he has to then fight another battle to get that increased, and he was very upset and extremely concerned with that, once he really took hold of what had happened to him.

And it took months for him to understand what happened by signing that waiver and what that did.

Mr. UDALL. Did he—do you know—have you talked to him what were the circumstances under signing the waiver? I mean, family members were not involved at all in the signing of the waiver?

Ms. STIFFLER. No. I had requested to be there, and I requested that through the social service department, as well as I articulated that to the staff, but that didn't happen, and I also asked that if there's any other signing of papers that would happen that I would be there, and that didn't happen either.

I would talk to him over the phone, but his ability to tell me minute details was not there. So he still doesn't remember things, you know, down the line so to speak to give us a more articulate view.

But I found out that he had signed the waiver after the fact. I found out the board had met after the fact and—even though I had requested to be present.

Mr. UDALL. And from what you know of the situation, if you had been there, you would have, I assume, recommended that he not sign the waiver?

Ms. STIFFLER. Well, it's not that I don't feel like the Veterans' Affair Administration and the system is going to take care of him. They are the ones that have pushed for him to have, you know, his wheelchair, his landford crutches, the adaptable prosthesis, things that he needs in order to make all the activities of daily living comfortable for him.

It's just that knowing the process and his rights and, you know, just being there as an advocate, there was no one there, even though he requested someone from social services to be present, to be an advocate, they didn't have an extra person to be by his side. And so he had to do that on his own.

And his wife wasn't there all the time they had a small child. She couldn't stay at Walter Reed continuously, and I was in North Carolina. So we didn't find out until after the fact that he had actually signed the papers.

Mr. UDALL. Thank you very much and let me say that I don't think that this is the way we should be treating one of our brave soldiers that has returned and is injured. I think everything should be done when you have a head injury and have some kind of indication of mental problems that you involve the family and reach out and you're given more options.

And I thank you for being here today and thank the rest of the panel. Thank you, Mr. Chairman.

Mr. BUYER. Thank you very much. Is there anyone else—recognize Mr. Strickland. You're now recognized.

Mr. STRICKLAND. Thank you, Mr. Chairman. I want to thank those of you who've have been here and shared your experiences with us today. I was particularly struck, Mrs. Stiffler, with your testimony. It's just very—it's very troublesome. The fact that the medical board did not recognize the head injury difficulties or did not consider that when your son was given his disability rating I don't know how to explain that.

I mean, I really think that's something that we need to look into. Because anyone who has any familiarity with head injuries would

know that that's going to be an impairment and, probably, a lifetime impairment; a significant impairment. And for them not to have considered that, I think is—I don't know if it's negligence or incompetence, but there has to be some explanation for that. And it's troublesome to me that that was not part of his disability rating.

You also indicated the need for the soldier and the soldier's family to have an advocate, and someone who is taking it upon themselves to fight through the morass of rules and regulations and circumstances and say, you know, this is what we ought to do for this person. And so—that's something that we ought to attend to.

I was also struck by the fact that you were complimentary of the people who provided the direct care. Colonel, you talked about the uniqueness of the VA system and the fact that the care you got was good care. And, you know, we're creating more and more disabled veterans, and the injuries are severe.

And the fact that there wasn't a social worker upon request to be available to your son. The way to solve that is to have more social workers and that takes money.

And I just would close my remarks by reiterating to my colleagues on this committee we are under funding VA health care. We need at least 1.8 billion dollars. The problems we're talking about here this morning are system problems, programmatic problems, but they are problems that can be solved in large part with resources.

And we can talk about procedures and processes, but if we don't have sufficient resources, there are going to be more people who are going to be experiencing the kinds of difficulties that you all have experienced. We need to own up to this responsibility as a Congress and provide the resources that are needed to try to keep these terrible things from happening to really good people.

I really honor you and what you have done for this country. Thank you so much for your testimony. I yield back.

Mr. BUYER. I'd like to thank all of you for coming and testifying here today. Behind us those of us who sit on this committee these flags depict all the veterans' service organizations in our country and the members. And, actually, they also serve even non-members of whom might be in like status.

If you'll turn around and you look to the back of the room—if you look to the back of the room, you'll see, not only the American flag in the middle, but you then see the service flags, and all of you have seen the color guard come forward, and you'll see the battle streamers there on those flags, representing many battles that have been fought. I just want the three of you to know and, mom, that your son—you did exactly what a lot of people did that came before you, and that is you answered your Nation's call to duty and you did your duty to your best.

Your country is grateful. I also want you to leave here today knowing, again—I'll reiterate—that you've made a contribution, and I also believe that we have also marched this forward, because I look back at the end of the Persian Gulf War and things that we wanted to do and began to work more on seamless integration. The fight then was gaining access to care, and how do we compensate

individuals for unknown diagnosed illnesses when we had tens of thousands of individuals who became ill, injured, and sick.

And, now, what we're talking about is how do we make that hand off better, and is the compensation enough. So what I want you to know is is that we're walking this toward a better system, and your contribution is admirable. You are now excused.

The second panel——

Ms. BROWN of Florida. Mr. Chairman——

Mr. BUYER. Yes.

Ms. BROWN of Florida. I just have a follow-up question, because I agree with you that the soldiers have really done their job. The fall down is right here. That we are falling the fund and 1.8. But I have a follow-up question to the mom.

I want——

Mr. BUYER. Oh, I'm sorry.

Ms. BROWN of Florida. No, no. She can't answer that question.

Mr. BUYER. Oh, all right.

Ms. BROWN of Florida. But this is something that we need accountability for. I don't know how they requested to be present and was not present when they pushed for the termination of this young man. I don't understand where is the breakdown there, and I think we need to do a follow-up, because if they put it in writing that they wanted assistance and it did not happen, that's a breakdown on, not their part, because they've done their part. It's accountability right here with us. And what can we do to get answers to your question.

Mr. BUYER. Thank you, Ms. Brown.

Ms. STIFFLER. May I make one last comment?

Ms. BROWN of Florida. Yes.

Ms. STIFFLER. I guess I would say that I know that Mr. Principi has tried to address this by sending some liaisons from the VA to help soldiers within the major hospitals across the United States. I would say that when family members do ask for social services to have a benefactor or an advocate there at the soldier's side that it should be honored.

That—I can't speak to the process. I know that there are very few of them in each of the institutions and they're very busy. To have that extra liaison, social services can work on the issues at hand, whereas a VA liaison and a coordinator can act as an advocate to that patient and that soldier.

So I think there's two different processes here that maybe need to be merged so that your—you have a total advocate for each soldier that's admitted.

Ms. BROWN of Florida. Can I ask you one. But you requested to be present?

Ms. STIFFLER. I did. I requested that to social services, as well as to the staff, that when the boards were to convene that I would be called. I didn't receive the call, and Jason couldn't articulate to me when that was going to happen. It was only after the fact that he called and said, "It's happened. This is the rating." The same with signing the waiver for the VA.

It's not that we didn't want him in the VA system. It would have just given us the ability to ask those pertinent questions, such as what does being on a temporary duty list, retired duty list mean

to him? What kind of benefits does he get and does he not qualify for?

Ms. BROWN of Florida. So no one articulated his rights or he wasn't able to do it, and you don't know whether or not he had any assistance during that time period?

Ms. STIFFLER. That's correct. Because I wasn't there and his wife wasn't there. So we have—you know, when you're trying to talk with head-injury patients, they can be very articulate, they can carry on conversations with you, but when you ask them the next day what happened, they can't verbalize it back to you. That's a typical secondary-head injury from trauma.

So it's something that he may have been able to say, yes, I understand my rights, but you need to understand with a head injury that can happen all the time, and families need to be brought into that process.

Ms. BROWN of Florida. Thank you, ma'am. Thank you very much.

Mr. BUYER. Thank you, Ms. Brown.

Now, I'd like to introduce the second panel, if you'll please step forward.

Neal P. Curtin is the director of the GAO's Defense Capabilities and Management Team with responsibility for managing GAO's work on military readiness and operations issues. His work covers all military services, focusing on readiness measurement, trends and problems.

Concurrently, Mr. Curtin serves as manager of GAO's Norfolk Office. He moved to Norfolk in 1995 to assume the role of the regional manager and became dual hatted in 1999. He resides in Virginia Beach, VA and maintains offices in Norfolk and Washington, DC

We'll also hear testimony from Chaplain Gary P. Mauck. He's a U.S. Army Reserve Lieutenant Colonel, currently serving on active duty with the 3rd Infantry Division at Fort Stewart, Georgia. He was commissioned Chaplain in the National Guard in 1978. He completed five overseas deployments for training in Turkey and Germany.

Chaplain Mauck was called to active duty for Operational Enduring Freedom this past May for 365 days. He was then mobilized to Fort Stewart, Georgia as the Deputy Installation Chaplain for Mobilization.

Please extend our appreciation for the commanding general of the 3rd Infantry Division permitting you to testify here today.

Lt. Col. MAUCK. Yes, sir.

Mr. BUYER. Dr. Harold S. Kudler is a mental health coordinator for Veterans Integrated Service Network Six, where he manages the mental health service line for eight VA medical centers and their outlying facilities across North Carolina, Virginia, and West Virginia.

Dr. Kudler is an expert on post-traumatic stress disorder, stemming from clinical and research work with combat veterans, ex-prisoners of war, survivors of other traumatic events, and their families. In 2000, Dr. Kudler was appointed co-chair of the Under Secretary of Veterans Affairs' Special Committee on PTSD, and in 2002, Dr. Kudler was selected to champion a joint VA/DOD project

to develop clinical practice guidelines for the management of traumatic stress.

Mr. Curtin, you're now recognized for 5 minutes.

STATEMENTS OF NEAL P. CURTIN, DIRECTOR, DEFENSE CAPABILITIES AND MANAGEMENT U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY CLIFTON SPRUILL, ASSISTANT DIRECTOR, DEFENSE CAPABILITIES AND MANAGEMENT, U.S. GENERAL ACCOUNTING OFFICE; CHAPLAIN GARY MAUCK, LT. COL., U.S. ARMY RESERVE, FORT STEWART, GEORGIA; AND HAROLD KUDLER, M.D., CO-CHAIRMAN, UNDER SECRETARY FOR HEALTH'S SPECIAL COMMITTEES ON POSTTRAUMATIC STRESS DISORDER, DEPLOYMENT OF VETERANS AFFAIRS

STATEMENT OF NEAL P. CURTIN

Mr. CURTIN. Thank you. This is Mr. Cliff Spruill, my assistant director, who headed up the specific study that we're going to talk about today. I especially appreciate being on the panel with Chaplain Mauck. People around town always say GAO should have a chaplain with them when they come to call. So I think it's very appropriate today.

And since my full statement is in the record, I'll try to summarize quickly. I just want to make one quick point about the importance of medical records. I mean, I'm basically going to talk today about our study, dealing with record keeping, which isn't always the most exciting subject, but I think this committee understands, more than most, that in the medical field good records aren't just important. They're really a matter of life and death in some cases.

And I think both DOD and VA recognize how much they need good health-status information and complete medical records to perform their missions. DOD needs it to make sure when it deploys forces they've got a healthy force that they're sending overseas and to track their continuing health status of its forces. And, of course, VA needs the data to adjudicate veterans' claims for disability compensation related to service-connected injuries or illnesses. Both organizations need this kind of data for epidemiological studies and trend analysis.

And with the rapid pace of deployments these days, more and more servicemembers are deploying to hot spots around the world for multiple deployments, so tracking health status related to these deployments is an increasing challenge and is more important than ever.

The work that we've done in this study I'm going to talk about today stems from requests from the House Armed Services Committee, the Subcommittee on Total Force, the Personnel Subcommittee. It's really based on the law that was passed back in November of 1997, Public Law 105–85, that required DOD after all the stories from the aftermath of the Persian Gulf War and work that we had done actually back in 1997 on deployments to Bosnia that recognized DOD was not gathering and maintaining the kind of data that it needed.

Congress actually put the requirements in law calling for things, such as a pre and post-deployment medical examination, immuni-

zation records, and retention of blood-serum samples, among other things. The law also called for centralized storage of medical records and for DOD to establish a quality assurance system to make sure that the proper data was collected and maintained. So proper records are a good thing to have. Clearly, important but they're also a part of the law now.

So our study was commissioned by the Armed Services Committee to take a look at how well DOD was carrying out those requirements and the regulations that they set up to implement the 1997 law. And let me first summarize our methodology a little bit, because what we're looking at is a complex system here, and the Committee asked us to look across all the services.

We limited our study to the Army and Air Force. They were the two main services deploying overseas at the time of our study, and we looked at the active-duty force only. The scope of our work included servicemembers deploying overseas for Operation Enduring Freedom, which was a Central Asia, Afghanistan operation, and to Kosovo for Operation Joint Guardian, a peace-keeping operation.

It covered deployments beginning during 2001 and returning to the United States—returning to their home station by May 31, 2002 with some exceptions. Let me emphasize that that timing does not include Iraqi Freedom. The scope of our study would have been before the deployments began for Iraqi Freedom.

We do a random sample——

Mr. BUYER. Mr. Curtin——

Mr. CURTIN. Yes, sir.

Mr. BUYER. Do you have any ability whatsoever to comment on Operation Enduring Freedom, based on Mr. Winkenwerder's testimony before our subcommittee?

Mr. CURTIN. I'm going to talk a little bit about what DOD has done since this study. There are things DOD has put in place. We don't know how well those are working at this point. We know DOD has reacted to the findings that I'll present here, but we don't have anything on the deployments for Iraqi Freedom.

Mr. BUYER. You can remain in scope then.

Mr. CURTIN. I hope you have a set of color charts. I think these are the best—it should have been in your package. I think these are the best way to summarize our findings. These are also in my prepared statement, and let me just kind of walk you through these, if you have them.

This figure one is the percent of servicemembers missing one or both health assessments, either the pre-assessment or the post-assessment. It's also on page 10 of our prepared statement. Let me interject here, and, Chairman Buyer, you know even more than I that these are health assessments. As you said earlier, these are not medical exams.

DOD is not doing medical exams before a deployment. What they're doing are these health assessments, which are basically a questionnaire. So we were looking at whether they were complying with the health-assessment requirement that they had set up, and what you see is a fairly high percentage of servicemembers who did not have either one or both of their pre-assessment or post-assessment. And you see it as high as 98 percent in one case.

The—I might mention all of these charts are based on samples that can be projected within the units we visited, not Army wide, not Air Force wide, but these are random samples that are statistically valid for the units we visited, including the 101st at Fort Campbell, the 10th Mountain Division at Fort Drum, and the units—special operations unit at Hurlburt Field, and Mobility Wings at Travis Air Force Base.

Figure two shows the results for immunizations, and as Congressman Snyder point out earlier, the rates for immunization records missing for two or more different immunizations were as high as 36 percent. Now, that's at Fort Drum, 10th Mountain Division for the OEF deployment, and if you recall, that was a fairly rapid deployment. They deployed within a month to 6 weeks of September 11 in 2001. So there might be some link there, because the deployment was so quick they might have missed some records. But everyone seems to have missed some or multiple immunizations.

Figures three and four deal with the centralized database, and we actually found records—in going through the personnel medical files for the selected-sample members, found records in their file that were not in the centralized database and vice versa. Figure three shows files—shows records that were in the centralized database in DOD, but there was nothing in the individual's medical file, so we're not sure where that—what the source of the data in the centralized database might have been.

Figure four shows the percentage that were in the personal files, but never got into the centralized database. So there are continuing problems with this interface between the individual's medical records and the centralized database that's required.

We also looked at some other elements; blood-serum samples, tuberculosis screening. Timeliness, when they do health assessments, were they done within the time frames required. Referrals for indications of problems. And the results were, frankly, similar. We have lots of room for improvement. Kind of mixed compliance in the different categories. No particular pattern to them.

Let me turn then to the one last thing I wanted to cover, and that's our recommendation. It kind of gets at the question you raised earlier. All along as we were doing this study and visiting individual bases, performing the sample study, we were sharing all that with DOD. In fact, DOD had—the services had representatives right there with us, kind of going through the files with us to make sure we weren't missing anything. And they knew the results at each location, as we finished the work.

And in March of this year, the assistant secretary, Dr. Winkenwerder, invited us to come up and brief him and the surgeons general on where we were at that point; what we were finding. And he asked me——

Mr. BUYER. Mr. Curtin.

Mr. CURTIN. Yes, sir.

Mr. BUYER. Can you hold your thought there. We're going to have to recess for approximately 25 minutes. We have votes on the floor and we'll return. You can hold that thought about your conversation with Mr. Winkenwerder. I'm most interested because he's not here today. And we'll resume after these votes.

[Recess.]

The CHAIRMAN. Welcome back. Mr. Curtin, you may resume.

Mr. CURTIN. I'll just pick up where I left off. He asked me at that meeting what did DOD do about this, and my response back in March was basically the same as the recommendation that's in our final report that's just been issued. DOD needs to establish a quality assurance system to make sure that the policies and requirements are being implemented at the unit level.

They've got the right set of regulations, the right set of policies for the most part, but they're not getting the attention they need down at the unit level. So unless DOD demonstrates to the services that this is an important activity, it's probably going to continue to get spotty compliance.

And establishing a system of quality assurance is not only a good idea, it's in the law. It's a requirement of the 1997 law, and DOD had never implemented it.

Now, to its credit, after that meeting and at the time of our draft report being sent to DOD, they did begin taking some action on this, even though it's 6 years since the law was passed. They have begun to do some things, and they outlined a number of actions in their response to our draft that they already have underway, including monitoring these pre and post-deployment health assessments at the centralized data collection point.

DOD also said that the services—each of the services have implemented quality assurance programs of their own now, and many of these are at the early stages, but they seem to be steps in the right direction. And we have not had a chance yet to look at the implementation of this quality assurance system DOD is putting in place, and, I think, the key to its success will be follow through, as with most things, to make sure that the system is working and there's continuing emphasis down at the unit level.

And let me go ahead and stop there, Mr. Chairman. I'll be glad to take any questions.

[The prepared statement of Mr. Curtin appears on p. 156.]

The CHAIRMAN. Thank you very much.

I'd like to ask Chaplain Mauck if you would proceed.

STATEMENT OF LT. COL. GARY MAUCK

Lt. Col. MAUCK. Good afternoon, Mr. Chairman. I am a chaplain in the Army Reserves. I was ordered to active duty on 10 May 2003 for 365 days to Fort Stewart, Georgia, home to the Army's 3rd Infantry Division.

I am the deputy installation's staff chaplain for mobilization, and I am tasked to work with both active duty and reserve-component soldiers at Fort Stewart. I work to provide counseling, liaison with mobilized Reservists, and work with returning active-duty personnel of the 3rd Infantry Division.

The mobilized Reservists are from both the U.S. Army Reserves and the Army National Guard. I work with the unit ministry teams that are being deployed to Bosnia, Kosovo, Afghanistan, Kuwait, and Iraq. I have also been the supervising chaplain in providing reunion briefings to the 3rd ID soldiers returning from Iraq.

Two other chaplains have been available to me to help with the briefings if I am unable to be at a particular briefing or if there

is more than one briefing at a time. The reunion briefings are part of the post-deployment and reconstitution program provided by both division and garrison elements.

It is a three-phase program. The first set of reintegration briefings took place in theatre and involved the leadership there. The second set of reintegration briefings took place at Fort Stewart and involved four groups of speakers. They are the Office of the Chaplain, Army Community Service Personnel, medical personnel from the Wynn Army Community Hospital, and the JAG officers from the legal section of the garrison.

The final phase of the program is the reconstitution phase and involves marriage enrichment retreats that are supervised by the Fort Stewart Family Life Chaplain. A program for single soldiers is available. It is called Pick a Partner Program and deals with dating, courtship, and marriage.

The third and final phase also includes ASIST training. ASIST is Applied Suicide Intervention Skills Training, and these briefings are held quarterly for all Fort Stewart personnel. These ASIST trainings are conducted by various unit chaplains of the division and garrison.

These briefings and retreats provide similar, well-coordinated information in order to reinforce the messages from the various support elements. In addition to the briefings, there is ongoing counseling support available from the active-duty personnel assigned to the 3rd ID and from the reserve soldiers called up to augment the work of the on-post personnel who are in support.

As a reserve chaplain, I work outside of the soldiers' normal chain of command and offer a place where a soldier can come for help without informing anyone in their rating chain. The types of problems that I encounter are separation issues, reintegration into the family and marriage, any problems of infidelity that may have occurred during the deployment, alcohol abuse, financial concerns, and flashbacks that some have experienced.

I am available to anyone who would like someone to talk with them about their experiences. My experiences in Vietnam and lessons learned in my years in the reserves and on active duty serve me well in my counseling situations. Some counseling sessions are by appointment. Most take place from walk ins and even take place in a more informal setting as I go around post and someone says, "Hi," and then stops to talk with me. I then follow up with those individuals at a later time.

The reunion briefings served to introduce myself to the 3rd ID soldiers, and they learned that I was available to them at any time. I also reminded them of their own unit chaplains that are available for counseling at any time.

The reintegration program is long overdue and very effective. I am pleased and honored to be a small part of this program and what it is able to do for the soldier and their family. Thank you, sir.

The CHAIRMAN. Thank you very much, Chaplain, for your testimony, and I'd like to ask, finally, Dr. Kudler, if you would proceed.

STATEMENT OF HAROLD KUDLER

Dr. KUDLER. Thank you, Mr. Chairman. The VA is the world leader in the care of post-traumatic stress disorder, but its clinical and research programs have primarily been directed towards veterans who suffer from chronic PTSD from Vietnam, Korea, and World War II. Starting with the first Gulf War and gaining momentum with September 11, the conflicts in Afghanistan and Iraq, the VA is learning to tackle PTSD proactively.

While VA must preserve our capacity to serve veterans of past conflicts, we now have to step up to meet the needs of a new generation of combat veterans. This means developing treatments for acute post-traumatic stress disorder, and whenever possible, preventing the development of chronic PTSD.

Over the past 4 years I've co-chaired the VA's Under Secretary for Health's Special Committee on PTSD. Our charge is to determine VA's capacity to provide assessment and treatment for post-traumatic stress disorder and guide VA's educational, research, and benefits activities with regard to PTSD.

One giant step in the right direction is a new joint DOD/VA clinical practice guideline for the management of post-traumatic stress. The work group for this project included members of Army, Navy, and Air Force, as well as VA medical centers, VA Readjustment Counseling Service, and the VA's National Center for PTSD.

The Joint Guideline is an evidence-based planning tool for the prevention, assessment, and treatment of men and women who have endured traumatic events. Perhaps the most fundamental element of the guideline is its recommendation to screen every man and woman at specific intervals in every DOD and VA primary care and mental health clinic. By identifying those at risk and those who are already suffering symptoms as early as possible, we may be able to prevent new cases of chronic PTSD.

VA has already identified liaisons to major military treatment facilities to assure seamless transition and transfer of care. They've also identified staff members to serve as points of contact at every VA medical center for returning new veterans.

The special committee is currently reviewing the role of these points of contact, as well as the VET centers in providing information about potential psychological effects of combat stress to veterans of Afghanistan and Iraq and to their families at the time of separation from service.

POCs could be provided with scripts based on scenarios they're most likely to confront, distribute brochures based on materials that have already been developed by the National Center for PTSD, and provide information about where veterans and their families could seek help if they need it.

The special committee is also considering how members of the military unit associations and VSOs might be able to provide support and referral to new veterans and their families when help is needed.

We've identified two key actions to complete the VA continuum of care. The first is to establish a PTSD clinical team at every VA medical center, and the second is to locate a family therapist in each VET center.

Current DOD efforts, such as the Army's Combat Stress Control Program and the Navy and Marine Corps OSCAR Program are excellent vehicles for implementing the Joint Guideline during ongoing military operations. Aspects of the new Joint Guideline have already been applied in Iraq and have been found useful there.

In military language "real grunts" see post-traumatic stress disorders, not as a reaction of a normal person exposed to a very abnormal situation, but rather, as a failure of training, of leadership, strength, or, perhaps, character. This is a stigma and it's the single greatest impediment to effective intervention and continuity of care.

Cultural change is needed across both VA and DOD. At present the single most effective recommendation I can offer is to embed the DOD/VA Joint Treatment Guideline with its assessment, treatment, and potential prevention capabilities into DOD and VA primary care and mental health clinics and to consistently apply it during DOD operations.

This will require development of software packages capable of seamlessly integrating the Guideline into both DOD and VA computer medical records system. And it has to be done in a manner that makes it easy, even preferable, for clinicians to use this rather than choose not to use it. VA is in the process of developing a monitoring system that will encourage utilization of the Joint Guideline.

In summary, many elements of a comprehensive transition process already exist, but they need to be strengthened, integrated, and more sharply focused. Ultimately, success in this area will require cultural change in both DOD and VA.

Mr. Chairman, this concludes my remarks, and I look forward to responding to questions.

[The prepared statement of Dr. Kudler appears on p. 183.]

The CHAIRMAN. Thank you very much, Doctor. Let me just begin with Chaplain Mauck. Some years ago I read the book, "The Grunt Padre," about Father Capadano, who received the Medal of Honor during the Vietnam War. It was written by Father Mode. It was a compelling story of a chaplain who out in the field made it his point to even go to the front lines and try to minister to the troops, and he died in the service of our country doing just that on a front line in Vietnam.

As I think was indicated earlier, some of our guys and ladies who are deployed might be less inclined to seek out care, based on some mental anguish they're going through; perhaps the beginnings of PTSD. They might feel more free and have more flexibility to go to a chaplain.

In your view, do we have sufficient chaplains deployed for Iraq and Afghanistan? Is there a deficiency there? And what has been your experience with what I had suggested might be the case; that there's an approachability, you know, you mentioned several of the things that you work on. Obviously, alcohol, financial reintegration, separation issues, and flashbacks, but is there an approachability that makes a chaplain more accessible?

Lt. Col. MAUCK. Speaking for the 3rd Infantry Division, they—all of the slots that they had for chaplains were filled, and one of my jobs is to make sure that every unit that's deployed from the

reserves and National Guard have a unit ministry team. That is a chaplain and a chaplain's assistant. And, of course, the chaplain is not required to carry a weapon, so the chaplain's assistant becomes an integral part of the survival of that chaplain on the battlefield.

The approachability of chaplains is the most important thing some people have. The chaplain is not judgmental, is always available, and you're right. The chaplains that mean the most are the ones that are right up there with them, sweating and sometimes dying with the troops.

The CHAIRMAN. Thank you for that and thank you for your service and all of you for your tremendous work on behalf of our military.

I do have a question now for the GAO with regards to your report, and I've read your report. It is chilling and compelling, disturbing. The one point that is made in your report is that the Air Force and the Army were not complying with DOD's own Force Health Protection and Surveillance policies, and you have the percentages that go up to 98 percent in terms of range.

My question is what impact does that have on an individual servicemember? What are the consequences for him or for her perhaps if a pre-existing problem is not caught, they're deployed, they don't get their immunization, they deployed? This could be very serious, wouldn't you say? Well, how would you respond to that?

Mr. CURTIN. Well, I think that's exactly right, Mr. Chairman. The purpose of the pre-assessment is to make sure before someone deploys if they are any conditions that need to be looked at before they would be sent overseas. And the purpose of the post-deployment is to make sure if anything happened overseas they have an opportunity to report that.

So not completing that requirement clearly have some implications there. Either there was no opportunity to express problems or to find problems or, you know, the opportunity has been missed.

The CHAIRMAN. And, Dr. Kudler, have you found that within the military there is a significant appreciation of PTSD? I mean, the VA has literally written the book—and you have been a part of that—on how best to deal with post-traumatic stress disorder, but it seems to me that there might be some deficiencies when it comes to the military in terms of recognizing what to look out for.

Obviously, there's a delayed reaction in many instances, so some of the early warning signs might be missed. The rapid deployment or re-deployments, all the movement, might make it harder to catch. Again, I'm sure there's a lot of collaboration with the chaplain corps to try to pass that baton off if somebody is more prone to a worse episode or episodes. What's been your sense on that?

Dr. KUDLER. Well, you're right. The chaplains really are a first line in the military, and, in fact, that's why we invited chaplains to be a part of developing the treatment guidelines so we wouldn't miss that. And I had a chance to work very closely for a year and a half with a group of DOD doctors. Some of them helped me create my testimony here and have already rotated through Iraq. They are back now, and have talked with me about how well the plans we made worked.

The fact is that there are obstacles in DOD. DOD is busy right now fighting a war. They've got a lot going on, and, yet, they sometimes miss the point that recognizing traumatic stress in the military during an ongoing operation is not going to weaken morale. It's actually going to increase the strength of the fighting force if they can catch that problem early and deal with it effectively. In addition, you've got troops rotating home and these people—especially, Guard and Reserve are not living within a community that supports who they are and what they do. You've got people just going back to their old neighborhoods. Where is the support for them and their families? They have really unique stresses and problems, and, yet, can the military meet their needs?

I think the biggest problem for officers in the military is that the people who have these problems are unlikely to come up and say "I have this problem," because they're concerned what will it mean for their career. And maybe many more of them are concerned what will it mean for the morale of the people I work with if I come and complain, if I come and say I can't do this. I better just keep doing it.

But all the officers know is they're just not hearing anything, so they say "no problem here." And, I think, they say it in all honesty. So there are built-in obstacles, but they can be overcome. Chaplains have always been a part of the solution, and I think by training administrators and leaders, as well as medical personnel, we could do much more.

The CHAIRMAN. Thank you. Let me ask one final question, and that would be to Mr. Curtin. On the issue of new policies, we have are new laws. Do we need new policies? Do we need new laws? Or does this basically come down to a leadership issue where we just need the right people to support it at the right time whether it be the seamless transition of data, more aggressive collection and chronicling of information and using IT to its utmost? What would be your take on that?

Mr. CURTIN. It's mainly a leadership issue at this point. It's the follow through, the emphasis, the priority. The policies are there.

The one area that's come up for—where there is a gap, I think, between what the law said and what DOD set up is this issue of the health assessments versus the medical examinations, and you may want to explore that with the DOD representatives. They implemented the law by going to these health assessments, a questionnaire, a screening-type of document, instead of a physical exam, which would ordinarily be what a medical exam is. And they have their reasons.

They said logistically it may be difficult for a rapid deployment to do a hands-on exam. Number one, we don't know if that's realistic or not, but I think that's an area if Congress feels these health assessments are not working that's the next step would be to require more of a hands-on physical exam.

Our point is you need compliance with the system you have in place to see if that works. We really don't know yet. I think, because of the poor compliance here, whether these pre and post-health assessments are accomplishing anything at this point.

The CHAIRMAN. Do you think it's likely that because there have not been the actual hands-on examinations, as opposed to the as-

sessment, that people have gotten sicker or have suffered? I mean, is there any empirical data on that?

Mr. CURTIN. A tough call. I don't have any data on that. The possibility is there but I can't say that I have cases where something was missed because it was a health assessment.

The CHAIRMAN. Is it because of lack of medical practitioners, doctors and nurses to do this that it's not being done?

Mr. CURTIN. Yes, probably a better question for the DOD representative. There are some logistical problems in doing it. I don't know that it's necessarily a personnel problem. Maybe a timing issue more than anything.

The CHAIRMAN. Let me just ask you who actually reviews the assessments to make a qualitative judgment as to whether or not somebody is deployable?

Mr. CURTIN. Well, the assessments are reviewed at each unit to see if there are any positive answers. If you have a condition—if you indicate, yes, I have a problem or a concern, those assessments then are reviewed at the local unit to see if there's any call for a referral or for follow up on that check mark, and, actually, we found problems with that process, as well.

Some of them that should have been referred for consultation did not get referred. So that system is not working perfectly either.

The CHAIRMAN. Was that an oversight or was that to provide sufficient troop strength for the deployment?

Mr. CURTIN. Well, I don't think we know. I don't know. A good question. I don't think we have any evidence.

The CHAIRMAN. Regarding the actual physical assessment sheet, is it comprehensive enough in your view? Does it capture the data we need to know?

Mr. CURTIN. Yes, I don't think we had any——

The CHAIRMAN. No problem with that?

Mr. CURTIN (continuing). Problems with that. One aspect of it that we might quibble with is the mental-health side of it. There are some questions, asking about the mental-health issues, but it's just a few questions in a long survey.

The CHAIRMAN. Well, let me ask you would some men and women in uniform be loathe to put that down on paper?

Mr. CURTIN. No question.

The CHAIRMAN. So a an actual examination with the privacy attendant to it would more likely reveal——

Mr. CURTIN. Absolutely. That's one of the problems with the questionnaires in general is that it's a self-diagnosis there, and the person could really want to go on this deployment and not want to show that he has any existing conditions, even though a medical exam might reveal one. There is some of that.

The CHAIRMAN. And that would be particularly true in the mental-health area?

Mr. CURTIN. Yes.

The CHAIRMAN. You know, unfortunately, there's still a stigma attached to mental-health issues. There ought not to be but there is.

Mr. CURTIN. Yes, sir.

The CHAIRMAN. And I can understand why somebody might falsify that, thinking they're okay.

Mr. CURTIN. Yes.

The CHAIRMAN. That is a good question for the DOD representative. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Mr. Curtin, I apologize for not being here when you did your testimony. I had to go to another meeting, but—before this issue of the immunizations, and I know that the bigger issue is the overall assessment but the immunizations is just one part of it. But it seems to me it really is an important part of it. That it's something that's pretty easy for everyone to understand.

I mean, there's even a culture in the military that you get lined up in boot camp and you get all your shots. I mean, this should be something that we all understood. You know, I can certainly remember getting them, and when I look at the list, I mean—having worked overseas a few times and not—I guess the longest was like 6 months in West Africa and 3 months in Asia and then another 3 months in Africa.

But when I look at these diseases, these are not unusual. Hepatitis A can be very common. Influenza is certainly common. I've seen measles overseas. I've seen mumps overseas. I've seen meningococcal disease overseas. I don't think I ever saw any acute polio, but I certainly saw people that had polio as youngsters.

I've seen tetanus, both in neo-natal tetanus and also tetanus in adults. I've even seen a case typhoid that—or at least what we believed was typhoid in a refugee camp in Thailand. So these are not rare—particularly rare things overseas, and, yet, when I looked at your chart here and you had at one facility or at one unit up to 36 percent had missed two or more immunizations and even higher numbers. I mean, almost half missing at least one. It's very concerning to me.

I understand in your testimony you said that it was—the leadership past had just established that as being important. Is that a fair assessment? Do you have any other comments you want to make?

Mr. CURTIN. Yes, sir. The only thing I might add on the highest level there for the missing immunizations was at Fort Drum for Operation Enduring Freedom, and if you recall that era there, September 11 came, and a month and a half later we had the 10th Mountain Division getting ready to deploy and showing up in Central Asia. So there was a short time period and an unusually quick deployment there.

So some of those numbers could be explained at Fort Drum for the 10th Mountain Division. Now, they're almost as high for some of these others. See, especially, an operation like Joint Guardian, which is a peace-keeping operation. Usually, the units know months and months in advance, maybe 6 months or a year in advance of when they're going to deploy.

So it's hard to see why you wouldn't make sure you had—everyone had their——

Dr. SNYDER. I may have missed it in your report, but you didn't break it out exactly which one was missing? I mean, if it came back, and it was all——

Mr. CURTIN. I do have some data on that. The two highest seem to be the influenza and hepatitis, either—hepatitis A, either the

first or second in the hepatitis series. But meningococcal was one of them. At Fort Campbell it was one of the highest, and it's hard to find a good pattern there, and it's hard to understand why the immunizations wouldn't happen.

Now, we looked everywhere we could look. We weren't just focused on the individual's personnel file. We looked anywhere that DOD sent us to try to find these immunization records and they just aren't there.

Dr. SNYDER. I'm going on a trip to the Middle East this weekend, and I got a call from our health clinic here that says you need a typhoid shot, and I went over there and there was my record with a big circle where it needed to be initialed and dated and it wasn't there. I mean, this is pretty basic stuff.

The other thing I noticed was that in DOD's response in your report back in September they—I know it meant a lot to you and I know it meant a lot to the guy who wrote it. For many of us who read those kinds of letters, it's like a lot of bureaucratic gobbledygook that—I have great admiration for people who can set up systems that work. And so I'm not minimizing what was said at all. I think it was really important to talk about.

I didn't see the word immunization or vaccination anywhere in that response. Did it not specifically address, you know, what I consider to be a canary in the mind as a sign that there may be some real problems with our health system. I would have thought that somebody may have been wiling to say, well, a lot of those influenza and these are young, healthy people that we don't necessarily——

Mr. CURTIN. DOD hasn't—even on—as we did these, base by base, location by location, DOD had all these results. The services knew just what we were finding and didn't really—never challenged the numbers at all.

Dr. SNYDER. I guess that's another point. No one came back and said, well, our record keeping wasn't as good as it should have been. We think it's 90-plus percent.

Mr. CURTIN. No, sir.

Dr. SNYDER. You'd have to think that they accept those numbers, which are not—you don't even have a herd immunity for these kinds of things. Thank you.

The CHAIRMAN. Chairman Buyer.

Mr. BUYER. In 1997, the GAO found problems with the Army's implementation of DOD's health-surveillance policies for the Bosnian deployment, and then in September of this year your office reported similar problems regarding the Army's and the Air Force's implementation of DOD's Forced Health Protection and Surveillance Policies for Operation Enduring Freedom in Central Asia and for Kosovo deployments.

In your opinion, Mr. Curtin, what will it take for the military services to comply with the Forced Protection and Surveillance policies?

Mr. CURTIN. I think it's going to take the top-level leadership to make it clear throughout the system and DOD that this is important. That this is valued. That's in the law. I think the emphasis has been on getting the regulations out there, getting the policy out there, letting the services implement it. And it hasn't worked.

What this shows is that leaving it up to the services to push the requirement down to the divisions and the unit level is going to provide these kind of results. You're going to have very spotty implementation, and what you'll get is if a particular base commander, a particular unit commander had some experience with this he'll put his emphasis on it. It will get done better at his location but not at other locations.

So it's got to come from above. It's got to come from the surgeons general. It's got to come from OSD, and that's the gist of the recommendation we made was to get some system in place so that the services know, not just—you know, there's a policy. You got to comply. But that somebody is going to be there to check on it. And that's what really makes things happen is when somebody knows you're watching and that this is important.

Mr. BUYER. Could you elaborate on the consequences to the individual servicemember if the services do not comply with the policies as stated in the statute.

Mr. CURTIN. Well, I think the biggest issue—well, obviously, the issue of the immunizations is important. People not getting the right immunizations are at real risk in some of the locations we're sending people nowadays.

These pre and post-deployment assessments are important, because they—not only could they help find an immediate problem and identify something that needs to be looked at right away, either before or after deployment—but they provide that record of what happened—what kind of condition a member was in before he deployed. What happened during the deployment, and then what he looked like when he finished that deployment.

That record is there then and should be very useful for—not only for the individual's help in keeping a good record of what happened to him—but for studies similar to what happened after the Gulf War where we really didn't know what was a pre-existing condition and what were things that happened in theatre that caused it. So there's both of those benefits to good record keeping here.

Mr. BUYER. You're very close.

Mr. CURTIN. There's more.

Mr. BUYER. No, I just—you're very close. It's—earlier, I used the word fascinating. Fascinating because obviously the next panel we're going to have Secretary Ed Wyatt. So when Secretary Ed Wyatt and I and John Chaplain we sit down and we write the law, how then was the law implemented? How were the words interpreted?

And now we are so far down range from where Mr. Wyatt and I and others intended when this legislation was put together and where are we today. And is it acceptable. That's kind of where we are, and that's why I'm anxious to get to the next panel.

You even were using the word assessments, as though that's what was the intent of the statute. It is not the intent of the statute, because we put in there physical exams.

Now, you're not the team that testified to the Oversight and Investigations Subcommittee here of VA, but—did you have an opportunity to speak with that team, referencing Dr. Winkenwerder's testimony?

Mr. CURTIN. Oh, yes. In fact, we had talked to Dr. Kanof even before that testimony. She knew our results. She was at that hearing.

Mr. BUYER. I'm trying to reconcile this, and if you are unable to answer, then I'll have to ask the next panel. This hearing was dated July 9th of 2003, okay. Did you give a briefing to Dr. Winkenwerder about your potential results or an update of your——

Mr. CURTIN. Absolutely.

Mr. BUYER. You did? And when would that have been?

Mr. CURTIN. In March of 2003, March 19.

Mr. BUYER. March 19th of 2003. So right in the middle of their deployments you gave him a brief? Okay, that's good.

Mr. CURTIN. Yes.

Mr. BUYER. Because in November of 2002, I met with Ellen Emory, who works for Secretary Wyatt, and what we're all trying to do is to get ahead of this one. And since the 10th Mountain Division didn't do very well—and that sits in Chairman John McHugh's district—I thought we could like get ahead of this one now.

And Ms. Emory told me in my office that you're right. We didn't get it right on the 10th Mountain Division, but we're going to get it right with those of whom they knew were about to deploy in a contingency or preparing for the contingency.

So I had to put myself in a comfort zone. That's what she said to me. It put me in a comfort zone.

I'm sorry. Mr. Chairman, may I have an additional few minutes?

And so I have to believe then that the system is going to work. Dr. Winkenwerder testifies before this committee on July 9th of 2003. On page 13 of his testimony, "We electronically archive each servicemember's pre and post-deployment health assessment in the Defense Medical Surveillance System. The Department of Defense has captured more than a million of these forms so far, and completed documents are available to health providers worldwide through our web-based program, etc."

Now, I have to look at your GAO report. How does the report reconcile with the testimony of Dr. Winkenwerder?

Mr. CURTIN. Good question. I don't doubt that they have a million records in their files, but they don't have all of them that they should. That's the distinction, I think. I don't think he's saying we have everything we should have. At least, he shouldn't be, because he should have known at that point that they didn't have all the records they were supposed to have.

He may have had a million. He may have felt that their database was accurate, but, clearly, the database is not accurate from our detailed sample here.

Mr. BUYER. Well, I want to thank you for your good work, and, hopefully—and I don't know the answer to this one, so I need to ask it. Is there a team within the GAO that is now taking your work and the other team's work forward with regard to Operation Iraqi Freedom?

Mr. CURTIN. Not at this point. The Armed Services Committee—the Total Force Subcommittee has indicated they want us to do that. Their suggestion was wait a few months to let the new system, you know, kick in here. DOD is setting up some systems fi-

nally to track this, and then come in next year and let's look at a similar sample here.

In fact, next year looking at Iraqi Freedom we include the Marines in what we've done, and we would probably include the reserves, as well.

Mr. BUYER. Now, be a good listener to the—be a good listener to what they've just asked of you. They're asking you to allow a passover—a passover over a major contingency and will let us then implement some new systems and then take a look at what we've done.

My suggestion, Mr. Chairman, would be that for us to have continuity is for you to—and Mr. Evans—send a letter over to the Armed Services Committee and ask for a joint request of GAO to continue their work. I think it would be beneficial. Mr. Curtin, would this be helpful?

Mr. CURTIN. Absolutely. And I think a joint request would be an excellent idea, because there's clearly interest from both sides here, and we can do it. We can do it. We were kind of responding to——

Mr. BUYER. How long do you think that would take? Six months?

Mr. CURTIN. Well, yeah. At least. Because of the—it depends on the state of the records. Our problem in this study was when we started to draw samples and try to find the database of who deployed the databases were so bad it took us months to sort that out. So given that there's better data this time, maybe—I mean, the actual, physical study of the files we can do——

Mr. BUYER. Mr. Chairman, I think this would be very productive if you were to send over that joint request with Chairman Hunter, because the operations are going to be continuing in Afghanistan and Iraq, and we're going to have multiple deployments. I recognize there's a very good spirit of goodwill here between Dr. Roswell and Dr. Winkenwerder and Ed Wyatt, along with the surgeons generals and others to really get it right.

And the GAO is playing a valuable role in the instrument of getting it right, and that would be my encouragement, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much, Chairman Buyer. And it's something we will do. And I would just add that, you know, we should verify the performance on the part of the DOD and the VA at all times, especially in light of your very disturbing report.

With our previous reports with non-compliance with Forced Health Protection and immunization surveillance policies and the like, this seems to be a no-brainer. Having an independent set of eyes look and document, helps all of us to be more accountable. So we will make that request. I'm sure Chairman Hunter will gladly co-sign that, as well as my good friend, Lane Evans.

I just want to ask you a question on the non-compliance issue. How long realistically does it take to insure full compliance? You point out and I think it's worth quoting for the record: "Continued non-compliance with these policies may result in servicemembers being deployed with unaddressed health problems or without immunization protection. Furthermore, incomplete and inaccurate medical records may hinder DOD's and VA's ability to investigate the causes of any future health problems that may arise coincident with deployments."

You also point out that DOD has not corrected the problems that you identified back in 1997, but that were related to the completeness and accuracy of the personnel deployment database designed to collect data reflecting which servicemember is deployed in certain areas, and it goes on from there.

There's a hurry-up offense now to get this right. When can we really expect this to be in place? I mean, we are planning a series of oversight hearings on this. This is one in a longer series that stretches over the last several years.

We'll be back in 2 months, and then another month after that, and then another month after that building to a crescendo that, okay, everyone knows the problem. We don't expect a magic wand to be waved, but we do expect for the health and well being of our men and women in uniform who then become veterans, to very aggressively addressed.

Mr. CURTIN. There's no reason it should take a long time to put the system in place. The elements are there. It's really making sure that the services are complying the way they're supposed to. So there's not a lot of new systems have to be put in place.

The one area where it may take some time is this accuracy of this centralized deployment database. In fact, the Armed Services Committee has asked us to take a look at that issue, based on what we found here. That the deployment databases just aren't usable right now, and we're looking at what DOD is doing to upgrade that system.

But as far as making sure that the documentation is there for it's deployments, that should be able to be done immediately.

The CHAIRMAN. Notwithstanding the fact that we probably will not be in session in December, we'll look at maybe even a joint Armed Services/VA Committee hearing, and certainly in January we'll look for the possibility of having a hearing, if Chairman Hunter is amenable to it, because I think the more we stay at this now the more we help the process.

We can't let this slip any further and not get to the point where we are comfortable that all that can be done is being done.

Mr. CURTIN. It will be hard for us to have much results by January.

The CHAIRMAN. Oh, I understand. I understand.

Mr. CURTIN. But give us a few more months, I think, we would have some things ready.

The CHAIRMAN. We'll see you then too. Would anyone like to add anything of our panelists? I want to thank you for being here and for your very valuable insights.

Mr. BUYER. May I ask one—I'm sorry. Chaplain, you provided excellent testimony with regard to what is occurring for those of whom are active duty. I had an opportunity to meet with a Guardsman at—who had been over there for a very long time, and he—you know, he sat on the couch next to his wife, of whom he had not seen for a long time. She's about 8 months pregnant. They sat about two feet apart. Their child was kept—their smaller 2-year-old was running around and grandparents were watching the 2-year-old and he was completely stoic.

He'd just arrived home. Definitely distant. Very distant. And that's no different than anybody else. You've just taken him out of

one environment and putting him into another, and there's a tremendous transition there that you counsel. But it's easier for you to do that for active duty. What about these Guardsmen and Reservists? I mean—of whom are now thrown back into that domesticated environment, and have no one to talk to?

Lt. Col. MAUCK. There is a reserve program called PREP. You're going to ask me what PREP means, and I don't know, because I've been out of the loop. I've been on active duty since May.

But there is a new program that my chaplains back in New England are working on, and, hopefully, that will address the problem.

Yes, I think the active duty has done a wonderful job. The reserves are working on it to my knowledge at this point, sir.

Mr. BUYER. Perhaps the good thing was is when he was there, not only was I there, but then there was a Vietnam veteran, who also was there, and I wanted to reach back to him and thank him and tell him, yes, you're home. But pulled him aside also and said, please, if anything, talk to us. Just come talk to us anytime. And maybe that's the cause that veterans will all do for each other, but I didn't know that there was a system within the reserve component. So I appreciate that testimony. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, gentlemen. Our third panel, if they can make their way to the witness table, will begin with the Honorable Robert H. Roswell. Dr. Roswell is the Under Secretary of Health for the Department of Veterans Affairs.

Prior to his nomination as Under Secretary, Dr. Roswell headed VA's health care network covering Florida and Puerto Rico. He previously held positions as chief of staff at VA medical centers in Birmingham, AL and Oklahoma City, OK.

As the head of the Veterans Health Administration, Dr. Roswell oversees the Nation's largest integrated health care system, employing more than 180,000 health care professionals and operating more than 1,300 sites of care.

In addition to its medical care mission, the veterans' health care system is the largest provider of graduate medical education and a major contributor to medical and scientific research.

We'll then hear from Mr. Edward P. Wyatt, Jr., who is the Principal Deputy Assistant Secretary of Defense for Health Affairs. His specific duties include oversight and coordination of Congressional and legislative activities for the Office of the Assistant Secretary of Defense for Health Affairs, and managing the public affairs program and strategic planning activities.

He enlisted in the Navy as a hospital corpsman in June of 1967. Mr. Wyatt was commissioned in the Medical Service Corps in 1975. Following his naval career, Mr. Wyatt also served as professional staff for a member of the House Armed Services Subcommittee on Military Personnel.

Dr. Roswell, if you could proceed.

STATEMENTS OF ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; MICHAEL J. KUSSMAN, M.D., DEPUTY CHIEF PATIENT CARE OFFICER, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ROBERT J. EPLEY, ASSOCIATE DEPUTY UNDER SECRETARY FOR POLICY AND PROGRAMS, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS, AFFAIRS; EDWARD P. WYATT, JR., PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE; LT. GEN. JAMES B. PEAKE, M.D., THE SURGEON GENERAL OF THE ARMY; VICE ADM. MICHAEL L. COWAN, M.D., SURGEON GENERAL OF THE NAVY; LT. GEN. GEORGE PEACH TAYLOR, JR., M.D., SURGEON GENERAL OF THE U.S. AIR FORCE; TOM BUSH, DIRECTOR, PROGRAM INTEGRATION, OFFICE OF THE SECRETARY DEFENSE RESERVE AFFAIRS, MANPOWER AND PERSONNEL

STATEMENT OF ROBERT H. ROSWELL

Dr. ROSWELL. Thank you, Mr. Chairman. I appreciate the opportunity to be here today.

We have worked diligently with the Department of Defense to improve coordination to identify men and women returning from combat theatres, and provide those discharged or needing VA services while on active duty with world-class VA service.

Because of our decade-long experience with Gulf War health issues and the President's commitment to improving VA/DOD collaboration, VA has successfully adapted many pre-existing programs and has improved outreach, clinical care, and VA's health care providers access to DOD records.

My formal statement outlines in greater detail the strategies, policies, and procedures we have implemented. At this time, I'd like to briefly summarize some of the important points. I'm pleased to report that DOD recently has provided VA with a roster of military personnel who recently served in theatres of combat operations in Afghanistan, Iraq, and subsequently separated from active duty.

Our review of these records indicates that approximately 17,000 veterans served in this capacity, and to date, approximately 2,000, or roughly 12 percent, have already sought and received care through the Department of Veterans Affairs. Fortunately, most of them as outpatients.

In August of this year, the Under Secretary for Benefits, Admiral Dan Cooper, and I charged a new VA task force for the seamless transition of returning servicemembers. This task force is intended to intensify efforts and continue to assure world-class services are provided to our military and veterans.

As an early focus, we've been working closely with DOD to enhance our ability to identify all returning servicemembers that sustained injuries or illnesses while serving their country. Some of the other activities that have taken place include the placement of a full-time VA social worker, as well as a full-time veterans' benefits administration representative at the Walter Reed Army Medical Center, as well as the National Naval Medical Center in Bethesda.

We've also placed social work staff at the Eisenhower Army Medical Center in Augusta, at the Madigan Army Medical Center in Oregon—excuse me—in Washington, and at the San Antonio Brook Army Medical Center where we, again, have a full-time VHA liaison.

We have social workers tracking patients from all of these major medical treatment facilities as they transfer to VA care, and have identified a point of contact at every VA medical center nationwide to work to coordinate transfers to these VA facilities at the time of separation and transfer from the MTF treatment facility. We're also working with DOD Health Affairs and DOD Reserve Affairs, and we developed a brochure that actually identifies benefits available to reservists and National Guardsmen.

This small brochure is being provided to all personnel who serve in the reserve or National Guard and are, subsequently, redeployed. Over one million copies of that brochure has been printed, and it's been actively distributed through the major reserve commands, National Guard Bureaus, and we continue to outreach to the individual reserve units to make sure that they have that information.

We're also working with DOD to develop separation physical examinations that enhance the evaluation of veterans as they separate from their military service. Today we have over a 130 sites where the Benefits Delivery Discharge Program is in place. This allows a single examination to serve both the military needs at the time of separation and VA needs to determine disability compensation.

We've also developed a number of training materials, including videos, a series of monographs called the Veterans Health Initiative, as well as case management guidance, clinical reminders in our automated records system, clinical practice guidelines that were mentioned earlier, and we continue to work to develop an integrated, automated medical records system that shares information between DOD and VA.

Last August, in a letter addressed to all VA employees, Secretary Principi emphasized VA's commitment to returning combat veterans. In his words—and I quote—"We will have failed to meet our very reason to exist as a department if a veteran is poorly served."

I agree with those words, Mr. Chairman, and assure you that VA will continue to improve services and coordination to insure the needs of these servicemembers are met.

Thank you very much.

[The prepared statement of Dr. Roswell appears on p. 190.]

The CHAIRMAN. Thank you. Mr. Wyatt.

STATEMENT OF EDWARD P. WYATT, JR.

Mr. WYATT. Thank you also for the opportunity to come here and testify before you today. Thank you again, with the microphone on, for the opportunity to come and testify before you today.

I'm joined here today by three of my colleagues from the military services, the Surgeons General of the Army, Navy, and Air Force: Lt. Gen. Peake, Vice Adm. Cowan, and Lt. Gen. Taylor, respectively.

I asked them to accompany me here, because as you know, they are responsible for implementing many of the policies which were established in the Department of Defense, and we worked together very closely in the development of those policies and in monitoring their execution.

With your forbearance, I'm going to forego the usual summary of the written testimony, which you already have and have had an opportunity to review. I'd like instead to take a couple of moments to comment on some of the testimony that we've heard so far this morning, so that we might set a background for our questions later.

First, I'd be remiss if I didn't honor the commitment and sacrifice made by your first panel of witnesses. Each of them has obviously made significant sacrifices in service to their country, and we are all deeply indebted to that service and that sacrifice.

Mr. Chairman, in the face of RPGs and AK–47s, these weapon systems and the people who use them against our forces don't distinguish between full-time active duty members and reservists serving on active duty as they seek to bring wreckage upon our soldiers, and neither should we. The outstanding medical teams on the front line make no such distinction when providing the superb emergency resuscitative and definitive care as testified to by many on your panel—your witnesses in your first panel—and neither should we.

The nursing staff and the medical staff at the military hospitals, such as Walter Reed and Bethesda, made no such distinctions when fitting prosthesis or providing other definitive and rehabilitative services to these Americans, and neither should we.

While these reserve personnel are our patients, meaning the Department of Defense, there should be no distinction between any of them, active or reserve. They're our patients first and last.

Now, I would like to say that I do believe that in the vast majority of the cases, both the care and the treatment is the same. However, that does not excuse or in any way minimize the insult to even one servicemember who did not receive the care and commitment that they earned.

We learned some very interesting things this morning. First, it is true that our goal is to create a seamless transition. And that is a useful goal, for it gives us a target toward which to aim. But the goal itself testifies to the very real seams that do exist and connect the two systems, not divide it.

What we're trying to do is stitch these seams together tighter, so that every servicemember has an opportunity to take full advantage of all of the benefits they have earned.

And second, the benefits earned by active and reserve personnel and veterans are superb, but they aren't of much value if you either don't know about them or you don't understand them. Clearly, some of the people testifying this morning either didn't know about their benefits or didn't understand them, and we need to do a better job in that area.

Mr. Chairman, that would conclude my remarks, and I look forward to responding to your questions, sir.

[The prepared statement of Mr. Wyatt appears on p. 198.]

The CHAIRMAN. Thank you very much, Mr. Wyatt. I appreciate it. You were here and obviously heard the testimony, and I'm sure

you read Mr. Curtin's GAO testimony in its entirety. What can be done and how quickly can it be done? The statement is really a serious indictment that the percentage of Army and Air Force servicemembers missing one or both of their pre-deployment and post-deployment health assessments range from 38 to 98 percent of our samples. Moreover, when health assessments were conducted, as many as 45 percent of them were not done within the required time frames. Furthermore, health care providers did not review all health assessments, and I would just note parenthetically, who did? I mean, who looks at the health assessment, if not someone who has a trained eye and the kind of background training requisite to do the job in a responsible way?

And then what is done with those? I would hope and would ask that you would make part of this record a copy of that health assessment, and ask whether or not you think it's adequate.

I did note that the department, or DOD, has suggested that it would be logistically impossible to do the medical examinations. You might want to touch on that as well. Why?

And again, if a health assessment is done by a health practitioner with the necessary privacy guidelines so that this doesn't get passed around in a way that we don't even know. It seems to me that would trigger, at least with somebody who might have mental or depression problems, or some of the problems that are surfacing, could have them exacerbated in the extreme upon deployment, putting themselves and their unit at risk.

This seems to be, you know, a very serious question. Could you touch on that, if you would? How do you respond to that?

Mr. WYATT. Yes, sir, I'd be glad to do that. Thank you for the question. I do have copies of the health assessment with me here today, which I will leave and submit for the record.

(The provided material follows:)

33823

PRE-DEPLOYMENT Health Assessment

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health before possible deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: **(Military personel and DoD civilian Employees Only)** Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

Demographics

Last Name

First Name **MI**

Deploying Unit

Today's Date (dd/mm/yyyy) / /

Social Security Number - -

DOB (dd/mm/yyyy) / /

Gender

- O Male
- O Female

Service Branch

- O Air Force
- O Army
- O Coast Guard
- O Marine Corps
- O Navy
- O Other

Component

- O Active Duty
- O National Guard
- O Reserves
- O Civilian Government Employee

Pay Grade

- O E1
- O E2
- O E3
- O E4
- O E5
- O E6
- O E7
- O E8
- O E9
- O O1
- O O2
- O O3
- O O4
- O O5
- O O6
- O O7
- O O8
- O O9
- O O10
- O W1
- O W2
- O W3
- O W4
- O W5
- O Other

Location of Operation

- O Europe
- O SW Asia
- O SE Asia
- O Asia (Other)
- O South America
- O Australia
- O Africa
- O Central America
- O Unknown

Deployment Location (IF KNOWN) (CITY, TOWN, or BASE):

List country (IF KNOWN):

Name of Operation:

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
O	O	O	Medical threat briefing completed
O	O	O	Medical information sheet distributed
O	O	O	Serum for HIV drawn within 12 months
O	O	O	Immunizations current
O	O	O	PPD screening within 24 months

[redacted] 33823

PLEASE FILL IN SOCIAL SECURITY # ☐☐☐ - ☐☐ - ☐☐☐☐

Health Assessment

1. Would you say your health in general is:	○ Excellent	○ Very Good	○ Good	○ Fair	○ Poor
2. Do you have any medical or dental problems?				○ Yes	○ No
3. Are you currently on a profile, or light duty, or are you undergoing a medical board?				○ Yes	○ No
4. Are you pregnant? (FEMALES ONLY)			○ Don't Know	○ Yes	○ No
5. Do you have a 90-day supply of your prescription medication or birth control pills?			○ N/A	○ Yes	○ No
6. Do you have two pairs of prescription glasses (if worn) and any other personal medical equipment?			○ N/A	○ Yes	○ No
7. During the past year, have you sought counseling or care for your mental health?				○ Yes	○ No
8. Do you currently have any questions or concerns about your health?				○ Yes	○ No

Please list your concerns: _____

_____

I certify that responses on this form are true.

Service Member Signature

Pre-Deployment Health Provider Review (For Health Provider Use Only)

After interview/exam of patient, the following problems were noted and categorized by Review of Systems. More than one may be noted for patients with multiple problems. Further documentation of problem to be placed in medical records.

REFERRAL INDICATED

- ○ None
- ○ Cardiac
- ○ Combat / Operational Stress Reaction
- ○ Dental
- ○ Dermatologic
- ○ ENT
- ○ Eye
- ○ Family Problems
- ○ Fatigue, Malaise, Multisystem complaint
- ○ GI
- ○ GU
- ○ GYN
- ○ Mental Health
- ○ Neurologic
- ○ Orthopedic
- ○ Pregnancy
- ○ Pulmonary
- ○ Other _____

FINAL MEDICAL DISPOSITION: ○ **Deployable** ○ **Not Deployable**

Comments: (If not deployable, explain)

_____

_____

_____

I certify that this review process has been completed.

Provider's signature and stamp:

Date (dd/mm/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

End of Health Review

33348

POST-DEPLOYMENT Health Assessment

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: (Military personnal and DoD civilian Employees Only) Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

Demographics

Last Name

First Name **MI**

Name of Your Unit or Ship during this Deployment

Today's Date (dd/mm/yyyy) / /

Social Security Number — —

DOB (dd/mm/yyyy) / /

Date of arrival in theater (dd/mm/yyyy) / /

Date of departure from theater (dd/mm/yyyy) / /

Gender
- O Male
- O Female

Service Branch
- O Air Force
- O Army
- O Coast Guard
- O Marine Corps
- O Navy
- O Other

Component
- O Active Duty
- O National Guard
- O Reserves
- O Civilian Government Employee

Pay Grade

O E1	O 001	O W1
O E2	O 002	O W2
O E3	O 003	O W3
O E4	O 004	O W4
O E5	O 005	O W5
O E6	O 006	
O E7	O 007	O Other
O E8	O 008	
O E9	O 009	
	O 010	

Location of Operation
- O Europe
- O SW Asia
- O SE Asia
- O Asia (Other)
- O Australia
- O Africa
- O Central America
- O Unknown
- O South America
- O North America
- O Other _____

To what areas were you mainly deployed: (mark all that apply - list where/date arrived)
- O Kuwait _____
- O Qatar _____
- O Afghanistan _____
- O Bosnia _____
- O On a ship _____
- O Iraq _____
- O Turkey _____
- O Uzbekistan _____
- O Kosovo _____
- O CONUS _____
- O Other _____

Name of Operation:

Occupational specialty during this deployment (MOS, NEC or AFSC)

Combat specialty: _____

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
O	O	O	Medical threat debriefing completed
O	O	O	Medical information sheet distributed
O	O	O	Post Deployment serum specimen collected

33348

Please answer all questions in relation to THIS deployment

1. Did your health change during this deployment?

- ○ Health stayed about the same or got better
- ○ Health got worse

2. How many times were you seen in sick call during this deployment?

No. of times

3. Did you have to spend one or more nights in a hospital as a patient during this deployment?

- ○ No
- ○ Yes, reason/dates: _____

4. Did you receive any vaccinations just before or during this deployment?

- ○ Smallpox (leaves a scar on the arm)
- ○ Anthrax
- ○ Botulism
- ○ Typhoid
- ○ Meningococcal
- ○ Other, list: _____
- ○ Don't know
- ○ None

5. Did you take any of the following medications during this deployment?
(mark all that apply)

- ○ PB (pyridostigmine bromide) nerve agent pill
- ○ Mark-1 antidote kit
- ○ Anti-malaria pills
- ○ Pills to stay awake, such as dexedrine
- ○ Other, please list _____
- ○ Don't know

6. Do you have any of these symptoms now or did you develop them anytime during this deployment?

No	Yes During	Yes Now		No	Yes During	Yes Now	
○	○	○	Chronic cough	○	○	○	Chest pain or pressure
○	○	○	Runny nose	○	○	○	Dizziness, fainting, light headedness
○	○	○	Fever	○	○	○	Difficulty breathing
○	○	○	Weakness	○	○	○	Still feeling tired after sleeping
○	○	○	Headaches	○	○	○	Difficulty remembering
○	○	○	Swollen, stiff or painful joints	○	○	○	Diarrhea
○	○	○	Back pain	○	○	○	Frequent indigestion
○	○	○	Muscle aches	○	○	○	Vomiting
○	○	○	Numbness or tingling in hands or feet	○	○	○	Ringing of the ears
○	○	○	Skin diseases or rashes				
○	○	○	Redness of eyes with tearing				
○	○	○	Dimming of vision, like the lights were going out				

7. Did you see anyone wounded, killed or dead during this deployment?
(mark all that apply)

○ No ○ Yes - coalition ○ Yes - enemy ○ Yes - civilian

8. Were you engaged in direct combat where you discharged your weapon?

○ No ○ Yes (○ land ○ sea ○ air)

9. During this deployment, did you ever feel that you were in great danger of being killed?

○ No ○ Yes

10. Are you currently interested in receiving help for a stress, emotional, alcohol or family problem?

○ No ○ Yes

11. Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?

None	Some	A Lot	
○	○	○	Little interest or pleasure in doing things
○	○	○	Feeling down, depressed, or hopeless
○	○	○	Thoughts that you would be better off dead or hurting yourself in some way

12. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ....

No	Yes	
○	○	Have had any nightmares about it or thought about it when you did not want to?
○	○	Tried hard not to think about it or went out of your way to avoid situations that remind you of it?
○	○	Were constantly on guard, watchful, or easily startled?
○	○	Felt numb or detached from others, activities, or your surroundings?

13. Are you having thoughts or concerns that ...

No	Yes	Unsure	
○	○	○	You may have serious conflicts with your spouse, family members, or close friends?
○	○	○	You might hurt or lose control with someone?

14. While you were deployed, were you exposed to:
(mark all that apply)

No	Sometimes	Often	
○	○	○	DEET insect repellent applied to skin
○	○	○	Pesticide-treated uniforms
○	○	○	Environmental pesticides (like area fogging)
○	○	○	Flea or tick collars
○	○	○	Pesticide strips
○	○	○	Smoke from oil fire
○	○	○	Smoke from burning trash or feces
○	○	○	Vehicle or truck exhaust fumes
○	○	○	Tent heater smoke
○	○	○	JP8 or other fuels
○	○	○	Fog oils (smoke screen)
○	○	○	Solvents
○	○	○	Paints
○	○	○	Ionizing radiation
○	○	○	Radar/microwaves
○	○	○	Lasers
○	○	○	Loud noises
○	○	○	Excessive vibration
○	○	○	Industrial pollution
○	○	○	Sand/dust
○	○	○	Depleted Uranium (If yes, explain) _____
○	○	○	Other exposures _____

15. On how many days did you wear your MOPP over garments?

[ ][ ] No. of days

16. How many times did you put on your gas mask because of alerts and NOT because of exercises?

[ ][ ] No. of times

17. Were you in or did you enter or closely inspect any destroyed military vehicles?

○ No ○ Yes

18. Do you think you were exposed to any chemical, biological, or radiological warfare agents during this deployment?

○ No ○ Don't know
○ Yes, explain with date and location

_____
_____
_____

Health Care Provider Only

SERVICE MEMBER'S SOCIAL SECURITY # ☐☐☐ — ☐☐ — ☐☐☐☐

Post-Deployment Health Care Provider Review, Interview, and Assessment

Interview

1. Would you say your health in general is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
2. Do you have any medical or dental problems that developed during this deployment? ○ Yes ○ No
3. Are you currently on a profile or light duty? ○ Yes ○ No
4. During this deployment have you sought, or do you now intend to seek, counseling or care for your mental health? ○ Yes ○ No
5. Do you have concerns about possible exposures or events during this deployment that you feel may affect your health? ○ Yes ○ No
   Please list concerns: _____
6. Do you currently have any questions or concerns about your health? ○ Yes ○ No
   Please list concerns: _____

Health Assessment

After my interview/exam of the service member and review of this form, there is a need for further evaluation as indicated below. (More than one may be noted for patients with multiple problems. Further documentation of the problem evaluation to be placed in the service member's medical record.)

REFERRAL INDICATED FOR:

- ○ None
- ○ Cardiac
- ○ Combat/Operational Stress Reaction
- ○ Dental
- ○ Dermatologic
- ○ ENT
- ○ Eye
- ○ Family Problems
- ○ Fatigue, Malaise, Multisystem complaint
- ○ Audiology
- ○ GI
- ○ GU
- ○ GYN
- ○ Mental Health
- ○ Neurologic
- ○ Orthopedic
- ○ Pregnancy
- ○ Pulmonary
- ○ Other _____

EXPOSURE CONCERNS (During deployment):

- ○ Environmental
- ○ Occupational
- ○ Combat or mission related
- ○ None

Comments: _____

I certify that this review process has been completed.
Provider's signature and stamp:

This visit is coded by V70.5 _ _ 6

Date (dd/mm/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

End of Health Review

The CHAIRMAN. Thank you.

Mr. WYATT. With regard to the specific report, I think it's important to note that the department agreed with all of the recommendations of the GAO. We had the normal quibbling about methods and what-have-you, but we agreed with the recommendations.

More importantly, the Assistant Secretary for Health Affairs, Dr. Winkenwerder, sought the approval of the chairman of the Managerial Personnel Committee to get an early look at the results of that report. As you know, these reports and their findings are the property of the chairman, and so we imposed on the—he graciously provided the opportunity for us to get an early peak at the—at fresh results.

We wanted to do that, because we had reason to believe that things were not going as well as we would have desired, and if there was something to be learned, especially in the face of what we knew to be large additional deployments forthcoming, we wanted to be able to put fixes in place prior to those deployments. We took those actions.

On April 22, the Under Secretary of Defense for Personnel and Readiness, David Chu, issued a memorandum of direction to the military departments, directing a series of activities that they undertake to strengthen our force health protection measures, and particularly, our medical surveillance measures. You've heard much testimony today about the quality of the health care that people achieve in our systems—what we had not been doing such a good job of is documenting the pre-and post-deployment assessments.

Your next question dealt with the——

The CHAIRMAN. If you could just suspend for one second. The GAO found that those very regulations were not even followed, the May 22, 2003, regulations you're talking about.

Mr. WYATT. I'm sorry, sir. I couldn't hear you.

The CHAIRMAN. It says, "In April 2003, DOD revised its health surveillance policy for blood samples and post-deployment health assessments," and then on the next page, "The Army and Air Force did not comply with DOD's force health protection and surveillance requirements."

I mean, the requirements went out from the head office only to be ignored?

Mr. WYATT. No, sir, they have not been ignored. They've been followed with great vigor, in fact. I'm not denying any of the findings in that GAO report. I would remind you that the data collected from that report came at a period prior to the Under Secretary issuing his additional guidance, and the services have responded quite well.

To the issue of health assessments—and I'm afraid I'm probably not going to get this in the order that you asked them, but I'll just respond to them as I can. The redeployment health assessments do involve an interview with a trained health care provider—these are the people coming back from overseas—whether they believe they have had a problem or not.

You might ask what's a trained health care provider. This would be, in most cases, a physician's assistant, a nurse practitioner, or—

if you'll excuse the Navy jargon—an independent duty corpsman, or the Army or Air Force equivalent, who has experience dealing one-on-one with patients, and is trained to do assessments and examinations. So that those are the people who actually get—whether they indicate they have a problem or not, they get a moment or a few moments with a health care—a trained health care provider.

Pre-deployment health assessment involves an encounter with a health care provider only if the member indicates that he or she believes they may have had a problem of some sort. And at that point, the member is referred on for consultation with the appropriate health care provider to provide either additional information or follow-up on the issue raised by the member.

I believe you asked about the mental health aspects of the deployment. One of the actions we took in response—partially, at least—to the GAO observations was that we added a significant number of questions, working closely with our VA colleagues to the post-deployment assessment, so that we tried to, in fact, get a little more granularity on the mental health status of the individual when they redeploy.

The CHAIRMAN. Just one other question.

Mr. WYATT. Yes, sir.

The CHAIRMAN. Is the DOD furnishing the VA with the health assessments?

Mr. WYATT. Yes, sir, they do. The health assessment is filed in the member's health record, and when the member separates from active duty, that assessment is provided. As we move forward with our TRICARE Online product, which is a web-based medical information system, any—"A," the post-deployment health assessments will be not only filed in the Army central database, but also will be accessible through this TRICARE Online product, which any authorized provider, including VA providers, will be able to go in and extract that information.

The CHAIRMAN. Dr. Roswell, do you agree with that assessment?

Dr. ROSWELL. I do in part. I certainly agree with Mr. Wyatt's answer. I would point out, though, that when the post-deployment survey information is filed in the medical record, and that if that record is retired to the Army Personnel Reserve Center or—excuse me—the Records Center—then it becomes difficult, not convenient, for us to do it.

If the servicemember is astute enough to obtain a copy of their medical records at the time of discharge, and keep those in their private possession at the time they seek care from the VA, then it's a useful tool for us to be able to evaluate those individuals.

And I would very strongly agree with Ed's comments about expanding the post-deployment survey to include additional questions concerning mental health. That's information that does, in fact, give us a much richer evaluation of possible stressors associated with the deployment experience that would indicate or possibly trigger a need for mental health services.

We certainly look forward to the TRICARE Online product being available to VA clinicians, and I think that will be a much more significant development.

Mr. Chairman, if I may, I apologize. I was derelict when I made my opening remarks. I failed to introduce Mr. Robert Epley from

the Veterans Benefits Administration who accompanies me, as well as Dr. Mike Kussman from our Patient Care Services, who is also accompanying me today.

The CHAIRMAN. Can I just ask one question? Do you think this lack of capture of information will lead to a difficulty in proving a service-connection disability, and also open up the possibility that something might be construed to be a pre-existing condition when, indeed, it was not? Do you see any or foresee any problems along those lines because of this lack of capture of data?

Dr. ROSWELL. I don't think it will preclude our ability to determine service connection. I do think it could potentially lengthen the process if the medical records are not retained by the servicemember and they're retired to the records center, and we then have to go to the records center and obtain those records, which can take several months to have them filed before we can then request them to get them back. That could lengthen the process for disability determination.

From my perspective, the post-deployment survey is much more useful as an immediate screening tool to identify when a veteran first presents to the VA where they might need services. If that individual sees a triage physician or a primary care physician who's not as expert in dealing with post-traumatic stress disorder or the post-combat sequelae that can affect mental health, then they may not pick up early that they need an appropriate referral to someone expert in PTSD management. And that's where I think the screening information would be useful at the original point of contact with the VA.

The CHAIRMAN. Mr. Ryan, the gentleman from Ohio.

Mr. RYAN. Thank you, Mr. Chairman. I apologize. I have to leave after this, but I did want to ask you one question regarding a letter that Secretary Principi wrote to Secretary Rumsfeld regarding VA's need for a certain amount of information? Are you familiar with the letter?

Dr. ROSWELL. Yes, I am.

Mr. RYAN. Okay. Just one of the pieces of information was the pre-and post-deployment health assessments, which have been talked about a little bit, and also some unclassified data on the possible exposure of our troops to environmental hazards. Have you received anything back that you can share with us, and have you received a letter back from Secretary Rumsfeld?

Dr. ROSWELL. Secretary Rumsfeld did reply to Secretary Principi. We have received that letter. As I indicated in my opening statement, we have received the Defense Manpower Data Center set of information, including types of services provided for the first 17,000 individuals coming back. We don't have any tabulative results of the pre-or post-deployment survey data, but as Mr. Wyatt said, that information can be obtained on an individual basis.

And finally, with regard to in-theatre possible environmental hazard exposure, though not privy to classified information, I'm not aware of any alleged occupational hazards that occurred in Operation Iraqi Freedom that would impact the health of the troops that served there. So the answer to that is at this point, no, I have not seen anything with regard to potential environmental hazards.

Mr. RYAN. The information that you get, is it a one-shot deal, or do you continually get updated?

Dr. ROSWELL. No. Our expectation is that there will be continuing information. The DMDC data set of the first 17,000 I mentioned was simply a first run. We've got an agreement that will continue to receive that information on a regular basis.

Mr. RYAN. Do we have a copy of the Rumsfeld letter that you received back? And if not——

Dr. ROSWELL. I don't have one with me, but we'll certainly get one and submit it for the record.

Mr. RYAN. Great. Thank you very much, Mr. Chairman.

The CHAIRMAN. Chairman Buyer.

(Subsequently, the Department of Veterans Affairs provided the following information:)

Memorandum

Department of Veterans Affairs

Date: **November 13, 2003**

From: **Assistant Secretary for Congressional and Legislative Affairs (009)**

Subj: **Letter from Secretary of Defense to Secretary of Veterans Affairs regarding deployment issues**

To: **Democratic Staff Director, House Veterans' Affairs Committee**

On October 16, 2003, the House Veterans' Affairs Committee held a hearing on the transitioning of servicemembers from DoD to VA care. At that hearing, Rep. Timothy Ryan requested from Dr. Roswell a copy of Secretary Rumsfeld's response to Secretary Principi's February 14, 2003, letter to DoD concerning deployment issues.

Attached is Secretary Rumsfeld's letter dated April 7, 2003, that provides a substantive response to Secretary Principi's letter. Secretary Rumsefeld's letter refers to a February 25, 2003 letter that was a non-substantive response to Secretary Principi.

Gordon H. Mansfield

Enclosure

THE SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

APR 7 2003

The Honorable Anthony J. Principi
The Department of Veterans Affairs
Washington, DC 20011

Dear Tony:

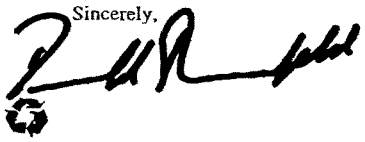
I would like to provide some additional information as a follow up to my letter of February 25, 2003. Force Health Protection remains the top medical priority within the Department of Defense. As you know, the Departments jointly developed the post-deployment clinical practice guidelines. The Department of Defense implemented this program in 2002 and trained its primary care providers to use this tool to address the health concerns servicemembers believe may be related to a deployment.

Our policy is to document, in electronic format, all medical care we provide to deployed servicemembers. We have provided some units hand-held computers for this purpose. Recently, we implemented a medical surveillance system that provides near real-time visibility of the health status of the force. Further, we conduct specialized environmental surveillance of deployed forces. In the event of a weapon of mass destruction exposure, our policy is to attempt to document all individuals exposed, provide necessary care, and conduct continual environmental monitoring.

The sharing of medical deployment data collected from individuals, units, and the environment will be of great value in providing optimal healthcare to our deployed forces and returning veterans. I understand that experts in both Departments are collaborating on methods to best achieve this goal. The Department of Defense will take responsibility for collecting information and monitoring activities while servicemembers are on active duty and deployed. We plan to enhance our efforts so the Department of Veterans Affairs can effectively assume its responsibilities when servicemembers are discharged.

I am hopeful that we have many linkages, including the DoD/VA Executive Committee and its associated Health Executive Council, to ensure that further needs are identified, and appropriate sharing processes are established. Please do let us know if you have additional thoughts in this regard.

Sincerely,



Mr. BUYER. Mr. Chairman, could we have the surgeons general sit at the table? Would that be acceptable?

The CHAIRMAN. Sure, that would be fine. I think we have more than one here too.

The CHAIRMAN. We have three. Do you want all three?

Mr. BUYER. The surgeons general?

The CHAIRMAN. The surgeons general.

Mr. BUYER. Mr. Wyatt, how many years of military service do you have?

Mr. WYATT. Thirty-one years, 9 months, and 23 days, about. Approximately.

Mr. BUYER. And what did you do in the military?

Mr. WYATT. I was privileged to serve as a hospital corpsman for 8 years prior to taking advantage of many of the good benefits afforded those on active duty and going to college and getting commissioned as a medical service corps officer. And I continued for the remainder of my career doing health policy kinds of things.

Mr. BUYER. Did you serve in Vietnam?

Mr. WYATT. Yes, sir, I did.

Mr. BUYER. As a Navy corpsman?

Mr. WYATT. Yes, sir.

Mr. BUYER. What did you do in Vietnam?

Mr. WYATT. I served with the Marines in counter-insurgency kinds of operations.

Mr. BUYER. And you took care of soldiers involved in battle?

Mr. WYATT. Yes, sir, I did.

Mr. BUYER. On the battlefield?

Mr. WYATT. Yes, sir.

Mr. BUYER. Do you think that experience had an effect upon—or strike that. Do you think that your experience helped shape who you are today in your leadership position?

Mr. WYATT. I don't think there's any question about that, yes, sir.

Mr. BUYER. I'll concur with that. I remember the level of your sincerity in the drafting of the legislation for which we're having difficulty here now with regard to its implementation. You know, this is a very unique circumstance whereby the author and the individual who as a staffer helped draft legislation now assumed a position in a chain of command in which was to implement the legislation. Kind of interesting, isn't it?

Mr. WYATT. Yes, sir, it is.

Mr. BUYER. So as I look at the legislation, you know, the interesting thing how Congress operates sometimes is members of Congress, you know, we had to put our name on it, as though we authored it. But most of the time, somebody else wrote it. And you wrote it.

So in your personal opinion when you wrote the word "medical examination," what did you mean?

Mr. WYATT. The use of the word "medical examination," as opposed to the word "physical examination," specifically, since we were doing it in law, provided, in fact, the department some room to interpret what a medical examination was.

Mr. BUYER. Is that what you mean today in your present capacity, or was that what you mean the day that you wrote it and the conversations that we had in regard to physical exams?

Mr. WYATT. The day that I wrote it, I specifically did not use the word "physical exam."

Mr. BUYER. Okay.

Mr. WYATT. The opportunity was clearly there, and I knew the connotation of the words "physical examination." I also knew that the words "medical examination" would leave some room for flexibility.

If at the front end of this thing, would I have done something different? I can't answer that. You know, I mean, that's a hypothetical. If you'll give me a moment, I would like to——

Mr. BUYER. Well, why don't you reflect on that. Let me turn now to the surgeons general. All of you are medical doctors, correct? And I'll go right down the line. General Peake, what is the definition of a medical exam? As a doctor, what is a medical examination?

Lt. Gen. PEAKE. Well, sir, I think that's the issue here. It's a subject for debate on what medical examination——

Mr. BUYER. I just am interested in your opinion.

Lt. Gen. PEAKE. My opinion is that the policy that we—that the DOD has promulgated is an appropriate policy. I do believe that medical examination is a total—is a whole-person evaluation, not necessarily a physical hands-on evaluation, which has oftentimes minimal benefit.

As we do this examination as a physician personally, probably the most important aspect of the examination is the history. The physical confirms, and sometimes, you know, pointed to by the history of the patient, what things you ought to look for.

As we do these examinations—medical examinations and review the post-deployment screening, we find these soldiers that then, through the medical evaluation process and medical examination process, do then require further follow-on, which does include a physical examination, when that is required.

So, I guess, sir, I'm not trying to quibble on this at all. I'm trying to tell you that I think a—within the construct of the words that were created in the law and the flexibility that Mr. Wyatt just talked about, that we can provide a quality service to our servicemen and women.

Mr. BUYER. Well, General Peake, you danced very well within the constructs of the policy from DOD. My question was what as a physician is a medical examination.

Vice Adm. Cowan, what is the definition of a medical examination within the medical field?

Vice Adm. COWAN. Sir, I hope this doesn't look like a dance to you. Let me define a physical examination first. It's as General Peake said, a history.

Mr. BUYER. I don't know. I'm not a doctor. Is a medical examination the umbrella, and under that, then you have physical exams and you have other things?

Vice Adm. COWAN. I think that's the construct I'm going to try to give you. When we say "physical examination," it's almost a buzz

word. It means a very specific thing, and it has parts to the history, it has then starting at the scalp and going to the toenails.

I'm a specialist in internal medicine and hematology. When I do a physical examination, it takes me about a half-hour, 45 minutes.

When we do a medical evaluation, as we have designed for the pre-and post-deployment surveys, what we have done is boiled down the essence to those things that are most likely to be triggers that will tell us if something more subtle is going on in that person's life.

So we've taken this complicated history part of the physical examination and boiled it down to the questions that would then lead to specific further evaluations, to include a hands-on physical if any of these sentinel signs come up.

So this is—the medical evaluation as we use it is a screening to further physical examination or further physical evaluation. And so I think I agree with both of the speakers in my own words that that's what this evolved into.

Mr. BUYER. General Peake, do you concur?

Lt. Gen. PEAKE. I do, sir.

Mr. BUYER. Gen. Taylor, what is a medical examination?

Lt. Gen. TAYLOR. To keep this short, it's the evaluation of a patient underneath—under medical supervision by a medical officer or enlisted person. Someone from the medical profession evaluating a patient. And that can take a wide range, based on the skills of that medic and the requirements of the situation.

Mr. BUYER. Mr. Wyatt, in response to the chairman's question about who are these health providers, a word was used artfully, I think. You used the word "trained." What's the difference between trained and licensed in the medical field? Mr. Wyatt or any of the surgeons general.

Mr. WYATT. Licensed is—it's probably a term art, but it generally connotes someone who has been subjected to a testing, review, certification procedure in a legal sense. In other words, a state board governing nursing——

Mr. BUYER. A licensed nurse practitioner.

Mr. WYATT. Yes, exactly. Right.

Mr. BUYER. And so am I to interpret—and I'm asking all of you—in your response to the chairman's question, you are comfortable that it be done by a trained licensed provider—trained health provider, not a licensed health provider? Are we splitting hairs here? I'm trying to understand what you're doing as you implement.

Mr. WYATT. It's the question of what point in that process you—it's appropriate for the—which kind of provider. In the screening process, where we're trying to move hundreds, sometimes thousands of troops through, it's important that we have someone with a bit more training than your average medic to interact with these troops. And if the troop indicates any problem at all, then they're referred on to a higher level of provider.

Mr. BUYER. So we incrementally walk this one, based upon how they answer the assessment?

Vice Adm. COWAN. Sir, could I amplify on that, if you don't mind? We have several kinds of primary care providers. The primary care provider that an individual person in our system may see may not be a physician. It could be a physician's assistant, it

could be a nurse practitioner, or it can be, in the Navy's case, more than the other services, an independent duty corpsman. And that was, I think, the point at which that question revolved.

Independent duty corpsmen are senior corpsmen, highly experienced, hand selected, sent to a school where they are taught to be individual, solo practitioners, to be primary care providers under a set of what we call credentials. They have a scope of practice that they can do. They can't do heart surgery, but they can do an evaluation. They can treat a cold. They can sew up a wound. They can do a variety of things.

When the Navy goes to sea, that doc is called doc and may be an HMI, but he is the provider for a destroyer or a submarine or a cruiser at sea, or with the Marines ashore for a unit. So they are primary care providers, just as—and are credentialed to be so, just as a nurse practitioner or a physician.

And they are the ones, when appropriate for their unit—the size of their unit—who do the initial screening. And then if they find things outside their scope of practice, then they are referred on just as anyone would refer in our system.

The CHAIRMAN. Would my friend yield for a moment?

Mr. BUYER. Yes.

The CHAIRMAN. In the GAO's report, they make the point that a health care provider did not review all health assessments. And although only a small number of assessments in our samples indicated a health concern, large percentages of these assessments were not referred for further consultations as required.

I mean, to whom, after an identified problem was found, did it go to? I mean, was it just a paper trail that went nowhere, or did it go to someone who could then say this person may not be fit for duty or for this kind of deployment?

Vice Adm. COWAN. I'll try to answer that, at least generically, because that question, I think, is not isolated to independent duty corpsmen.

When a positive answer is found, then the follow-up questions are to be pursued, and then that individual is referred to the appropriate level of practice. That may be a surgeon. It may be an internist. But they then go into our referral system, just as when we find disease or indications of disease or injury in anyone else.

The CHAIRMAN. But according to the GAO, these assessments were not referred for further consultation. How can that be fixed? Or is it being fixed, or has it been fixed?

Lt. Gen. PEAKE. I would tell you that we all, in another committee hearing, testified about our concern about the GAO report. Not refuting it, but, you know, the fact that we had—we agreed that those were legitimate concerns.

I think we have all tried to do a better job of implementing the intent of Congress, frankly. I will tell you—I mean, I just pulled from my ops update last night was how we're following it in the Army. Just for the week of 4 to 10 October, we had 2,301 redeployments. A hundred percent of those had redeployment forms completed. We had, of that group, 820 that had referrals out of that group that required referral. We're tracking it, I guess, is the point I'm making, sir.

You know, I've got a couple here that were read that we didn't catch. So now they're going to come back, and they'll clean that up.

So part of it is disciplining a very big system that talks about lots of individuals in that system with lots of components to the evaluation of those individuals.

And this is not—it's not an excuse, but it's not really easy stuff to do, and it is a matter of diligence. I am sending—I signed letters today to installation commanders asking them to refocus on making sure that we don't allow any one of our soldiers, active or reserve, to fall through the cracks. And so, you know, I think we are paying attention to the details, which is really what this is about, sir.

I would also say that all of our servicemembers live in a big system of health care, and there's not an access issue. So that, you know, if there is something of a medical problem, they have the opportunity to interface with that health care system and get the care that they need. It's not like the 47 million Americans that are uninsured that are out there with no other health care system. They're in an integrated system with its seams that we are trying to smooth over, really.

The CHAIRMAN. If you'll yield one brief second. I thank you for that insight, and if you would, make that a part of the record. I think that shows aggressive diligence on your part in trying to remedy this situation, so I thank you for bringing it to the attention of the committee. I yield back to my good friend.

(The information follows:)

UNCLASSIFIED

POST DEPLOYMENT MEDICAL SCREENING

RMC DEMOB DATA 4-10 OCTOBER 2003							
	NARMC	GPRMC	WRMC	SERMC	ERMC	PRMC	CONUS TOTAL
NUMBER PROCESSED	668	1022	88	102	421	0	2301
COMPLETED 2796's	668	1022	88	102	421	0	2301
2796's FOLLOW UP	0	0	0	0	0	0	0
REFERRALS	201	187	15	14	403	0	820
HIV	668	1022	88	102	419	0	2299
HIV FOLLOW UP	0	0	0	0	2	0	2
PPD	643	969	59	91	17	0	1779
PPD NOT REQUIRED	25	53	29	4	0	0	111
FOLLOW UP	0	0	0	7	404	0	411

UNCLASSIFIED

AS OF 14 OCT 03

RMC: Regional Medical Command

DEMOB: Demobilization

NARMC: North Atlantic Regional Medical Command - Located near Walter Reed Army Medical Center in Washington DC. There are 11 medical facilities that fall under NARMC

GPRMC: Great Plains Regional Medical Command - Located near Brook Army Medical Center in San Antonio, TX. There are 10 medical facilities that fall under GPRMC.

WRMC: Western Region Medical Command - Located in Madigan Army Medical Center in Tacoma, Washington. There are 3 medical facilities that fall under WRMC.

SERMC: Southeast Region Medical Command - Located near Eisenhower Medical Center in Augusta, Georgia. There are 10 medical facilities that fall under SERMC.

ERMC: European Regional Medical Command - Located in Heidelberg, Germany. There 30 medical facilities throughout Europe that fall under ERMC.

PRMC: Pacific Regional Medical Command - Tripler Army Medical Center in Honolulu, Hawaii. There are 3 medical facilities that fall under PRMC.

CONUS: Continental United States

PPD is the TB Tine test.

Mr. BUYER. Well, I thank you for, sir, your open process. The question here—and Mrs. Davis, if you want to jump in. I don't want to monopolize. This is a tremendous opportunity for us.

Am I to take, General Peake, from your testimony that with regard to a request from Chairman Smith and Chairman Hunter from the GAO, as they then have their continuity—strike the word "continuity"—they have their continuous oversight over this process, that we're not going to get a report like we just did?

Lt. Gen. PEAKE. Sir, I think we will be a lot better off than what you saw there. And as a matter of fact, when——

Mr. BUYER. There's going to be a good——

Lt. Gen. PEAKE (continuing). The GAO came and briefed Dr. Winkenwerder, and the three of us were there, I invited him to "Okay, go look now, because I think it's different." You know, there is still lags in the database. You know, the DMDC database. There are still lags in—we have a paper system in many cases that has to be then transported, scanned, and then gotten into that centralized database, but we now have processes where we follow them through the FEDEX system.

I will tell you that we are trying to go paperless. We have 25 physicians' assistants that we put into theatre in Iraq today and into Kuwait today to capture digitally the information, so that we can transfer it without this paper process. So we're catching them on the front end.

Talking to the theatre just recently, you know, we're understanding that because you guys are trying to really cover it, you're actually repeating these things at some of the redeployment stations. So we'll have some folks with two post-deployment screenings, and that's okay with me.

Vice Adm. COWAN. And we have had strong support from line leadership. The Chief of Naval Operations sent a personal letter to all Naval forces deployed, and the Commandant of Marine Corps sent a similar letter, and I think the Army and Air Force have had very similar high-level involvement. So this has been something that has become a very high priority for us all.

Mr. BUYER (presiding). Mrs. Davis is now recognized.

Mrs. DAVIS. Thank you, Mr. Chairman. And I'm sorry that I missed your presentations. And perhaps I'm going to repeat some questions, but I wonder if I could just follow up for a moment.

Dr. Roswell, in your testimony, you had mentioned it was about 17,000 veterans, I guess, in the last 2 years that were coming into the VA system that had seen active duty in Afghanistan and Iraq. What do you see as the challenges now? I mean, in terms of numbers and in terms of readiness, I guess, of the system to take on a large number of our returning veterans.

And certainly, we know in terms of a lot of the medical problems that are existing, we've met—most of us have surely been to Walter Reed Hospital and talked to a number of our amputees. What do you see as the big challenge that you'll be facing in terms of numbers and in terms of disabilities?

Dr. ROSWELL. Well, thank you for the question. It's a very important question. Of the roughly 2,000 people we've seen already in VA medical centers, most were patients who were discharged without combat-related or duty-related injuries or disabilities. So most

of the health care they have accessed thus far are the usual types of health care problems one would expect to see in this age population.

Obviously, we're much more concerned about the people who still serve who are still on active duty, such as the first panel this morning. Col. Frame, for example, still on active duty, but with a serious, a very serious injury that will clearly affect his professional life for the rest of his life.

It's those kind of people that we need to be prepared for. And we need to make sure that we have the resources within the department to eliminate waiting lists, to make sure that we have the doctors and nurses on board so that we can be prepared to meet that demand, and also to be sure that as post-combat sequelae occur in this population, as they inevitably do, whether that's post-traumatic stress disorder or the unexplained illnesses we saw in servicemembers who served in the Gulf War that occurred months and even years after their service in the Gulf War, we need the clinical staff, the facilities, and the resources to be able to provide that care.

Mrs. DAVIS. Do you think you're prepared for that?

Dr. ROSWELL. I think we are extremely well-prepared at this point.

Mrs. DAVIS. Has there been any advocacy on your part or others to be certain that—right now we're looking at a very large budget, and a lot of us have worked very hard to make sure that force protection is part of that, even though initially, it was not put into the budget for the troops. But there are some other issues. And the concerns around veterans have not been addressed, and they're not part of the budget. They're not included. They're ruled out of order. Is there an advocacy for that? Is that something that really should not be ignored right now?

Dr. ROSWELL. Well, certainly, Secretary Principi has stated repeatedly, and I concur, that our core mission, our core population of veterans, are those with service-related disabilities and injuries, those who are indigent, and those who have special needs that the VA is well-suited, well-equipped to care for, whether that's post-traumatic stress disorder, serious mental illness, spinal cord injury. That's our core population.

We do need pay reform for our physicians. We do need to hire over the next year at least 2500 additional nurses and at least 800 additional physicians.

Mrs. DAVIS. And judging from our testimony earlier, quite a few social workers as well. Because we heard from our witness Mrs. Stiffler that, in fact, her son wasn't even—didn't even have a social worker present, even though they had asked for one, when he was looking at his waiver.

So, I mean, I'm just concerned that perhaps we're not advocating as strongly as we should for some of the people who really are needed as advocates, as mentors, helping people through the system. And I'm just suggesting that perhaps, you know, we would look to you to help us as we do that.

Dr. ROSWELL. Well, I appreciate that, and we're certainly committed to this. I understood Mrs. Stiffler to say that the social work availability was limited while her son was still receiving care

through the military treatment. And in my opening statement, I mentioned that we now have VA social workers actually working in DOD facilities, including Walter Reed right here in Washington, but in several locations throughout the Nation.

Certainly, we have also identified——

Mrs. DAVIS. I appreciate that. Thank you. I'm sorry, I missed that comment.

Dr. ROSWELL. We've also identified points of contacts so that we have seamless transition for any servicemember nationwide.

So I think that, clearly, we have learned significant lessons from the Gulf War. We've learned even more important lessons in our experience thus far with Operation Enduring Freedom and Operation Iraqi Freedom. I really believe that we have to continue our collaborative efforts, maintain open lines of communication, and be a—and continue to learn from our experiences and evolve to meet the need.

Mrs. DAVIS. Thank you. And we certainly want you to have the resources that you need.

If I may, Mr. Chairman, just one other question. We were talking a lot about physical illness. And clearly, a lot of the problems in the service-connected disabilities are mental illness. Some of that, perhaps, has to do with some pre-service screening, but a lot of it, obviously, is from the traumatic experiences that our men and women have.

Do you think there's any bias at all, or can you determine it, when it comes to service-connected disability? I know that, again, just taking the testimony from this morning, and I know in being at hospitals in San Diego and other places, that this is a concern, and hearing from many of our men and women who are constituents, the way in which we determine service-connected disability and benefits as it relates to mental illness.

Could you comment on that? I know sometimes it may be difficult to do, but I'm wondering whether you think we should work harder at that, perhaps, or that the guidelines, perhaps, are not as clear as they should be.

Dr. ROSWELL. We have a wealth of experience. We know that, for example, post-traumatic stress disorder is seen with a much higher frequency in veterans who have served in a combat situation. That was true in Vietnam. We saw the same results in the cohort of military personnel who served in the Gulf War. And we fully anticipate to see that in veterans in this conflict, particularly when you consider some of the atrocities that took place in Iraq, not necessarily with our troops, in all cases, but with civilians, Iraqi civilians, Iraqi children. So we do anticipate that there will be a significant problem there in diagnosing that.

In the veterans seen thus far, only 9.4 percent of the roughly 2,000 seen had an ICD–9 diagnosis of mental illness, but we expect that number to grow. We do have—that's why we have the clinical practice guideline that's available at all VA facilities to specifically help clinicians not only identify, but then manage mental illness, including post-traumatic stress disorder.

And that's why the post-deployment health information that we've been discussing this afternoon is so important, because it

serves as a preliminary screen to identify a servicemember who may be at risk for the subsequent development of PTSD.

Mrs. DAVIS. Thank you. I appreciate that. And if you had addressed that earlier, I guess I would just lend my voice to someone who is concerned about those issues, meet with individuals in my district who seem to feel less fairly treated in that area than in some other areas. I appreciate that. Thank you very much.

Mr. EPLEY. If I may add a comment on that. In the evaluation process for service-connected disabilities, we really emphasize almost continual training, so that our evaluators use the clinical evaluations from Dr. Roswell's staff and that they evaluate with all the compassion that they can, so that we are not showing any bias towards that component.

Mrs. DAVIS. Thank you. Thank you, Mr. Chairman.

Mr. BUYER. Thank you very much. Mr. Epley, if you step forward just a second back to the mike. Earlier, there was testimony and we heard from the panel with regard to these VA benefit advisors at the hospitals. And congratulations. I think that's excellent to do that. But we also have learned now if you have a soldier who is seen in one of our hospitals abroad, and then comes back with that unit, and then is discharged, somehow, something's not working.

And earlier, when I first mentioned, I brought up the surgeons general, and then realized, you know, that's a G1 function of the personnel shop. And we all then have to turn to you, Mr. Wyatt, because you work for Dr. Chu in charge of personnel for DOD.

Mr. WYATT. Yes, sir.

Mr. BUYER. So if we can try to—let's try to put this one together to make sure that this doesn't happen. Tell us with regard to overseas hospitals or major medical centers, do you have them at these installations?

Mr. EPLEY. Mr. Chairman, we have overseas VA personnel at Landstuhl, Germany, and in Korea. Those are the two major installations. We also have itinerant counselors that go out for 6 to 9 months to do briefings to separating servicemen and women. But we have permanent locations in Landstuhl and in Korea. They're there when these men and women are being sent back and go to Landstuhl for medical difficulties. We do try, where the medical conditions allow, to get in and begin the briefing process for all benefits that they may accrue.

Mr. BUYER. All right, Mr. Wyatt. Mr. Secretary, we have a synergy now between the—what your health affairs, what they do, and personnel policies. So tell me what's going on out there with regard to guardsmen and reservists or someone from active duty being discharged, if you know.

Mr. WYATT. Well, the last part of your question really gets to the essence. I frankly was not aware that there were significant problems out there with regard to the transition, particularly of reserve members from active duty into the VA system. We need to learn more about that. And I will take it upon myself working with—and I've been remiss in failing to introduce my colleague from OSD Reserve Affairs, Mr. Tom Bush, who is the Director of Program Integration over there.

Mr. BUYER. Thank you, Mr. Wyatt. I was just getting ready to go to him. He was sitting here nice and quiet. But we also have Col. Gaffney is here, right? Col. Gaffney?

Mr. WYATT. I don't know, sir.

Mr. BUYER. Can you come forward? Are you prepared to come forward? See, when you show up to these things, you never know what's going to happen. No, she can come right on over here. We put the Army Reserves and the Guard Bureau right next to each other. Please, you'll scoot right on over, ma'am. And would you please state your full name for the record?

Col. GAFFNEY. Sir, my name is Col. Cherry Lynn Gaffney.

Mr. BUYER. And what is your occupation?

Col. GAFFNEY. I'm a medical corps officer in the U.S. Army.

Mr. BUYER. And where do you work?

Col. GAFFNEY. I'm now working at the Army—you'll have to excuse me. You really caught me off guard here. I'm working with the Army National Guard at the Readiness Center.

Mr. BUYER. Okay, thank you. Now you can pause for a second. Mr. Bush, can you tell us with regard to what measures are being taken to insure the early deploying Army Reserve component personnel are receiving their examinations on a regular basis? I'm talking now physical exams. I want you to answer that one for me. And then with regard to insuring that these reserve component soldiers are receiving information with regard to their—as they transition off——

Mr. BUSH. First of all, the physical exams. We're following the guidelines of physical exam every 5 years. And we're following under the policies. And we're talking about the pre-deployment/post-deployment medical exams, particularly when we're calling people up for the ongoing operations, that they receive the same medical exams as any member serving on active duty. And could you repeat——

Mr. BUYER. Can you tell us about early deploying units? And include dental.

Mr. BUSH. If we have—when we're calling on people, essentially, as is part of the mobilization process, we're screening them for medical and dental readiness. If we have dental problems—and that's our biggest problem with mobilizing reservists is dental problems—we will correct those problems before they're mobilized. But this is part of the mobilization, or the call-up process.

What we have right now, what we've requested, and what's included in both the House and the Senate marks for the Authorization Act for this year is the authority to, as soon as we alert an individual that they're going to be mobilized, to be able to provide exams and treatment.

And so we're not waiting for that actual mobilization in order to bring them on active duty. As soon as they receive the notification, then we would have the authority to start taking corrective action, if need to, to be sure they were medically ready, dentally ready. And if there's corrective measures that need to be taken, we would take it at that time. And that will help expedite the mobilization process.

Mr. BUYER. In March of 2001, the Army Reserve created a very innovative program called the Federal Strategic Health Alliance, the FEDS-HEAL program. Does that also include the Guard?

Dr. ROSWELL. It does.

Mr. BUYER. All right. Thank you. And can you give us an assessment on how well that program is? And I direct that to the two of you and to General Peake. Go ahead.

Mr. BUSH. What we've seen in monitoring it, it seems to be fairly effective. I don't have any specific data on that. But I know in talking to our representatives from the Army Reserve and the Guard units that are using it, it's more predominant in the Army Reserve. But they found it to be an effective program.

The need that it meets specifically is it provides access to health care providers around the country. And that's a key element that is a challenge for the Guard and Reserve, because we're so, as you're well aware, so geographically dispersed. We're not clustered around medical treatment facilities.

In fact, this morning, the latest figure we have is about 50 percent of guardsmen and reservists live within a catchment area, a catchment area of an MTF. And so that poses problems and challenges for us, which the FEDS-HEAL program helps address.

Mr. BUYER. Col. Gaffney, do you have any comment on that?

Dr. ROSWELL. I was just going to say that I'm quite familiar——

Mr. BUYER. Can I go to Col. Gaffney first?

Col. GAFFNEY. What I would say is that the Guard has had a good bit of experience in seeing this, both using FEDS-HEAL, and also using their own assets within the Guard unit. And since the Guard deals with Level 1 and Level 2 care, which is very primary care, I think that there tends to be a preference to want to use their own internal assets to accomplish that, because it links their health care providers directly with their readiness.

But FEDS-HEAL has given us a surge capacity. So that when there's a rapid mobilization, and there's far more work to be accomplished than the handful of health care providers there at the unit can actually take care of, then FEDS-HEAL provides a wonderful capability for surge.

Mr. BUYER. Thank you. Dr. Roswell?

Dr. ROSWELL. Well, it's actually a program that I know very well, because it began with a grant to the 81st Reserve Support Command, headquartered in Birmingham, Alabama. But that's the Army Reserves support command that serves Army Reserve units in the southeastern United States.

When that program began, I commanded an Army Reserve hospital unit in Florida, and also served as the VA VISN director for Florida and Puerto Rico. So I was instrumental in crafting the initial sharing agreements that made VA—initially, VA resources available to support the medical needs of reserve units.

A major training detractor for any reserve unit is the need to do periodic examinations. The intent of FEDS-HEAL as it was first created or first envisioned was to offload that training detractor from the reserve unit, so that those examinations could be scheduled at VA facilities, at times away from the one-weekend-a-month training opportunity. The program was very successful, and it was

expanded. It now includes federal occupational health, in addition to VA health care facilities nationwide.

It's been primarily used as a program on a pre-deployment basis. But as you so correctly allude to in your questioning, Mr. Chairman, it would be an invaluable resource for post-deployment support for Reserve and National Guard units.

We have done a truly remarkable job of coordinating health care benefits in transitioning those who have a need for VA health care when they're on active duty or when they're retained on active duty. But when they're demobilized, go to their Reserve or Guard unit, and then are separated, particularly if they don't continue their service in the Guard and Reserve, as unfortunately, a number of them choose not to do, then they're basically, if you will, out of contact with the military health care system, and they may not have those assets.

It's very difficult for a Reserve or National Guard unit commander to be able to provide and mobilize the medical support needed at the time of redeployment, particularly once they pass the mob or the demob site, and are back at home station.

And again, that's where VA could be, through the existing MOA that allows access to VA under the FEDS-HEAL program, could be used as a tremendous resource for those units. I think it's an excellent idea.

Mr. BUYER. Thank you. General Peake.

Lt. Gen. PEAKE. I would agree that FEDS-HEAL is superb. The National Guard, in addition to using FEDS-HEAL, has gone out and contracted with local dentists, because they don't have the capacity to do all of the improvement in the dental readiness of their soldiers within their own capabilities. So we clearly have to reach out and leverage the VA and federal occupational health.

And I think that it is a—the confounding factor sometimes is getting enough time before the deployment to be able to do that. You know, we've got three E brigades getting ready to go now, and we're pumping resources in to try to get their dental readiness up and their medical readiness up.

Mr. BUYER. I recall that there was a—and I can't remember if this is a Guard Bureau regulation or an Army regulation—it's not in statutory law—that does not permit an Army dentist to provide dental care for their guardsmen on a 2-day training.

Dr. ROSWELL. Not just dental care. I think it——

Mr. BUYER. Pardon?

Dr. ROSWELL. Not just dental care. Reservists or National Guardsmen drilling in an IDP status aren't entitled to health care.

Mr. BUYER. And I know this is an issue that is being bantered about. But can you tell us what is being done? I mean, are we going to—are you going to change that regulation? Is it a Guard Bureau or is it an Army regulation?

Mr. EPLEY. Could I address that, sir? We went to a DOD general counsel to ask that very question, if a Guard or Reserve dentist could provide exams. It is basically an issue of exams, because there is a problem with treatment. We asked whether they could provide exams on a drill weekend, and the answer to that is yes, that they can provide exams. And the only limitation that DOD told us they would place on that is that you can't have the reserve

dentist going to his civilian practice and using his personal—or his professional practice——

Mr. BUYER. Well, that's pretty obvious.

Mr. EPLEY. But if he's in a military treatment facility——

Mr. BUYER. All right, what's the next step? General counsel says you can do it. Now what's being done?

Lt. Gen. PEAKE. Sir, he said, "exams," not "treatment."

Mr. EPLEY. Exams.

Mr. BUYER. Well, all right. So then they were going to refer them out.

Well, then, let me ask this, Secretary Wyatt. You know, we were also there when we put together that dental program for reservists, and it's probably not going as well as we had hoped.

Mr. WYATT. Right.

Mr. BUYER. One thing kind of leads to another. And I apologize, but——

Mr. WYATT. Yes, sir. I've seen some reports that as many as 80 percent of reservists have access to some kind of dental insurance, which would lead you to believe that the problem is not the access to care. The problem is accessing the care, is using it. Which I think while there's certainly a medical component there with regard to the examination and making sure people are up to speed, there's also a leadership element that I think probably needs to be buffed up a little bit.

Mr. BUYER. Mrs. Davis, I don't mean to be monopolizing questions. If you have anything, just feel free to jump right in.

Dr. Roswell, you had mentioned that—strike that. Of the 6,000 wounded/diseased/not-battle-injury individuals from Operation Iraqi Freedom, Dr. Roswell, you say that 2,000 have been seen, but only 700 are enrolled. What's happened to everybody else?

Dr. ROSWELL. Anyone—well, I'm not sure which statistic you're talking about. We've only interfaced with 2,000 individuals who were on the roughly 17,000 from the DMDC list that was transferred to us. That list was split into those who served prior to the onset of Operation Iraqi Freedom, which would be considered the combat period, and those who served on or after that. So there was a smaller number who would be defined as OIF combat veterans.

Of the total number we've seen, 2,000, of the combat veteran, we've seen approximately 700. All of those, though, who have received care through the VA are enrolled by virtue of having been seen.

Now, let me point out that Public Law 105–368 gives 2 years of, if you will, priority care for anyone who served in a combat zone for any condition possibly related to their military combat experience. For conditions clearly unrelated to their military service, such as an illness that clearly occurred or an injury that clearly occurred after the separation from military service, they would have eligibility for VA health care similar to any other veteran.

Currently, as you know, only priority 1 through 7 can enroll, so a priority 8 veteran with no service-related disability and a higher income would be ineligible.

But all of these——

Mr. BUYER. Is that being interpreted in the field as it has to be a combat-related injury?

Dr. ROSWELL. No. It only has to be——

Mr. BUYER. Just within the theatre of combat operation.

Dr. ROSWELL. Anything that related—possibly related—the actual definition we use is "possibly related to their military service." And we defer to the veteran.

Mr. BUYER. So with regard to the sergeant from the National Guard that testified, he discharged, he has 60 days of TRICARE, and then he immediately can be seen within the VA system, right?

Dr. ROSWELL. Correct. And in his situation, there would be no question. A better example might be someone who separated, was very healthy, had no need for health care, and then 6 months after separating from the military service, began to experience vague headaches, or lapses of memory, or musculoskeletal aches, the kind of symptoms we've seen in a number of veterans following the Gulf War. In that situation, because that might possibly be related to their military service, they would still be extended priority care for a period of 2 years, which would allow us to fully evaluate and identify whether that's service-related. And everyone who has been seen is enrolled.

Mr. BUYER. Gen. Taylor, you have the responsibility over guardsmen. Medical of guardsmen? Would you? Do you have the responsibility over guardsmen? Air Guard?

Lt. Gen. TAYLOR. I advise the Chief on health matters, yes. We set up the health system. The Air National Guard is——

Mr. BUYER. They belong to you. They don't belong to General Peake, right, with regard to health?

Lt. Gen. TAYLOR. Yes, sir. They belong to the Chief and the Secretary.

Mr. BUYER. They belong to the Chief.

Lt. Gen. TAYLOR. Yes, sir.

Mr. BUYER. With regard to responsibility of providing health care, they're yours.

Lt. Gen. TAYLOR. Very clearly, when federalized, they belong to us. Yes, sir.

Mr. BUYER. Yes, they belong to you.

Lt. Gen. TAYLOR. Yes, sir.

Mr. BUYER. So with regard to the guardsman that testified, did something not feel right with this testimony with regard to—why wouldn't he have been left on active duty?

Lt. Gen. TAYLOR. You know, I haven't seen his medical records, so I can't tell you why the determination was made as to whether he should be retained on active duty on MPA days. Normally, those people are maintained if they need to have ongoing evaluations or another operation. But for simple physical therapy, occupational therapy, normally, we don't retain those folks on active duty.

Mr. EPLEY. Mr. Chairman, if I might?

Mr. BUYER. You know, there's a sense out there that "You're a reservist. You're a guardsmen. We're active duty. You're this, we're that."

And Mr. Wyatt, I embrace your testimony in your opening, but let's talk about what's kind of happening out there. When the soldier, sailor, airman, marine comes back, what do they want most? They want to see their family, and they want to get out of that uniform. Right?

And what I hopefully—it is not systematic. But we get to hear responses with regard to someone is out processing, and they say, "Well, don't file that with us. File that with the VA. You file that with us, we're going to hold you on active duty here at the mobilization site."

Now, what do you think the soldier thinks about that? He's not too anxious to do that. "I'll just put that off. I'll just go ahead and file that. I can get to be with my family, and I'll file with the VA, and"—do you think that's happening out there? General Peake?

Lt. Gen. PEAKE. I guarantee it, sir. I mean, what we have now that we didn't have before is a 2-year safety net to grab those people when they finally realize, "You know, I probably ought to have done something." And the issue is making sure that they know about it, as you said, ma'am. The issue is trying to get the teachable moment for some of these young men and women who really do just want to get back with their lives.

You know, we have the other side of the story, sir. As you know, we've got about 5,000 folks that we're hanging around in a medical hold circumstance to try to make sure that we do the right thing by them as quickly as we possibly can.

On the other side of, you know, the rush out, there's people that we're trying to make sure that we, through these surveys, that we follow up on them in detail and do the right thing by them.

So it is a complicated business, and——

Mr. BUYER. So your doctors, though, are part of this counseling process, right?

Lt. Gen. PEAKE. Yes, sir.

Mr. BUYER. I guess that's why some of us are uneasy. And I hate to go back to the semantics of this on post-deployment and who do they actually see, you know? And it's all—you're right, Secretary Wyatt, about they go up different levels. But as you also go up at different levels, the trusts in the words increase at different levels. It's just a fact of life. Mrs. Davis?

Mrs. DAVIS. Yes. Mr. Chairman, one thing that strikes me. and I think this applies more to the reserve units. I know how active the ombuds people are in my community of San Diego are, for example, with the Navy. And they're doing a fabulous job.

But they also interact with some of the families of reserve units who might be in San Diego, but their unit is in Sacramento or somewhere. They have very little support system. They really don't know what's going on. And they just don't have that connection.

And what I'm wondering is if we haven't developed that enough, or created something for the reserve unit, so that I would think that, you know, their wives, even though they are gone, they want to know that the family is well taken care of. But I suspect that in many cases—and it could be spouses, wives or husbands or parents—who are kind of willing to do the homework and some of the ground work on these issues, but they don't have anybody to connect with readily.

And so I know there are folks out there, but that's one of the major complaints that I was hearing. And so I don't know whether we're gearing up for that. But it seems to me that we might be able to deal with some of these issues that come up later on if we did a better job early on, and certainly at a time of deployment for re-

serve units that are feeling disconnected from any warm body on the other end of the line.

Lt. Gen. PEAKE. If I can just comment. You know, I know that—and I can probably speak for Gen. Helmly, who is the Chief of the Army Reserve, that this has been a big focus area of the family readiness groups within the reserves. I mean, it's been a part of our way of life and active side for a long time. And even there, it can be strengthened.

But the fact is I know that there has been a lot of attention to that. And now that we have, you know, the TRICARE benefit available to the reservists as they go, counseling is much more meaningful to the family members, you know, in terms of being pulled in to our health care system. We're having the opportunity to do that.

So I think, frankly, we're doing probably better than we've done it before, but it's always an area that we need to—that requires attention and work.

Mr. BUSH. Could I just comment on that, please? We recognized after the first Persian Gulf War that family support for Guard and Reserve was not very good. Probably the best component that had family support system was the Guard.

And we've taken those lessons learned, and we have aggressively pursued expanding and reaching out to the Guard and Reserve. We have members of our staff that work daily, the family readiness issues. We're working with the services, with the components. We're working with VA. We're working across the boundaries so that it doesn't matter whether they're guardsmen, they're reservists, or they're active duty, that they know where they can go and they can get help and assistance.

So one of the problems we have , as I stated before, is that we're so dispersed, and we're not necessarily located where the bases are, where the facilities are. And so what we're trying to do is push into the units the same type of ombudsman services, the same type of connectivity that the families have for active duty people that the reserve units have.

As I said, probably the best example we have, and they continue to improve, is the Guard, both the Army Guard and the Air Guard. And we're pushing that very, very hard, because we know how important the families are.

Lt. Gen. TAYLOR. Mr. Chairman, just another note. For the National Guard, we began this large mobilization—Noble Eagle—after 9/11. The Guard quickly recognized that transitioning people to active duty and their family members into TRICARE wasn't going to be simple. TRICARE is a little bit of a complex operation. Particularly, most of the Guard bases and guardsmen were not located around major medical military treatment facilities.

And the Air National Guard put together a very comprehensive program to advise folks about benefits, and you'll be happy to know they actually mobilized two medics at each Guard operating location to help smooth out these exact kind of health care issues.

I can't explain exactly what happened to Sergeant Halcomb at Terre Haute. I would suspect that there are—there have been medics activated there to help this process, and somehow, he missed his piece. But at each Guard base, we've activated medics to help with exactly this process.

Mr. BUYER. Well, it is far—it's easier than what it was. I mean, it was Mr. Wyatt and I that put in the waiving of the deductibles for the guardsmen and reservists so we could make it a little easier on the families.

I don't mean to keep you all afternoon, but I've got about four questions left, just to let you know where we are.

We had mentioned about the FEDS-HEAL program, and I didn't do the follow-up question. Secretary Wyatt, I have this sense that everybody feels pretty good, from the Guard and the Reserves and the active, about the FEDS-HEAL program. Good initiative. Let's ask about the funding—and Dr. Roswell. Let's ask about the funding. Is it funded well enough, or is it not? Are you comfortable with the level of funding? More? Less? If you can't answer today, you can answer for the record.

Mr. WYATT. I don't have any indication that it's not funded adequately. So I will research that and provide you the information for the record.

Mr. BUYER. All right. Thank you.

Mr. WYATT. Yes, sir.

(Subsequently the Department of Veterans Affairs provided the following information:)

The Federal Strategic Health Alliance (FEDS-HEAL) is designed to provide routine and pre-mobilization medical and dental readiness services. It is the primary means of accomplishing this mission for the Army Reserve, and is being used on a limited basis by the Army National Guard and Air Force Reserve. FEDS-HEAL services also include post-deployment diagnostic testing (blood specimen collection, tuberculin skin testing, diagnostic radiography, leishmaniasis screening, and other services as requested). The FEDS-HEAL is adequately funded to perform its mission.

The program funding of $25 million in FY 2004 provides:

- dental services for mobilizing forces
- limited officer candidate applicant physical examinations
- routine periodic examinations
- some immunizations
- limited dental screening
- some pre-mobilization site processing of vision examinations and spectacle/lens insert ordering

Mr. BUYER. I have a question in reference to blood samples. In a case—and what initiated this question is what occurred with the World Trade Center when a fireman, his remains could not be found, but they did have a blood sample, and they turned it over to the family. Has the question ever been debated or discussed within DOD now that we have this requirement upon DOD to hold blood samples in cases where no remains are found, whether or not blood samples are released to the family, or do you believe that that blood sample is best to be archived in case, you know, such as we're finding these circumstances whereby remains were found 50 years ago?

I pose that to you only because it's a question, I think, that may come towards you. I'm curious. Mr. Wyatt?

Mr. WYATT. I've had no discussions on that matter, although the surgeons may have had some discussions on that.

Lt. Gen. PEAKE. Sir, first of all, I've not been asked the question. It has not come up in anything that I know of with the DOD.

Mr. BUYER. Are there two samples?

Lt. Gen. PEAKE. There's a DNA sample, which is basically a blood card with a splotch on it that is stored separately. These samples that are part of the pre-and post-deployment screening business—and we've got about 30 million samples on board—is a by-product of our HIV screening program. And that is really not DNA material used for identification of remains or anything like that. So, I mean, it is available——

Mr. BUYER. It is a matter that could be open for discussion with regard to the families.

Lt. Gen. PEAKE. It would be.

Mr. BUYER. Gen. Taylor?

Lt. Gen. TAYLOR. But we do have a separate program to use DNA for identification. All military people have DNA samples stored in a completely separate program for identification purposes.

Mr. BUYER. Thank you. I have to do this. Because I'm going to put this to rest. I'm going to try to put this question to rest about medical examinations versus physical examinations. Because the veterans service organizations out there like to write about it. I'm not picking just on the VSOs. I'm talking about others within the communities, about you didn't do your job because you were supposed to do physical exams.

There is a June 19, 2003, letter in which, Mr. Wyatt, you signed on behalf of Secretary Winkenwerder to the GAO. And in this letter, instead of using the terms "medical examinations," you used the term in its place, "physical examinations." So will you please correct the record as to was this a semantic problem on your part, or did you—were you thinking that the two are the same?

Mr. WYATT. Well, sir, this may be the clearest example in this whole two-hearing-long conversation now that is not semantic. That letter refers to the GAO's recommendations and report. The GAO speaks to physical examinations. I was referring to their work, not our health assessments. So the proper way to refer to their work would be to use their words, which is "physical examination."

Mr. BUYER. So then perhaps what you should have done is put quotes around "physical examination"?

Mr. WYATT. No, sir. The GAO's work is—I presume you're talking about not the work we've discussed today, but the other piece of work that the GAO did——

Mr. BUYER. Yes.

Mr. WYATT (continuing). Is predicated on their view that physical examinations is what's required.

Mr. BUYER. Okay. Now, help me out here. I also serve on the Health Subcommittee in Commerce. So now when I deal with medical doctors, other medical doctors, you are educating me that now when I work with other medical doctors, that when I use the term "medical examination," it doesn't mean physical examination. They're going to know what I mean. Or are we creating a different standard within the military versus the rest of your medical society? I just——

Lt. Gen. PEAKE. Sir, I think if you had this discussion with a group of doctors, you'd have the same kind of discussion. I would pose the notion that a physical examination for a heart surgeon is

quite—may have a variety of different components than an internist, may have a variety of different components than the flight surgeon, may have a variety of different components than the proctologist.

And so, you know, the issue is the examination is a cognitive function that is an evaluation that leads to a variety of outcomes, some of which may be a biopsy, some of which may be another diagnostic procedure, some of them may be a more complete physical examination.

A question about a neurologic condition may trigger a detailed neurologic examination that I would tell you, sir, is not part of anybody's routine physical examination.

And so I guess the issue is the intent. And the intent, I would think, is to make sure that we, in a reasonable manner, assess the condition and try not to miss something of a——

Mr. BUYER. Okay. Let me go back. The intent——

Mrs. DAVIS. Mr. Chairman, can I ask just a quick question? Where does social history come into this?

Lt. Gen. PEAKE. It is part of the medical history, ma'am. It's a component of the history——

Mrs. DAVIS. You would never consider that part of a physical exam. It's a medical history. Social history.

Lt. Gen. PEAKE. Yes, ma'am.

Mr. BUYER. I'll use the word—let me go from intent, okay? I can tell you what I intended. How's that? Now I'll tell you what I intended. Because what I've intended, and then from our discussions, Ed, this committee—this committee here, along with DOD, post-Gulf War, said that we are going to make sure that these individuals get taken care of. So we gave them access to health care, and then we had the Kennedy-Boulier legislation that said, "We're going to provide compensation for undiagnosed illnesses." All right? Wow. What have we done? We've kind of moved away from the causal connections, right? And why did all that occur? Because we didn't have a good baseline. So we needed to get a good baseline, and that's what the purpose of this law is.

So when you say, "What was intended by all of this?" The intent of this, it wasn't just to say, "Oh, are we going to make sure that the individual is physically ready to deploy? Oh, that's something you need to know." That's what you need to know with regard to your commanders to make sure that they're physically fit to do the job to succeed on the battlefield.

That was not the intent. Or that may have been part of the other reasons. But the true intent of why we were doing this is we need to provide physical baselines. We need to know exactly what this person is like when they deploy, and we want to know what they're like when they come home.

And because what this committee needs to do, and Congress, then, is begin to close the U.S. Treasury with regard to this whole thing about compensation for undiagnosed illnesses. We want to get back to the causal linkage. Because we are now paying disability benefits for a lot of veterans out there that perhaps would have been injured or diseased, anyway. Strike the word "injured." They could have been diseased or subject to an illness in any circumstance.

So we're trying to walk it back, but we can't walk it back unless we get a perfected baseline.

Which now I have to go to you, Dr. Roswell. Maybe we can put all this to bed. Are you, the VA, getting what you need based on these medical assessments from active duty? Are you getting what you need as a baseline with regard to your doctors as they perform these evaluations for disability?

Dr. ROSWELL. Mr. Chairman, if the intent of the pre-and post-deployment is to, if you will, put a lock and key on the Treasury, no, we're not. And quite frankly, I don't think any examination, no matter how comprehensive, would be able to do that.

The problem following the Gulf War was undiagnosed illnesses that, even after months and sometimes years of evaluation at tertiary referral centers with the world's best experts, still remained undiagnosed.

Our VA adjudication rules, compensation and benefits rules, state that we must have two conditions to be able to provide disability compensation. First, we have to have a diagnosis, and then we have to somehow relate that diagnosis to military service. It either had to occur during or immediately after military service, or be exacerbated during the period of military service, unless it's a disease which has a very long latency period, such as certain neurological conditions, where the latency period for onset may be as much as 7 years.

In the case of the Gulf War, we had patients coming back who became disabled very shortly after their return. Others became disabled months or even years after their return. But they were in a catch–22 situation, because we couldn't pin a diagnosis on their non-specific symptoms, we couldn't provide disability compensation.

So the legislation you spoke of was actually designed not to just provide free access to disability benefits to anyone who served, but to deal with a very specific situation.

My view, my personal view, of the pre-and post-deployment examinations mandated by Public Law 105–85 are that they give us a much better insight to what a veteran might be at risk for, and how the VA can reach out and provide those services. That's why I'm interested in the enhanced granularity, I believe is referred to, in those questions added for mental health, because they're excellent screening questions that identify a veteran who may be at serious risk for the development of post-traumatic stress disorder, a diagnosable condition, I might point out, that we can diagnose and service connect or not, as the case may be, with very discrete disability benefits rules.

Would I like more ready access to those pre-and post-deployment examination results? Absolutely. Because it helps me provide better care for the veterans I'm responsible to provide care for. But would access to those pre-and post-deployment benefits—excuse me—examinations curtail the amount of benefits being provided? I don't think so.

Mr. BUYER. Well, I'm willing to put my thinking cap on, and I want to work with you.

The last question that we haven't touched on is part of one of the seams that you mentioned, Mr. Secretary, is the information technology architecture. We have spent billions and billions of dollars

over the years to "try to get this one right." And there's been a new effort that the Secretary of the VA has been in, and working cooperatively with all of you. Can you give us a quick update? I mean, this is at the heart of being seamless and transparent and moving these medical records without paper.

Mr. WYATT. Yes, sir. Go ahead.

Dr. ROSWELL. Let me point out that through the Joint Executive Council structure between VA and DOD, one of the significant accomplishments is the signing of a Federal Health Information Exchange Agreement that was assigned last year. Through that exchange agreement, we have begun the electronic transfer of information, and that's a very important first step, something that didn't occur in the past.

But much more important than that FHIE agreement is a commitment between both departments to move to a similar architecture for our information systems, a data repository architecture. In DOD, that would be the clinical data repository architecture. In VA, it would be the health data repository architecture.

VA currently operates a graphically user interface-based electronic medical records system known as CPRS. It's an outstanding electronic medical records system. In fact, it's been highly regarded not only in this country, but around the world as a state-of-the-art superb electronic medical records system.

Despite its enhanced functionality, it resides at our individual medical centers, and even we can't move a medical record from one medical center to another medical center.

Our solution to that was to go to a health data repository structure, which would move all of the key information from the computerized patient record at any location of VA care anywhere in the Nation into a central data repository. So that if a veteran who lived in Michigan came to Florida for the summer, we could query the data repository using a master patient index and reconstitute the entire medical records system.

At the same time, DOD has been working on the development of their Consolidated Health Care System Two, or CHCS II, which is a graphically user interface-based electronic medical records system. There is a remarkable similarity, though there are separate electronic medical records systems between CHCS II and CPRS and VA.

Mr. BUYER. We can let Secretary Wyatt talk about DOD's.

Dr. ROSWELL. Okay. The point is that the—let me——

Mr. BUYER. The reason I'd like Secretary Wyatt, or even any of the surgeon generals, to comment on it, because after you comment, then I want to find out if the two systems actually talk to each other.

Dr. ROSWELL. They will. That's my point.

Mr. BUYER. They will. That means in the future?

Dr. ROSWELL. They will. That's the whole point I was trying to make, that the CHCS II will go to a clinical data repository in DOD. And because the interfaces between the CDR and DOD and the HDR and VA are identical, it will allow sharing of information anywhere between the systems. But this is very complex IT architecture.

Mr. BUYER. But they don't today.

Dr. ROSWELL. They don't today, because CHCS II doesn't exist at all sites within DOD, something that I'm sure Secretary Wyatt can address.

They don't today, because in VA, we don't have the health data repository yet. It's being pilot tested. But we can't move even within VA, so we certainly couldn't move a record to an MTF location.

But we have the commitment. We have an architecture. We know where we need to go. We simply need the resources, the time, and the talent to finish the development of CHCS II and migrate to the CDR at the same time we roll out the CPRS system in VA and migrate it to an HDR platform.

Mr. BUYER. Secretary Wyatt?

Mr. WYATT. Mr. Chairman, you may recall from the report of the Presidential Task Force on Veterans that in the area of information systems, the high-level recommendations had to do with similar architectures, as Secretary has mentioned, and standardization of data.

Because one of the things we know about the modern electronic health record is you kind of create it on the fly. You don't need to have this big stack of papers in front of you all the time. What you need is the information you need to assess the patient's history, the current situation, the lab results, what-have-you, so you can make a clinical finding about the patient. These health data repositories will enable us to be able to do that.

We're actually dealing with two implementation schedules here. One is, as Secretary Roswell indicated, our bringing along or rolling out of CHCS II. We, in fact, took a very deliberate, slow approach in our initial roll-out of CHCS II, tested it in a large center, a medium center, a small center. The surgeons can testify to this, but I believe the view is that we've learned enough now that it—we may want to accelerate to the extent we can, the deployment of CHCS II. And obviously, we're delighted to hear that.

The other kind of deployment we do is when each of us, the VA and DOD, is developing some subcomponent of that system. And a good example of that would be scheduling and appointing. We needed to upgrade our capabilities. The VA needed to do the same. Two different systems, and fundamentally, two different sets of needs.

But at the end of the day, because we started with the premise that we were going to use similar architectures and base it on the same standards, same communication kinds of standards, they will be what we have termed interoperable.

Now, what does that mean? At the end of the day, we will be able to access one another's data and those systems, and will be able to act on it. And those are the two important things that you need to be able to do: reliably save and accurately retrieve information about any given patient. We expect the interoperable patient record, if you will, to be well underway by the end of 2005.

Mr. BUYER. Any comment, surgeons generals?

Vice Adm. COWAN. Sir, we're all fully engaged with our IT departments. We're fully in agreement—I think I speak for the other two—with the architecture. And we're just eager to get that system up.

Mr. BUYER. How are you going to deal with HIPAA problems?

Mr. WYATT. HIPAA has been a consideration in this process from the very beginning, so all of our business processes are designed with HIPAA in mind. We have security information privacy officers in all the right places.

Mr. BUYER. Okay. General Peake.

Lt. Gen. PEAKE. Well, HIPAA is a challenge for a lot of reasons, to be honest with you, sir. But when it comes to sharing information with Mrs. Stiffler, as an example, who's on the other end of the phone. Is it a reporter or is it Mrs. Stiffler? You know. I mean, there's a variety of issues that go along with that that talk about the seams here.

But from an electronic patient record, I was down at Fort Eustice, which is one of our pilot places. I sat in the room with one of the physicians using it. He was able to immediately access the MRI that was done at Portsmouth on this young soldier, being able to see that he had an orthopedic appointment, and what the orthopedist had said about that patient, and put it together in a heartbeat, as opposed to chasing around a variety of record rooms trying to find different information. It is clearly the way we need to go, and I think that it's been articulated very clearly.

We are looking for a 30-month deployment. This is a big system. There's no system that is as big as our two combined, I don't believe. And the scalability of information systems, sir, as you know, is a significant challenge. And so we need to approach it deliberately, but with vigor, I think.

Mr. BUYER. Well, I want to thank all of you. I want to thank you for enduring this long hearing. And I'd like to thank the staff for their work, and your staffs who helped prepare you for today.

As I was a good listener from the first panel, their complaints were more about systematic. And it was reassuring. I'd even strike the word "reassuring." I think it was wonderful to hear their compliments about the quality of care. Not only did they receive from your medical teams on active duty—as a matter of fact, those of combat support teams that were in the field—Ed, the things that you did, or right to that combat support hospital and transferred. So through the systems, it worked.

And the compliments to the VA health system. It's just the humps and bubbles and, you know, trying to put it together is our challenge.

And that was really the purpose, I think, the chairman called this hearing today was to provide our oversight and to find out what—how is it working? Here's what we intended when we wrote it. Here's how you've implemented it. It might be a little different. But is it working? Are you getting what you need? And what things must we continue to work on?

And obviously, it's very clear that with regard to these issues of compensation for undiagnosed illnesses, we've got to address this one somehow, because we just can't leave this as a complete opening to cover an individual that might 6 or 7 years from now say, "Oh, yeah, that occurred back in such-and-such a war," and then try to seek some type of compensation for something which has no causal link whatsoever.

And so we have to be careful. As we look back, our compassion, sincerity, it was all real. The unfortunate thing is is there are indi-

viduals who are going to try to take advantage of that, which is unfortunate.

But please extend to your medical teams and your professionals the admiration of this committee. Thank you, and God speed to your work. This hearing is now concluded.

[Whereupon, the committee was adjourned.]

APPENDIX

United States General Accounting Office

GAO

Report to the Chairman and Ranking Minority Member, Subcommittee on Total Force, Committee on Armed Services, House of Representatives

September 2003

DEFENSE HEALTH CARE

Quality Assurance Process Needed to Improve Force Health Protection and Surveillance

GAO-03-1041

GAO
Accountability Integrity Reliability

Highlights

Highlights of GAO-03-1041, a report to the Chairman and Ranking Minority Member, Subcommittee on Total Force, Committee on Armed Services, House of Representatives

Why GAO Did This Study

Following the 1990-91 Persian Gulf War, many servicemembers experienced health problems that they attributed to their military service in the Persian Gulf. However, a lack of servicemember health and deployment data hampered subsequent investigations into the nature and causes of these illnesses. Public Law 105-85, enacted in November 1997, required the Department of Defense (DOD) to establish a system to assess the medical condition of service members before and after deployments. GAO was asked to determine whether (1) the military services met DOD's force health protection and surveillance requirements for servicemembers deploying in support of Operation Enduring Freedom (OEF) in Central Asia and Operation Joint Guardian (OJG) in Kosovo and (2) DOD has corrected problems related to the accuracy and completeness of databases reflecting which servicemembers were deployed to certain locations.

What GAO Recommends

GAO recommends that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to establish an effective quality assurance program that will help ensure that the military services comply with the force health protection and surveillance requirements for all servicemembers. DOD concurred with the recommendation.

www.gao.gov/cgi-bin/getrpt?GAO-03-1041

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cliff Spruill at (202) 512-4531.

September 2003

DEFENSE HEALTH CARE

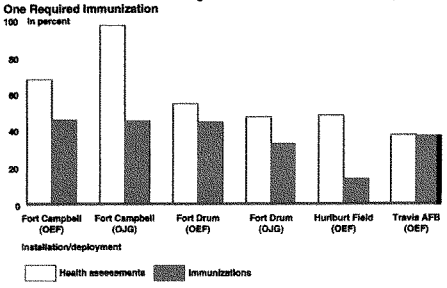
Quality Assurance Process Needed to Improve Force Health Protection and Surveillance

What GAO Found

The Army and Air Force—the focus of GAO's review—did not comply with DOD's force health protection and surveillance policies for many active duty servicemembers, including the policies that they be assessed before and after deploying overseas, that they receive certain immunizations, and that health-related documentation be maintained in a centralized location. GAO's review of 1,071 servicemembers' medical records from a universe of 8,742 at selected Army and Air Force installations participating in overseas operations disclosed that 38 to 98 percent of servicemembers were missing one or both of their health assessments and 14 to 46 percent were missing at least one of the required immunizations (see figure).

DOD also did not maintain a complete, centralized database of servicemembers' medical assessments and immunizations. Health-related documentation missing from the centralized database ranged from 0 to 63 percent for pre-deployment assessments, 11 to 75 percent for post-deployment assessments, and 8 to 93 percent for immunizations. There is no effective quality assurance program at the Office of the Assistant Secretary of Defense for Health Affairs or at the Army or Air Force that helps ensure compliance with policies. GAO believes that the lack of such a program was a major cause of the high rate of noncompliance. Continued noncompliance with these policies may result in servicemembers deploying with health problems or delays in obtaining care when they return. Finally, DOD's centralized deployment database is still missing the information needed to track servicemembers' movements in the theater of operations. By July 2003, the department's data center had begun receiving location-specific deployment information from the services and is currently reviewing its accuracy and completeness.

Percent of Servicemembers Missing One or Both Health Assessments, and Missing at Least One Required Immunization



Sources: GAO analyses of DOD data.

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Abbreviations

AMSA	Army Medical Surveillance Activity
CITA	Comprehensive Immunization Tracking Application
DCAPES	Deliberate Crisis and Action Planning and Execution Segment
DIMHRS	Defense Integrated Military Human Resource System
DMDC	Defense Manpower Data Center
DOD	Department of Defense
MEDPROS	Medical Protection System
OEF	Operation Enduring Freedom
OJG	Operation Joint Guardian
SOCOM	U.S. Special Operations Command
TMIP	Theater Medical Information Program

GAO
Accountability * Integrity * Reliability
United States General Accounting Office
Washington, DC 20548

September 19, 2003

The Honorable John McHugh
Chairman
The Honorable Vic Snyder
Ranking Minority Member
Subcommittee on Total Force
Committee on Armed Services
House of Representatives

Following the 1990-91 Persian Gulf War, many servicemembers experienced health problems that they attributed to their military service in the Persian Gulf. However, subsequent investigations into the nature and causes of these illnesses were hampered by a lack of servicemember health and deployment data. Moreover, in May 1997, we reported on several similar problems associated with the implementation of the Department of Defense's (DOD) deployment health surveillance policies for servicemembers deployed to Bosnia in support of a peacekeeping operation.[1]

In response, the Congress enacted legislation[2] in November 1997 requiring DOD to establish a system for assessing the medical condition of servicemembers before and after their deployment to locations outside the United States and requiring the centralized retention of certain health-related data associated with the servicemember's deployment. The system is to include the use of pre-deployment medical examinations and post-deployment medical examinations, including an assessment of mental health and the drawing of blood samples. DOD has implemented specific force health protection and surveillance policies. These policies include pre- and post-deployment health assessments designed to identify health issues or concerns that may affect the deployability of servicemembers or that may require medical attention; pre-deployment immunizations to address possible health threats in deployment locations; pre-deployment

[1] See U.S. General Accounting Office, *Defense Health Care: Medical Surveillance Improved Since Gulf War, but Mixed Results in Bosnia*, GAO/NSIAD-97-136 (Washington, D.C.: May 13, 1997).

[2] Section 765 of Pub. L. No. 105-85 amended title 10 of the United States Code by adding section 1074f.

screening for tuberculosis; and the retention of blood serum samples on file prior to deployment.

Given the many deployments of servicemembers to overseas locations since 1997, you asked us to examine the military services' implementation of DOD's force health protection and surveillance policies and its progress in correcting the types of problems we found in 1997.[3] More specifically, we focused our work on Army and Air Force active duty deployments[4] for Operation Enduring Freedom (OEF) in Central Asia and Operation Joint Guardian (OJG) in Kosovo to address the following two questions:

1. Are the military services meeting DOD's force health protection and surveillance system requirements for servicemembers deploying in support of OEF and OJG?

2. Has DOD corrected problems related to the accuracy and completeness of databases reflecting which servicemembers deployed to certain locations?

To accomplish these objectives, we obtained the force health protection and surveillance policies applicable to the OEF and OJG deployments from the Army, Air Force, combatant commanders, the office of the Assistant Secretary of Defense, and the services' Surgeons General. To test the implementation of these policies, we reviewed statistical samples totaling 1,071 active duty servicemembers selected from a universe of 8,742 active duty servicemembers at four military installations. To provide assurances that our review of the selected medical records was accurate, we requested the installations' medical personnel to reexamine those medical records that were missing required health assessments or immunizations and adjusted our results where documentation was subsequently identified. We also requested installation medical personnel to check all possible sources for missing pre- and post-deployment health

[3] Problems cited in our May 1997 report included the following: required medical assessments not prepared for many servicemembers; incomplete medical record keeping; an incomplete centralized health assessment database; and an inaccurate personnel deployment database.

[4] In April 2003, we reported on problems experienced by the Army in assessing the health status of all early-deploying reservists. See U.S. General Accounting Office, *Defense Health Care: Army Needs to Assess the Health Status of All Early-Deploying Reservists*, GAO-03-437 (Washington, D.C.: Apr. 15, 2003); and U.S. General Accounting Office, *Defense Health Care: Army Has Not Consistently Assessed the Health Status of Early-Deploying Reservists*, GAO-03-997T (Washington, D.C.: July 9, 2003).

assessments and missing immunizations. We also requested the U.S. Special Operations Command (SOCOM) to query its database for health-related documentation for servicemembers in our sample at one of the selected installations. We also examined, for Army and Air Force servicemembers in our samples, the completeness of the centralized records at the Army Medical Surveillance Activity[5] (AMSA), which is tasked with centrally collecting deployment health-related records. Further, we interviewed officials at the office of the Deployment Health Support Directorate and at the Defense Manpower Data Center (DMDC) regarding the accuracy and completeness of DMDC's personnel deployment database and planned improvements. For more detailed information of our scope and methodology, see appendix I.

Results in Brief

The Army and Air Force did not comply with DOD's force health protection and surveillance policies for many of the servicemembers at the installations we visited. Our review of medical records at those installations disclosed that problems continue to exist in several areas.

- **Deployment health assessments.** The percentage of Army and Air Force servicemembers missing one or both of their pre- and post-deployment health assessments ranged from 38 to 98 percent of our samples. Moreover, when health assessments were conducted, as many as 45 percent of them were not done within the required time frames. Furthermore, a health care provider did not review all health assessments and, although only a small number of assessments in our samples indicated a health concern, large percentages of these assessments were not referred for further consultations as required.
- **Immunizations and other pre-deployment requirements.** Servicemembers missing evidence of receiving at least one of the pre-deployment immunizations required for their deployment location ranged from 14 percent to 46 percent. Furthermore, servicemembers missing current tuberculosis screening at the time of their deployment ranged from 7 to 40 percent. As many as 29 percent of the servicemembers in our samples had blood serum samples in the repository older than the required maximum age of 1 year at the time of deployment, ranging, on average, from 2 to 15 months out-of-date.

[5] The Army Medical Surveillance Activity is DOD's executive agent for collecting and retaining the military services' deployment health-related documents—including the pre-deployment and post-deployment health assessments and immunizations.

- **Completeness of medical records and centralized data collection.** Servicemembers' permanent medical records at the Army and Air Force installations we visited did not include documentation of the completed health assessments that we found at AMSA and at the U.S. Special Operations Command, ranging from 8 to 100 percent for pre-deployment health assessments and from 11 to 62 percent for post-deployment health assessments. Our review also disclosed that the AMSA database—designed to function as the centralized collection location for deployment health-related information for all military services—was still, over 5 years after congressional action, lacking documentation of many health assessments and immunizations that we found in the servicemembers' medical records at the installations visited. Specifically, health-related documentation missing from the centralized database ranged from 0 to 63 percent for pre-deployment health assessments, 11 to 75 percent for post-deployment health assessments, and 8 to 93 percent for immunizations.

  Furthermore, DOD did not have oversight of departmentwide efforts to comply with health surveillance requirements. There is no effective quality assurance program at the Office of the Assistant Secretary of Defense for Health Affairs or at the Offices of the Surgeons' General of the Army or Air Force that helps ensure compliance with force health protection and surveillance policies. We believe the lack of such a system was a major cause of the high rate of noncompliance we found at the units we visited. Continued noncompliance with these policies may result in servicemembers being deployed with unaddressed health problems or without immunization protection. Furthermore, incomplete and inaccurate medical records may hinder DOD's ability to investigate the causes of any future health problems that may arise coincident with deployments.

  DOD has not corrected the problems we identified in 1997 that were related to the completeness and accuracy of a central personnel deployment database that is designed to collect data reflecting which servicemembers deployed to certain locations. The Defense Manpower Data Center's (DMDC) deployment database still does not include the information needed for effective deployment health surveillance. Prior to April 2003, the services were not reporting location-specific deployment data to the DMDC because, according to a DMDC official, the data was not available from the services. By July 2003, all of the services had begun submitting classified deployment data to DMDC, which is currently reviewing the deployment information received to determine its accuracy and completeness. However, DMDC still does not have a system to track the movement of servicemembers within a given theater, because this

information has not been available from the services and the development of a new tracking system at the service unit level may be required. DOD is developing a new system for tracking the movements of servicemembers and civilian personnel in the theater of operation with plans for implementation by about September 2005 for the Army and by 2007 or early calendar year 2008 for the other services.

We are recommending that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to establish an effective quality assurance system to ensure that the military services comply with force health protection and surveillance requirements for all servicemembers. In commenting on a draft of this report, DOD concurred with the report's recommendation.

Background

In May 1997, we reported on DOD's actions to improve deployment health surveillance before, during, and after deployments, focusing on Operation Joint Endeavor, which was conducted in the countries of Bosnia-Herzegovina, Croatia, and Hungary.[6] We commented on the provisions of a joint medical surveillance policy draft that called for a comprehensive DOD-wide medical surveillance capability to monitor and assess the effects of deployments on servicemembers' health. DOD subsequently finalized its joint medical surveillance policy in August 1997. Our 1997 review disclosed problems with the Army's implementation of the medical surveillance plan for Operation Joint Endeavor in the following areas:

- **Medical assessments.** Many Army personnel who should have received post-deployment medical assessments did not receive them and the assessments that were completed were frequently done late. Of the 618 servicemembers in the 12 Army units whose medical records we reviewed, 24 percent did not receive in-theater post-deployment medical assessments, and 21 percent did not receive home station post-deployment medical assessments. Servicemembers who received home station post-deployment medical assessments received them, on average, nearly 100 days after they left theater instead of within 30 days as required by the plan. Further, pre-deployment blood serum samples were not available for 9.3 percent of the 26,621 servicemembers who had deployed to Bosnia as

[6] GAO/NSIAD-97-136.

of March 12, 1996. The most recent blood samples for 6.4 percent of the pre-deployment blood samples were more than 5 years old.

- **Medical record keeping.** Many of the servicemembers' medical records that we reviewed were incomplete and missing documentation of in-theater post-deployment medical assessments, medical visits during deployment, and receipt of an investigational new vaccine. More specifically, we found that 91 of the 473 servicemembers (19 percent) with a post-deployment in-theater medical assessment and 9 of the 491 servicemembers (1.8 percent) with a post-deployment home unit medical assessment did not have the assessments documented in their medical records. Furthermore, about 29 percent of the 50 battalion aid station visits we reviewed were not documented in the members' permanent medical records. Finally, 141 of 588 servicemembers (24 percent) who received an investigational drug vaccine did not have the immunization documented in their medical records.
- **Centralized database.** The centralized database for collecting in-theater and home unit post-deployment medical assessments was incomplete for many Army personnel. More specifically, the database omitted 12 percent of the in-theater medical assessments done and 52 percent of the home unit medical assessments done for the 618 servicemembers whose records we reviewed.
- **Deployment information.** DOD officials considered the database used for tracking the deployment of Air Force and Navy personnel inaccurate.

Following the publication of our report, the Congress, in November 1997, included a provision in the Defense Authorization Act for Fiscal Year 1998 requiring the Secretary of Defense to establish a medical tracking system for servicemembers deployed overseas as follows:

"(a) SYSTEM REQUIRED—The Secretary of Defense shall establish a system to assess the medical condition of members of the armed forces (including members of the reserve components) who are deployed outside the United States or its territories or possessions as part of a contingency operation (including a humanitarian operation, peacekeeping operation, or similar operation) or combat operation.

"(b) ELEMENTS OF SYSTEM—The system described in subsection (a) shall include the use of predeployment medical examinations and postdeployment medical examinations (including an assessment of mental health and the drawing of blood samples) to accurately record the medical condition of members before their deployment and any changes in their medical condition during the course of their deployment. The postdeployment examination shall be conducted when the member is redeployed or otherwise leaves an area in which the system is in operation (or as soon as possible thereafter).

"(c) RECORDKEEPING—The results of all medical examinations conducted under the system, records of all health care services (including immunizations) received by members described in subsection (a) in anticipation of their deployment or during the course of their deployment, and records of events occurring in the deployment area that may affect the health of such members shall be retained and maintained in a centralized location to improve future access to the records.

"(d) QUALITY ASSURANCE—The Secretary of Defense shall establish a quality assurance program to evaluate the success of the system in ensuring that members described in subsection (a) receive predeployment medical examinations and postdeployment medical examinations and that the recordkeeping requirements with respect to the system are met."[7]

As set forth above, these provisions require the use of pre-deployment and post-deployment medical examinations to accurately record the medical condition of servicemembers before deployment and any changes during their deployment. In a June 30, 2003, correspondence with the General Accounting Office, the Assistant Secretary of Defense for Health Affairs stated that "it would be logistically impossible to conduct a complete physical examination on all personnel immediately prior to deployment and still deploy them in a timely manner." Therefore, DOD required both pre- and post-deployment health assessments for servicemembers who deploy for 30 or more continuous days to a land-based location outside the United States without a permanent U.S. military treatment facility. Both assessments use a questionnaire designed to help military healthcare providers in identifying health problems and providing needed medical care. The pre-deployment health assessment is generally administered at the home station before deployment, and the post-deployment health assessment is completed either in theater before redeployment to the servicemember's home unit or shortly upon redeployment.

As a component of medical examinations, the statute quoted above also requires that blood samples be drawn before and after a servicemember's deployment. DOD Instruction 6490.3, August 7, 1997, requires that a pre-deployment blood sample be obtained within 12 months of the servicemember's deployment.[8] However, it requires the blood samples be

[7] Section 765 of Pub. L. No. 105-85 amended title 10 of the United States Code by adding section 1074f.

[8] DOD Instruction 6490.3, "Implementation and Application of Joint Medical Surveillance for Deployments," August 7, 1997.

drawn upon return from deployment only when directed by the Assistant Secretary of Defense for Health Affairs. According to DOD, the implementation of this requirement was based on its judgment that the Human Immunodeficiency Virus serum sampling taken independent of deployment actions is sufficient to meet both pre- and post-deployment health needs, except that more timely post-deployment sampling may be directed when based on a recognized health threat or exposure. Prior to April 2003, DOD did not require a post-deployment blood sample for servicemembers supporting the OEF and OJG deployments.

In April 2003, DOD revised its health surveillance policy for blood samples and post-deployment health assessments. Effective May 22, 2003, the services are required to draw a blood sample from each redeploying servicemember no later than 30 days after arrival at a demobilization site or home station.[9] According to DOD, this requirement for post-deployment blood samples was established in response to an assessment of health threats and national interests associated with current deployments. The department also revised its policy guidance for enhanced post-deployment health assessments to gather more information from deployed servicemembers about events that occurred during a deployment. More specifically, the revised policy requires that a trained health care provider conduct a face-to-face health assessment with each returning servicemember to ascertain (1) the individual's responses to the health assessment questions on the post-deployment health assessment form; (2) the presence of any mental health or psychosocial issues commonly associated with deployments; (3) any special medications taken during the deployment; and (4) concerns about possible environmental or occupational exposures.

[9] Under Secretary of Defense for Personnel and Readiness Memorandum, "Enhanced Post-Deployment Health Assessments," April 22, 2003.

The Army and Air Force Did Not Comply with Deployment Health Surveillance Policies for Many Servicemembers

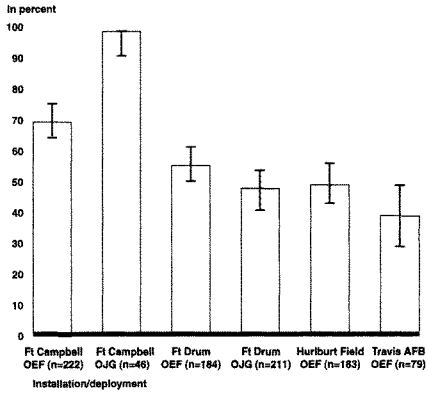
The Army and Air Force did not comply with DOD's force health protection and surveillance requirements for many of the servicemembers in our samples at the selected installations we visited. Specifically, these Army and Air Force servicemembers were missing: pre-deployment and/or post-deployment health assessments; evidence of receiving one or more of the pre-deployment immunizations required for their deployment location; and other pre-deployment requirements related to tuberculosis screening and blood serum sample storage. Also, servicemembers' permanent medical records were missing required health-related information, and DOD's centralized database did not include documentation of servicemember health-related information. Neither the installations nor DOD had monitoring and oversight mechanisms in place to help ensure that the force health protection and surveillance requirements were met for all servicemembers.

Many Servicemembers Lacked Pre-deployment and Post-deployment Health Assessments

We found that servicemembers missing one or both of their pre- and post-deployment assessments ranged from 38 to 98 percent in our samples.[18] For example, at Fort Campbell for the OEF deployment we found that 68 percent of the 222 active duty servicemembers in our sample were missing either one or both of the required pre-deployment and post-deployment health assessments. The results of our statistical samples for the deployments at the installations visited are depicted in figure 1.

[18] Because we checked all known possible sources for the existence of deployment health assessments, we concluded that the assessments were not completed in those instances where we could not find required health assessments.

Figure 1: Percent of Servicemembers Missing One or Both Health Assessments



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

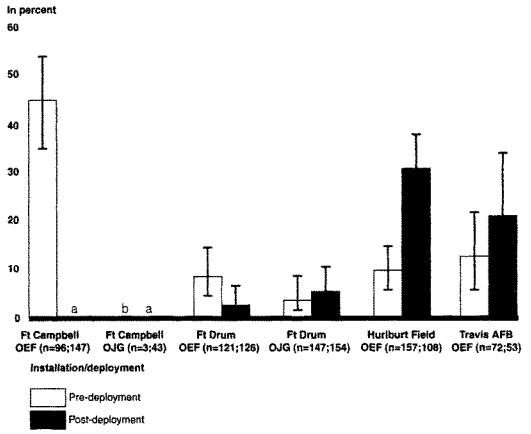
Notes: ⌈ = 95 percent confidence interval, upper and lower bounds for each estimate.

These percentages reflect assessments from all sources and without regard to timeliness.

For those servicemembers in our samples who had completed pre- or post-deployment health assessments, we found that as many as 45 percent of the assessments in our samples were not completed on time in accordance with requirements (see fig. 2). DOD policy requires that servicemembers complete a pre-deployment health assessment form within 30 days of their deployment and a post-deployment health assessment form within 5 days upon redeployment back to their home station.[11] These time frames were established to allow time to identify and resolve any health concerns or problems that may affect the ability of the servicemember to deploy, and to promptly identify and address any health concerns or problems that may have arisen during the servicemember's deployment.

[11] Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-2, "Updated Procedures for Deployment Health Surveillance and Readiness," February 1, 2002.

Figure 2: Percent of Health Assessments *Not* Completed Within Required Time Frames



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

Notes: | = 95 percent confidence interval, upper and lower bounds for each estimate.

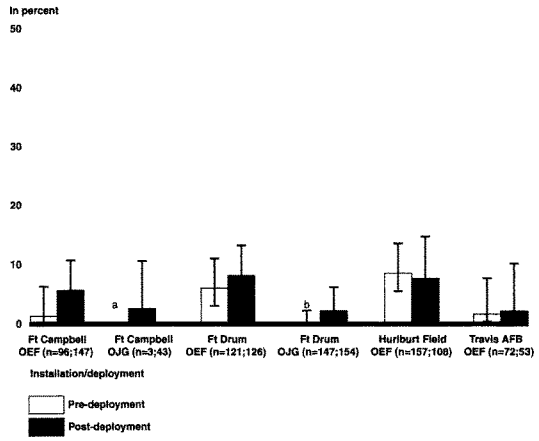
[a]Unable to compute because exact redeployment date was unavailable.

[b]All three pre-deployment cases for Fort Campbell were completed within the required time frame, but unable to compute confidence intervals due to insufficient size.

Not all health assessments were reviewed by a health care provider as required, as shown in figure 3. DOD policy requires that pre-deployment and post-deployment health assessments are to be reviewed immediately by a health care provider to identify any medical care needed by the servicemember.[12]

[12] The Joint Staff, Joint Staff Memorandum MCM-251-98.

Figure 3: Completed Assessments That Were *Not* Reviewed by Health Care Provider



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

Notes: [= 95 percent confidence interval, upper and lower bounds for each estimate.

[a]All three pre-deployment cases for Fort Campbell were reviewed by the health care provider, but unable to compute confidence intervals due to insufficient size.

[b]Zero cases: confidence level shown.

The services did not refer some servicemember health assessments that indicated a need for further consultation. According to DOD policy, a medical provider, namely a physician, physician's assistant, nurse, or independent duty medical technician is required to further review a servicemember's need for specialty care when the member's pre-deployment and/or post-deployment health assessment indicates health concerns such as unresolved medical or dental problems or plans

to seek mental health counseling or care.[13] This follow-up may take the form of an interview or examination of the servicemember, and forms the basis of a decision as to whether a referral for further specialty care is warranted. In our samples, the number of assessments that indicated a health concern was relatively small, but large percentages of these assessments were not referred for further specialty care. For example, our sample at Travis Air Force Base included five pre-deployment health assessments that indicated a health concern, but four (80 percent) of the health assessments were not referred for further specialty care.

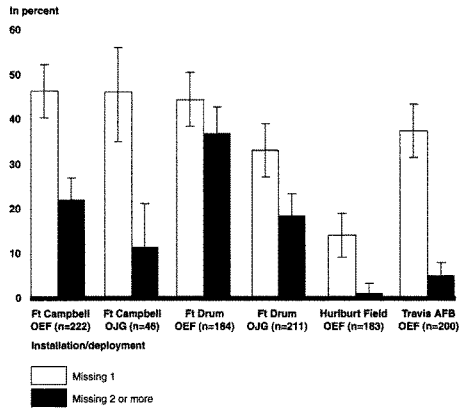
Noncompliance with the requirement for pre-deployment health assessments may result in servicemembers with existing health problems or concerns being deployed with unaddressed health problems. Also, failure to complete post-deployment health assessments may risk a delay in obtaining appropriate medical follow-up attention for a health problem or concern that may have arisen during or following the deployment.

Immunizations and Other Pre-Deployment Health Requirements Not Met

Based on our samples, the services did not fully meet immunization and other pre-deployment requirements. Evidence of pre-deployment immunizations receipt was missing from many servicemembers' medical records. Servicemembers missing the required immunizations may not have the immunization protection they need to counter theater disease threats. Based on our review of servicemember medical records for the deployments at the four installations we visited, we found that between 14 and 46 percent of the servicemembers were missing at least one of their required immunizations prior to deployment (see fig. 4). Furthermore, as many as 36 percent of the servicemembers were missing two or more of their required immunizations.

[13] Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-02, "Updated Procedures for Deployment Health Surveillance and Readiness," February 1, 2002.

Figure 4: Percent of Servicemembers Missing Required Immunizations



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

Notes: | = 95 percent confidence interval, upper and lower bounds for each estimate.

The U.S. Central Command required the following pre-deployment immunizations for all servicemembers that deployed to Central Asia in support of OEF: hepatitis A (two-shot series); measles, mumps, and rubella; polio; tetanus/diphtheria within the last 10 years; yellow fever within the last 10 years; typhoid within the last 5 years; influenza within the last 12 months; and meningococcal within the last 5 years.[14] For OJG deployments, the U.S. European Command required the same immunizations cited above, with the exception of the yellow fever inoculation that was not required for Kosovo.[15]

[14] U.S. Central Command, "Personnel Policy Guidance for U.S. Individual Augmentation Personnel in Support of Operation Enduring Freedom," October 3, 2001.

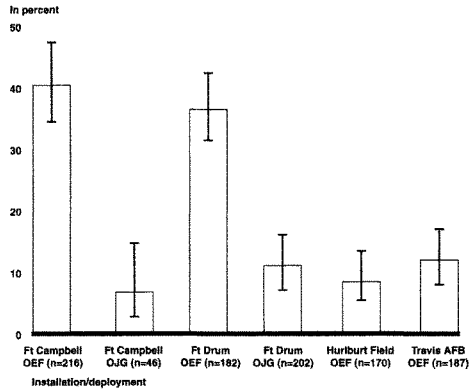
[15] Headquarters U.S. European Command, "Greece and the Balkans: Force Health Protection Guidance," January 4, 2002.

Figure 5 indicates that 7 to 40 percent of the deploying servicemembers in our review were missing a current tuberculosis screening. A screening is deemed "current" if it occurred 1 to 2 years prior to deployment. Specifically, the U.S. Central Command required servicemembers deploying to Central Asia in support of OEF to be screened for tuberculosis within 12 months of deployment.[16] For OJG deployments, the U.S. European Command required Army and Air Force servicemembers to be screened for tuberculosis with 24 months of deployment.[17]

[16] U.S. Central Command, "Personnel Policy Guidance for U.S. Individual Augmentation Personnel in Support of Operation Enduring Freedom," October 3, 2001.

[17] Headquarters U.S. European Command, "Greece and the Balkans: Force Health Protection Guidance," January 4, 2002.

Figure 5: Percent of Servicemembers That Did Not Have Current Tuberculosis Screening



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

Notes: | = 95 percent confidence interval, upper and lower bounds for each estimate.

U.S. Central Command and U.S. European Command policies require that deploying servicemembers have a blood serum sample in the serum repository not older than 12 months prior to deployment.[18] While nearly all deploying servicemembers had blood serum samples held in the Armed Services Serum Repository prior to deployment, as many as 29 percent had serum samples that were too old (see table 1). The samples that were too old ranged, on average, from 2 to 15 months out-of-date.

[18] U.S. Central Command, "Personnel Policy Guidance for U.S. Individual Augmentation Personnel in Support of Operation Enduring Freedom," October 3, 2001; and Headquarters U.S. European Command, "Greece and the Balkans: Force Health Protection Guidance," January 4, 2002.

Table 1: Deploying Servicemember Blood Serum Samples Held in Repository

Status of Blood Serum	Fort Campbell (OEF)	Fort Campbell (OJG)	Fort Drum (OEF)	Fort Drum (OJG)	Hurlburt Field (OEF)	Travis AFB (OEF)
Had serum sample in repository	100%	100%	100%	99.5%	100%	100%
Serum out-of date (older than 1-year requirement) at time of deployment	22%	7%	5%	1%	7%	29%
Average months out-of-date	8	2	11	5	15	14

Source: GAO analyses of DOD data.

Servicemember Medical Records and Centralized Database Were Not Complete

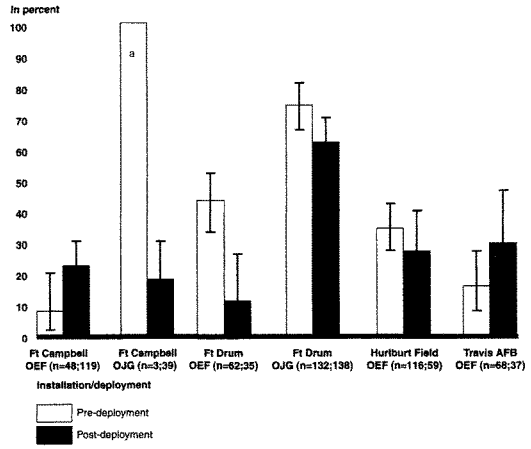
Servicemembers' permanent medical records were not complete, and DOD's centralized database did not include documentation of servicemember health-related information. Many servicemembers' permanent medical records at the Army and Air Force installations we visited did not include documentation of completed health assessments and servicemember visits to Army battalion aid stations. Similarly, the centralized deployment record database did not include many of the deployment health assessments and immunization records that we found in the servicemembers' medical records at the installations we visited.

Many Completed Deployment Health Assessments and Medical Interventions Were Not Documented in Servicemembers' Medical Record

DOD policy requires that the original completed pre-deployment and post-deployment health assessment forms be placed in the servicemember's permanent medical record and that a copy be forwarded to AMSA.[19] Figure 6 shows that completed assessments we found at AMSA and at the U.S. Special Operations Command for servicemembers in our samples were not documented in the servicemember's permanent medical record, ranging from 8 to 100 percent for pre-deployment health assessments and from 11 to 62 percent for post-deployment health assessments.

[19] Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-02, "Updated Procedures for Deployment Health Surveillance and Readiness," February 1, 2002.

Figure 6: Percent of Assessments Found in Centralized Database That Were Not Found in Servicemembers' Medical Records



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

Notes: | = 95 percent confidence interval, upper and lower bounds for each estimate.

[a]All three pre-deployment cases at Fort Campbell found in the centralized database were missing from servicemembers' medical record, but unable to compute confidence intervals due to insufficient size.

Army and Air Force policies also require documentation in the servicemember's permanent medical record of all visits to in-theater medical facilities.[20] Except for the OEF deployment at Fort Drum, officials were unable to locate or access the sign-in logs for servicemember visits to in-theater Army battalion aid stations and to Air Force expeditionary medical support for the OEF and OJG deployments at the installations we

[20] Army Regulation 40-66, "Medical Records Administration," October 23, 2002, and Air Force Instruction 41-210, "Health Services Patient Administration Functions," October 1, 2000.

visited. Consequently, we limited the scope of our review to two battalion aid stations for the OEF deployment at Fort Drum. We found that 39 percent of servicemember visits to one battalion aid station and 94 percent to the other were not documented in the servicemember's permanent medical record. Representatives of the two battalion aid stations said that the missing paper forms documenting the servicemember visits may have been lost en route to Fort Drum. Specifically, a physician's assistant for one of these battalion aid station said the battalion aid station moved three times in theater and each time the paper forms used to document in-theater visits were boxed and moved with the battalion aid station. Consequently, the forms missing from servicemembers' medical records may have been lost en route to Fort Drum.

The lack of complete and accurate medical records documenting all medical care for the individual servicemember complicates the servicemembers' post-deployment medical care. For example, accurate medical records are essential for the delivery of high-quality medical care and important for epidemiological analysis following deployments. According to DOD health officials, the lack of complete and accurate medical records complicated the diagnosis and treatment of servicemembers who experienced post-deployment health problems that they attributed to their military service in the Persian Gulf in 1990-91.

DOD is implementing the Theater Medical Information Program (TMIP) that has the capability to electronically record and store in-theater patient medical encounter data. TMIP is currently undergoing operational testing by the military services and DOD intends to begin fielding TMIP during the first quarter of fiscal year 2004.

Centralized Database Missing Health-Related Documentation

Based on our samples, DOD's centralized database did not include documentation of servicemember health-related information. As set forth above, Public Law 105-85, enacted November 1997, requires the Secretary of Defense to retain and maintain health-related records in a centralized location. This includes records for all medical examinations conducted to ascertain the medical condition of servicemembers before deployment and any changes during their deployment, all health care services (including immunizations) received in anticipation of deployment or during the deployment, and events occurring in the deployment area that may affect the health of servicemembers. A February 2002 Joint Staff memorandum

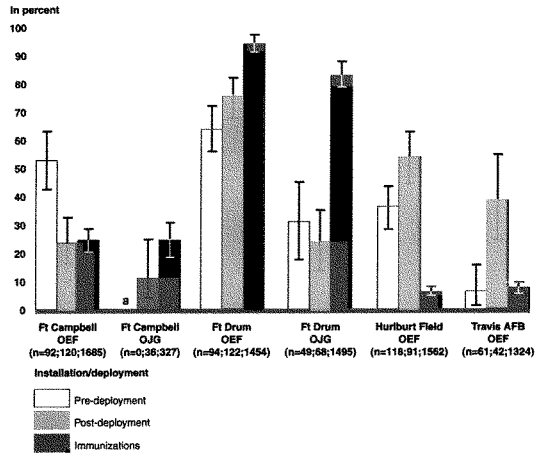
requires the services to forward a copy of the completed pre-deployment and post-deployment health assessments to AMSA for centralized retention.[21] Also, the U.S. Special Operations Command (SOCOM) requires deployment health assessments for special forces units to be sent to the Command for centralized retention in the Special Operation Forces Deployment Health Surveillance System.[22]

Figure 7 depicts the percentage of pre- and post-deployment health assessments and immunization records we found in the servicemembers' medical records that were not available in a centralized database at AMSA or SOCOM. Health-related documentation missing from the centralized database ranged from 0 to 63 percent for pre-deployment health assessments, 11 to 75 percent for post-deployment health assessments, and 8 to 93 percent for immunizations.

[21] Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-02, "Updated Procedures for Deployment Health Surveillance and Readiness," February 1, 2002.

[22] U.S. Special Operations Command Directive 40-4, "Medical Surveillance," October 18, 2000; Appendix 1 to Annex Q to U.S. Central Command Operations Order, "Special Operation Forces Deployment Health Surveillance System," November 30, 2001.

Figure 7: Percent of Assessments and Immunizations Found in Servicemembers' Medical Records That Were *Not* Found in the Centralized Database



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

Notes: | = 95 percent confidence interval, upper and lower bounds for each estimate.

Centralized database is AMSA for all but Hurlburt Field, which reports to either AMSA or SOCOM based on classification of military personnel. Hurlburt Field results reflect combined health assessment and immunization data found at either AMSA or SOCOM.

[a]Zero cases found in servicemembers' medical record that were not found in the centralized database.

All but one of the servicemembers in our sample at Hurlburt Field were special operations forces. A SOCOM official told us that pre-deployment and post-deployment health assessment forms for servicemembers in special operations force units are not sent to AMSA because the health assessments may include classified information that AMSA is not equipped to receive. Consequently, SOCOM retains the deployment health assessments in its classified Special Operations Forces Deployment Health Surveillance System. Also, a SOCOM medical official told us that the

system does not include pre-deployment immunization data. A Deployment Health Support Directorate official told us that the Directorate is examining how to remove the classified information from the deployment health assessments so that SOCOM can forward the assessments to AMSA. For presentation in figure 7, we combined the health assessment and immunization data we found at AMSA and SOCOM for Hurlburt Field.

An AMSA official believes that missing documentation in the centralized database could be traced to the services' use of paper copies of deployment health assessments that installations are required to forward to the centralized database, and the lack of automation to record servicemembers' pre-deployment immunizations. DOD has ongoing initiatives to electronically automate the deployment health assessment forms and the recording of servicemember immunizations. For example, DOD is implementing a comprehensive electronic medical records system, known as the Composite Health Care System II, which includes pre- and post-deployment health assessment forms and the capability to electronically record immunizations given to servicemembers. DOD has deployed the system at five sites and will be seeking approval in August/September 2003 for worldwide deployment.[23] DOD officials believe that the electronic automation of the deployment health-related information will lessen the burden of installations in forwarding paper copies and the likelihood of information being lost in transit.

DOD and Installations Did Not Have Oversight of Force Health Protection and Surveillance Requirements

DOD does not have an effective quality assurance program to provide oversight of, and ensure compliance with, the department's force health protection and surveillance requirements. Moreover, the installations we visited did not have ongoing monitoring or oversight mechanisms to help ensure that force health protection and surveillance requirements were met for all servicemembers. We believe that the lack of such a system was a major cause of the high rate of noncompliance we found at the units we visited. The services are currently developing quality assurance programs designed to ensure that force health protection and surveillance policies are implemented for servicemembers.

[23] In September 2002, we reported that DOD had experienced delays and cost overruns in implementing the Composite Health Care System II. See U.S. General Accounting Office, *Information Technology: Greater Use of Best Practices Can Reduce Risk in Acquiring Defense Health Care System*, GAO-02-345 (Washington, D.C.: Sept. 26, 2002).

Although required by Public Law 105-85 to establish a quality assurance program,[24] neither the Assistant Secretary of Defense for Health Affairs nor the offices of the Surgeons General of the Army or Air Force had established oversight mechanisms that would help ensure that force health protection and surveillance requirements were met for all servicemembers. Following our visit to Fort Drum in October 2002, the Army Surgeon General wrote a memorandum in December 2002 to the commanders of the Army Regional Medical Commands that expressed concern related to our sample results at Fort Drum. He emphasized the importance of properly documenting medical care and directed them to accomplish an audit of a statistically significant sample of medical surveillance records of all deployed and redeployed soldiers at installations supported by their regional commands, provide an assessment of compliance, and develop an action plan to improve compliance with the requirements.

At three of the four installations we visited, officials told us that new procedures were implemented that they believe will improve compliance with force health protection and surveillance requirements for deployments occurring after those we reviewed. Specifically, following our visit to Fort Drum in October 2002, Fort Drum medical officials designed a pre-deployment and post-deployment checklist patterned after our review that is being used as part of processing before servicemembers are deployed and when they return. The officials told us that this process has improved their compliance with force health protection and surveillance requirements for deployments subsequent to our visit. Also, the hospital commander at Fort Campbell told us that they implemented procedures that now require all units located at Fort Campbell to use the hospital's medical personnel in their processing of servicemembers prior to deployment. The hospital commander believes that this new requirement will improve compliance with the force health protection and surveillance requirements at Fort Campbell because the medical personnel will now review whether all requirements have been met for the deploying servicemembers. At Hurlburt Field, officials told us that they implemented a new requirement in November 2002 to withhold payment of travel expenses and per diem to re-deploying servicemembers until they complete the post-deployment health assessment. Officials believe that this change will improve servicemembers' completion of the post-deployment health assessments. While it is noteworthy that these

[24] 10 U.S.C. sec. 1074f(d).

installations have implemented changes that they believe will improve their compliance, the actual measure of improvements over time cannot be known unless the installations perform periodic reviews of servicemembers' medical records to identify the extent of compliance with deployment health requirements.

In March 2003, we briefed the Subcommittee on Total Force, House Committee on Armed Services, about our interim review results at selected military installations.[25] Subsequently, at a March 2003 congressional hearing, the Subcommittee discussed our interim review results with the Assistant Secretary of Defense for Health Affairs and the services' Surgeons General. Based on our interim results that DOD was not meeting the full requirement of the law and the military services were not effectively carrying out many of DOD's force health protection and surveillance policies, in May 2003 the House Committee on Armed Services directed the Secretary of Defense to take measures to improve oversight and compliance. Specifically, in its report accompanying the Fiscal Year 2004 National Defense Authorization Act, the Committee directed the Secretary of Defense "... to establish a quality control program to begin assessing implementation of the force health protection and surveillance program, and to provide a strategic implementation plan, including a timeline for full implementation of all policies and programs, to the Senate Committee on Armed Services and the House Committee on Armed Services by March 31, 2004."[26]

In April 2003, the Under Secretary of Defense for Personnel and Readiness issued an enhanced post-deployment health assessment policy that required the services to develop and implement a quality assurance program that encompasses medical record keeping and medical surveillance data.[27] In June 2003, the Office of Assistant Secretary of Defense for Health Affairs' Deployment Health Support Directorate began reviewing the services' quality assurance implementation plans and establishing DOD-wide compliance metrics—including parameters for conducting periodic visits—to monitor service implementation.

[25] Prior to briefing the Subcommittee, we also briefed the Senior Military Medical Advisory Committee including the Assistant Secretary of Defense for Health Affairs and the Surgeons General or their representatives about our interim review results.

[26] H.R. Rep. No. 108-106 at 336 (2003).

[27] Under Secretary of Defense for Personnel and Readiness Memorandum, "Enhanced Post-Deployment Health Assessments," April 22, 2003.

Centralized Deployment Database Still Missing Information Needed for Deployment Health Surveillance

The DMDC deployment database still does not include the deployment information we identified in 1997 as needed for effective deployment health surveillance. In 1997, we reported that knowing the identity of servicemembers who were deployed during a given operation and tracking their movements within the theater of operations are major elements of a military medical surveillance system.[28] The Institute of Medicine reported in 2000 that the documentation of the locations of units and individuals during a given deployment is important for epidemiological studies and for the provision of appropriate medical care during and after deployments.[29] This information allows (1) epidemiologists to study the incidence of disease patterns across populations of deployed servicemembers who may have been exposed to diseases and hazards within the theater, and (2) health care professionals to treat their medical problems appropriately. Because of concerns about the accuracy of the DMDC database, we recommended in our 1997 report that the Secretary of Defense direct an investigation of the completeness of the information in the DMDC personnel database and take corrective actions to ensure that the deployment information is accurate for servicemembers who deploy to a theater.

DOD's established policies notwithstanding, the services did not report location-specific deployment information to DMDC prior to April 2003, because, according to a DMDC official, the services did not maintain the data. DOD Instruction 6490.3, issued in August 1997, requires DMDC, under the Department's Under Secretary for Personnel and Readiness, to maintain a system that collects information on deployed forces, including daily-deployed strength, total and by unit; grid coordinate locations for each unit (company size and larger); and inclusive dates of individual servicemember's deployment.[30] In addition, the Joint Chief of Staff's Memorandum MCM-0006-02, dated February 1, 2002, required combatant commands to provide DMDC with their theater-wide rosters of all deployed personnel, their unit assignments, and the unit's geographic locations while deployed.[31] This memorandum stressed that accurate

[28] GAO/NSIAD-97-136.

[29] Institute of Medicine, *Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces* (National Academy Press, Washington, D.C.: 2000).

[30] DOD Instruction 6490.3, "Implementation and Application of Joint Medical Surveillance for Deployments," August 7, 1997.

[31] Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-02, "Updated Procedures for Deployment Health Surveillance and Readiness," February 1, 2002.

personnel deployment data is needed to assess the significance of medical diseases and injuries in terms of the rate of occurrence among deployed servicemembers. The Under Secretary of Defense for Personnel and Readiness expressed concern about the services' failure to report complete personnel deployment data to DMDC in an October 2002 memorandum.[32]

To address the services' lack of reporting to DMDC, the Under Secretary of Defense for Personnel and Readiness established a tri-service working group that outlined a plan of action in March 2003 to address the reporting issues. In July 2003, a DMDC official told us that significant improvements had recently occurred and that all of the services had begun submitting their classified deployment databases—including deployment locations—to DMDC. DMDC is currently reviewing the deployment information submitted by the services to determine its accuracy and completeness. It plans to complete this review during the summer of 2003.

With regard to DMDC's efforts to create a system for tracking the movements of servicemembers within a given theater of operations, DMDC officials told us that little progress has been made. They said that the primary reason for a lack of progress in developing this system is that the source information has generally not been available from the services and this may require the development of new tracking systems at the unit level. In June 2003, a DMDC official told us that it had been recently determined that the Air Force has implemented a theater tracking system that may have applicability to the other services. The tracking system—known as the Deliberate Crisis and Action Planning and Execution Segment (DCAPES)—enables field teams to enter classified information about the whereabouts of deployed Air Force personnel at the longitude/latitude level of detail. DMDC began receiving information from this system in April 2003. The Under Secretary of Defense for Personnel and Readiness is reviewing this system to determine whether it could be used for the same purposes by the other services.

Also, DOD is developing the Defense Integrated Military Human Resource System (DIMHRS), which will have the capability to track the movements of all servicemembers and civilians in the theater of operations. As of

[32] This memorandum was dated October 25, 2002, and sent to the Vice Chief of Staff of the Army, Vice Chief of Staff of the Air Force, Vice Chief of Naval Operations, and the Assistant Commandant of the Marine Corps.

June 2003, DOD plans to implement this system for the Army by about September 2005 and for the other services by 2007 or early calendar year 2008.

Conclusions

While DOD and the military services have established force health protection and surveillance policies, at the units we visited we found many instances of noncompliance by the services. Moreover, because DOD and the services do not have an effective quality assurance program in place to help ensure compliance, these problems went undetected and uncorrected. Continued noncompliance with these policies may result in servicemembers with existing health problems or concerns being deployed with unaddressed health problems or without the immunization protection they need to counter theater disease threats. Failure to complete post-deployment health assessments may risk a delay in obtaining appropriate medical follow-up attention for a health problem or concern that may have arisen during or following the deployment. Similarly, incomplete and inaccurate medical records and deployment databases would likely hinder DOD's ability to investigate the causes of any future health problems that may arise coincident with deployments.

Recommendation for Executive Action

To improve compliance with DOD's force health protection and surveillance policies, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to establish an effective quality assurance program, as required by section 765 of Public Law 105-85 (10 U.S.C. 1074f), that will ensure that the military services comply with the force health protection and surveillance requirements for all servicemembers.

Agency Comments and Our Evaluation

The Department of Defense provided written comments on a draft of this report, which are found in appendix II. DOD concurred with the report's recommendation.

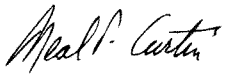
The Assistant Secretary of Defense for Health Affairs commented that his office has already established a quality assurance program for pre- and post-deployment health assessments. This program monitors pre- and post-deployment health assessments and blood samples being archived electronically at the Army Medical Surveillance Activity (AMSA) and assures that indicated referrals on the post-deployment health assessments are being conducted by all the services. However, the Assistant Secretary of Defense for Health Affairs' comments did not

discuss how his office is using the monitoring activities to assure the military services' compliance with force health protection and surveillance policies.

According to the Assistant Secretary of Defense for Health Affairs, the services have implemented their quality assurance programs. The Army has developed automated versions of the pre- and post-deployment health assessment forms, and has established a corporate monitoring system that is built upon deployment personnel rosters and monitored weekly by the Army Surgeon General. The Air Force is now receiving monthly deployment health surveillance compliance reports from its medical treatment facilities, and has scheduled a special compliance study through the Air Force Inspection Agency in fiscal year 2004. Navy fleet commanders have implemented their own quality assurance programs, with anticipation of standardization through centralized automated systems. And the Marine Corps has also established unit/command quality assurance procedures. We view these actions as responsive to our recommendation and commend the department for taking quick action to address the compliance issues we found during our audit. However, it remains to be seen how effective these activities will be in ensuring that force health protection and surveillance policies are implemented for all servicemembers.

We are sending copies of this report to the Secretary of Defense and the Secretaries of the Army and the Air Force. We will also make copies available to others upon request. In addition, the report is available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions regarding this report, please contact me on (757) 552-8100. Key contributors to this report are listed in appendix III.



Neal P. Curtin, Director
Defense Capabilities and Management

Appendix I: Scope and Methodology

To meet our objectives, we interviewed responsible officials and reviewed pertinent documents, reports, and information related to force health protection and deployment health surveillance requirements obtained from officials at the Office of the Assistant Secretary of Defense for Health Affairs; the Office of the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness; the Office of the Assistant Secretary of Defense for Reserve Affairs; the Joint Staff; the Marine Corps Force Health Protection Office; and the Offices of the Surgeons General for the Army and Air Force Headquarters in the Washington, D.C., area. We also performed additional work at the Deployment Health Support Directorate, Falls Church, Virginia; the U.S. Army Center for Health Promotion and Preventive Medicine, Aberdeen, Maryland; the Armed Forces Medical Intelligence Center, Fort Dietrick, Maryland; the Army Medical Surveillance Activity, Walter Reed Army Medical Center, Washington, D.C.; the Navy Environmental Health Center in Portsmouth, Virginia; the Defense Manpower Data Center in Monterey, California; and the U.S. Central Command and the U.S. Special Operations Command at MacDill Air Force Base, Tampa, Florida.

To determine whether the military services were meeting DOD's force health protection and surveillance requirements for servicemembers deploying in support of OEF and OJG, we identified DOD and each service's overall deployment health surveillance policies. We also obtained the specific force health protection and surveillance requirements applicable to all servicemembers deploying to Central Asia in support of OEF from the U.S. Central Command and these requirements for all servicemembers deploying to Kosovo in support of OJG from the U.S. European Command. We tested the implementation of these requirements at selected Army and Air Force installations. To identify locations within each service where we would test implementation of the policies, the Assistant Secretary of Defense for Health Affairs requested the services to identify, by military installation, the number of active duty servicemembers who met the following criteria:

- For OEF, those servicemembers who deployed to Central Asia for 30 or more continuous days to areas without permanent U.S. military treatment facilities following September 11, 2001, and redeployed back to their home unit by May 31, 2002.
- For OJG, those servicemembers who deployed to Kosovo for 30 or more continuous days to areas without permanent U.S. military treatment facilities from January 1, 2001, and redeployed back to their home unit by May 31, 2002.

Based on deployment data obtained from the services, we decided to limit our testing of the force health protection and surveillance policy implementation to selected Army and Air Force military installations with the largest numbers of servicemembers meeting our selection criteria (described above). We limited our review of medical records for servicemembers deploying in support of OJG to the two Army locations. We decided not to review Navy installations because there were only small numbers of servicemembers who met our selection criteria. We decided not to review Marine Corps installations because officials at the Marine Corps headquarters had difficulty identifying the number of servicemembers who went ashore 30 or more continuous days consistent with our selection criteria.

The largest deployers for OEF and OJG were selected and are listed below:

OEF:

- 10th Mountain Division, Fort Drum, N.Y.
- 101st Airborne Division, Fort Campbell, Ky.
- Travis Air Force Base, Calif.
- Hurlburt Field, Fla.

OJG:

- 10th Mountain Division, Fort Drum, N.Y.
- 101st Airborne Division, Fort Campbell, Ky.

For our medical records review, we selected statistical samples of servicemembers at the selected installations to be representative of those deploying from those military installations for those specific operations.

For various reasons, medical records were not always available for review. We, therefore, sampled without replacement, to choose additional records when we were unable to meet our sampling threshold of cases for review. Specifically, there were five reasons identified for not being able to physically secure the servicemember's medical record for review:

1. **Charged to patient.** When a patient visits a clinic (on-post or off-post), the medical record is physically given to the patient. The procedure is that the medical record will be returned by the patient following their clinic visit.

2. **Expired term of service.** Servicemember separates from the military and their medical record is sent to St. Louis, Missouri, and therefore not available for review.

3. **Record is not accounted for by the medical records department.** No tracking sheet is in the file system to indicate the patient has checked it out or otherwise. (Note: There were not any cases for which the medical record could not be accounted.)

4. **Permanent change of station.** Servicemember is still in the military, but has transferred to another base. Medical record transfers with the servicemember.

5. **Temporary duty off site.** Servicemember has left military installation, but is expected to return. The temporary duty is long enough to warrant that the medical record accompany the servicemember.

The sample size for deployments was determined to provide 95 percent confidence with a 5-percent precision. The number of servicemembers in our samples and the applicable universe of servicemembers for the OEF and OJG deployments at the installations visited are shown in table 2.

Table 2: Servicemember Sample Sizes at Each Visited Installation

Installation	Deployment	Sample	Universe
Fort Campbell	OEF	8	333
	OEF (post May 31)*	222	2,953
	OJG (post May 31)*	46	92
Fort Drum	OEF	184	491
	OJG	211	2,754
Hurlburt Field	OEF	184	927
Travis Air Force Base	OEF	215	1,192
Total		**1,071**	**8,742**

*In order to obtain a larger universe of servicemembers from which to select medical records for review, we extended our date for redeployment to home unit from May 31, 2002, to October 31, 2002.

At Fort Campbell, there were only 333 servicemembers identified as having met our criteria based on a redeployment date of May 31, 2002; however, only 8 charts were available for review due to rotation of soldiers to other military locations or departure from the military. It was, therefore, necessary to extend our redeployment date to October 31, 2002.

Doing so provided an additional 2,953 servicemembers who met all criteria except for a redeployment by May 31, 2002. At Fort Campbell, there were 92 servicemembers who deployed in support of OJG and met our selection criteria if we extended the redeployment date to October 31, 2002. Because the number of servicemembers for OJG at Fort Campbell was small, we reviewed the medical records for all of servicemembers who were still at Fort Campbell.

At each sampled location, we examined servicemember medical records for evidence of the following force health protection and deployment health-related documentation required by DOD's force health protection and deployment health surveillance policies:

- Pre- and post-deployment health assessments,
- Tuberculosis screening test (within 1 year of deployment for OEF and 2 years for OJG)
- Pre-deployment immunizations:
  - hepatitis A;
  - influenza (within 1 year of deployment);
  - measles, mumps, and rubella;
  - meningococcal (within 5 years of deployment);
  - polio;
  - tetanus-diphtheria (within 10 years of deployment);
  - typhoid (within 5 years of deployment); and
  - yellow fever (within 10 years of deployment), not required for OJG.

To provide assurances that our review of the selected medical records was accurate, we requested the installations' medical personnel to reexamine those medical records that were missing required health assessments or immunizations and adjusted our results where documentation was subsequently identified. We also requested that installation medical personnel check all possible sources for missing pre- and post-deployment health assessments and immunizations. These sources included the Army's Soldier Readiness Check folders and automated immunization sources, including the Army's Medical Protection System (MEDPROS) and the Air Force's Comprehensive Immunization Tracking Application (CITA). We checked all known possible sources for the existence of deployment health assessments related to servicemembers in our samples. In those instances where we did not find a deployment health assessment, we concluded that the assessments were not completed. Furthermore, installation officials were unable to logistically access the servicemembers' individual records of immunizations, commonly referred to as yellow-shot records that may have provided documentation for

missing immunizations. Consequently, our analyses of the immunization records was based on our examination of the servicemember's permanent medical record and immunizations that were in the Army's MEDPROS and the Air Force's CITA. In analyzing our review results at each location, we considered documentation from all identified sources (e.g., servicemember's medical record, soldier readiness check folder, Army Medical Surveillance Activity, and immunization tracking systems) in presenting data on compliance with deployment health surveillance policies.

To identify whether required blood serum specimens were in storage at the Armed Services Serum Repository, we requested that the Army Medical Surveillance Activity staff query the Repository to identify whether the servicemembers in our samples had a blood serum sample in the repository and the date of the specimen.

To determine whether the Army and Air Force are documenting in-theater medical interventions in servicemembers' medical records, we requested, at each installation visited for medical records review, the patient sign-in logs for in-theater medical care providers, namely the Army's battalion aid station and the Air Force's expeditionary medical support, when they were deployed to central Asia in support of OEF and for the two Army installations we visited that deployed in support of OJG. Officials were unable to locate or access the logs at all of our selected installations except for Fort Drum for the OEF deployment. Consequently, we were able to perform our planned examination for this objective at only Fort Drum for the OEF deployment. From these logs, we selected a random sample of 36 patient visits from one battalion aid station and 18 patient visits from another battalion aid station. We did not attempt to judge the importance of the patient visit in making our selections. For the selected patient visits, we then reviewed the servicemember's medical record for any documentation—such as the Army's Standard Form 600—of the servicemember's visit to the battalion aid station.

To determine whether the Army and Air Force's deployment health-related records are retained and maintained in a centralized location, we requested that officials at the Army Medical Surveillance Activity (AMSA) query the AMSA database for the servicemembers included in our samples at the selected Army and Air Force installations. For servicemembers in our samples, AMSA officials provided us with copies of deployment health assessments and immunization data found in the AMSA database. We analyzed the completeness of the AMSA database by comparing the deployment health assessments and the pre-deployment immunization

data we found during our medical records review with those in the AMSA database. Since Air Force special operations force units use the Hurlburt Field, we also requested the U.S. Special Operations Command (SOCOM) to query their Special Operation Forces Deployment Health Surveillance System database for servicemembers in our sample at Hurlburt Field for deployment health assessments and pre-deployment immunization data. We then compared the data identified from the SOCOM and AMSA queries with the data we found during our medical records review.

To determine whether DOD has corrected problems related to the accuracy and completeness of databases reflecting which servicemembers deployed to certain locations, we interviewed officials within the Deployment Health Support Directorate and the Defense Manpower Data Center and reviewed documentation related to the completeness of deployment databases and planned improvements in capabilities.

Our review was performed from June 2002 through July 2003 in accordance with generally accepted government auditing standards.

Appendix II: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

SEP 11 2003

Mr. Neal P. Curtin
Director
Defense Capabilities and Management
U. S. General Accounting Office
Washington, DC 20548

Dear Mr. Curtin:

This is the Department of Defense (DoD) response to the GAO draft report, "DEFENSE HEALTH CARE: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance," dated August 12, 2003, (GAO Code 350216/GAO-03-1041). The Department concurs with the GAO draft report. Comments to the recommendation are enclosed.

Protecting the health of military personnel before, during, and after their deployment is a paramount concern of the Department of Defense and my office. Working with other OSD offices as well as the Military Services, the Joint Staff, and the Combatant Commands, my office has already established a quality assurance program for pre-and post-deployment health assessments. This program monitors pre- and post-deployment health assessments and blood samples being archived electronically at the Army Medical Surveillance Activity (AMSA) and assures that indicated referrals on the post-deployment health assessment are being conducted by all the Services. The Deployment Health Support Directorate has been monitoring the flow of pre- and post-deployment health assessments going to AMSA on a weekly basis since June 2003. We have also implemented several recent force health protection initiatives such as establishing an automated theater-wide health surveillance data collection and reporting system and developing DoD-wide individual medical readiness standards and reporting metrics. These initiatives will serve as the foundation of a broader more comprehensive force health protection and surveillance quality assurance program which will ensure compliance with DoD-wide force health protection policies, programs and metrics.

The Department appreciates the opportunity to comment on the GAO draft report. Our primary point of contact is Ellen Embrey, DASD/Force Health Protection and Readiness, at 703-578-8504.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

GAO DRAFT REPORT DATED AUGUST 12, 2003
GAO-03-1041 (GAO CODE 350216)

"DEFENSE HEALTH CARE: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance"

Department of Defense Comments to the GAO Recommendation

RECOMMENDATION: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense/Health Affairs to establish an effective quality assurance program as required by section 795 of Public Law 105-85 (10 U.S.C. 1074f). (p.22/GAO Draft Report)

DoD RESPONSE: The Department concurs that an effective quality assurance program is essential to ensure compliance with force health protection and surveillance requirements.

The ASD/Health Affairs has already established a quality assurance program for pre- and post-deployment health assessments. This program monitors pre-and post-deployment health assessments and blood samples being archived electronically at Army Medical Surveillance Activity (AMSA) and assures that indicated referrals from the post-deployment health assessment are being conducted. The Deployment Health Support Directorate has been monitoring the flow of pre- and post-deployment health assessments going to AMSA on a weekly basis since June 2003.

The ASD/Health Affairs is also establishing and coordinating the parameters of a DoD force health protection and surveillance QA program with the Services. The elements of this comprehensive program include:

- The DASD/Force Health Protection and Readiness, on behalf of the ASD/Health Affairs, is responsible for developing and executing the DoD Force Health Protection and Health Surveillance Quality Assurance Program.
- An automated theater-wide health surveillance data collection and reporting system has been established. Theater-wide health surveillance data is now available on a near real-time basis to operational commanders and OSD medical leadership. The joint-Service system was established in January of this year and includes daily reports and weekly analyses prepared by the Air Force Institute for Operational Health.
- Individual medical readiness standards and metrics have been developed to provide operational commanders, Service headquarters, and OSD staff with the ability to monitor individual medical readiness across six key elements. Reporting by the Services to the Force Health Protection Council began in July.
- Metrics indicating degree of Service and Combatant Command compliance with ongoing theater health surveillance reporting requirements will be assessed at least monthly.

- Metrics indicating degree of Service compliance to individual medical readiness reporting requirements will be assessed at least quarterly based on inputs from the Services.
- Periodic audits of each Service QA program performance will be scheduled and performed. Specific focus will be on assurance that medical records have been appropriately updated with relevant deployment-related health and medical data.
- Periodic visits to Service installations and Combatant Command theaters will be conducted to assess effectiveness of their Force Health Protection programs, processes, and procedures.
- Recommendations derived from the DoD quality assurance program assessments, audits, and visits will be brought to the Force Health Protection Council prior to submission to the ASD/Health Affairs for approval.

The Services have implemented their QA programs. The Army has developed automated versions of the pre- and post-deployment health assessment forms, and has established a corporate monitoring system that is built upon deployment personnel rosters and monitored weekly by the Army Surgeon General. The Air Force Surgeon General is now receiving monthly deployment health surveillance compliance reports from its medical treatment facilities, and has scheduled an Eagle Look special compliance study through the Air Force Inspection Agency in FY2004. Navy fleet commanders have implemented their own QA programs, with anticipation of standardization through centralized automated systems. The Marine Corps has also established unit/command quality assurance procedures.

The DASD/Force Health Protection and Readiness will formally publish the Department's force health protection and surveillance quality assurance program policies by the end of the current calendar year. The ODASD/FHP&R and the Deployment Health Support Directorate will execute the DoD force health protection quality assurance program.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact	Clifton E. Spruill (202) 512-4531
Acknowledgments	In addition to the individual named above, Steve Fox, Rebecca Beale, Lynn Johnson, William Mathers, Terry Richardson, Kristine Braaten, Grant Mallie, Herbert Dunn, and R.K. Wild made key contributions to this report.

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PREPARED STATEMENT OF CHAIRMAN SMITH

Good Morning.

For many years, this Committee has been seeking to improve the procedures which separating service members must follow to obtain post-service benefits. Thanks to efforts by VA and Defense officials, we have seen some notable improvements in those years. For instance, servicemembers with disabilities usually begin the VA benefits process before they leave service; physical examinations are performed to meet VA requirements, sometimes even by VA doctors; a complete record allows the VA to make a prompt initial decision concerning disability benefits, sometimes in less than 30 days.

Similarly, the Administration will testify about its recent decision to place additional VA employees at military hospitals to help severely wounded veterans make a smoother transition to civilian life.

I believe these efforts are both commendable and necessary, but they do not go far enough. This is at least the sixth time since January 2002 that this Committee has called on Administration officials to address administrative obstacles which confront persons leaving military service with health concerns. Each time, we learn of new efforts being made to overcome problems and address issues identified by physicians and caregivers.

However, in the end, veterans and their families don't care about policy manuals and regulations; what they want to know is whether there is a compassionate person available to minister to them, who understands their particular pain, and who has the resources to make sure their care is first-rate.

Not all of the problems we will hear about today are new. Some of them take more time to solve than others. I want to be clear that by holding these hearings, we do not intend to question the dedication of caregivers on the front lines who are striving daily to heal and console individuals who have been harmed defending this Nation. However, important decisions which could lead to more consistent and compassionate treatment, and less bureaucracy and confusion, continue to be deferred. Policies intended to make the healthcare handoff simpler are ignored by those who have been instructed to implement them.

For instance, a recently completed Presidential Task Force recommended that the President direct HHS to declare the two Departments to be a single health care system for purposes of privacy regulations. Failure to take this one step forces both departments to use cumbersome and inefficient mechanisms which directly impede the delivery of "seamless" health care.

Another example is the Congressional mandate adopted in 1997 requiring the military services to document a servicemember's health before and after deployments. There is almost unanimous agreement that this policy will improve the delivery of health care to servicemembers during and after service. However, GAG will testify that this mandate has been ignored in many instances, and undermined in important respects; battlefield treatment records, immunization records, and mandatory health questionnaires are missing or nonexistent. Moreover, even when these records exist, some of them cannot be shared with VA after the servicemember becomes a veteran.

There are other examples. A shared electronic medical record is both vitally needed and feasible, but bickering and heedless administrators have delayed its deployment. Incentives for collaboration between the two departments are sadly lacking, despite a Congressional directive to establish them. Budget makers have not requested, and Congress often belatedly supplies, the necessary funding to care for an increasing workload at VA treatment facilities.

I want to commend all of the witnesses who have prepared testimony for the Committee to hear this morning. In particular, I wish to thank each of the individuals who will appear before us today to relate how they or a family member fared in making the transition from active service to civilian life. We understand and appreciate that they may never have testified before a hearing such as this. The careful thought and detailed experiences reflected in their testimony is of enormous importance and assistance to this committee and the Congress.

Taken together, their testimony gives an indication of the serious challenges which hundreds of thousands of separating servicemembers have faced in the last ten years. They also demonstrate what is possible when a government is focused and dedicated to understanding and addressing these challenges. Regrettably, they also tell us how much more can be done.

A recent memorandum issued by two of the VA's Under Secretaries, Dr. Roswell and Admiral Cooper, said "Our nation's newest veterans deserve to receive hassle-free services from VA." This is an admirable goal; let's figure out how to make it a reality.

PREPARED STATEMENT OF CONGRESSMAN BILIRAKIS

Thank you, Mr. Chairman.

First, let me commend you for scheduling today's hearing on the transitioning health care needs of military servicemembers following deployments. I think everyone agrees that there needs to be a smooth transition of new veterans from active duty military status to veteran status. After reading press accounts of some servicemembers' experiences, I am greatly concerned about recent reports that our veterans are having difficulties receiving proper disability benefits and may not be able to access the health care services that they need in a timely fashion.

Over the last several years, our Committee has conducted numerous hearings on issues pertaining to the transition from military to veterans status. I am pleased that we are continuing in our oversight responsibilities on this important matter to ensure that our servicemembers returning from Afghanistan and Iraq are receiving the benefits and care they need.

In that regard, I want to welcome our witnesses here today. I am anxious to hear about your personal experiences, and I hope that you will share your recommendations on what can be done to improve the transition from military to civilian life.

Mr. Chairman, I also look forward to working with you and the other members of the Committee on this important issue.

PREPARED STATEMENT OF CONGRESSMAN EVANS

Thank you, Mr. Chairman, for calling this critically important hearing to examine what is and isn't being done for our service personnel in their transition from military to VA care.

I am particularly interested in determining if the cases we've read about in the news media are indicative or aberrant. For years now, we've been told that the Departments of Defense and Veterans Affairs are making great strides toward "seamless" information systems. Today we will hear testimony that VA soon will be permitted to access certain DOD data systems by the end of 2005 and that DOD and VA are working to share electronic medical records by the end of fiscal year 2005. Why is this not yet done? Yet VA does not have access to veterans' health assessments or medical records until after the servicemembers are separated—perhaps too late to effect a seamless transition.

We will hear from one witness today that her son's transition—and I use the term loosely—from active duty to veteran status meant being "pushed aside" into poverty and desperation. That was one case we became aware of through the news media. It was one case too many.

The staffs and programs of the two departments—VA and DOD—should be a community of providers. Separate agencies with a single mission—to carry individuals from enlistment to civilian life, walking with them every step of the way, giving them the information and outreach they need, and following through to make certain no one, especially someone hurt in service to their country, falls into a chasm of indifference or neglect. This continuum of care and concern should not be a challenge to the servicemember or veteran; it should not be an obstacle. It is not the veteran's responsibility, it is ours—the Congress, VA and DOD. The only challenge should be ours to make certain it gets done.

There are good, hard-working people in both Departments doing good things for those who are serving and who have served. I've seen it throughout the VA system, and I've seen it most recently in visits with severely disabled personnel returned from Iraq and now at Walter Reed. But I also believe there is room and need for marked improvement in the way DOD and VA work together at all levels in caring for the men and women returning from war.

Mr. Chairman, I want to take this opportunity to commend three gentlemen who have joined us today. Their actions exemplify selfless service and concern for their fellow man. Jim Mayer, Fred Downs and Chris Reid are VA employees and severely-disabled veterans who devote their on-the-clock time and volunteer their off-duty time to helping veterans cope with disability, visiting them at their bedsides, counseling them, and simply being friends to them. These gentlemen and the veterans and family members on our first panel deserve our applause and highest accolades.

We will not hold a more important hearing in this Congress. I welcome our witnesses and look forward to their testimony.

PREPARED STATEMENT OF CONGRESSMAN BROWN OF SOUTH CAROLINA

Mr. Chairman, I thank you and Mr. Evans for holding this morning's hearing on providing seamless healthcare coverage to transitioning veterans. Assistance with respect to disability compensation, vocational rehabilitation, and long-term sustained employment also is a vital part of a successful transition.

With us in the audience today is Mr. Christopher Reid, an inspiring Veterans Benefits Administration employee who personifies VA's mission. Mr. Reid served with distinction in the U.S. Army from 1989 to 1994. He was honorably discharged after being seriously injured while serving in Mogadishu, Somalia.

Since April 2003, Mr. Reid has been "the face of VA" at Walter Reed Army Medical Center, where he assists servicemembers injured in Operation Enduring Freedom and Operation Iraqi Freedom. Mr. Reid provides benefits information, takes claims and manages individual cases. But he actually does more than that. Mr. Reid is an outstanding personal example of how our servicemembers, with help from dedicated VA and Department of Defense professionals, can overcome the obstacles of severe injuries incurred in selfless service to our Nation. Mr. Reid, we appreciate you. Could I ask you to stand, please?

I would also like to take a moment and congratulate the Secretary of Veterans Affairs, Anthony Principi, and Under Secretary for Benefits, Daniel Cooper, for making good on the President's pledge of reducing the backlog of compensation claims. The inventory dropped from a high of 432,000 to 253,000—a 41 percent reduction! It is also worth noting that the average wait time for a new claim has been drastically reduced. The folks who we are discussing today will be waiting a shorter period of time then those a few years ago.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF CONGRESSMAN RODRIGUEZ

Mr. Chairman, thank you for holding this important hearing today. Let me first thank the servicemen and women who join us today as well as those who have served, for their service, sacrifices and commitment to this Nation. I am looking forward to hearing the compelling stories from the veterans, soldiers, and their family members who are joining us on our first panel. Some of their experiences may help us to improve transitions from active-duty service to civilian life as veterans.

I also wish to extend my thanks to the volunteers we have asked to appear today-sometimes you can do more to say "welcome home" with a milkshake and a warm smile than you can with a dozen Congressional resolutions! You are living examples that show these young men and women that an indomitable spirit overcomes the physical limitations they will reckon with for the rest of their lives. Thank you for all you do for our veterans.

As the Global War on Terrorism continues, we expect that the military and VA will continue to require coordination between agencies to deal with an increasing number of casualties. As our troops leaving service attempt to pick up the pieces of lives forever altered by battle injuries, accidents or other health conditions experienced during their military service, VA must be available to ensure that their needs are addressed. To do that, it must have timely and accurate information about those troops who will soon become veterans.

Unfortunately, too often the information VA obtains from the military appears to be "too little, too late." The General Accounting Office will report that even though last year it assessed the files troops returning from Kosovo and Afghanistan little progress had been made in implementing the requirements of Public Law 105–85 which was enacted in 1997. The military interpreted clinical examinations to be self-administered health assessments. It is doubtful to me that the few questions asked of troops ready to deploy and eager to serve with their units reflect any information that will be of value in assisting veterans sometime in the future. Even the information collected from the pre- and post-deployment health assessments was not centrally or routinely collected. GAO found that neither it nor the military could track down many of the surveys for the returning troops.

There is some good news to report. According to the Congressional visitors and our dedicated corps of volunteers, soldiers at Walter Reed regularly report they are receiving excellent care. Once they get in the door, most veterans are pleased with VA health care services. For those servicemembers who separate after receiving care from Walter Reed or Bethesda, the protocol VA has in place seems to be effective—if all goes well, veterans will be enrolled and have a contact person and case manager at each VA medical center at the point at which they are discharged.

I am also pleased with the proactive work VA and DOD have collaborated on which will lead to 16 clinical practice guidelines and hope that these will be quickly deployed to clinical practice. I understand that Dr. Roswell and Dr. Kudler will further address this important initiative in their statements.

It is the gap between military health care and veterans' health care with which we must remain concerned and I know this Committee will do its part in maintaining our vigilance on the troops' behalf.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF CONGRESSMAN MILLER OF FLORIDA

Thank you Mr. Chairman.

I want to thank all of our panelists today. This is a critically important topic, and your viewpoints will contribute to our due diligence in responding to the need for effective transition between the Department of Defense and the Department of Veterans Affairs of servicemembers requiring health care immediately following deployments, including those who come from Guard and Reserve forces.

Often today, the media equates the human costs of going to war by counting the number of those killed in action. We must not lose sight of those wounded in action or injured in combat-zone accidents.

Your testimony today puts a human face on statistics. The immediate treatment, the handoff, and the follow-up care between DOD and VA are critical to the long-term prognosis and ultimately to the long-term costs to care for the overall health needs of our sick, wounded or injured "nonfatal casualties of war." I look forward to hearing about your experiences, and we welcome your thoughts about how we can partner with DOD and VA so that they may provide the first-rate care that America's finest deserve.

Thank you.

TO: House Subcommittee for Veterans Affairs

From: Arvilla Stiffler RN, BSN, MA
1841 MT Carmel Church Rd
Chapel Hill, NC 27517

RE. Statement in reference to Jason Stiffler (Soldier)

First, I would like to thank this committee for giving me the opportunity to submit this statement.

Historical Perspective / Jason's Military Service

It has been nearly a year since my son Jason, was released from Walter Reed Army Medical Center. His journey began when he left home and college in North Carolina, to visit family in Indiana. We were extremely proud of Jason when he enlisted into the Army especially, since this was something he spoke of frequently as a young teenager.

After joining the Army, Jason did his basic training at FT Benning, GA and in July of 2001 was assigned to FT Campbell, Kentucky to the 101st Airborne Division. Following 9-11-01, Jason's Division was placed on high alert and sent to Afghanistan, right after the first of the year.

In April of 2002, my son was injured. While the reports have been sketchy, we know that after the injury he was taken to a hospital in Kandehar. He was then transported to K2, then moved to Uzbekistan and finally to Landstuhl, Germany. Initially, we were told by the Neurosurgeon at Landstuhl, that Jason's guard tower had collapsed during some type of explosion. The story has since changed a couple of times yet what's important is that something collapsed on the guard tower and Jason went falling to the ground.
Jason sustained injuries that initially left him unable to move any of his extremities and according to his records and physicians; he was seizing at the scene (tonic/clonic) and unresponsive. He was intubated, on a ventilator and remained on paralytics until his arrival to Lanstuhl, where I was able to speak to the physicians in the ICU. He was diagnosed with a spinal cord injury verses spinal shock with significant motor and sensory deficits (initially a quadriplegic), additionally; he had a closed head injury with two subgaleal hematomas in the right and left parietal areas of the brain.

Jason began to fight back and within days began to move his upper extremities and no longer required assistance via the ventilator to breath. The lower extremities remained unchanged and arrangements were made to transport him to Walter Reed Army Medical Center in Washington D.C.

Walter Reed Medical Center

Once at Walter Reed they began an intensive PT/OT program and Jason made significant progress showing a marked improvement. By the end of May he attempted to take a few steps with braces and landford crutches. Jason's diagnosis of spinal shock verses spinal cord injury was evident and with a few additional tests performed a diagnosis of bilateral nerve damage was noted to the lower extremities. He became somewhat depressed at the thought of never walking again, yet continued to make progress, especially, with the hospital staff assisting to keep up his spirits. He would routinely asked me the same questions over and over again and called me at home sometimes two to three times a day just to ask me if he'd ever walk again. While Jason's head injury was diagnosed as mild, it resulted in memory loss, including poor retention capability along with high anxiety levels. Additionally, there was a question of some diminished nerve loss to his right arm, and visual disturbance of the right eye.

Jason continued his course at Walter Reed making great progress physically, yet we felt his mental state was on the decline. Jason was suffering from depression and I requested an antidepressant to see if this may ease the anxious behavior. Jason remained mostly confined to a wheel chair and I began to look toward the global picture by requesting a consultation with the Social Worker (SW) overseeing his case.

We asked the Social Worker if Jason was medically boarded due to his condition what disability rating would Jason potentially receive? The Social Worker advised us that for paraplegia typically the rating is 40%. When the Army Medical Board reviewed Jason's file he did in fact receive a 40% disability rating. No disability rating was given for his head injury, his daily physical pain or for the problems he was having mentally. I was disappointed to say the least, yet even more deflated to know the medical board convened without one of us being present, when we specifically asked to be in attendance for the

hearing and received no phone call from Walter Reed.

Jason's head injury frequently left him cranky, anxious, and unable to keep up with his daily routine. His wife, Jackie, was able to stay at Walter Reed for a significant period of time, however; they had an infant son who required much of her attention. My job responsibilities left me unable to remain at Walter Reed continuously and when I was at home he couldn't remember things correctly to elaborate on potential dates or important information. Jackie felt lost in the system. Several weeks later upon my return to Walter Reed I read a written report given to Jason by a Neuropsychologist, indicating that even if Jason was to walk again, due to his cognitive status he would not be able to return to duty until a full neuropsychological exam was repeated. Strong evidence in the report indicates concern over his mental and cognitive status as a result of his head injury. Yet no rating was ever established to include the aforementioned concerns.

As many members of this subcommittee know from the article in the Wall Street Journal my response was one of disbelief upon hearing the disability rating. My growing concerns hit new heights when I found out Jason signed a waiver to accept the VA benefits in lieu of military pay and did this without a single family member being present. Military representatives had a patient with a known head injury with documented memory loss, who was taking scheduled narcotic pain medication around the clock for his back and leg discomfort related to his spinal injury, and who was on scheduled antidepressants, sign legal papers even though Jason had requested a Social Worker to accompany him. The Social Worker was unable to meet him due to scheduling conflicts, so the process proceeded with no one acting as his advocate. Even though we may have agreed with this decision there should have been a discussion period where frequently asked questions could of been answered.

Integration into the VA System

Jason had made fairly good progress and by the beginning of October 2002 the physicians felt he could be released with follow up at the VA Hospital located in FT Wayne, Indiana. He was released with our understanding that the VA Hospital in FT Wayne, Indiana would contact Jason after his discharge to schedule appointments, his

wife had already returned to Indiana and I was in North Carolina. By November, and with Jason's condition beginning to decline both mentally and physically, I encouraged him to present himself at the emergency room in Ft Wayne and ask for assistance. The faculty at the hospital informed Jason they didn't know anything about his case and no one from Walter Reed had ever contacted them for any future therapy or interventions.

At the same time the aforementioned problems were occurring regarding his physical condition, his pay declined to $700 per month and due to the nature of his injuries he couldn't work even though he made attempts, he frequently collapsed or stumbled trying to get around. In January, after much distress, he was informed by the VA Medical Center they were going to begin the process to increase his disability rating. An increase could take as long as 18 months and only after an exam by multiple physicians who agreed he should receive a higher disability rating.

Jason continued to deteriorate, he had terrible post-traumatic stress and it began to take its toll on his family. His wife tried to work yet frequently, had called out because of his episodes of nightmares. Additionally, she would awaken at night to find him missing from their home. Several times Jason was taken to the emergency department at a local hospital to receive medical attention for post-traumatic stress.

I believe much of this was due in part to lack of education and training for two young adults who found themselves in a situation that was on a downward spiral. No one could have predicted this kind of mental and physical stress on top of an already bad situation.

Once the VA Hospital was involved in his care they attempted to begin a mental health intervention and developed an educational process. However, Jason and his wife Jackie were already overwhelmed by the situation and felt unable to cope with any additional developments. Jason broke down at the VA Hospital on several occasions due to his increasing financial problems. The social worker from the VA Hospital in Indiana began what I would call crisis intervention. I applaud her for her efforts and for all the calls she made to my home to keep my family up to date and incorporated into the process.

Unfortunately, Jason's car was repossessed; they had to ask for public assistance

and began to receive food stamps. They were living in a trailer that was not handi-capped accessible because they couldn't afford anything else. The owner of the trailer assisted Jason and his family and built a ramped in order for Jason to come in and out of his home. They allowed his family to become behind on their rent and for that I thank them and the countless others who gave them food and money at Christmas.

In the spring of 2003 Jason qualified for 100% disability, yet with the strength in his legs declining while awaiting physical therapy and occupational therapy, the strength that he had gained at Walter Reed was now a faint memory. Once assessed at the VA his strength went from 3+ to 1.5(strength scale of 1-5). Jason's appointments were sometimes cancelled due to case overload; while others were cancelled because they had no car or gas money to make the long drive and many times had no one available to take him. The Social Worker for the VA Hospital began to make home visits and I truly believe she was his saving grace. She gave him hope, applied for grants and she pushed Jason to continue to hang in there when he wanted to just give up.

I would like to say that even though my son's case received such special attention it is quite concerning that he was deprived mentally and physically of the care he deserved as a soldier of the United States Army. He put himself in harms way for this country only to feel pushed aside as soon as he returned because he couldn't wear the uniform anymore. Promises were made to him and his fellow soldiers; he feels he was blind sided by the very people he left home to protect. While I am not writing this statement to accuse any one person or establishment, I would like to express my disappointment in several areas.

First, As Jason's Mother I must take this opportunity to thank my precious colleagues who rendered care to my son and to which I have never been able to thank you. Please take heart and forever know that you saved my sons life and for this I'm eternally grateful.

Secondly, due to the aforementioned problems related to my son's care I would suggest assigning; Care Coordinators to each soldier on arrival to a military hospital, to coordinate their care, to assist families, educate on resources, and create a smooth transition upon discharge from the military service to include discussion on an

assignment to the Temporary Disability Retired List (This piece was lacking in all phases of the hospitalization at Walter Reed)

and;

Additionally, NO SOLDIER diagnosed with a closed head injury and on pain medication should ever sign documents, be able to waive their rights, and be given discharge instructions regarding their care without additional family members present or at a minimum have a member of the care team assigned to the soldier call the family. Health professionals should not assume a head injured patient, unless they have been shown to have fully recovered, that he/she clearly understands or can effectively comprehend statements even if they appear to carry on an articulate conversation or agree at the time they understand. Head injury patients should be given extra attention for the aforementioned reasons.

As a Captain in the US Army Reserves and after witnessing my son's journey, I would never be activated without having extra life and disability insurance. If recruiters would inform new recruits of the consequences they will suffer if injured while performing their duty which would included; an expectation to become frustrated with a system that leaves you living below the poverty line, cause you to receive food stamps and enter into the welfare system, and lastly, leave will you waiting long periods of time to receive medical care. I ask you would you sign up?

Healthcare Professional:

As a healthcare professional that directs patient care everyday for multi-system injured patient, I can say I understand;

a) the lack of and the declining resources the VA System has with respect to nurses and physicians.
b) the financial burdens placed on healthcare systems in America is underscored only by the continual dilemma between an increasing patient population and diminishing capabilities to serve their needs adequately.

Identifiable Problems

a) The lack of an integrated system between the military hospitals and the VA System which must be resolved. Patients are and will continue to suffer.

b) The lack of discharge planning that occurs in many cases between the military and the VA System has been astonishing. These soldiers deserve at a minimum a caseworker that assures soldiers upon discharge have confirmed appointments, are given full instructions with a clear understanding and a smooth transition from the military service into the VA System.

c) As healthcare professionals it is not a responsible practice for patients who are on narcotics to sign legal papers, especially if they are diagnosed with a head injury.

d) Waiting significant times for medical care should not be an option

Proposed changes to the current system include;

a) improvements in the discharge planning process,
b) increase the number of healthcare professionals available to care for our Veteran population,
c) increase the support capabilities to assure soldiers who live miles from a VA Hospital so they can receive care locally,
d) timeliness of care should be a priority,
e) decrease the time it takes to increase a disability rating and
f) increase fiscal support for the VA System

Integration of the military and VA systems can eliminate many of these discrepancies and miscommunications currently being experienced by our soldiers.

In closing, I truly hope that this committee understands the value of commitment, to which my son gave for his country, if you asked my son if he had full use of his legs again would he return to his division and without hesitation, he would say yes.

> This process is unorganized and exclusive. We owe it to the soldiers still in battle and returning everyday to improve our practice and never let another soldier who was injured receive a second insult because he felt abandoned by his country. All men and women of the military at a minimum deserve that from all of us.

I once again want to thank this committee for the honor of expressing my opinion

Arvilla Stiffler

Captain in the United Stated Army Reserves

and proud Mother of my son Jason Stiffler PFC

STATEMENT OF DR. ROBERT T. FRAME

HOUSE COMMITTEE ON VETERANS' AFFAIRS
16 OCTOBER 2003 HEARING

SUBJECT: Transition from DOD to VA

Greetings:

I am Dr. Robert T. Frame, an army reserve officer currently on active duty, recovering from wounds received from hostile action against the enemy while serving in Iraq. I was the Public Health Team Chief for the 352nd Civil Affairs Command in Iraq for Operation Iraqi Freedom (OIF). I also served in Afghanistan/Pakistan prior to this deployment. In my civilian capacity, I serve as Assistant Under Secretary for Health for Dentistry for the Department of Veterans' Affairs.
I am very proud to serve my country in both capacities.

I wish to make clear that any comments I offer today are my own and do not represent either agency.

As an injured soldier with injuries that have left me with a disability, I think about the continuity of care that will be available to my fellow soldiers and me in the future constantly. I have given much thought to the transition away from the safety of the military care I am receiving.

On April 27th my public health team was ambushed while traveling through central Baghdad, on the way to the Ministry of Health. All my team members and our interpreter were wounded; I suffered a gunshot wound to my left arm. I had a tourniquet put on the shoulder by one of my partners after a long firefight and escaping to a safe area. Within 90 minutes of being wounded, a Forward Surgical Team (FST) restored circulation to my arm with a plastic shunt. I was transported to a Combat Surgical Hospital (CSH) and stabilized, had an external fixator placed to stabilize the bone fracture, and had a saphenous vein graft to replace the plastic shunt. I was then transported to a Navy Combat Zone Fleet Hospital in Rota, Spain, and on to Walter Reed Army Medical Center. The care I have received has been superb.

I have been away from my VA position from October 2001 thru August 2002 and again from February 2003 till present. In my military role I work in Civil Affairs and not AMEDD.

My comments are from the perspective of a patient with a future need for specialized care. My comments reflect concerns shared by many men and women at WRAMC and other like facilities. We would like to feel assured that we will experience a seamless transition from DOD care to VA care.

I am aware that both DOD and VA have been and are working extensively to ensure this transition.

I would like to comment on two areas for consideration:

First is the flow or movement of patient information as a patient moves through the treatment system. As I moved through the system, information about my care accompanied me. At each stop clinicians used the information and added to it. Eventually, this compilation of data which is my medical record will tell my health story and eventually will pass on to the VA for benefits, disability ratings and continuing care. If this record is not clear and complete, it will not help me. If this record is not clear and complete, my clinicians and others may not have the information they need to properly care for me and make critically important decisions. The purpose of en route care is to continue the same high standard of care provided from the point of injury. Accurate and complete patient information is essential at every juncture of this process. Once in a fixed facility, the data should be put in an electronic format and the ability to share, transmit, and access it becomes easier. I see the ability for those data to flow electronically between DOD and VA, to be a critical factor. The seamless movement of patient medical information, to include imaging, would give patients a great deal of comfort and a feeling of security, as well as ensure optimal services. Clinicians and administrators would have the tools to make the best and most appropriate determinations on matters affecting each patient.

The other area of concern to patients on the road to transitioning to VA is the question of capacity for caring and continued existence of the organization. The men and women I have spoken to, all ask if VA will have the skills, staff, and ability to care for our health care needs from the time we are released from active duty and as we age. Many also ask if VA will be around to care for us. Family members who are fearful of not being able to properly care for their loved ones also voice this concern. As we age, most desire not only the skilled care, but also convenient and accessible services.

Transition from DOD care to VA care is extremely important to numerous soldiers, veterans, and their families who would not have any other recourse for unique and very needed care if VA did not exist. In addition to the unique care, VA provides and environment and an atmosphere of security and familiarity for veterans. VA provides a center of gravity and balance for a unique member of our society who oftentimes cannot share their experiences and feel understood our community.

Thank you for the unique opportunity to share some thoughts and feelings shared by many men and women who have served their country and given their all in this service.

STATEMENT FOR THE RECORD
NELSON J. VILLEGAS
FOR
THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS

HEARING, OCTOBER 16, 2003

Good morning Mr. Chairman, Ranking Member and distinguished Members of the Committee. First of all I would like to take this opportunity to express my sincere appreciation for allowing me the honor to appear before you today. I would also like to praise the Committee Members for conducting an oversight hearing on such a significant issue.

My name is Nelson J. Villegas and it is indeed a privilege for me to share my experience as I transitioned from the Department of Defense to the Department of Veterans' Affairs heath care services. As I look back I ask myself the following question, was I provided with seamless heath care coverage during my transition? The answer is, absolutely.

On May 3rd 2003 I was medically evacuated from Germany to Walter Reed Army Medical Center for further management of severe rhabdomyolysis and lactic acidosis with subsequent compartment syndrome. Furthermore, my hospital course was complicated by blood loss, renal and respiratory failure. As a result, I underwent a bilateral below the knee amputation just before Mother's Day.

My prognosis was tenuous at best and expected to expire within 72 hours. An expeditious medical retirement took place based on death being imminent. This would secure my retired status and greater benefits for the next of kin. Therefore, I was medically retired from active duty on May 7th 2003. I gained consciousness a week later and suddenly became aware of my condition.

My new status as a retiree presented me with unthinkable personal challenges that needed to be met. These included pay issues, living arrangements, property management and transportation. The procurement of durable medical equipment and prosthetic care were also of great concern. All of these obstacles were surpassed thanks to coordinating efforts between the Department of Defense and the Department of Veterans' Affairs staff.

Currently, I receive care interchangeably from both departments without any complications. All of my physical rehabilitation, prosthetic fittings and medical follow-ups take place at Walter Reed Army Medical Center. I seek dental care, driving rehabilitation and the acquisition of medical equipment from the Department of Veterans' Affairs.

I have scheduled several appointments within both institutions and have being seen shortly after requesting an appointment. Also, medical equipment ordered has arrived within a reasonable time. Evidently, an aggressive effort has being made on their part in order to provide me with the best care possible. The high level of concern expressed by both hospitals regarding my disability bears witness to their joint commitment to care for veterans just like myself.

Furthermore, to my relief, the existence of the Foreign Medical Program has reassure me that future care of conditions related to my disability will be properly covered overseas. Also, the Vocational Rehabilitation program has made possible for me to continue pursuing my educational and employment goals. Also, disability compensation payments provide me with means of subsistence that I would otherwise be unable to attain.

Whether I was an active duty soldier or retiree, either an inpatient or an outpatient; the continuum of care that I received at both hospitals has being nothing other than excellent. I have being treated with the outmost professionalism and respect. Therefore, my transition before and after my medical discharge was completely seamless and transparent regardless of my unique situation.

In closing, I would like to thank the Committee on Veterans' Affairs for granting me the opportunity to share my testimony before such an honorable group of our society.

Nelson J. Villegas

SGT USA (Ret)

Mr. Villegas is a retired U.S. Army sergeant serving over seventeen years, ten of which were in active duty. He has served as a reservist, guardsman and active duty soldier. On May 7th 2003 he was medically retired shortly after an accident that nearly claimed his life.

His military assignments included the 328th General Hospital, Fort Douglas, Utah; 19th Special Forces Group, Camp Williams, Utah; 2nd General Hospital, Landstuhl, Germany; 5th MASH, Fort Bragg, North Carolina; 43rd MASH, Pyontek, Republic of South Korea; Madigan Army Medical Center, Fort Lewis, Washington and Landstuhl Regional Army Medical Center, Landstuhl, Germany.

His occupations included combat medic, pharmacy technician, respiratory technician and polysomnography technician. He was awarded the Expert Field Medical Badge, Airborne Paratrooper Badge and instructor special skill identifier. He has been in several tours overseas to include activation during Desert Storm.

On May 3rd 2003, Nelson Villegas was medically evacuated from Germany to Walter Reed Army Medical Center for further management of a life-threatening condition. As a result, Mr. Villegas underwent a bilateral below the knee amputation on May 10th 2003.

Since his retirement, he has recovered remarkably and was discharged from the hospital two months after his admission. Currently, he is undergoing rehabilitation as an outpatient with the primary goal to return to his favorite sport of backpacking. Even as a recent disabled veteran, Mr. Villegas continues to encourage fellow disabled soldiers with occasional informal visits.

He was admitted at the University of Maryland where he is planning to further his education and receive a degree in information systems management. His long-term goal is to become a systems analyst and serve as a role model to other disabled veterans.

Statement of Senior Master Sergeant Robbin Halcomb, Air National Guard

Good morning Ladies and Gentlemen. My name Robbin D. Halcomb, and I'm a Senior Master Sergeant with the Indiana Air National Guard, assigned to the 181st Fighter Wing, Terre Haute, Indiana "Home to the "Racers". I have been in the Air National Guard and the United States Air Force for almost 29 years. During that time, I have been deployed to Italy, Norway, Germany, Macedonia, Bahrain, Guatemala, and most recently to Turkey, participating in Operation Northern Watch, Operation Noble Eagle and Operation Enduring Freedom. I would like to thank you for the opportunity to tell my story and the story of thousands just like me who have had the greatest honor to serve in the armed forces of this great nation as a member of the reserve component.

On March 8th, 2003 I was injured while stationed at Incirlik Air Force Base, Turkey. I had 7 hours of surgery to repair a shattered right elbow. After 3 days in the hospital I was released and continued my duties with the 39th Air Expeditionary Wing. After returning home to the U.S. on the 22nd of April, I made an appointment to see my family physician for follow-up physical therapy, as I had been told to do, as I needed to correct the range of motion in my right arm I had lost because of the injury. Because of the extent of my injury, the Commander of the 181st Medical Group, Colonel John P. McGoff, requested that I remain on active duty. The National Guard Bureau denied that request along with several others from our unit. I was released from active duty on the 15th of June 2003.

On the 16th of June of this year, I applied for Veterans benefits at my local courthouse. The first words spoken to me were "You're in the Guard, what makes you eligible". I promptly showed them my DD 214 and their attitude immediately changed to a more professional one. I was told that the process would take up to 9 months before a final review of my case would be determined. I received notification on or about the 15th of July to report to the Roudebush VA Medical Center in Indianapolis for a medical appointment on 16th of August for testing and evaluation. I am still awaiting word of approval. The medical evaluation at the Veterans Hospital in Indianapolis was the very best treatment I have received in any medical facility.

I have been around for many years and have many good friends who have retired from active duty and they were the ones who advised me about possible benefits to which I may be entitled. The problem is, I never would have had any idea that I could apply for Veterans medical benefits had they not told me. I still have pins and wires in my arm that I need removed. But who is going to pay for my medical follow up treatments now that I am off active duty? Will my own personal Blue Cross Blue Shield pay for it since I was on active duty when injured? Will the VA over the costs if my claim is approved? Or will Tri-care pay for it because of the line of duty determination that was accomplished? These questions remained unanswered until September.

I am personally saddened by the fact that several guardsmen from my unit who have been injured on active duty, have been discharged or are pending discharge from military service, and some have lost their full-time job because they were unable to perform their duties due to the injuries or illnesses that occurred to them while on active duty. Six members of the 181st Fighter Wing requested to stay on active duty pending medical recovery and they were denied that entitlement. This type of action is commonly known

in the Guard as Operation Deny Entitlements. Federal agencies also need to be made aware of "who" or "what" is a Veteran. It shouldn't matter if the veteran holding the DD 214 is a guardsman or reservist.

I am not here to whine nor complain about the medical treatment I received while on active duty or any other place. The medical care given to us has been second to none. I am here today because there is a disconnect between what happens to active duty personnel when they are injured or retire and what happens to a member of the reserve component when the same thing happens. There is no equity, just ask TSgt James Wilson, MSgt Dave Roberts and TSgt Marty Lathrop all these men have legitimate military related injuries and all have been denied equity.

When a member of the active duty forces retires, they are afforded an opportunity to attend a retirement school. Then 60-90 days prior to his or her discharge he or she is given a physical. VA representatives are there to take their claim and process it if they so desire. The members of the reserve components are not afforded the same opportunity and many go throughout their retirement years without ever knowing about or applying for their Veterans benefits that they have earned. We also do not receive a retirement physical or retirement counseling.

I work side by side with my active duty counterparts every day, and have done so for almost 3 decades. There are thousands more just like me, only they do not know about the benefits they may be entitled to. There needs to be an equitable process so that when you return from defending our nation's freedom on active duty, you, as a guardsman or women, have the opportunity to seek VA benefits without trying to track down what their entitlements are on your own. I cannot stress enough, the need for equity. If I were on active duty and developed high blood pressure after serving for ten years, I would be given a disability. If I were a guardsman and developed the same high blood pressure problem, my condition would be found to be a pre-existing condition and I would be discharged. We need awareness of our Veteran's Rights while we serve and when we retire. But most of all we need equity with our Active Duty counterparts.

I have read the budget reports sent to Congress, and the numbers are troubling. Seventy thousand more heroes will be added to the VA roles than anticipated this year alone. I hope 35,000 of them are from the Reserve Forces helping achieve equity with the active duty. Thank you for your time. May I answer any questions for you?

United States General Accounting Office

GAO

Testimony
Before the Committee on Veterans' Affairs, House of Representatives

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DEFENSE HEALTH CARE

DOD Needs to Improve Force Health Protection and Surveillance Processes

Statement of Neal P. Curtin
Director, Defense Capabilities and Management

GAO-04-158T

October 16, 2003

GAO
Accountability · Integrity · Reliability
Highlights

Highlights of GAO-04-158T, testimony before the Committee on Veterans' Affairs, House of Representatives

DEFENSE HEALTH CARE

DOD Needs to Improve Force Health Protection and Surveillance Processes

Why GAO Did This Study

Following the 1990-91 Persian Gulf War, many servicemembers experienced health problems that they attributed to their military service in the Persian Gulf. However, a lack of servicemember health and deployment data hampered subsequent investigations into the nature and causes of these illnesses. Public Law 105-85, enacted in November 1997, required the Department of Defense (DOD) to establish a system to assess the medical condition of service members before and after deployments. GAO reported on (1) the Army's and Air Force's compliance with DOD's force health protection and surveillance requirements for servicemembers deploying in support of Operation Enduring Freedom (OEF) in Central Asia and Operation Joint Guardian (OJG) in Kosovo and (2) the status of DOD efforts to correct problems related to the accuracy and completeness of databases reflecting which servicemembers were deployed to certain locations. (*Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance [GAO-03-1041, Sept. 19, 2003]*)

GAO was asked to testify on its findings regarding the Army's and Air Force's compliance with DOD's force health protection and surveillance policies. For its report, GAO reviewed records for statistical samples of active duty servicemembers at four military installations.

www.gao.gov/cgi-bin/getrpt?GAO-04-158T.

To view the full testimony, click on the link above. For more information, contact Neal Curtin at (757) 552-8100.

What GAO Found

The Army and Air Force—the focus of GAO's review—did not comply with DOD's force health protection and surveillance policies for many active duty servicemembers, including the policies that they be assessed before and after deploying overseas, that they receive certain immunizations, and that health-related documentation be maintained in a centralized location. GAO's review of 1,071 servicemembers' medical records from a universe of 8,742 at selected Army and Air Force installations participating in overseas operations disclosed that 38 to 98 percent of servicemembers were missing one or both of their health assessments and as many as 36 percent were missing two or more of the required immunizations.

GAO found that many servicemembers' medical records did not include health assessments found in DOD's centralized database. Similarly, DOD also did not maintain a complete, centralized database of servicemembers' health assessments and immunizations. Health-related documentation missing from the centralized database ranged from 0 to 63 percent for pre-deployment assessments, 11 to 75 percent for post-deployment assessments, and 8 to 93 percent for immunizations. There was no effective quality assurance program at the Office of the Assistant Secretary of Defense for Health Affairs or at the Army or Air Force that helped ensure compliance with policies. GAO believes that the lack of such a program was a major cause of the high rate of noncompliance. Continued noncompliance with these policies may result in servicemembers deploying with health problems or delays in obtaining care when they return. Finally, DOD's centralized deployment database is still missing the information needed to track servicemembers' movements in the theater of operations. By July 2003, the department's data center had begun receiving location-specific deployment information from the services and is currently reviewing its accuracy and completeness.

GAO's report recommended that DOD establish an effective quality assurance program that will ensure that the military services comply with the force health protection and surveillance policies for all servicemembers. DOD agreed with the recommendation and outlined a number of actions the military services are already taking to implement their quality assurance programs. While we view these actions as responsive to our recommendation, the effectiveness of these actions to ensure compliance will depend on follow-through by DOD and the services.

Mr. Chairman and Members of the Committee:

I am pleased to be here as you discuss health assessments and the importance of complete medical records for our servicemembers. Both the Department of Defense (DOD) and the Department of Veterans Affairs (VA) need this information to perform their missions. DOD needs health status information and complete medical records to help ensure the deployment of healthy forces and the continued fitness of those forces. VA's Veterans Benefits Administration uses health information to adjudicate veterans' claims for disability compensation related to service-connected injuries or illnesses. As you know, VA's Veterans Health Administration needs complete and accurate medical records documenting all medical care for individual servicemembers are needed for the delivery of high-quality, post-deployment care. In this context, you asked us to discuss our recent report on the Army's and Air Force's compliance with DOD's force health protection and surveillance policies that require servicemembers to be assessed before and after deploying overseas, that require servicemembers to receive certain immunizations, and that require health-related documentation to be maintained in a centralized location.

Following the 1990-91 Persian Gulf War, many servicemembers experienced health problems that they attributed to their military service in the Persian Gulf. However, subsequent investigations into the nature and causes of these illnesses were hampered by a lack of servicemember health and deployment data. Moreover, in May 1997, we reported on several similar problems associated with the implementation of the DOD deployment health surveillance policies for servicemembers deployed to Bosnia in support of a peacekeeping operation.[1]

[1] U.S. General Accounting Office, *Defense Health Care: Medical Surveillance Improved Since Gulf War, but Mixed Results in Bosnia*, GAO/NSIAD-97-136 (Washington, D.C.: May 13, 1997).

In response, the Congress enacted legislation[2] in November 1997 requiring DOD to establish a system for assessing the medical condition of servicemembers before and after their deployment to locations outside the United States and requiring the centralized retention of certain health-related data associated with the servicemember's deployment. The system is to include the use of pre-deployment and post-deployment medical examinations, including an assessment of mental health and the drawing of blood samples. DOD has implemented specific force health protection and surveillance policies. These policies include pre-deployment and post-deployment health assessments designed to identify health issues or concerns that may affect the deployability of servicemembers or that may require medical attention; pre-deployment immunizations to address possible health threats in deployment locations; pre-deployment screening for tuberculosis; and the retention of blood serum samples on file prior to deployment. In February 2002, we testified before the Subcommittee on Health of this Committee that DOD had several initiatives under way to improve the reliability of deployment information and to enhance its information technology capabilities, as we and others have recommended.[3] Although its recent policies and reorganization reflect a commitment by DOD to establish a comprehensive medical surveillance system, much needed to be done to implement the system.

My testimony today is based on our September 2003 report on the Army's and Air Force's compliance with DOD's force health protection and surveillance policies for active duty deployments for Operation Enduring Freedom (OEF) in Central Asia and Operation Joint Guardian (OJG) in Kosovo.[4] We also examined whether DOD has corrected problems related

[2] Section 765 of Pub. L. No. 105-85 amended title 10 of the United States Code by adding section 1074f.

[3] U.S. General Accounting Office, *VA and Defense Health Care: Military Medical Surveillance Policies in Place, but Implementation Challenges Remain*, GAO-02-478T (Washington, D.C.: Feb. 27, 2002).

[4] U.S. General Accounting Office, *Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance*, GAO-03-1041 (Washington, D.C.: Sept. 19, 2003). Moreover, we reported in April 2003 and testified in July 2003 on problems experienced by the Army in assessing the health status of all early-deploying reservists. See U.S. General Accounting Office, *Defense Health Care: Army Needs to Assess the Health Status of All Early-Deploying Reservists*, GAO-03-437 (Washington, D.C.: Apr. 15, 2003); and U.S. General Accounting Office, *Defense Health Care: Army Has Not Consistently Assessed the Health Status of Early-Deploying Reservists*, GAO-03-997T (Washington, D.C.: July 9, 2003).

to the accuracy and completeness of databases reflecting which servicemembers deployed to certain locations.

To do our work, we obtained the force health protection and surveillance policies applicable to the OEF and OJG deployments from the Army, Air Force, combatant commanders, the office of the Assistant Secretary of Defense, and the services' Surgeons General. To test the implementation of these policies, we reviewed statistical samples totaling 1,071 active duty servicemembers selected from a universe of 8,742 active duty servicemembers at four military installations.[5] To provide assurances that our review of the selected medical records was accurate, we requested the installations' medical personnel to reexamine those medical records that were missing required health assessments or immunizations and adjusted our results where documentation was subsequently identified. We also requested installation medical personnel to check all possible sources for missing pre-deployment and post-deployment health assessments and missing immunizations. We also requested the U.S. Special Operations Command (SOCOM) to query its database for health-related documentation for servicemembers in our sample at one of the selected installations. We also examined, for Army and Air Force servicemembers in our samples, the completeness of the centralized records at the Army Medical Surveillance Activity[6] (AMSA), which is tasked with centrally collecting deployment health-related records. Further, we interviewed officials at the office of the Deployment Health Support Directorate and at the Defense Manpower Data Center (DMDC) regarding the accuracy and completeness of DMDC's personnel deployment database and planned improvements. We conducted our work from June 2002 through July 2003 in accordance with generally accepted government auditing standards.

[5] Includes samples of records for servicemembers who deployed from Fort Drum, New York; Fort Campbell, Kentucky; Travis Air Force Base, California; and Hurlburt Field, Florida.

[6] The Army Medical Surveillance Activity is DOD's executive agent for collecting and retaining the military services' deployment health-related documents—including the pre-deployment and post-deployment health assessments and immunizations.

Summary

In summary, the Army and Air Force did not comply with DOD's force health protection and surveillance policies for many of the servicemembers at the installations we visited. Our review of medical records at those installations disclosed that problems continue to exist in several areas.

- **Deployment health assessments.** The percentage of Army and Air Force servicemembers missing one or both of their pre-deployment and post-deployment health assessments ranged from 38 to 98 percent of our samples. Moreover, when health assessments were conducted, as many as 45 percent of them were not done within the required time frames. Furthermore, a health care provider did not review all health assessments and, although only a small number of assessments in our samples indicated a health concern, large percentages of these assessments were not referred for further consultations as required.
- **Immunizations and other pre-deployment requirements.** Servicemembers missing evidence of receiving one of the pre-deployment immunizations required for their deployment location ranged from 14 percent to 46 percent. As many as 36 percent of the servicemembers were missing two or more of their required immunizations. Furthermore, servicemembers missing current tuberculosis screening at the time of their deployment ranged from 7 to 40 percent. As many as 29 percent of the servicemembers in our samples had blood serum samples in the repository older than the required maximum age of 1 year at the time of deployment, ranging, on average, from 2 to 15 months out-of-date.
- **Completeness of medical records and centralized data collection.** Servicemembers' permanent medical records at the Army and Air Force installations we visited did not include documentation of the completed health assessments that we found at AMSA and at the U.S. Special Operations Command, ranging from 8 to 100 percent for pre-deployment health assessments and from 11 to 62 percent for post-deployment health assessments. Our review also disclosed that the AMSA database was still, over 5 years after congressional action, lacking documentation of many health assessments and immunizations that we found in the servicemembers' medical records at the installations visited. Specifically, health-related documentation missing from the centralized database ranged from 0 to 63 percent for pre-deployment health assessments, 11 to 75 percent for post-deployment health assessments, and 8 to 93 percent for immunizations.

Furthermore, DOD did not have oversight of departmentwide efforts to comply with health surveillance requirements. There was no effective quality assurance program at the Office of the Assistant Secretary of Defense for Health Affairs or at the Offices of the Surgeons' General of the

Army or Air Force that helped ensure compliance with force health protection and surveillance policies. We believe the lack of such a system was a major cause of the high rate of noncompliance we found at the units we visited. Continued noncompliance with these policies may result in servicemembers being deployed with unaddressed health problems or without immunization protection. Furthermore, incomplete and inaccurate medical records may hinder DOD's and VA's ability to investigate the causes of any future health problems that may arise coincident with deployments.

Also, DOD has not corrected the problems we identified in 1997 that were related to the completeness and accuracy of a central personnel deployment database that is designed to collect data reflecting which servicemembers deployed to certain locations. DMDC's deployment database still does not include the information needed for effective deployment health surveillance. Prior to April 2003, the services were not reporting location-specific deployment data to the DMDC because, according to a DMDC official, the services did not maintain the data. By July 2003, all of the services had begun submitting classified deployment data to DMDC, which is currently reviewing the deployment information received to determine its accuracy and completeness. However, DMDC still does not have a system to track the movement of servicemembers within a given theater, because this information has not been available from the services and the development of a new tracking system at the service unit level may be required. DOD is developing a new system for tracking the movements of servicemembers and civilian personnel in the theater of operation with plans for implementation by about September 2005 for the Army and by 2007 or early calendar year 2008 for the other services.

We recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to establish an effective quality assurance system to ensure that the military services comply with force health protection and surveillance requirements for all servicemembers. DOD agreed with our recommendation and outlined a number of actions the military services are already taking to implement their quality assurance programs. While we view these actions as responsive to our recommendation, the effectiveness of these actions to ensure compliance will depend on follow-through by DOD and the services.

Background

In May 1997, we reported on DOD's actions to improve deployment health surveillance before, during, and after deployments, focusing on Operation Joint Endeavor, which was conducted in the countries of Bosnia-Herzegovina, Croatia, and Hungary.[7] Our 1997 review disclosed problems with the Army's implementation of the medical surveillance plan for Operation Joint Endeavor in the following areas:

- **Medical assessments.** Many Army personnel who should have received post-deployment medical assessments did not receive them and the assessments that were completed were frequently done late.
- **Medical record keeping.** Many of the servicemembers' medical records that we reviewed were incomplete and missing documentation of in-theater post-deployment medical assessments, medical visits during deployment, and receipt of an investigational new vaccine.
- **Centralized database.** The centralized database for collecting in-theater and home unit post-deployment medical assessments was incomplete for many Army personnel.
- **Deployment information.** DOD officials considered the database used for tracking the deployment of Air Force and Navy personnel inaccurate.

Following the publication of our report, the Congress, in November 1997, included a provision in the Defense Authorization Act for Fiscal Year 1998 requiring the Secretary of Defense to establish a medical tracking system for servicemembers deployed overseas as follows:

"(a) SYSTEM REQUIRED—The Secretary of Defense shall establish a system to assess the medical condition of members of the armed forces (including members of the reserve components) who are deployed outside the United States or its territories or possessions as part of a contingency operation (including a humanitarian operation, peacekeeping operation, or similar operation) or combat operation.

"(b) ELEMENTS OF SYSTEM—The system described in subsection (a) shall include the use of predeployment medical examinations and postdeployment medical examinations (including an assessment of mental health and the drawing of blood samples) to accurately record the medical condition of members before their deployment and any changes in their medical condition during the course of their deployment. The postdeployment examination shall be conducted when the member is redeployed or otherwise leaves an area in which the system is in operation (or as soon as possible thereafter).

[7] GAO/NSIAD-97-136.

"(c) RECORDKEEPING—The results of all medical examinations conducted under the system, records of all health care services (including immunizations) received by members described in subsection (a) in anticipation of their deployment or during the course of their deployment, and records of events occurring in the deployment area that may affect the health of such members shall be retained and maintained in a centralized location to improve future access to the records.

"(d) QUALITY ASSURANCE—The Secretary of Defense shall establish a quality assurance program to evaluate the success of the system in ensuring that members described in subsection (a) receive predeployment medical examinations and postdeployment medical examinations and that the recordkeeping requirements with respect to the system are met."[8]

As set forth above, these provisions require the use of pre-deployment and post-deployment medical examinations to accurately record the medical condition of servicemembers before deployment and any changes during their deployment. In a June 30, 2003, correspondence with the General Accounting Office, the Assistant Secretary of Defense for Health Affairs stated that "it would be logistically impossible to conduct a complete physical examination on all personnel immediately prior to deployment and still deploy them in a timely manner." Therefore, DOD required both pre-deployment and post-deployment health assessments for servicemembers who deploy for 30 or more continuous days to a land-based location outside the United States without a permanent U.S. military treatment facility. Both assessments use a questionnaire designed to help military healthcare providers in identifying health problems and providing needed medical care. The pre-deployment health assessment is generally administered at the home station before deployment, and the post-deployment health assessment is completed either in theater before redeployment to the servicemember's home unit or shortly upon redeployment.

As a component of medical examinations, the statute quoted above also requires that blood samples be drawn before and after a servicemember's deployment. DOD Instruction 6490.3, August 7, 1997, requires that a pre-deployment blood sample be obtained within 12 months of the servicemember's deployment.[9] However, it requires the blood samples be

[8] Section 765 of Pub. L. No. 105-85 amended title 10 of the United States Code by adding section 1074f.

[9] DOD Instruction 6490.3, "Implementation and Application of Joint Medical Surveillance for Deployments," August 7, 1997.

drawn upon return from deployment only when directed by the Assistant Secretary of Defense for Health Affairs. According to DOD, the implementation of this requirement was based on its judgment that the Human Immunodeficiency Virus serum sampling taken independent of deployment actions is sufficient to meet both pre-deployment and post-deployment health needs, except that more timely post-deployment sampling may be directed when based on a recognized health threat or exposure. Prior to April 2003, DOD did not require a post-deployment blood sample for servicemembers supporting the OEF and OJG deployments.

In April 2003, DOD revised its health surveillance policy for blood samples and post-deployment health assessments. Effective May 22, 2003, the services are required to draw a blood sample from each redeploying servicemember no later than 30 days after arrival at a demobilization site or home station.[10] According to DOD, this requirement for post-deployment blood samples was established in response to an assessment of health threats and national interests associated with current deployments. The department also revised its policy guidance for enhanced post-deployment health assessments to gather more information from deployed servicemembers about events that occurred during a deployment. More specifically, the revised policy requires that a trained health care provider conduct a face-to-face health assessment with each returning servicemember to ascertain (1) the individual's responses to the health assessment questions on the post-deployment health assessment form; (2) the presence of any mental health or psychosocial issues commonly associated with deployments; (3) any special medications taken during the deployment; and (4) concerns about possible environmental or occupational exposures.

[10] Under Secretary of Defense for Personnel and Readiness Memorandum, "Enhanced Post-Deployment Health Assessments," April 22, 2003.

The Army and Air Force Did Not Comply with Deployment Health Surveillance Policies for Many Servicemembers

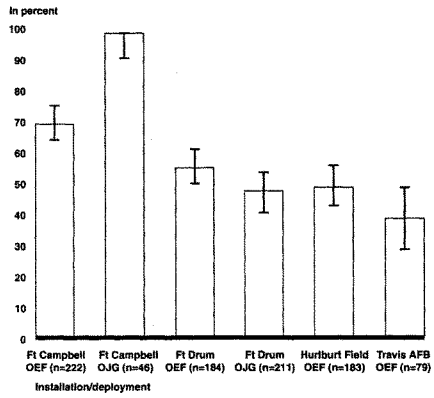
The Army and Air Force did not comply with DOD's force health protection and surveillance requirements for many of the servicemembers in our samples at the selected installations we visited. Specifically, these Army and Air Force servicemembers were missing: pre-deployment and/or post-deployment health assessments; evidence of receiving one or more of the pre-deployment immunizations required for their deployment location; and other pre-deployment requirements related to tuberculosis screening and blood serum sample storage. Also, servicemembers' permanent medical records were missing required health-related information, and DOD's centralized database did not include documentation of servicemember health-related information. Neither the installations nor DOD had monitoring and oversight mechanisms in place to help ensure that the force health protection and surveillance requirements were met for all servicemembers.

Many Servicemembers Lacked Pre-deployment and Post-deployment Health Assessments

We found that servicemembers missing one or both of their pre-deployment and post-deployment assessments ranged from 38 to 98 percent in our samples.[11] For example, at Fort Campbell for the OEF deployment we found that 68 percent of the 222 active duty servicemembers in our sample were missing either one or both of the required pre-deployment and post-deployment health assessments. The results of our statistical samples for the deployments at the installations visited are depicted in figure 1.

[11] Because we checked all known possible sources for the existence of deployment health assessments, we concluded that the assessments were not completed in those instances where we could not find required health assessments.

Figure 1: Percent of Servicemembers Missing One or Both Health Assessments



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

Notes: | = 95 percent confidence interval, upper and lower bounds for each estimate.

These percentages reflect assessments from all sources and without regard to timeliness.

For those servicemembers in our samples who had completed pre-deployment or post-deployment health assessments, we found that as many as 45 percent of the assessments in our samples were not completed on time in accordance with requirements. DOD policy requires that servicemembers complete a pre-deployment health assessment form within 30 days of their deployment and a post-deployment health assessment form within 5 days upon redeployment back to their home station.[12] These time frames were established to allow time to identify and resolve any health concerns or problems that may affect the ability of the servicemember to deploy, and to promptly identify and address any health concerns or problems that may have arisen during the

[12] Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-2, "Updated Procedures for Deployment Health Surveillance and Readiness," February 1, 2002.

servicemember's deployment. Additionally, DOD policy requires that pre-deployment and post-deployment health assessments are to be reviewed immediately by a health care provider to identify any medical care needed by the servicemember.[13] We found, however, that not all health assessments were reviewed by a health care provider as required.

The services did not refer some servicemember health assessments that indicated a need for further consultation. According to DOD policy, a medical provider, namely a physician, physician's assistant, nurse, or independent duty medical technician is required to further review a servicemember's need for specialty care when the member's pre-deployment and/or post-deployment health assessment indicates health concerns such as unresolved medical or dental problems or plans to seek mental health counseling or care.[14] This follow-up may take the form of an interview or examination of the servicemember, and forms the basis of a decision as to whether a referral for further specialty care is warranted. In our samples, the number of assessments that indicated a health concern was relatively small, but large percentages of these assessments were not referred for further specialty care. For example, our sample at Travis Air Force Base included five pre-deployment health assessments that indicated a health concern, but four (80 percent) of the health assessments were not referred for further specialty care.

Noncompliance with the requirement for pre-deployment health assessments may result in servicemembers with existing health problems or concerns being deployed with unaddressed health problems. Also, failure to complete post-deployment health assessments may risk a delay in obtaining appropriate medical follow-up attention for a health problem or concern that may have arisen during or following the deployment.

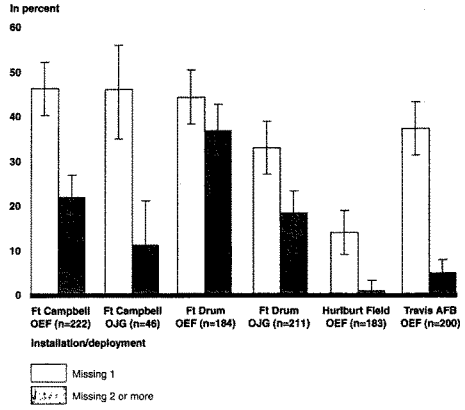
[13] The Joint Staff, Joint Staff Memorandum MCM-251-98.

[14] Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-02, "Updated Procedures for Deployment Health Surveillance and Readiness," February 1, 2002.

Immunizations and Other Pre-Deployment Health Requirements Not Met

Based on our samples, the services did not fully meet immunization and other pre-deployment requirements. Evidence of pre-deployment immunizations receipt was missing from many servicemembers' medical records. Servicemembers missing the required immunizations may not have the immunization protection they need to counter theater disease threats. Based on our review of servicemember medical records for the deployments at the four installations we visited, we found that between 14 and 46 percent of the servicemembers were missing one of their required immunizations prior to deployment (see fig. 2). Furthermore, as many as 36 percent of the servicemembers were missing two or more of their required immunizations.

Figure 2: Percent of Servicemembers Missing Required Immunizations



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

Notes: [ ] = 95 percent confidence interval, upper and lower bounds for each estimate.

The U.S. Central Command required the following pre-deployment immunizations for all servicemembers that deployed to Central Asia in support of OEF: hepatitis A (two-shot series); measles, mumps, and rubella; polio; tetanus/diphtheria within the last 10 years; yellow fever

within the last 10 years; typhoid within the last 5 years; influenza within the last 12 months; and meningococcal within the last 5 years.[15] For OJG deployments, the U.S. European Command required the same immunizations cited above, with the exception of the yellow fever inoculation that was not required for Kosovo.[16]

Furthermore, deploying servicemembers in our review that were missing a current tuberculosis screening ranged from 7 to 40 percent. A screening is deemed "current" if it occurred 1 to 2 years prior to deployment. Specifically, the U.S. Central Command required servicemembers deploying to Central Asia in support of OEF to be screened for tuberculosis within 12 months of deployment.[17] For OJG deployments, the U.S. European Command required Army and Air Force servicemembers to be screened for tuberculosis with 24 months of deployment.[18]

U.S. Central Command and U.S. European Command policies require that deploying servicemembers have a blood serum sample in the serum repository not older than 12 months prior to deployment.[19] While nearly all deploying servicemembers had blood serum samples held in the Armed Services Serum Repository prior to deployment, as many as 29 percent had serum samples that were too old. The samples that were too old ranged, on average, from 2 to 15 months out-of-date.

[15] U.S. Central Command, "Personnel Policy Guidance for U.S. Individual Augmentation Personnel in Support of Operation Enduring Freedom," October 3, 2001.

[16] Headquarters U.S. European Command, "Greece and the Balkans: Force Health Protection Guidance," January 4, 2002.

[17] U.S. Central Command, "Personnel Policy Guidance for U.S. Individual Augmentation Personnel in Support of Operation Enduring Freedom," October 3, 2001.

[18] Headquarters U.S. European Command, "Greece and the Balkans: Force Health Protection Guidance," January 4, 2002.

[19] U.S. Central Command, "Personnel Policy Guidance for U.S. Individual Augmentation Personnel in Support of Operation Enduring Freedom," October 3, 2001; and Headquarters U.S. European Command, "Greece and the Balkans: Force Health Protection Guidance," January 4, 2002.

Servicemember Medical Records and Centralized Database Were Not Complete

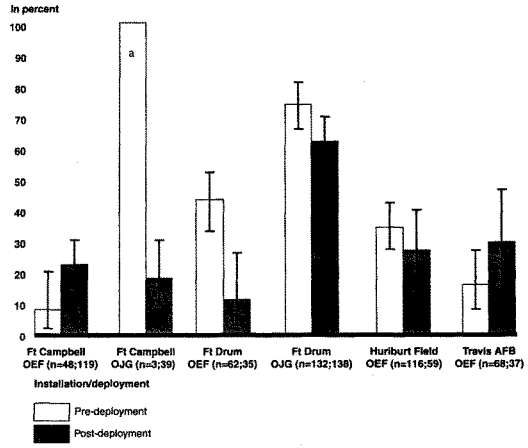
Servicemembers' permanent medical records were not complete, and DOD's centralized database did not include documentation of servicemember health-related information. Many servicemembers' permanent medical records at the Army and Air Force installations we visited did not include documentation of completed health assessments and servicemember visits to Army battalion aid stations. Similarly, the centralized deployment record database did not include many of the deployment health assessments and immunization records that we found in the servicemembers' medical records at the installations we visited.

Many Completed Deployment Health Assessments and Medical Interventions Were Not Documented in Servicemembers' Medical Record

DOD policy requires that the original completed pre-deployment and post-deployment health assessment forms be placed in the servicemember's permanent medical record and that a copy be forwarded to AMSA.[20] Figure 3 shows that completed assessments we found at AMSA and at the U.S. Special Operations Command for servicemembers in our samples were not documented in the servicemember's permanent medical record, ranging from 8 to 100 percent for pre-deployment health assessments and from 11 to 62 percent for post-deployment health assessments.

[20] Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-02, "Updated Procedures for Deployment Health Surveillance and Readiness," February 1, 2002.

Figure 3: Percent of Assessments Found in Centralized Database That Were Not Found in Servicemembers' Medical Records



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

Notes: | = 95 percent confidence interval, upper and lower bounds for each estimate.

[a]All three pre-deployment cases at Fort Campbell found in the centralized database were missing from servicemembers' medical record, but unable to compute confidence intervals due to insufficient size.

Army and Air Force policies also require documentation in the servicemember's permanent medical record of all visits to in-theater medical facilities.[21] Except for the OEF deployment at Fort Drum, officials were unable to locate or access the sign-in logs for servicemember visits to in-theater Army battalion aid stations and to Air Force expeditionary medical support for the OEF and OJG deployments at the installations we

[21] Army Regulation 40-66, "Medical Records Administration," October 23, 2002, and Air Force Instruction 41-210, "Health Services Patient Administration Functions," October 1, 2000.

visited. Consequently, we limited the scope of our review to two battalion aid stations for the OEF deployment at Fort Drum. We found that 39 percent of servicemember visits to one battalion aid station and 94 percent to the other were not documented in the servicemember's permanent medical record. Representatives of the two battalion aid stations said that the missing paper forms documenting the servicemember visits may have been lost en route to Fort Drum. Specifically, a physician's assistant for one of these battalion aid stations said the battalion aid station moved three times in theater and each time the paper forms used to document in-theater visits were boxed and moved with the battalion aid station. Consequently, the forms missing from servicemembers' medical records may have been lost en route to Fort Drum.

The lack of complete and accurate medical records documenting all medical care for the individual servicemember complicates the servicemembers' post-deployment medical care. For example, accurate medical records are essential for the delivery of high-quality medical care and important for epidemiological analysis following deployments. According to DOD and VA health officials, the lack of complete and accurate medical records complicated the diagnosis and treatment of servicemembers who experienced post-deployment health problems that they attributed to their military service in the Persian Gulf in 1990-91.

DOD is implementing the Theater Medical Information Program (TMIP) that has the capability to electronically record and store in-theater patient medical encounter data. TMIP is currently undergoing operational testing by the military services and DOD intends to begin fielding TMIP during the first quarter of fiscal year 2004.

Centralized Database Missing Health-Related Documentation

Based on our samples, DOD's centralized database did not include documentation of servicemember health-related information. As set forth above, Public Law 105-85, enacted November 1997, requires the Secretary of Defense to retain and maintain health-related records in a centralized location. This includes records for all medical examinations conducted to ascertain the medical condition of servicemembers before deployment and any changes during their deployment, all health care services (including immunizations) received in anticipation of deployment or during the deployment, and events occurring in the deployment area that may affect the health of servicemembers. A February 2002 Joint Staff memorandum

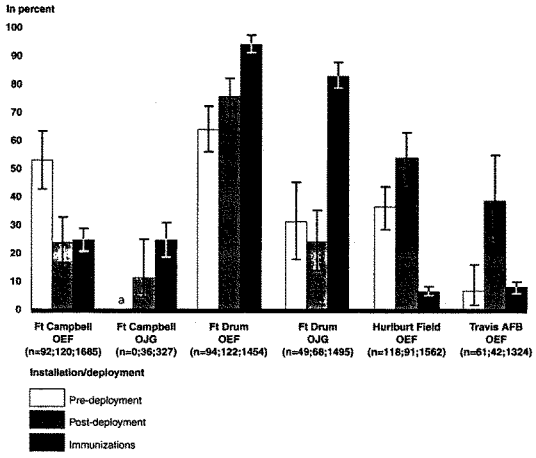
requires the services to forward a copy of the completed pre-deployment and post-deployment health assessments to AMSA for centralized retention.[22] Also, the U.S. Special Operations Command (SOCOM) requires deployment health assessments for special forces units to be sent to the Command for centralized retention in the Special Operation Forces Deployment Health Surveillance System.[23]

Figure 4 depicts the percentage of pre-deployment and post-deployment health assessments and immunization records we found in the servicemembers' medical records that were not available in a centralized database at AMSA or SOCOM. Health-related documentation missing from the centralized database ranged from 0 to 63 percent for pre-deployment health assessments, 11 to 75 percent for post-deployment health assessments, and 8 to 93 percent for immunizations.

[22] Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-02, "Updated Procedures for Deployment Health Surveillance and Readiness," February 1, 2002.

[23] U.S. Special Operations Command Directive 40-4, "Medical Surveillance," October 18, 2000; Appendix 1 to Annex Q to U.S. Central Command Operations Order, "Special Operation Forces Deployment Health Surveillance System," November 30, 2001.

Figure 4: Percent of Assessments and Immunizations Found in Servicemembers' Medical Records That Were *Not* Found in the Centralized Database



Sources: GAO analyses of documentation from servicemember medical records and DOD medical databases.

Notes: ⁞ = 95 percent confidence interval, upper and lower bounds for each estimate.

Centralized database is AMSA for all but Hurlburt Field, which reports to either AMSA or SOCOM based on classification of military personnel. Hurlburt Field results reflect combined health assessment and immunization data found at either AMSA or SOCOM.

[a]Zero cases found in servicemembers' medical record that were not found in the centralized database.

All but one of the servicemembers in our sample at Hurlburt Field were special operations forces. A SOCOM official told us that pre-deployment and post-deployment health assessment forms for servicemembers in special operations force units are not sent to AMSA because the health assessments may include classified information that AMSA is not equipped to receive. Consequently, SOCOM retains the deployment health assessments in its classified Special Operations Forces Deployment Health Surveillance System. Also, a SOCOM medical official told us that the

system does not include pre-deployment immunization data. A Deployment Health Support Directorate official told us that the Directorate is examining how to remove the classified information from the deployment health assessments so that SOCOM can forward the assessments to AMSA. For presentation in figure 4, we combined the health assessment and immunization data we found at AMSA and SOCOM for Hurlburt Field.

An AMSA official believes that missing documentation in the centralized database could be traced to the services' use of paper copies of deployment health assessments that installations are required to forward to the centralized database, and the lack of automation to record servicemembers' pre-deployment immunizations. DOD has ongoing initiatives to electronically automate the deployment health assessment forms and the recording of servicemember immunizations. For example, DOD is implementing a comprehensive electronic medical records system, known as the Composite Health Care System II, which includes pre-deployment and post-deployment health assessment forms and the capability to electronically record immunizations given to servicemembers. DOD has deployed the system at five sites and will be seeking approval in August/September 2003 for worldwide deployment.[24] DOD officials believe that the electronic automation of the deployment health-related information will lessen the burden of installations in forwarding paper copies and the likelihood of information being lost in transit.

DOD and Installations Did Not Have Oversight of Force Health Protection and Surveillance Requirements

DOD did not have an effective quality assurance program to provide oversight of, and ensure compliance with, the department's force health protection and surveillance requirements. Moreover, the installations we visited did not have ongoing monitoring or oversight mechanisms to help ensure that force health protection and surveillance requirements were met for all servicemembers. We believe that the lack of such a system was a major cause of the high rate of noncompliance we found at the units we visited. The services are currently developing quality assurance programs designed to ensure that force health protection and surveillance policies are implemented for servicemembers.

[24] In September 2002, we reported that DOD had experienced delays and cost overruns in implementing the Composite Health Care System II. See U.S. General Accounting Office, *Information Technology: Greater Use of Best Practices Can Reduce Risk in Acquiring Defense Health Care System*, GAO-02-345 (Washington, D.C.: Sept. 26, 2002).

Although required by Public Law 105-85 to establish a quality assurance program,[25] neither the Assistant Secretary of Defense for Health Affairs nor the offices of the Surgeons General of the Army or Air Force had established oversight mechanisms that would help ensure that force health protection and surveillance requirements were met for all servicemembers. Following our visit to Fort Drum in October 2002, the Army Surgeon General wrote a memorandum in December 2002 to the commanders of the Army Regional Medical Commands that expressed concern related to our sample results at Fort Drum. He emphasized the importance of properly documenting medical care and directed the commanders to accomplish an audit of a statistically significant sample of medical surveillance records of all deployed and redeployed soldiers at installations supported by their regional commands, provide an assessment of compliance, and develop an action plan to improve compliance with the requirements.

At three of the four installations we visited, officials told us that new procedures were implemented that they believe will improve compliance with force health protection and surveillance requirements for deployments occurring after those we reviewed. Specifically, following our visit to Fort Drum in October 2002, Fort Drum medical officials designed a pre-deployment and post-deployment checklist patterned after our review that is being used as part of processing before servicemembers are deployed and when they return. The officials told us that this process has improved their compliance with force health protection and surveillance requirements for deployments subsequent to our visit. Also, the hospital commander at Fort Campbell told us that they implemented procedures that now require all units located at Fort Campbell to use the hospital's medical personnel in their processing of servicemembers prior to deployment. The hospital commander believes that this new requirement will improve compliance with the force health protection and surveillance requirements at Fort Campbell because the medical personnel will now review whether all requirements have been met for the deploying servicemembers. At Hurlburt Field, officials told us that they implemented a new requirement in November 2002 to withhold payment of travel expenses and per diem to re-deploying servicemembers until they complete the post-deployment health assessment. Officials believe that this change will improve servicemembers' completion of the post-deployment health assessments. While it is noteworthy that these

[25] 10 U.S.C. sec. 1074f(d).

installations have implemented changes that they believe will improve their compliance, the actual measure of improvements over time cannot be known unless the installations perform periodic reviews of servicemembers' medical records to identify the extent of compliance with deployment health requirements.

In March 2003, we briefed the Subcommittee on Total Force, House Committee on Armed Services, about our interim review results at selected military installations.[26] Subsequently, at a March 2003 congressional hearing, the Subcommittee discussed our interim review results with the Assistant Secretary of Defense for Health Affairs and the services' Surgeons General. Based on our interim results that DOD was not meeting the full requirement of the law and the military services were not effectively carrying out many of DOD's force health protection and surveillance policies, in May 2003 the House Committee on Armed Services directed the Secretary of Defense to take measures to improve oversight and compliance. Specifically, in its report accompanying the Fiscal Year 2004 National Defense Authorization Act, the Committee directed the Secretary of Defense "... to establish a quality control program to begin assessing implementation of the force health protection and surveillance program, and to provide a strategic implementation plan, including a timeline for full implementation of all policies and programs, to the Senate Committee on Armed Services and the House Committee on Armed Services by March 31, 2004."[27]

In April 2003, the Under Secretary of Defense for Personnel and Readiness issued an enhanced post-deployment health assessment policy that required the services to develop and implement a quality assurance program that encompasses medical record keeping and medical surveillance data.[28] In June 2003, the Office of Assistant Secretary of Defense for Health Affairs' Deployment Health Support Directorate began reviewing the services' quality assurance implementation plans and establishing DOD-wide compliance metrics—including parameters for conducting periodic visits—to monitor service implementation.

[26] Prior to briefing the Subcommittee, we also briefed the Senior Military Medical Advisory Committee including the Assistant Secretary of Defense for Health Affairs and the military services' Surgeons General or their representatives about our interim review results.

[27] H.R. Rep. No. 108-106 at 336 (2003).

[28] Under Secretary of Defense for Personnel and Readiness Memorandum, "Enhanced Post-Deployment Health Assessments," April 22, 2003.

Centralized Deployment Database Still Missing Information Needed for Deployment Health Surveillance

The DMDC deployment database still does not include the deployment information we identified in 1997 as needed for effective deployment health surveillance. In 1997, we reported that knowing the identity of servicemembers who were deployed during a given operation and tracking their movements within the theater of operations are major elements of a military medical surveillance system.[29] The Institute of Medicine reported in 2000 that the documentation of the locations of units and individuals during a given deployment is important for epidemiological studies and for the provision of appropriate medical care during and after deployments.[30] This information allows (1) epidemiologists to study the incidence of disease patterns across populations of deployed servicemembers who may have been exposed to diseases and hazards within the theater, and (2) health care professionals to treat their medical problems appropriately. Because of concerns about the accuracy of the DMDC database, we recommended in our 1997 report that the Secretary of Defense direct an investigation of the completeness of the information in the DMDC personnel database and take corrective actions to ensure that the deployment information is accurate for servicemembers who deploy to a theater.

DOD's established policies notwithstanding, the services did not report location-specific deployment information to DMDC prior to April 2003, because, according to a DMDC official, the services did not maintain the data. DOD Instruction 6490.3, issued in August 1997, requires DMDC, under the Department's Under Secretary for Personnel and Readiness, to maintain a system that collects information on deployed forces, including daily-deployed strength, total and by unit; grid coordinate locations for each unit (company size and larger); and inclusive dates of individual servicemember's deployment.[31] In addition, the Joint Chief of Staff's Memorandum MCM-0006-02, dated February 1, 2002, required combatant commands to provide DMDC with their theater-wide rosters of all deployed personnel, their unit assignments, and the unit's geographic locations while deployed.[32] This memorandum stressed that accurate

[29] GAO/NSIAD-97-136.

[30] Institute of Medicine, *Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces* (National Academy Press, Washington, D.C.: 2000).

[31] DOD Instruction 6490.3, "Implementation and Application of Joint Medical Surveillance for Deployments," August 7, 1997.

[32] Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-02, "Updated Procedures for Deployment Health Surveillance and Readiness," February 1, 2002.

personnel deployment data is needed to assess the significance of medical diseases and injuries in terms of the rate of occurrence among deployed servicemembers. The Under Secretary of Defense for Personnel and Readiness expressed concern about the services' failure to report complete personnel deployment data to DMDC in an October 2002 memorandum.[33]

To address the services' lack of reporting to DMDC, the Under Secretary of Defense for Personnel and Readiness established a tri-service working group that outlined a plan of action in March 2003 to address the reporting issues. In July 2003, a DMDC official told us that significant improvements had recently occurred and that all of the services had begun submitting their classified deployment databases—including deployment locations—to DMDC. DMDC is currently reviewing the deployment information submitted by the services to determine its accuracy and completeness. It plans to complete this review during the summer of 2003.

With regard to DMDC's efforts to create a system for tracking the movements of servicemembers within a given theater of operations, DMDC officials told us that little progress has been made. They said that the primary reason for a lack of progress in developing this system is that the source information has generally not been available from the services and this may require the development of new tracking systems at the unit level. In June 2003, a DMDC official told us that it had been recently determined that the Air Force has implemented a theater tracking system that may have applicability to the other services. The tracking system—known as the Deliberate Crisis and Action Planning and Execution Segment (DCAPES)—enables field teams to enter classified information about the whereabouts of deployed Air Force personnel at the longitude/latitude level of detail. DMDC began receiving information from this system in April 2003. The Under Secretary of Defense for Personnel and Readiness is reviewing this system to determine whether it could be used for the same purposes by the other services.

Also, DOD is developing the Defense Integrated Military Human Resource System (DIMHRS), which will have the capability to track the movements of all servicemembers and civilians in the theater of operations. As of

[33] This memorandum was dated October 25, 2002, and sent to the Vice Chief of Staff of the Army, Vice Chief of Staff of the Air Force, Vice Chief of Naval Operations, and the Assistant Commandant of the Marine Corps.

June 2003, DOD plans to implement this system for the Army by about September 2005 and for the other services by 2007 or early calendar year 2008.

Concluding Observations

While DOD and the military services have established force health protection and surveillance policies, at the units we visited we found many instances of noncompliance by the services. Moreover, because DOD and the services did not have an effective quality assurance program in place to help ensure compliance, these problems went undetected and uncorrected. Continued noncompliance with these policies may result in servicemembers with existing health problems or concerns being deployed with unaddressed health problems or without the immunization protection they need to counter theater disease threats. Failure to complete post-deployment health assessments may risk a delay in obtaining appropriate medical follow-up attention for a health problem or concern that may have arisen during or following the deployment. Similarly, incomplete and inaccurate medical records and deployment databases would likely hinder DOD's and VA's ability to investigate the causes of any future health problems that may arise coincident with deployments.

Mr. Chairman, this concludes my prepared statement. I will be pleased to answer any questions you or other members of the committee may have at this time.

Contacts and Acknowledgments

For further information regarding this testimony, please contact Neal P. Curtin at (757) 552-8100. Clifton Spruill, Steve Fox, Rebecca Beale, Lynn Johnson, William Mathers, Terry Richardson, Kristine Braaten, Grant Mallie, Herbert Dunn, and R.K. Wild also contributed to this testimony.

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Statement of
Harold Kudler, MD
Co-Chair, Under Secretary for Health's Special Committee on PTSD
Department of Veterans Affairs
Before the
Committee on Veterans' Affairs
Subcommittee on Health
on Handoffs or Fumbles? Are DoD and VA Providing Seamless Health Care Coverage to Transitioning Veterans?

October 16, 2003

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Mr. Chairman, I appreciate this opportunity to testify before the Subcommittee on the care of American military men and women serving in Afghanistan and Iraq as they transition from the Department of Defense (DoD) to the Department of Veterans Affairs (VA). My remarks reflect over twenty years experience as a VA psychiatrist, my ongoing service as Co-Chair of the Under Secretary for Health's Special Committee on Posttraumatic Stress Disorder (PTSD), and my active involvement in the development of a new joint DoD/VA Clinical Practice Guideline for the Management of Posttraumatic Stress.

VA is the world leader in PTSD treatment and research but it still has to overcome a longstanding misperception that PTSD treatment and research are primarily concerned with mental scars from long-past conflicts. Like many VA clinicians, I learned about PTSD by treating Vietnam veterans years after the war ended. In fact, when I first joined VA in 1980, the disorder was known as Vietnam Stress Syndrome. Later, we recognized that PTSD was also a significant problem among veterans of Korea and WWII. Over the next several years, VA developed clinical and research programs to meet the needs of patients with chronic PTSD. But, starting with the first Gulf War and then gaining momentum following the events of September 11, 2001 and the conflicts in Afghanistan and Iraq, VA is increasingly focused on tackling PTSD *proactively*.

We must preserve our capacity to serve veterans of past conflicts but we must also step up to meet the needs of a new generation of combat veterans. This means developing treatments for acute posttraumatic reactions and, whenever possible, preventing the development of chronic PTSD.

The Under Secretary's Special Committee on PTSD

The Charge of the Special Committee

The statutory charge to the Special Committee, laid out in section 110 of Public Law (PL) 98-528 (1984), as amended by section 206 of PL 106-117, the Veterans Millennium Health Care and Benefits Act, is to determine VA's capacity to provide assessment and treatment for Post-traumatic Stress Disorder and to guide VA's educational, research and benefits activities with regard to PTSD. The Special Committee is composed of PTSD experts from across a broad spectrum of VA's Mental Health and Readjustment Counseling Services (RCS). The Committee is currently developing its fourth and final annual report as required by PL 98-528, as amended.

Status of the Committee's Work

The Committee has found that VA faces significant challenges in its efforts on behalf of veterans suffering from this most prevalent mental disorder arising from combat. Our first annual report, prepared in 2001, reviewed the needs of veterans with PTSD and made 37 specific recommendations for action. In our second report, we honed and bundled those recommendations into 22 measurable objectives, each with a defined time frame. We continue to track progress on these recommendations and objectives in a spreadsheet that serves as an attachment to our third and (pending) fourth reports.

The Committee's Key Recommendations

Based on our four years of study, the essential things that VA must accomplish to meet the challenge of PTSD are:

1. Provide the range and intensity of specialized programs necessary to meet the service-related needs of veterans with PTSD

2. Promote best practices and evidence-based care for PTSD and other debilitating psychological responses to military trauma and:
3. Ensure VA's readiness to respond to the mental health consequences of combat, terrorism, and incidents of mass violence by supporting programs that are essential to its PTSD mission

The Joint DoD/VA Clinical Practice Guideline for the Management of Posttraumatic Stress

An Essential Step in Meeting the Committee's Recommendations

As a result of my work with the Special Committee, I was asked to help organize the development of the Joint DoD/VA Clinical Practice Guideline for the Management of Posttraumatic Stress. The working group for this project included members of Army, Navy, and Air Force as well as VA Medical Centers, RCS, and VA's National Center for PTSD. Disciplines represented included psychiatrists, primary care physicians, psychologists, nurses, pharmacists, occupational therapists, social workers, counselors, chaplains, and administrators. The goal was to create an evidence-based algorithm for the prevention, assessment, and treatment of military men and women who have survived traumatic events. These events include (but are not limited to) combat, peacekeeping and humanitarian operations, bioterrorism or disaster response or sexual or domestic abuse.

The Challenges

Although PTSD is the most widely known mental disorder resulting from exposure to such overwhelming events, it is not the only such disorder. The Work Group had to develop a guideline that addresses the full range of posttraumatic reactions/disorders including: Acute Stress Response/Combat and Operational Stress Response (a mixed group of reactions that affect the survivor within moments and up to a few days after the event); Acute Stress Disorder (a narrower group of symptoms and signs that develop within the first month after the event), and PTSD (which may be acute, chronic, or of delayed response and which may be complicated by other mental and physical disorders). In pursuing

its charge, the Work Group had to confront the fact that DoD and VA have two very different cultures with respect to disorders of traumatic stress.

Within DoD, many consider it a very bad idea to report symptoms of PTSD because they are concerned that it will interfere with their mission, disrupt the morale of their colleagues, and possibly curtail their military careers. In contrast, veterans within VA often consider talking about PTSD a good thing because it can lead to effective treatment and, sometimes, to needed disability benefits. Providers and leadership in DoD are therefore less likely to hear about pathological responses to traumatic events within their unit and may not realize the extent to which such problems exist.

VA staff, on the other hand, get to know the end of a veteran's PTSD story and often wonder why they can't learn more about how the problem began from DoD records or why intervention did not begin during the patient's military service. In the course of developing the Joint Guideline, the Work Group came to recognize the important implications of this cultural divide for service personnel transitioning from DoD to VA. In the House Subcommittee's metaphor, we set about ensuring good handoffs and preventing fumbles.

Applying the Lessons Learned

The Importance of Screening

Perhaps the most fundamental element of the Joint Guideline is the recommendation to screen every man and woman at specific intervals for symptoms of posttraumatic stress in every DoD and VA primary care and mental health clinic. The screening tool is a four-question instrument developed by the National Center for PTSD and validated in primary care populations. These same four questions have now been incorporated into DoD's Post-Deployment Questionnaire. It is hoped that, by identifying those at risk as early as possible, we can prevent new cases of chronic PTSD. A good deal of clinical experience and research will be needed before we can determine if this is, in fact, possible. Despite improvements in record sharing between DoD and VA, VA clinicians still lack the ability to access the post-deployment responses of the veterans they serve.

Weaving a Continuum of Care between DoD and VA

VA has already identified VHA/DoD Liaisons to major DoD Military Treatment Facilities (MTFs) to assure seamless transition and transfer of care. VA has also identified staff members to serve as Points of Contact (POCs) at every VAMC. The principle role of the POC is to receive and expedite referrals and transfers of care from the VA/DoD Liaison and to assure that appropriate linkage is made for clinical follow-up services.

Enhancing the Continuum of Care

The Special Committee is currently reviewing the role of the POCs and Vet Centers in providing information to combat veterans of Afghanistan and Iraq and their families at the time of the veteran's separation from service on the possible effects of combat stress. POCs could be provided with scripts based on the scenarios they are most likely to confront and distribute brochures based on materials already developed by the National Center for PTSD (available on the web at http:// ncptsd.org/topics/war/html), and would provide information about where to get help. POCs would continue to be responsible for meeting the needs of active duty personnel and new veterans and their families as they present for VA services at their respective medical centers.

The Special Committee is also considering how military unit associations and Veterans Service Organizations might be engaged to help identify, refer and help support veterans who need care.

The Special Committee, in its third report, identified two actions needed to complete the VA continuum of care: (1) the establishment of a PTSD Clinical Team (PCT) at every VA medical center and (2) the location of a family therapist within each Vet Center. The VHA has concurred in concept with these recommendations and will address them consistent with local needs assessments and availability of resources.

Cultural Change in DoD and VA with Respect to Disorders of Posttraumatic Stress

Changing the Culture

In military language, "real grunts" see posttraumatic stress disorders not as the reaction of a normal person living through a very abnormal situation (such as combat) but rather as a failure of training, leadership, strength or character. This stigma is reflected at all levels of DoD and VA and forms the greatest single impediment to effective intervention and continuity of care. Cultural change is required across both systems. At present, the single most effective recommendation I can offer is to embed the DoD/VA Joint Treatment Guideline (with its assessment, treatment, and potential prevention capabilities) into DoD and VA primary care and mental health clinics and to consistently apply them during DoD operations. This will require development of software packages capable of seamlessly integrating the Joint Guideline into DoD and VA computer medical record systems in a manner that makes it easy and even preferable, for clinicians to use it. VA is also developing a system that monitors and encourages utilization of the Joint Guideline.

Current DoD efforts such as the Army's CSC (Combat Stress Control) Program and the Navy/Marine Corps' OSCAR (Operational Stress Control and Readiness) Program, both of which aim at peer-based early intervention with appropriate health care followup, are excellent vehicles for implementing the Joint Guideline during ongoing military operations. Aspects of the new Joint Guideline have already been applied in Iraq and have been found useful. These DoD programs are essential elements of the DoD/VA continuum of prevention and care and should be supported and cultivated across DoD.

Summary

DoD and VA must work together to build, integrate, and maintain the continuum of care needed by active duty men and women and veterans, present and future, who have placed themselves in harm's way in defense of our Nation. In their effort to meet the evolving challenge of posttraumatic stress, DoD and VA

are now focused on the practical problem of identifying new cases, researching and applying new interventions, and, whenever possible, preventing chronic PTSD. The efforts of the VA Under Secretary for Health's Special Committee on PTSD and the DoD and VA staff who developed the Joint Clinical Practice Guideline for the Management of Disorders of Traumatic Stress will help ensure effective handoffs rather than fumbles as military men and women transition from DoD to VA. Many elements of a comprehensive transition process already exist but they need to be strengthened, integrated, and more sharply focused. Ultimately, success in this area will require cultural change in both DoD and VA. This can best be accomplished through the development of specific performance measures that favor the implementation of the evidence-based Joint Guideline.

Mr. Chairman, this concludes my statement, which can be placed in the record. I will be happy to respond to any questions that you or other members of the subcommittee might have.

Statement of
Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
Before the Committee on Veterans' Affairs
U. S. House of Representatives
Hearing on the Transition of Returning Service Members

October 16, 2003
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Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to discuss the Department of Veterans Affairs' (VA) efforts toward a seamless transition for returning service members.

We have been working hard both internally and with the Department of Defense (DoD) to improve coordination to identify the men and women returning from combat theaters and provide those discharged or needing VA services while on active duty with world-class VA service. Anyone who has been wounded or injured or has become ill in defense of our country deserves the best and most timely service possible from their Government.

Recent media attention focused on some returning service members whose interactions with VA were not acceptable. We have developed processes to try to prevent these types of situations from recurring, and, in addition, we have implemented a number of longer-term strategies, policies, and procedures to provide timely, appropriate services to our returning service members.

Seamless Transition Taskforce

In August, the Under Secretary for Benefits and I charged a new VA Taskforce for the Seamless Transition of Returning Service Members to intensify and continue efforts to assure world class services are provided to our military and veterans. This taskforce, composed of VA senior leadership from key program offices as well as the VA/DoD Executive Council structure, is initially focusing on internal coordination efforts to ensure that VA approaches this mission in a comprehensive manner. An additional goal is improving dialogue and collaboration with DoD at all levels between our two Departments, including the Military Services, Personnel and Readiness, Health Affairs, and Reserve Affairs. As an early focus, we are working closely with DoD to enhance our ability to identify and serve all returning service members that sustained injuries or illnesses while serving our country.

Thanks to the leadership of Dr. David Chu and Dr. Bill Winkenwerder, I am pleased to report that DoD transferred to VHA a roster of military personnel who

recently served in theaters of combat in Afghanistan and Iraq and subsequently separated from active duty. Our records indicate that of approximately 17,000 veterans listed in this initial roster, to date, about 2,000 (12%) have sought health care from VA for a wide variety of health problems. Of this group, most have been seen as outpatients.

To ensure that our commitment is understood and shared at every level of the Department of Veterans Affairs, the Taskforce has developed a number of training materials for staff including a script and video for front line staff to ensure that they can identify veterans who have served in a theater of combat operations and take the steps necessary to ensure they receive appropriate care. Through the Taskforce, each VHA facility and each VA regional office has identified a point of contact to coordinate activities locally and to work as a team to assure that the needs of these service members or veterans are met and that contact is made should the veteran relocate. Case management guidance has been produced and was recently distributed to VHA and VBA field staff to ensure that these processes and expectations are communicated. We are committed to reducing red tape and streamlining access to health care services and VA benefits programs for these veterans.

Additional Supports for Seamless Transition

Working in collaboration with the military Surgeons General, who have been enthusiastic about improving coordination of care, the Veterans Benefits Administration (VBA) has detailed two full-time benefits counselors and the Veterans Health Administration (VHA) has detailed a full-time social worker to the Walter Reed Army Medical Center, the Military Treatment Facility (MTF) receiving the largest numbers of casualties. Beginning in late August, VHA social workers and VBA Veterans Service Representatives have also been assigned as VA/DoD Liaisons to the Brooke, Eisenhower, and Madigan Army Medical Centers; the National Naval Medical Center at Bethesda; and other MTFs receiving casualties. They work closely with military medical providers and social workers to assure that returning service members receive information and counseling about VA benefits and programs and to arrange for appropriate transfer of health care to VA facilities. Through this new collaboration, we have improved our ability to identify and serve returning service members that sustained serious injuries or illnesses while serving our country.

The VA social workers augment the clinical coordination through discharge planning activities at these MTFs. They are tracking these patients as they transfer to VA care, with the assistance of identified points of contact at every VA facility. Prior to discharge from the MTFs, the social workers enroll those transferring to VA care in order to expedite the transfer. By having representatives on site at military treatment facilities, we have also been able to assist those from recent deployments who have come into the medical center on their own. Utilizing the new case management and

coordination strategies developed with the military services at the 5 MTFs, since August 25 we have met with more than 150 patients, transferred over 30 and have over 30 patients pending transfer from these MTFs to VA. We are working to expand these efforts and have partnered with the Army Disabled Solder Liaison Team to draft an agreement to standardize information transfer processes to sustain our progress. We believe these coordination and collaborative efforts have greatly improved and streamlined the transition for those seeking care through VA.

Further, we are working to improve our collaboration with DoD to enhance outreach to returning members of the Reserves and National Guard. Too often Reservists and National Guard personnel have not received timely information about the benefits and access to health care they have earned. To address this problem, working with DoD Health Affairs and DoD Reserve Affairs, we have jointly developed and distributed a new brochure summarizing the benefits available to this special population of veterans upon their return to civilian life. We have printed a million copies of this brochure to ensure the widest possible dissemination through DoD channels. It is also available on line at http://www.va.gov/environagents/docs/SVABENEFITS.pdf.

We are also actively working to ensure successful implementation of Public Law 105-368, authorizing VHA to provide health care for a two-year period to veterans who serve on active duty in a theater of combat operations during a period of war after the Gulf War, or in combat against a hostile force during a period of hostilities after November 1, 1998. Consequently those who have served or are now serving in Afghanistan and Iraq, will have a two-year period of access to free VA health care for conditions possibly related to their combat service. We are aggressively reaching out to this group of current and former service members, including those who served in the National Guard and Reserves.

Veterans Outreach and Educational Activities

Earlier this year, VA's Vet Centers began to serve veterans returning from the current conflicts in Afghanistan and Iraq. As the community-based outreach arm of VHA, the Vet Centers have initiated outreach to area military installations and are closely coordinating their efforts with military family support services on the various military bases. In addition to community outreach to new veterans, the Vet Centers provide trauma counseling, family counseling, employment services and a range of social services to assist veterans in readjusting from war-time military service to civilian life. To date the Vet Centers have seen approximately 1,400 veterans from the conflicts in Iraq and Afghanistan. The Vet Centers also function as community points of access for many returning veterans, providing them with information and referrals to VA medical facilities for health care and VA regional offices for benefits issues.

Each VBA Regional Office assigns a point of contact to offer information on VA benefits and answer questions relating to benefits to wounded or injured veterans and

their families. Case managers are assigned to process expeditiously claims for compensation or other benefits, ideally within 30 days of receipt.

VBA's Transition Assistance Program (TAP) disseminates information about VA benefits and services to separating and retiring service members. VBA military service coordinators have conducted several thousand briefings this fiscal year to service members, local Reserve Commands, and National Guard Units. VBA recently conducted a series of TAP briefings aboard the USS Constellation on its return to Honolulu from the Persian Gulf and will continue to support requests from the Department of Defense. Each separating or retiring service member also receives information from VA through the Veterans Assistance at Discharge System (VADS) when his or her DD 214, Discharge Certificate, is received by VA's Austin Automation Center directly from the military service departments. The initial "Welcome Home" letter includes a copy of VA Pamphlet 21-00-1, A Summary of VA Benefits; VA Form 21-0501, Veterans Timetable; and information on life insurance and education benefits, as applicable.

Surviving spouses, dependent children, and parents of military personnel, Reservists, and National Guard members killed on active duty are provided specialized outreach services through our Casualty Assistance Program. Through this program, VBA works with military casualty assistance officers to schedule outreach visits with families. In addition, the Secretary recently authorized the VHA Readjustment Counseling Service to provide bereavement counseling to family members of active duty military personnel who are killed in the line of duty. Bereavement counseling is a natural extension of the core components of the Vet Center readjustment counseling service mission, which includes a welcoming consumer-oriented environment; recognition of veterans' service and sacrifice to country; ease of access via 206 conveniently located community-based facilities; maximum sensitivity to the need for confidentiality; and expertise in providing psychological trauma counseling to veterans' families.

In-service death claims for Dependency and Indemnity Compensation are generally processed within 48 hours of receipt. At the time of the initial outreach visit, family members are in an acute stage of grief and are not always able to absorb and understand the full range of benefits available to them. Accordingly, VBA initiates a 6-month follow up letter to surviving spouses and dependent children outlining benefits and services, which they may be ready to discuss in further detail at that later time. If requested, a second outreach visit is made.

VHA is also partnering to conduct outreach by actively participating in discharge planning and orientation sessions for returning service members. Social Work Service, Readjustment Counseling Service, and other offices within VHA are involved in outreach activities. Posters, flyers, and information brochures are being produced to be distributed as well as posted in prominent places at VA medical centers and other VA

offices explaining VA services to returning service members and "our newest veterans." As service members are discharged from the military, and VHA is made aware, staff is making contact with the individuals to explain local services available and welcome them home.

Mr. Chairman, we testified before the Oversight and Investigations Subcommittee in early July on the longer- term strategies involving outreach that VA is pursuing to assure the best possible care is provided to returning Iraqi Freedom and Afghanistan Enduring Freedom service members. Many of these efforts are coordinated with DoD under the umbrella of the Health Executive Council.

Any health or exposure data that DoD collects regarding the deployment of service members potentially will be useful to VA. Through the Deployment Health Work Group, we are actively engaged with DoD in obtaining as much deployment health and exposure information as possible. Members of the Work Group are charged with reviewing appropriate coordination of data on troop locations and the data collected as part of pre- and post-deployment health screening implemented by DoD in their Recruit Assessment Program. Further we are actively working with DoD to develop separation physical examinations that thoroughly document a veteran's health status at the time of separation from military service and that also meet the requirements of the physical examination needed by VA in connection with a veteran's claim for compensation benefits. We are optimistic that as a result of the improved collaboration between VA and DoD in these programs, we will be better positioned to evaluate health problems among service members and veterans after they leave military service, to address post-deployment health questions, and to document changes in health status for disability determination.

A critical outreach activity to veterans and families concerns the potential health effects of hazardous military deployments. In addition to VA's outreach efforts discussed above, VHA has produced a brochure that addresses the main health concerns for military service in Afghanistan, another brochure for the current conflict in the Gulf region and one recently distributed on health care for women veterans returning from the Gulf region. These brochures answer health-related questions that veterans, their families, and health care providers have about these hazardous military deployments. They also describe relevant medical care programs that VA has developed in anticipation of the health needs of veterans returning from combat and peacekeeping missions abroad. These are widely distributed to military contacts, veterans service representatives and are on VA's website.

Another challenge for outreach is to address the specific concerns of veterans and their families over the potential health impact of environmental exposures during deployment. Veterans also have questions about their symptoms and illnesses following deployment. These concerns are addressed through newsletters and fact-sheets to veterans covering health and compensation issues, including environmental

health issues; regular briefings of veterans service organizations; organization of national meetings on health and research issues; media interviews; other educational material and websites with information, like www.va.gov/environagents.

Other Long-Term Strategies

In addition to the outreach activities discussed above, our strategy to assist returning service members and veterans includes the following:

- In 2002, VA established two national centers for the study of war-related illness and post-deployment health issues in East Orange New Jersey, and Washington, DC, to provide specialized health care for veterans from all combat and peace-keeping missions who suffer difficult to diagnose but disabling conditions. These centers are available to eligible veterans from all eras, including the war in Afghanistan and Iraq. These centers also provide research and education programs for our health care providers.
- A screening instrument in the form of a clinical reminder triggered by the veteran's separation date is being implemented for returning Iraqi Freedom and Afghanistan veterans that present for care in VA. This assessment tool will prompt the provider with specific data requirements to assure that veterans are screened for medical and psychological conditions that may be related to recent combat deployment.
- VA has developed evidence based clinical approaches for treating veterans following deployment. These clinical practice guidelines (CPGs) give health care providers the needed structure, clinical tools, and educational resources that allow them to diagnose and manage patients with deployment-related health concerns. Two post-deployment CPGs have been developed in collaboration with DoD, a general purpose post-deployment CPG and a CPG for unexplained fatigue and pain. Our goal is that all veterans will find their VA doctors well informed about specific deployments and related health hazards. The VA website contains these CPGs as well as information about unique deployment health risks and new treatments.
- VA and DoD will soon release a new CPG on the management of traumatic stress. This guideline pools DoD and VA expertise to help build a joint assessment and treatment infrastructure between the two systems in order to coordinate primary care and mental health care for the purpose of managing, and, if possible, preventing acute and chronic Post Traumatic Stress Disorder (PTSD).
- The Veterans Health Initiative (VHI) is a program designed to increase recognition of the connection between military service and certain health effects; better document veterans' military and exposure histories; improve patient care; and establish a database for further study. The education component of VHI

prepares VA healthcare providers to better serve their patients. A module was created on "Treating War Wounded," adapted from VHA satellite broadcasts in April 2003 and designed to assist VA clinicians in managing the clinical needs of returning wounded from the war in Iraq. Modules on spinal cord injury, cold injury, traumatic amputation, Agent Orange, the Gulf War, PTSD, POW, blindness/visual impairment and hearing loss, and radiation are available. We are developing additional modules on infectious disease health risks in Southwest Asia, military sexual trauma, traumatic brain injury, pulmonary diseases of military occupational significance, and Weapons of Mass Destruction Experiments and Exposures involving US veterans. Further, VA's National Center for PTSD has developed the Iraq War Clinician's Guide for use across VA. The website version, which can be found at WWW.NCPTSD.ORG, contains the latest fact sheets and medical literature available and is updated regularly. These important tools are integrated with other VA educational efforts to enable VA practitioners to arrive at a diagnosis more quickly and accurately and to provide more effective treatment.

- Section 110 of Public Law 98-528, as amended by section 206 of Public Law 106-117, established the Under Secretary for Health's Special Committee on PTSD. This group, composed of PTSD experts from across VA, is charged with reviewing VA's capacity to provide assessment and treatment for PTSD and guiding VA's educational, research, and benefits activities concerning PTSD. The Special Committee, which is currently meeting in Washington to develop the last of its four mandated annual reports, has provided specific, prioritized, proactive recommendations designed to build, integrate, and maintain the continuum of PTSD services needed by veterans, present and future.
- VA and DoD are closely collaborating to develop the ability to share medical information electronically. Since June 2002, the Departments have successfully been sharing electronic medical information. Key initiatives in the Electronic Health Records Plan are the Federal Health Information Exchange (FHIE) and HealthePeople (Federal). FHIE provides historical data on separated and retired military personnel from the DOD's Composite Health Care System to the FHIE Data Repository for use in VA clinical encounters and potential future use in aggregate analysis. Patient data on laboratory results, radiology reports, outpatient pharmacy information, and patient demographics are now being sent from DoD to VA via secure messaging. This second phase of FHIE has been deployed and is operational at VA medical centers nationwide. It includes admission, discharge, transfer data, discharge summaries, allergies, and consult tracking.

Summary

A service member separating from military service and seeking health care through VA today will have the benefit of VA's decade-long experience with Gulf War health issues as well as the President's commitment to improving VA/DoD collaboration. VA has successfully adapted many existing programs, improved outreach, improved clinical care through practice guidelines and educational efforts, and improved VA health provider's access to DoD health records. Secretary Principi re-emphasized VA's commitment to returning combat veterans in a letter to all employees last August, in which he reminded us that every VA employee has an obligation to ensure that every veteran who is wounded, injured, or ill from training for, preparing for, or fighting for our war on terror receives priority service. In his words, "We will have failed to meet our very reason to exist as a Department if a veteran is poorly served." I agree with that, Mr. Chairman, and VA will continue to improve services and coordination to ensure that the needs of these service members are met.

This concludes my statement. My colleagues and I will be happy to respond to any questions that you or other members of the Subcommittee might have.

Prepared Statement

of

The Honorable Edward P. Wyatt, Jr.

Principal Deputy Assistant Secretary of Defense
(Health Affairs)

on

The Transition of Service Members Requiring Health Care

Between the Department of Defense and the Department of Veterans Affairs

Before the

Committee on Veterans' Affairs
U.S. House of Representatives

October 16, 2003

Introduction

Mr. Chairman and members of this distinguished committee, thank you for the opportunity to be here today to discuss the coordination of health care for transitioning service members between the Department of Defense (DoD) and the Department of Veterans Affairs (VA). Today, we have more than 253 thousand service men and women deployed in support of our nation's defenses, including those serving in Afghanistan and Iraq. DoD is firmly committed to providing the best health care services for our operating forces. In the past year, more than 180 thousand men and women have left military service, and the vast majority are eligible for VA care. Our concern for the well being of service members extends well beyond their time on active duty. I want to assure you that as the Principal Deputy Assistant Secretary of Defense for Health Affairs, my highest priority is to maintain the health of our military members with a continuum of medical care protecting each service member from entrance into the military to separation from the military and transition to the VA healthcare system. I also acknowledge that we need to make improvements to our Force Health Protection and surveillance programs. GAO has recently completed a report on our health-assessment programs and noted various shortcomings. The Department of Defense has accepted GAO's recommendations regarding the implementation of an effective quality assurance program to ensure compliance with force health protection and surveillance requirements. The Assistant Secretary of Defense, Health Affairs is establishing a comprehensive quality assurance program and coordinating Service specific quality assurance force health protection and surveillance programs.

As you know, the Department of Defense and Department of Veterans Affairs have joined forces to provide our nation's military and veterans with improved health care services. Over the past year, many initiatives between the two Departments have launched a new era of DoD/VA collaboration, with unprecedented strides toward a new federal partnership that promises to transcend business as usual, and is already seen as a model for inter-agency cooperation across the Federal government.

We are pleased to report that we have just approved a VA-DoD Joint Strategic plan to guide our relationship over the coming years. We believe that this plan not only institutionalizes our current collaborative efforts but also identifies joint objectives, strategies and best practices for future collaboration. Through our VA-DoD Joint Executive Council, we will ensure

leadership oversight is given to all of these initiatives as we continue to develop our strategic partnership. Coordination of health care services for our transitioning service members is a major area of focus in this joint strategic plan.

Force Health Protection

Protecting our forces is the primary mission of the Military Health System. As part of our Force Health Protection program, our objectives are to recruit and maintain a healthy and fit force, to prevent disease and injury, and to provide medical and rehabilitative care to those who become ill or injured. The rigorous requirements of the medical entrance physical examination and our periodic physical examinations, HIV screening, annual dental examinations, physical fitness training and testing, immunizations and regular medical record reviews ensure a healthy force.

Deploying personnel receive pre-deployment health assessments that check the individual's current health and include reviews of required immunizations and other protective medications and measures, personnel protective and medical equipment, serum (HIV) samples — preserved in the DoD Serum repository — dental readiness classification, and briefings on deployment-specific health threats and countermeasures.

We routinely deploy preventive medicine, environmental surveillance, and forward laboratory teams to support our worldwide operations. Extensive environmental assessments of staging areas and base sites are conducted before and during deployments. The Army's Center for Health Promotion and Preventive Medicine also supplies environmental sampling materials for deployed forces, and develops pocket-sized "staying healthy" guide books for deployed service members.

Our post-deployment health assessments gather information from deployed service members to help medical personnel evaluate health concerns or problems that may be related to the deployment. Face-to-face health assessments with licensed health care providers determine referrals for appropriate medical follow-up. Blood samples are taken within 30 days and are archived. Pre- and post-deployment health assessments and deployment health records are maintained in the individual's permanent health record, which is available to the VA upon the service member's separation from the military.

After service members return from deployments, health care focused on post-deployment problems and concerns is provided by military and VA providers using the jointly developed Post-Deployment Health Clinical Practice Guideline. The guideline provides a structure for the evaluation and management of service members, their families and veterans with deployment-related concerns. It provides health care professionals access to expert clinical support for patients with difficult symptoms and illnesses, as well as deployment-related information.

The military health care system is actively providing world class health care to those in uniform every day. We see 193 thousand active duty outpatients each week. In a typical week nearly 14 hundred of our service members are admitted to our health care facilities, and we issue them more than 2 hundred thousand prescriptions each week. Since the start of Operation Iraqi Freedom, 13 percent of those medically evacuated were for combat related injuries, and 87 percent were evacuated for disease or non-battle injuries. Irrespective of the cause of a military member's illness or injury, our focus is to provide the care needed and whenever possible, to return that person to duty.

A service member's ability to return to full duty is based on a careful health evaluation by a physician. If a member is found to be unfit for continued active duty by their attending physician, a Medical Board review process is initiated. This document is counter-signed by another specialist within the discipline of the attending physician - usually the attending physician's clinical supervisor. The service member is referred to a Physical Evaluation Board (PEB) where it is determined if the individual is fit to perform duties. If the determination is made that the individual is not fit to perform duties, he or she may be discharged from military service with or without severance pay, permanently retired with disability pay, or placed on the Temporary Disability Retirement List (TDRL) with DoD disability retired pay, or they can apply for VA disability compensation and can elect to receive that benefit.

Those placed on TDRL are periodically evaluated over a five-year period to determine if they are fit to perform duties. At each step along these medical processes, the service members are provided information about their rights and their choices.

Seamless Transition of Health Care Services

We in DoD recognize that those men and women in uniform who are our beneficiaries will become beneficiaries of the Department of Veterans Affairs. We have worked to develop systems for a smooth and seamless transition from our health care system to the VA's.

All members referred to a Physical Evaluation Board (PEB) must attend Disability Transition Assistance Program (DTAP) training. During this training, a counselor from the VA addresses the group and informs them of the benefits provided by the VA, how to file a claim with the VA and discusses how disability ratings are determined. In addition, before separation, members with disabilities are required to file or decline to file a claim with the VA for compensation, pension or hospitalization.

As an example, at the National Naval Medical Center, Bethesda, the Naval treatment facility that treated all Marine Corps casualties from Operation Iraqi Freedom early in the conflict, VA counselors conduct the DTAP VA sessions in person and VA dispatches a counselor twice weekly to meet with returning casualties to explain potential benefits and initiate claims processing actions. VA counselors are full-time at Walter Reed Army Medical Center in Washington.

Active duty members voluntarily separating from the service, who have not been referred to the PEB are required to receive mandatory pre-separation counseling through the Transition Assistance Management Program (TAMP). The TAMP program is a cooperative effort between the DoD, Department of Labor and the VA. Each separating member is required to fill out a Pre-separation Counseling Checklist, which includes a requirement for the member to be briefed regarding VA benefits, including health care services available.

The process for notifying the VA when a service member is being discharged from DoD care depends on whether the member is referred to the Physical Evaluation Board (PEB) or not. For members referred to the PEB, VA notification occurs during Disability Transition Assistance Program counseling. For members not referred to the PEB, the member's separating command submits a claim package to the VA.

The Benefits Delivery at Discharge program has VA doctors actually performing separation physicals for service members, which will serve as their compensation and pension examination. Their objective is to make disability evaluation decisions and award benefits within thirty days of separation. Today there is a fully functional Veterans Benefits

Administration presence at 133 military installations in 42 states, Washington D.C., Germany and Korea.

As another new pilot program, the Army has integrated VA social workers into medical facilities to work with patients before they separate from the military.

Since 1998, the VA has had the authority to provide veterans of combat operations a two-year access period to medical care for deployment related health concerns, even without a service-connected disability, following their separation from active service.

We have already made significant progress in ensuring pertinent medical data is transferred to the VA on service members upon their separation from active duty. Through our Federal Health Information Exchange, an exemplary model of collaboration between both Departments, DoD transfers electronic health information on separating Servicemembers to the VA. Currently, DoD sends VA laboratory results, outpatient military treatment facility pharmacy data, radiology results, discharge summaries, demographic information and admission, disposition and transfer information. By the end of this year, DoD will also send allergy information and consult results. DoD has transmitted to VA more than 54 million messages of health information on 1.76 million discharged or retired service members over the last 22 months. To further strengthen DoD/VA electronic medical information exchange, while leveraging departmental systems investments, we are working with our VA counterparts to ensure the interoperability of our electronic medical records by the end of FY 2005.

New Opportunities

DoD and VA are moving forward jointly to improve the efficiency and accuracy of enrollment and eligibility information through the creation of integration points that will permit VA to access the Defense Enrollment and Eligibility Reporting System (DEERS) in real time by the end of 2005, a key objective in the President's Management Agenda. This information technology initiative will be a significant step to a seamless transition and will markedly enhance the continuity of care for our nation's veterans.

Mr. Chairman, my VA colleague, Dr. Roswell, and I, share a common vision of quality health care for our men and women serving our country, their families, and those that have served us so well in the past. DoD's concern for the well being of our servicemembers extends

beyond just their time on active duty. Cooperative efforts with the VA will provide the best possible service through improved coordination of health care services and increased efficiency to the benefit of the servicemembers, veterans and taxpayers.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN SMITH TO U.S. GENERAL ACCOUNTING OFFICE

United States General Accounting Office
Washington, DC 20548

November 24, 2003

The Honorable Christopher H. Smith
Chairman
Committee on Veterans' Affairs
House of Representatives

Subject: *Veterans Affairs: Posthearing Questions Concerning the Departments of Defense and Veterans Affairs Providing Seamless Health Care Coverage to Transitioning Veterans*

Dear Mr. Chairman:

On October 16, 2003, I testified before your Subcommittee at a hearing on *Hand-off or Fumble: Are DOD and VA Providing Seamless Health Care Coverage to Transitioning Veterans?*[1] This letter responds to your request that we provide answers to follow-up questions from the hearing. Your questions, along with my responses, follow.

1. "GAO, at the request of this Committee, has examined VA's Information Technology (IT) needs a number of times. Also, GAO has studied DOD's IT infrastructure. VA and DOD have pledged over the years to be working toward common solutions to their IT challenges, most particularly in the area of computerized patient care records and the portability of these records across the several systems involved. Yet, they soldier on separately. What are the basic problems in the view of GAO, that prevent or obstruct the accomplishment of this goal of a single patient care record that can accompany a military servicemember from active duty to veteran status?"

Answer: VA and DOD have been pursuing ways to share data in their health information systems and create electronic records since 1998, when the Government Computer-Based Patient Record (GCPR) project was initiated. GCPR was envisioned as an electronic interface that would allow physicians and other authorized users at VA, DOD, and Indian Health Service (IHS) health facilities to access data from any of the other agencies' health facilities.[2] The interface was expected to compile requested patient information in a "virtual" record that could be displayed on a user's computer screen.

[1]U.S. General Accounting Office, *Defense Health Care: DOD Needs to Improve Force Health Protection And Surveillance Processes*, GAO-04-158T (Washington, D.C.: Oct. 16, 2003).

[2]The Indian Health Service became involved in GCPR because of its expertise in population-based research and its longstanding relationship with VA in caring for the American Indian veteran population.

Since undertaking this mission, however, VA and DOD have faced considerable challenges, leading to repeated changes in the focus of their initiative and the target dates for its accomplishment. Our prior reports discussing the initiative[3] noted disappointing progress, exacerbated in large part by inadequate accountability and poor planning and oversight, which raised doubts about the departments' ability to achieve an electronic interface among their health information systems. When we reported on the initiative in September 2002,[4] VA and DOD had taken some actions aimed at strengthening their joint efforts. For example, they had clarified key roles and responsibilities for the initiative and begun executing revised near- and long-term strategies for achieving the electronic information exchange capability.

The near-term initiative—the Federal Health Information Exchange—was completed in July 2002 and enabled the one-way transfer of data from DOD's existing health care information system to a separate database that VA hospitals could access. This initiative has shown success in allowing clinicians in VA medical centers ready access to information—such as laboratory, pharmacy, and radiology records—on almost 2 million patients.

However, the departments' strategy for an envisioned longer-term, two-way exchange of clinical information is farther out on the horizon. This initiative, HealthePeople (Federal), is premised upon the departments' development of a common health information infrastructure and architecture comprising standardized data, communications, security, and high-performance health information systems. VA and DOD anticipated achieving a limited capability for two-way data exchange by the end of 2005.

Nonetheless, VA and DOD continue to face significant challenges in realizing this longer-term capability. While the departments have developed a high-level strategy for the initiative, they face the challenge of clearly articulating a common health information infrastructure and architecture to show how they intend to achieve the data exchange capability or what exactly they will be able to exchange. Such an architecture is necessary for ensuring that the departments have defined a level of detail and specificity needed to build the exchange capability, including requirements and design specifications.

In addition, critical to the two-way exchange will be completing the standardization of the clinical data that these departments plan to share. Data standardization is essential to allowing the exchange of health information from disparate systems and improving decision-making by providing health information when and where it is needed. Currently, VA and DOD face an enormous task of standardizing their health data. VA will have to migrate over 150 variations of clinical and demographic data to one standard, and DOD will have to migrate over 100 variations of clinical data to one standard. VA and DOD officials maintain that their departments, along with the Department of Health and Human Services, are actively pursuing the development and adoption of data standards. Nonetheless, they remain uncertain as to when the necessary standardization will be

[3]U.S. General Accounting Office, *Computer-Based Patient Records: Better Planning and Oversight by VA, DOD, and IHS [Indian Health Service] Would Enhance Health Data Sharing*, GAO-01-459 (Washington, D.C.: Apr. 30, 2001); *VA Information Technology: Progress Made, but Continued Management Attention Is Key to Achieving Results*, GAO-02-369T (Washington, D.C.: Mar. 13, 2002); and *VA Information Technology: Management Making Important Progress in Addressing Key Challenges* GAO-02-1054T (Washington, D.C.: Sept. 26, 2002).

[4]GAO-02-1054T.

accomplished. Without standardization, the task of sharing meaningful data is made more complex and may not prove successful.

2. "Assuming that VA and DOD actually unify their patient care record keeping, will this accomplishment solve the "seamless transition" challenge, or will the records problem be supplanted by some other new one, such as HIPAA [Health Insurance Portability and Accountability Act] or another cause, and what are your reasons for this conclusion?"

Answer: Achieving the technical capability to unify VA's and DOD's patient care records in and of itself will not ensure the seamless transition of health care data. Other issues that the departments need to address include the following:

- Reaching consensus on and implementing data standards. As we pointed out in our previous response, an essential aspect of making the data usable will be establishing data standards. Accomplishing this is particularly challenging, as consensus must be reached with clinicians and other health care providers to achieve common acceptance of the standards.

- Capturing complete and accurate medical information on service members. The departments must establish and closely adhere to a process that will ensure the complete and accurate capture of medical information of service members stored in their respective databases.[5] As noted in our testimony, DOD's database does not currently contain patient health information (such as health assessments and immunizations) for all service members.

- Ensuring privacy and security compliance. The departments will have to ensure that the exchange of medical information is compliant with privacy requirements established in the HIPAA. In addition, given the sensitivity of patient health information, the departments must ensure that adequate security is an integral feature of the data exchange capability.

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We are sending copies of this letter to the Secretary of Veterans Affairs and the Secretary of Defense and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on the GAO Web site at http://www.gao.gov. Should you or your staff have any questions on matters discussed in this letter, please contact me at (757) 552-8100. I can also be reached by e-mail at curtinn@gao.gov.

Sincerely yours,

Neal P. Curtin
Director, Operations and Readiness Issues

(350472)

[5]VA and DOD plan to implement a capability to share patient health information that will be collected in data repositories that each is implementing.

CONGRESSMAN EVANS TO U.S. GENERAL ACCOUNTING OFFICE

United States General Accounting Office
Washington, DC 20548

November 25, 2003

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans Affairs
House of Representatives

Subject: *Veterans Affairs: Post-hearing Questions Regarding the Departments of Defense and Veterans Affairs Providing Seamless Health Care Coverage to Transitioning Veterans*

Dear Mr. Evans:

On October 16, 2003, I testified before your Subcommittee's hearing on *Hand-off or Fumble: Are DOD and VA Providing Seamless Health Care Coverage to Transitioning Veterans?*[1] This letter responds to your request that we provide answers to follow-up questions from the hearing. Your questions, along with my responses, follow.

1. "Is there any reason for us to be optimistic that DOD [Department of Defense] is in better compliance with force protections and surveillance policies for Operation Iraqi Freedom than it was for Operation Enduring Freedom and Operation Joint Guardianship? Why or why not?"

Answer: We believe that strong leadership and appropriate follow-through are key to improving compliance. We are encouraged that the compliance problems we found for Operation Enduring Freedom and Operation Joint Guardian prompted the Assistant Secretary of Defense for Health Affairs and the military services' Surgeons General to promptly take a number of actions to help ensure compliance with DOD's force health protection and surveillance policies. As you know, we recommended that DOD establish an effective quality assurance program that will ensure compliance with these policies for all servicemembers.[2] In commenting on our report, the Assistant Secretary of Defense stated that his office had already established a quality assurance program for pre-deployment and post-deployment health assessments and that the services have implemented their quality assurance programs. As you know, Operation Iraqi Freedom is an ongoing operation with deployments of servicemembers who presumably are covered by the new quality assurance programs. On the basis these actions, we are optimistic that progress is

[1] See U.S. General Accounting Office: *Defense Health Care: DOD Needs to Improve Force Health Protection and Surveillance Processes*, GAO-04-158T (Washington, D.C.: Oct. 16, 2003).
[2] See U.S. General Accounting Office: *Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance*, GAO-03-1041 (Washington, D.C.: Sept. 19, 2003).

occurring. However, the extent of compliance can be determined only from an examination of servicemembers' medical records.

2. "You still believe DOD lacks data on troop locations that obviously calls into question its ability to provide effective surveillance. It won't have a system in place until 2007 at the earliest. How could that impair VA's [Department of Veterans Affairs] ability to determine presumption of service-connection and effective treatments for exposures?"

Answer: Knowing which servicemembers were at certain locations at specific times in the theater of operations is important for determining their possible exposures to chemical, biological, or environmental health hazards that DOD may know about currently or later discover. Without this exposure information, it would likely be more problematic for VA to determine a presumption of service-connection and to ascertain whether treatments are appropriate.

3. "Has anything improved since your last report on compliance with policies on force protection and surveillance?"

Answer: When we issued our May 1997 report,[3] DOD had not finalized its draft joint medical surveillance policy. DOD subsequently finalized its joint medical surveillance policy in August 1997. Although there are some methodological differences between our May 1997 and September 2003 reports, it is clear that force health protection and surveillance compliance problems continue in several areas. However, there appears to be some improvement in DOD's collection of pre-deployment blood serum samples from deploying servicemembers. Specifically, we reported, in our May 1997 report, that 9.3 percent of the 26,000 servicemembers who had deployed to Bosnia did not have a blood serum sample on file. In contrast, nearly 100 percent of our samples for deployments examined in our September 2003 report had blood serum samples on file.

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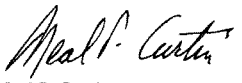
We are sending copies of this report to the Secretary of Veterans Affairs, the Office of the Secretary of Defense, and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on the GAO Web site at http://www.gao.gov.

[3] See U.S. General Accounting Office: *Defense Health Care: Medical Surveillance Improved Since Gulf War, but Mixed Results in Bosnia*, GAO/NSIAD-97-136 (Washington, D.C.: May 13, 1997).

If you have any questions about this report or need additional information, please call me at (757) 552-8100.

Sincerely yours,



Neal P. Curtin
Director, Operations and Readiness Issues

(350473)

CHAIRMAN SMITH TO DEPARTMENT OF DEFENSE

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question # 1

Question: Should the Department consolidate a list of every Service member who is separating from active duty and share that list with VA? What is DoD doing to overcome this obstacle? When might we expect to see all branches of the military routinely providing this information to VA?

Answer: The Department of Defense (DoD) currently sends the Department of Veterans Affairs (VA) a list of every Service member separating from active duty. DoD has made other significant progress in ensuring pertinent medical data is transferred to the VA when Service members separate from active duty. The Federal Health Information Exchange (FHIE) permits the transfer of electronic health information from DoD to VA at the point of a Service member's separation. This information includes: laboratory results, pharmacy data, radiology results, discharge summaries, demographic information and admission, disposition and transfer information. To date, DoD has transmitted over 56 million messages to the FHIE data repository on 1.78 million unique retired or discharged Service members.

To provide a more robust capability and institute a two-way exchange of pertinent electronic health information, DoD and VA are working on interoperability in Fiscal Year 2005 between DoD's Clinical Data Repository and VA's Health Data Repository.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question #2

Question: Your testimony informed us of a newly approved Department of Defense–Department of Veterans Affairs Joint Strategic Plan. Please provide a copy of this new plan for the hearing record. What specific objectives will this plan achieve for Service members and veterans, and what are the timelines for meeting these objectives?

The guiding principles used in the development of the Joint Strategic Plan are:

- *Collaboration* – to achieve shared goals through mutual support of both our common and unique mission requirements
- *Stewardship* – to provide the best value for our beneficiaries and the taxpayer
- *Leadership* – to establish clear policies and guidelines for VA/DoD partnership, promote active decision-making, and ensure accountability for results

The mission of the Department of Defense/Department of Veterans Affairs Joint Strategic Plan is to improve the quality, efficiency, and effectiveness of the delivery of benefits and services to veterans, Service members, military retirees and their families through an enhanced VA and DoD partnership. The vision is a world-class partnership that delivers seamless, cost-effective, quality services for beneficiaries and value to our nation.

The Joint Strategic Plan contains 6 goals and 22 objectives which are shown below. Supporting these objectives are initiatives with deliverables and target completion dates. Because there are over 60 individual initiatives, each initiative and the target completion date is not listed in this section; however, a complete copy of the Defense/Department of Veterans Affairs Joint Strategic Plan is attached and contains specific information for each objective.

[Note: Because of the file size and formatting of the Joint Strategic Plan, the Committee accepts the strategic goals detailed below as a complete response for the record.]

Strategic Goals:

Goal 1 – Leadership Commitment and Accountability – Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.

1) Formalize the VA/DoD Executive Council's governance structure.
2) Oversee the Development and Implementation of a Joint Strategic Plan.
3) Enhance internal and external communication regarding VA/DoD collaboration.

Goal 2 – High Quality Health Care – Improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities.

1) To be recognized as leaders in the development and delivery of innovative clinical processes and programs designed to enhance the quality of care delivered.
2) Actively engage in joint training and sharing of research and development.

3) Encourage continued development of sharing agreements that make the most efficient use of federal resources.

Goal 3 ~ Seamless Coordination of Benefits - Promote the coordination of benefits to improve understanding of and access to benefits and services earned by Service members and veterans through each stage of life, with a special focus on ensuring a smooth transition from active duty to veteran status.

1) Enhance collaborative efforts to educate active duty, reserve, and National Guard personnel on VA and DoD benefits programs, eligibility criteria, and application processes.
2) Provide for a seamless transition from active duty to veteran status through a streamlined benefits delivery process.
3) Provide for the seamless transfer of beneficiary data between VA and DoD to expedite all benefit and entitlement processes.

Goal 4 ~ Integrated Information Sharing - Enable the efficient sharing of beneficiary data, medical records, and other information through secure and interoperable information management systems.

1) DoD and VA will improve the interoperability of their enterprise architectures to support sharing of timely and consistent, health, personnel and business data.
2) Adopt common data standards to facilitate greater interoperability.
3) Increase the effectiveness and efficiency with which separating and separated military member data is transferred from DoD to VA.
4) Create an environment whereby personnel demographic data is shared between DoD and VA to support the delivery of services of both organizations.
5) Develop plan to share information needed by VA to support the claims adjudication process.
6) Develop and document the information technology infrastructure to support the objectives listed above, to include telecommunications interconnections and security, which include individual identification for information access, such as Public Key Infrastructure (PKI) solutions.

Goal 5 ~ Efficiency of Operations - Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

1) VA and DoD will improve coordination in planning and managing capital assets in order to enhance long-term partnering and achieve cost savings.
2) VA and DoD will improve collaboration in the acquisition of commodities and services related to health care.
3) VA and DoD will collaborate to improve the efficiency and effectiveness of financial transactions between the two Departments.
4) VA and DoD will develop methods to facilitate recruitment, retention, and potential sharing of personnel in positions critical to the Departments' complementary missions.

Goal 6 ~ Joint Contingency/Readiness Capabilities - Ensure the active participation of both agencies in Federal and local incident and consequence response through joint contingency planning, training, and exercising.

1) The Health Executive Council shall establish a Contingency Response Work Group to: (1) oversee the Departments' collaborative efforts with respect to incident and consequence management; (2) support the development of the National Response Plan through participation in existing national/federal forums; (3) review and update the VA/DoD Hospital Contingency Plan to reflect current and future requirements; (4) coordinate Departmental directives to implement DoD and VA responsibilities identified in the National Response Plan; and (5) provide semiannual reports to the Joint Executive Council on the status of joint initiatives in support of the National Response Plan.
2) Collaborate in the training and education for incident and consequence management.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question # 3

Question: What was the discharge policy in effect prior to August 12th at Walter Reed and other military treatment facilities (MTF) for separating wounded, ill, or injured patients: Has that policy changed, and if so, would you please describe the changes made?

Answer: In early October 2003 Reserve Component soldiers in a medical holdover status were living in housing conditions not equivalent to the 1+1 barracks standard established for single soldiers. Initial areas of concern centered around Ft. Stewart, Georgia, where several thousand Active Duty and Reserve Component soldiers had been mobilized and deployed to Iraq. Reserve Component soldiers who were not medically fit for deployment remained at Ft. Stewart for medical treatment and were either returned to duty or processed for discharge if they did not meet the medical requirements to stay in the military. Assistance teams from the US Army Medical Department and from the US Army Forces Command found that medical holdover soldiers had received quality healthcare equal to the active component counterpart that met the TRICARE access standards. However, the Department recognizes that medical hold soldiers living in temporary housing conditions need to receive care more quickly.

As a result, the medical leadership initiated a staffing action to implement new access standards for medical holdover soldiers which would reduce the wait time for getting appointments and treatment. The new standards will be implemented in the near future and include: 72 hours for initial specialty consultation, one week for magnetic resonance imaging, two weeks for surgery and 30 days for Medical Evaluation Board Processing. Additionally, the Army Personnel Secretariat is preparing a change to policy and mobilization orders whereby if a soldier is declared medically unfit for deployment during the first 25 days of mobilization, that soldier can be released from active duty. This will reduce the number of medical holdover soldiers in the military healthcare system.

In addition, in mid-August the Department of Veterans Affairs (DVA), in coordination with Medical Treatment Facilities, initiated an effort to streamline and expedite enrollment in the DVA healthcare system. At this same time, the DVA initiated an effort to facilitate coordination of continuing care. The DVA effort includes placement of social workers at selected MTFs (Walter Reed Army Medical Center/National Naval Medical Center) who ensure the enrollment of Service members eligible for DVA healthcare and establish medical Points of Contact (POCs) at every DVA medical facility to coordinate and schedule follow-up appointments for the separated Service members.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question # 4

Question: As we heard during the hearing, in some cases Guard and Reserve members are encouraged to return to their homes and file for disability compensation with the VA rather than seek military disability ratings. Is this a good policy, and do you intend to investigate this matter further? Are the Service members being held at Ft. Stewart exceptions to the policy, and what actions is the Department taking to relieve them from duty?

Answer: This is not consistent with DoD policy. DoD policy states that Reserve component members who are on active duty orders specifying a period of more than 30 days and who incur or aggravate an injury, illness or disease while serving on active duty shall be treated as any other active duty member in that they are to be retained on active duty until they are fit for duty or processed through the Disability Evaluation System (DES). This guidance is contained in both DoD Instruction 1241.2 - *Reserve Component Incapacitation System Management* and the *Mobilization and Demobilization Personnel and Pay Policy for Reserve Component Members Ordered to Active Duty in Response to the World Trade Center and Pentagon Attacks* issued by the Under Secretary of Defense for Personnel and Readiness on September 20, 2001.

However, both the DoD Instruction and the mobilization/demobilization policy guidance allow the member to request to be released from active duty before completing medical treatment and possible DES processing. If released, the member is then entitled to pay and allowances under section 204(g) of title 37, United States Code, and medical/dental care for the service-connected condition. This option allows the Guard or Reserve member to return to his or her home while completing medical care or awaiting DES processing. Placing a Guard or Reserve member in this status does require careful case management to ensure the member receives the required health care in a timely manner and that pay is not interrupted. Astute case management is the key to success.

While the member may file for VA disability compensation, this does not take the place of DoD's responsibility to provide care until the member is fit for duty or until the member is processed through the Department's Disability Evaluation System.

In regard to medical hold issues, all National Guard and Reserve soldiers who are on mobilization orders for 31 days or longer are processed through the Medical Evaluation Board (MEB) proceedings the same as Active Duty soldiers. Prior to the initiation of an MEB, the soldier may have undergone a series of treatments, rehabilitation, and a trial of duty which allows the physician to monitor the soldier's ability to accomplish assigned duties and perform physical activity. If after this phase the soldier is determined to not be able to perform his duties due to his medical condition, an MEB is initiated. The MEB is an informal process comprised of at least two physicians who have the responsibility of compiling, assessing, and evaluating the medical history of the soldier.

During the MEB process a physician orders a complete physical examination of the soldier and initiates the necessary consults. When the clinical information is completed, it is assembled and put into a narrative summary. A Physical Evaluation Board Liaison Officer (PEBLO) is assigned to the case and reviews all the information with the soldier and advises the soldier throughout the process. All documentation is forwarded to the Physical Evaluation Board (PEB) which evaluates and adjudicates all cases of physical disability.

Throughout the process the soldier has the right to appeal the PEB findings. After the case is adjudicated, it will be reviewed by the Physical Disability Branch (PDB). If the soldier is found unfit by the PEB and all appeals/reviews have been completed, the PDB will assign a suspense date for out processing and the soldier will begin the transition from Active Duty to civilian life. During this transition phase, the soldier will attend several briefings, one of them being a three day seminar on all of the Veteran's Benefits he is entitled to. If the soldier is disabled, there is a Disabled Transition Assistance Program (DTAP) the soldier and his family member can attend up to 180 days after separation.

There are instances when a soldier's disability rating is higher within the VA system than in the military system, but soldiers are not encouraged to wait to return home before filing for disability compensation. The PEBLO will advise and guide the soldier through the process ensuring the most equitable and fair rating is adjudicated for the soldier and the Army. Additionally, returning RC Soldiers have several options after their mobilization orders run out:

1. Request an Active Duty Medical Extension, stay with the active duty system and continue treatment.
2. Exercise their benefits under TRICARE (60 days for those with less than 6 years active duty, 120 days for those with more).
3. Exercise their benefits with the Veterans Administration.
4. Exercise their benefits under the FEDS-HEAL program.

The MEB process runs parallel to the benefits and treatment described above. The MEB process begins when a provider determines that a soldier has a condition that will likely render the soldier unfit for retention under Chapter 3 of AR 40-501. We are obligated to give the soldier time to heal, to reach Optimum Therapeutic Benefit prior to initiating a MEB. That process can take up to one year.

Access standards for the soldiers at Ft. Stewart, Georgia, who are in the medical holdover category were being met. However, due to the less than optimum living conditions, some of the soldiers felt that the process was taking too long.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question # 5

Question: In years past, DoD made the policy decision to unify its health service management under a single system of health care for the military community. What is the current state of the unification of the Army, Navy and Air Force health systems, health records, and management? Has this unification been successful, what challenges remain and have the benefits outweighed the challenges?

Answer: In April 1999, the Military Health System Information Technology Program Executive Office was established to be responsible for Tri-Service procurement, development, implementation, maintenance, and operations of information systems to support the Military Health System (MHS) worldwide. Since then, several applications have been successfully implemented worldwide. Some of these systems include the Defense Medical Logistics Standard Support System, which replaces aging Service legacy systems with one standard DoD medical logistics system; the Centralized Credentials & Quality Assurance System, which allows the military medical community to electronically manage the credentials, malpractice claims, and adverse actions of its providers and other medical support personnel; and TRICARE Online which provides increased access to care, trusted health data, and information about medical facilities and providers.

Currently the MHS is preparing for the worldwide deployment of the Composite Health Care System II (CHCS II). CHCS II is DoD's electronic health record that will generate and maintain a comprehensive record of all health care rendered to MHS beneficiaries at any military treatment facility, enabling improved quality of care. CHCS II was created by providers for providers, allowing care givers at any of the more than 900 MHS hospitals, clinics, and dental facilities worldwide, immediate and secure access to 8.7 million beneficiary health records 24 hours 7 days a week.

Additionally, the MHS Enterprise Architecture unified the process by which the MHS aligns technology solutions with business requirements and it serves as the basis for the MHS capital investment process. This unification of acquisition and system life cycle management for Tri-Service health information technology solutions has been extremely successful. Unified processes have been established to address challenges as they arise.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question # 6

Question: If an active duty Marine was treated in an Air Force medical facility in a deployment theater: (a) Is the Marine's health care and medical information contained in a single record and which military service has the responsibility for and custody of the record or records? (b) Is the Marine's post-deployment record available to the medical detachment responsible for that Service member's continuing care when he or she returns to CONUS? (c) In summary, is the medical record and transfer of patient information "seamless" within DoD, or are there still challenges for post-deployed active duty Service members? (d) To take this question to the next step in the transition to veteran status, would a VA hospital later treating this same former Marine as a veteran have all the pertinent health records for his or her care?

Answer: Each of the Services has established procedures for managing medical records of military members from other Services. Procedures are also in place to manage health information transfer from DoD to the VA.

In the above example: (a) The Air Force would have responsibility for maintaining a single inpatient or outpatient record of the Marine's care in a deployed Air Force hospital. (b) The Air Force would be responsible for ensuring that a copy of the outpatient care or a summary of the inpatient care is provided to the Marine medical detachment in theater or the appropriate records custodian at the member's home station in CONUS. (c) The seamless medical record and transfer of medical information for post-deployed active duty Service members is challenging. These challenges will be mitigated by the full deployment of the Composite Health Care System II and the Theater Medical Information Program. (d) All pertinent DoD health records, including copies of the pre- and post-deployment health assessments that are filed in the individual's permanent medical record, are available to VA hospitals caring for former Service members. Additionally, the Federal Health Information Exchange permits the transfer of electronic health information from DoD to VA at the point of a Service member's separation. VA providers nation-wide and Veterans Benefits Administration personnel have access to this data which are being utilized in the delivery of health care and adjudication of disability claims. The DoD and VA are also working on interoperability between DoD's Clinical Data Repository and VA's Health Data Repository, to provide a more robust capability and institute a two-way exchange of electronic health information.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question # 7

Question: What is the state of your knowledge of VA coordination efforts with MTFs in CONUS today? Are you confident that VA has deployed personnel in MTFs sufficient to the need presented by our wounded returning from overseas deployments?

Answer: The Department of Veterans Affairs (DVA) deployed benefits counselors to military treatment facilities (MTFs) receiving casualties from Operation Iraqi Freedom (OIF). DVA representatives meet with each of the returning Service members while they are still inpatients. Initial reports indicate that this is an effective program to enhance communications between active duty members and the DVA.

All members referred to a Physical Evaluation Board (PEB) must attend Disability Transition Assistance Program (DTAP) training. During this training, a counselor from the VA addresses the group and informs them of the benefits provided by the VA, how to file a claim with the VA, and discusses how disability ratings are determined. In addition, before separation, members with disabilities are required to file or decline to file a claim with the VA for compensation, pension or hospitalization.

For example, at the National Naval Medical Center, Bethesda, the military treatment facility that treats almost all Marine Corps casualties from Operation Iraqi Freedom, VA counselors conduct the DTAP VA sessions in person and VA dispatches a counselor twice weekly to meet the returning casualties to explain potential benefits and initiate claims processing actions. VA counselors are full-time at Walter Reed Army Medical Center in Washington.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question # 8

Question: To date, some 6000 Service members have been injured or have become ill as a consequence of Operation Iraqi Freedom. Are you following these cases and can you assure the Committee that these Service members, some of whom are still on active duty, some of whom are Reserve and Guard, and some of whom are back in civilian life as veterans, are receiving appropriate care and services, and how do you know what you know?

Answer: As part of the re-deployment and demobilization process all returning personnel are administered an Individual Post-Deployment Health Assessment, DD Form 2796. This 4-page assessment form documents Service members' answers to 24 questions on health and exposure concerns from the current deployment. The enhanced assessment includes a face-to-face provider interaction with each Service member, a blood sample, medical records review, and prompt evaluation and appropriate referral for indicated conditions and concerns. Follow-up health care is available through military and VA providers using the jointly-developed Post-Deployment Health Clinical Practice Guideline, which has been designed specifically for addressing deployment-related health concerns.

The post-deployment health care process is managed by the DoD Deployment Health Clinical Center (DHCC) located at Walter Reed Army Medical Center. The DHCC is a "center of excellence" for post-deployment health care that provides clinical guidance, training, and tools. Processes are monitored through quality assurance programs. As of October 15, 2003, approximately 186,900 DD Forms 2796 had been received at the DHCC.

The Air Force has very clear policy and an extremely robust execution plan for addressing the health and health related concerns of Service members returning from all deployments – Operation Enduring Freedom /Operation Iraqi Freedom (OEF/OIF) included. All returning troops (Active Duty (AD) and Active Reserve Components (ARC)) are assessed, face-to-face, by a provider. The Air National Guard and Reserves have both provided additional medical assets to support the mobilization/demobilization process for unit members and for Geographically Separated Units (GSUs) and helps Service members gain access to the TRICARE system. Our numbers demonstrate that we have assessed 95% of all re-deployed members in this fashion.

Any member who identifies a health concern (that cannot be immediately addressed during this visit) is given an appointment with their Primary Care Manager (PCM). To date, 89% of personnel requesting a follow-up visit have been seen by their PCM. Additionally, at each medical encounter, Service members are asked if they believe their condition/concern is deployment related. If "yes," the condition is managed using the DoD-DVA Post Deployment Health Clinical Practice Guidelines (CPGs). The CPG assists our providers to appropriately diagnose and care for related conditions. Deployment related health visits are assigned a specific code that allows us to maintain a register of all personnel with deployment related illnesses or injuries.

Personnel with persistent or permanent conditions related to military duties, whether related to a deployment or not, are closely tracked through completion of medical evaluation boards. They are either returned to duty with routine follow-ups appropriate for their condition, or medically retired and referred to the DVA as described in question 7 above. To date there are a total of 108 members (AD and ARC) currently on medical hold/extension awaiting definitive evaluations.

Post deployment metrics are collected from each MTF on the entire post deployment health assessment process (the source of the numbers above). As a result, the USAF knows the number of personnel who re-deploy, the number who are assessed, and the number requiring further follow-up. Additionally, USAF Health Services Inspection teams routinely evaluate the post deployment process for compliance with USAF and DoD requirements.

The Navy has assigned case managers to coordinate medical services received for 777 active duty members and reservists on active duty seriously injured or seriously ill from diseases contracted in the Operation Iraqi Freedom (OIF) theater of operations. Every Naval Medicine military treatment facility (MTF) with inpatient services has at least one case manager on staff. These case managers coordinate care for patients within the local MTF and if appropriate, with referral physicians in Department of Veterans Affairs or civilian providers.

Although no directive specifically required MTFs to assign case managers to every OIF patient, active duty patients have first priority for receiving these services. Those Service members with complex conditions were assigned case managers to follow their treatment. Documentation of the medical services that active duty members receive is maintained locally in written records and is documented in electronic form in a centralized database, the Canopy Case Management System. This commercial product is also used by civilian treatment facilities and other health care organizations to track the medical services provided to beneficiaries.

The Army evacuated more than 6000 soldiers from OIF for treatment of wounds, non-battle injuries, and disease. The number 6000 does not include those soldiers hospitalized but returned to duty without leaving theater or the soldiers treated as outpatients for illness and injury.

Automated databases and routine reports allow the Army to survey the health issues requiring evacuation. The Army can look at trends and patterns and identify issues that need further study and analysis. That is what was done with the pneumonia cases last summer.

With only rare exceptions like the clustering of pneumonia cases, soldiers being evacuated from OIF have the same kinds of illnesses and diseases as soldiers here in the Continental United States. Once again, digital technology helps us look for patterns and trends. We do not have real-time surveillance yet but we are getting there.

Once the soldiers return home, the Army continues to track their status and progress through the clinical operations of Regional Medical Commands and military treatment facilities. The Army continues to follow reports of unusual occurrences and watch for trends and patterns. However, continuing to keep tabs on soldiers after they leave active duty is more difficult. The transitional benefits offered by TRICARE are helpful as well as our working relationship with the DVA.

This assists the Army in keeping track of clinical issues that surface after redeployment and release from active duty. The ultimate solution is the electronic digital patient record that follows the patient from active duty to the DVA's system.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question # 9

Question: The "Joint Executive Council" (JEC) that promotes VA/DoD health resources sharing, is an excellent venue for exploring ways to avoid the breakdowns that the Jason Stiffler and Vanessa Turner cases represent. How is DoD using the JEC to deal with bringing a permanent seamless transition into existence? Has the JEC asked the Secretary of HHS to make DoD and VA treatment records a part of one system for HIPAA purposes?

Answer: The Department of Defense/Department of Veterans Affairs Joint Strategic Plan was developed by the Joint Strategic Planning Steering Committee which directly reports to the Joint Executive Council, co-chaired by the Under Secretary of Defense (Personnel and Readiness) and the Deputy Secretary of the VA. Department of Defense/Department of Veteran Affairs health resources sharing and the creation a seamless transition from active to veteran status are important components of the Joint Strategic Plan.

Initiatives contained within the Joint Strategic Plan have been assigned to the Health Executive Council and the Benefits Executive Council that report directly to the Joint Executive Council. Progress on initiatives are tracked through these two sub-councils and reported quarterly to the Joint Executive Council.

In reference to requesting that the Department of Health and Human Services make the Department of Defense and Department of Veterans Affairs treatment records a part of one system for HIPPA purposes, the Department of Defense believes the Department of Defense and Department of Veterans Affairs can achieve the appropriate sharing of protected health information within the guidelines of the current regulations.

The Health and Human Services *Health Insurance Portability and Accountability Act* Privacy Rule has a specific exception authorizing one-way sharing of health data at the time of a Service members' separation. This supports the "seamless transition to veteran status." Also, with respect to any dually-eligible beneficiary (e.g., veteran/retiree), the Rule allows the sharing of medical information among providers who have a treatment relationship with the patient. These provisions permit the needed sharing of protected health information.

The Health and Human Services Privacy Rule prohibits different health systems from sharing private medical information without patient authorization based solely on the *possibility* that the patient might use the other system. Only a small fraction of the Department of Defense/Department of Veterans Affairs total populations receives care in both Department of Defense and Department of Veterans Affairs facilities.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question # 10

Question: In May of 2001, President Bush established a Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF), particularly looking at ways to improve coordination and cooperation between the DoD and VA. The PTF's final report, delivered to the President in May of this year, included a chapter entitled "Providing a Seamless Transition to Veterans Status," which included seven specific recommendations for improvement. Please update the Committee on your progress in implementing each of these recommendations.

PTF Recommendation 3.1

VA and DoD should develop and deploy by Fiscal Year 2005 electronic medical records that are interoperable, bi-directional, and standards-based.

Department of Defense Response – The Department of Defense strongly supports the need for appropriate sharing of electronic health information between the two Departments. Through the Federal Health Information Exchange, an exemplary model of collaboration between both Departments, the Department of Defense transfers to the Department of Veterans Affairs electronic health information at the point of a Service member's separation. Currently the Department of Defense sends the Department of Veterans Affairs laboratory results, outpatient military treatment facility pharmacy data, radiology results, discharge summaries, demographic information, allergy information, consult results, and admission, disposition and transfer information. In the 2nd Quarter Fiscal Year 2004, Department of Defense will also send pharmacy information from the Department's mail order and retail pharmacy programs and selected elements of the Standard Ambulatory Data Record, such as diagnosis codes, primary care manager, and treatment provider. To date, the Department of Defense has transmitted to the Department of Veterans Affairs 54 million messages of health data on 1.76 million discharged or retired Service members.

To further strengthen joint electronic medical information exchange, while leveraging departmental systems investments, the Department of Defense is working with the Department of Veterans Affairs to ensure the interoperability of our electronic medical records by the end of Fiscal Year 2005. A chartered senior management joint work group is developing an implementation plan with milestones to support this two-way electronic medical information exchange. The Department of Defense is firmly committed to achieving this goal. It will be a significant step to a seamless transition and will markedly enhance the continuity of care to our nation's veterans.

PTF Recommendation 3.2

The Administration should direct HHS to declare the two Departments to be a single health care system for purposes of implementing HIPPA regulations.

Department of Defense Response – The Department of Defense believes the Department of Defense and Department of Veterans Affairs can achieve the appropriate sharing of protected health information within the guidelines of the current regulations.

The Health and Human Services *Health Insurance Portability and Accountability Act* Privacy Rule has a specific exception authorizing one-way sharing of health data at the time of a Service members' separation. This supports the "seamless transition to veteran status." Also, with respect to any dually-eligible beneficiary (e.g., veteran/retiree), the Rule allows the sharing of medical information among providers who have a treatment relationship with the patient. These provisions permit the needed sharing of protected health information.

The Health and Human Services Privacy Rule prohibits different health systems from sharing private medical information without patient authorization based solely on the *possibility* that the patient might use the other system. Only a small fraction of the Department of Defense/Department of Veterans Affairs total populations receives care in both Department of Defense and Department of Veterans Affairs facilities.

PTF Recommendation 3.3

The Departments should implement by Fiscal Year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process. Upon separation, DoD should transmit an electronic DD214 to VA.

Department of Defense Response – The Department agrees with the need to establish a single separation physical. Goal 3 of the Department of Defense/Department of Veterans Affairs Joint Strategic Plan clearly sets target dates and states actions to accomplish design and implementation of the single separation physical. Goal 3 also addresses actions and target dates for seamless transfer of beneficiary "data" that should encompass paper, and current and future electronic transfer of the necessary information to validate eligibility for various kinds of benefits and entitlements.

The Department of Defense and Department of Veterans Affairs are currently testing an advanced technological demonstration project between the Defense Personnel Records Image Retrieval System and Department of Veterans Affairs Personnel Information Exchange System that transfers images of paper personnel documents to the Department of Veterans Affairs from official military personnel file repositories in the Army, Navy, and Marine Corps, with Air Force integration into the program in process. This includes the DD214, the most often requested personnel document. The DD Form 214, Report of Separation, is filed in the Official Military Personnel File. This document includes the veteran's complete name used while in service, service number or social security number, branch of service, and dates of service. When fully operational, this system will send digital images of any personnel record documentation to the

Department of Veterans Affairs within 48 hours of the request. The demonstration project is currently sending these images in much shorter time, and the Department may be able to compress the time for the performance parameter to 24 hours or less after testing is complete.

The Department of Defense is also building the Defense Integrated Military Human Resources System. It will be operational in the Army in 2005 and operational for all Services in 2007. When fully operational in 2007, this system will provide for electronic transfer of current personnel data to the Department of Veterans Affairs and other authorized users almost instantaneously.

The Defense Manpower Data Center is also collaborating with Department of Veterans Affairs to provide for a bi-directional feed between the Department of Veterans Affairs and Defense Enrollment Eligibility Reporting System repositories. In addition the Joint Strategic Plan states the Department's intent to enhance existing systems for exchanging military separation data.

To require the Department of Defense to develop and field a new system solely for electronic transfer of the DD214 would deflect much needed funding and emphasis from these other initiatives, one of which is already exchanging critical information with the Department of Veterans Affairs.

PTF Recommendation 3.4

VA and DoD should expand the one-stop shopping process to facilitate a more effective seamless transition to veteran status. This process should provide, at a minimum: 1) a standard discharge examination suitable to document conditions that might indicate a compensation condition; 2) full outreach; 3) claimant counseling; and 4) when appropriate, referral for a Compensation and Pension examination and follow-up claims adjudication and rating.

Department of Defense Response – The Department of Defense supports the recommendations of the Task Force to provide a seamless transition from active duty to veteran status. Our concern for the well-being of Service members extends well beyond their time on active duty. As discussed in the previous recommendation, the need for a single separation physical has been incorporated into the Joint Strategic Plan. The Plan further addresses actions and target dates for programs that address dissemination of information, enhanced communication and education of benefit programs, eligibility criteria, and application processes.

PTF Recommendation 3.5

VA and DoD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events.

Department of Defense Response – The Department of Defense and Department of Veterans Affairs have established a joint Deployment Health Working Group which has already enhanced collaboration and communication on identifying individuals who deploy, locations of

deployment, environmental exposures during deployment and illnesses or injuries occurring during deployments. The two Departments have also initiated a 20 year, prospective study of 140,000 military personnel (Millennium Cohort Study) to determine relationships of health outcomes to their military service.

PTF Recommendation 3.6

By Fiscal Year 2004, VA and DoD should initiate a process for routine sharing of each Service member's assignment history, location, occupational exposure, and injuries information.

Department of Defense Response – The Department of Defense is already providing the Department of Veterans Affairs daily information on personnel separating from active duty, which includes the assignment history, location and occupational duties through the DD 214. The Department of Defense TRICARE On Line program has the individual Service member's pre- and post-deployment health assessments and a significant portion of medical history, including illnesses and injuries.

The Defense Occupational and Environmental Health Readiness System will integrate occupational health information by providing automated support for the Military Health System Occupational Medicine, Industrial Hygiene, Environmental Health, and Hearing Conservation and Safety management communities. The Defense Occupational and Environmental Health Readiness System will interface with the Composite Health Care System II, the military's electronic medical record, capturing data on occupational exposures and transferring it to the clinical data repository. When these systems are fully operational appropriate information will be able to be shared via a two-way exchange with the Department of Veterans Affairs.

PTF Recommendation 3.7

The Departments should: 1) add an ex officio member from VA to the Armed Forces Epidemiological Board and to the DoD Safety and Occupational Health Committee; 2) implement continuous health surveillance and research programs to identify the long-term health consequences of military service in high-risk occupations, settings, or events; and 3) jointly issue an annual report on Force Health Protection, and make it available to the public.

Department of Defense Response – The Department of Defense has now established an ex officio Department of Veterans Affairs member to its Armed Forces Epidemiological Board. Additionally, the Department of Defense welcomes Department of Veterans Affairs participation on its Armed Forces Pest Management Board and the Department of Defense Safety and Occupational Health Committee and has sent a request for membership to the Department of Veterans Affairs. There is continuous health surveillance in the Department of Defense through its electronic inpatient and outpatient databases. Many recognized health outcomes today do not have a unique associated risk factor. A Force Health Protection annual report could chronicle disease rates across diagnostic codes for the Department of Defense and Department of Veterans Affairs beneficiary populations, however determining etiological cause for each diagnosis is not possible. Longitudinal studies are required over periods of years to develop an understanding of consequences of exposures. The two Departments have initiated a 20 year, prospective study of 140,000 military personnel (Millennium Cohort Study) to determine relationships of health outcomes to their military service.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Christopher H. Smith
Witness: Mr. Wyatt
Question # 11

Question: In the final report, the PTF cited a 1998 Presidential Directive establishing the "Military and Veterans Health Care Coordinating Board," which was co-chaired by the Secretaries of Defense, Veterans Affairs, and Health and Human Services. The mission of this Board was to ensure coordination among the three departments to protect the health of Service men and women. According to the PTF, the co-chairs dissolved the Board in 2002, and later an interagency leadership committee was established, which has met only sporadically and which appears to be ineffective. Why was this Board dissolved? What did it accomplish during its four years?

Answer: The President established the Persian Gulf Veterans Coordinating Board in January 1994, with the Secretaries of Defense, Health and Human Services, and Veterans Affairs as the official members. Its mission was to coordinate efforts within the three departments that were directed toward understanding, evaluating and treating the health concerns of Gulf War veterans.

On November 11, 1998, the Presidential Review Directive/NSTC-5 directed the Secretaries of Defense, Health and Human Services, and Veterans Affairs to establish the Military and Veterans Health Coordinating Board (MVHCB) to improve the Federal response to the health needs of our military, veterans and their families. The charter for the MVHCB defined the primary mission of the Board as ensuring coordination among the Departments of Veterans Affairs, Defense, and Health and Human Services on a broad range of military and veterans' health matters to achieve the nation's commitment to maintain, protect, and preserve the health of the men and women who serve in the U.S. Armed Forces. The MVHCB charter was set to expire December 31, 2000, subject to rechartering by the members. It was not rechartered.

In January 2002, DoD and DVA agreed to incorporate deployment health within the scope of activities of the Executive Council established between DoD's Health Affairs/TRICARE Management Activity and DVA's Office of the Under Secretary of Health. The DoD had taken steps during the previous three years to meet or exceed the objectives for which the MVHCB was established. The previous Office of the Special Assistant for Gulf War Illnesses was incorporated as a component of the Office of the Assistant Secretary for Health Affairs and enhanced record keeping systems in DoD were linked to the DVA to provide a process for addressing health protection, disease prevention and medical care for military forces. The DoD Centers for Deployment Health, along with the parallel and complimentary inter-Departmental National Deployment Health Centers, provided a process for continuing collaboration on issues related to deployment health, research and communication of health risks. The post-deployment health clinical practice guideline developed jointly by DoD and DVA provided a structure for aiding primary care providers in addressing the health concerns of veterans, regardless of deployment location.

The VA/DoD Health Executive Council established the Work Group on Deployment Health in October 2002. The Department of Health and Human Services and allied nation representatives are full participants in this Work Group. The VA/DoD Deployment Health Work Group has met on a monthly basis since December 2002 and established a Deployment Health Research subcommittee to ensure coordination of related research among DoD, VA and HHS. It also established a Deployment Health Risk Communication subcommittee to coordinate sharing of information provided to Service members during deployments with healthcare providers who may be evaluating health concerns subsequent to deployments. The Deployment Health Work Group also distributed a DVA/DoD brochure on VA benefits for National Guard and Reserve members. Bimonthly reports on Deployment Health Work Group activities have been provided to the VA/DoD Health Executive Council.

The MVHCB continued the VA, DoD and HHS coordination of Gulf War Illnesses related research and deployment health related research, and organized two Plenary Meetings for subject matter experts from the three departments to present current activities related to deployment health support and investigations of unexplained illnesses in Gulf War veterans. Annual reports to Congress on the status of the interagency coordinated research on Gulf War Illnesses were prepared by the DVA and submitted under the auspices of the Board. The final product was a 35-page document entitled "Health Consequences of the Gulf War -- An Ongoing Analysis" which summarized the effort and progress of the Federal government in identifying the causes of illnesses in some Gulf War veterans.

CONGRESSMAN EVANS TO DEPARTMENT OF DEFENSE

Hearing Date: October 16, 2003
Committee: House Veterans Affairs Committee
Member: Representative Evans
Witness: Secretary Rumsfeld
Question # 1

Question: VA reported that DoD sent a list of 17,000 veterans separated from service. DoD reported that about 180,000 troops have returned from combat service and may be eligible for service. Who are the 17,000 veterans for whom VA has records? Where are the records for the other 163,000 DoD says have separated from service?

Answer: The 17,000 refers to only one specific data extract to the Department of Veterans Affairs (DVA). At the request of the DVA Epidemiological Service, the DoD Defense Manpower Data Center (DMDC), started sending data monthly in September 2003. This first data feed included 17,000 personnel who had been in theater from October 1, 2002, to May 30, 2003, and had subsequently separated from active duty. The second monthly data feed done in October 2003, included data through August 2003, and the total of the records sent increased to 61,000 personnel.

With all records, there is a time lag between when personnel leave the theater and then separate from the military, and the time when this is reported to the DMDC by the Military Services and DoD Components. The VA will only receive a record from the DMDC on Service members if they have actually separated from the military – not just when they leave the theater. As each month passes more and more records will be sent to the DVA Epidemiological Service.

Besides this data feed, for the past several years, the DMDC has been providing the Veteran's Benefit Administration (VBA) a nightly electronic feed of all separations from the Defense Department. Over 400,000 records have been provided in this way. As soon as a record is reported as a separation it is sent to the VBA the same day.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Lane Evans
Witness: Mr. Wyatt
Question # 2

Question: I have heard moving stories of family members who were told they must provide their own transportation to the bedside of critically ill Service members in Germany and other locations because the military had medically retired the Service member with the expectation that he or she would not survive. The Department of Defense was therefore no longer responsible for providing transportation to the family members. What actions can DoD take to assure that when medically appropriate, immediate family can be provided transportation to critically ill Service members injured or disabled in Iraq, Afghanistan and other locations?

Answer: As stipulated, Section 411h of Title 37, United States Code, does not provide family members of active duty Service members who have been medically retired for an illness or injury because of being seriously ill, seriously injured, or in a situation of imminent death, with government-paid transportation to the medical facility. The President of the United States signed the Fiscal Year 2004 National Defense Authorization Act on November 24, 2003, and Section 632 (Transportation of Dependents to the Presence of Members of the Armed Forces Retired for Illness or Injury Incurred in Active Duty) of the Act authorizes round-trip transportation between the home of such family member(s) to the location of the medical facility in which the Service member is hospitalized at government expense. Specifically, it states (emphasis added):

"Sec. 411h. - Travel and transportation allowances: transportation of family members incident to the serious illness or injury of members

(a)

(1) Under uniform regulations prescribed by the Secretaries concerned, ***transportation*** described in subsection (c) ***may be provided for not more than two family members of a member*** described in paragraph (2) if the attending physician or surgeon and the commander or head of the military medical facility exercising control over the member determine that the presence of the family member may contribute to the member's health and welfare.

(2) A member referred to in paragraph (1) is a ***member of the uniformed services*** who -

(A) is serving on active duty is entitled to pay and allowances under section 204(g) of this title (or would be so entitled were it not for offsetting earned income described in that section), or ***is retired for the illness or injury referred to in subparagraph (B)***;

(B) ***is seriously ill, seriously injured, or in a situation of imminent death, whether or not electrical brain activity still exists or brain death is declared***; and

(C) is hospitalized in a medical facility in or outside the United States."

Hearing Date: October 16, 2003
Committee: HVAC
Member: Lane Evans
Witness: Mr. Wyatt
Question # 3

Question: What is the status of implementation of DoD's quality assurance program meant to ensure the GAO's concerns about non-compliance with force-wide protection policies?

Answer: The Assistant Secretary of Defense for Health Affairs established a quality assurance program for pre-and post-deployment health assessments. This program monitors pre- and post-deployment health assessments and blood samples being archived electronically at the Army Medical Surveillance Activity and assures that indicated referrals on the post-deployment health assessment are being conducted. Several force health protection initiatives have also recently been implemented, such as establishing an automated theater-wide health surveillance data collection and reporting system and developing DoD-wide individual medical readiness standards and reporting metrics. These initiatives will serve as the foundation of a broader more comprehensive DoD force health protection and surveillance quality assurance program, including periodic visits to military installations and periodic audits of Service-specific quality assurance activities, which will ensure compliance with DoD-wide force health protection policies, programs, and metrics.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Lane Evans
Witness: Mr. Wyatt
Question # 4

Question: How does DoD intend to ensure that its health information, including pre- and post-deployment health assessments and medical records, is readily accessible from a centralized database? Who will be accountable for its maintenance? How will this data be shared with VA?

Answer: DoD's beneficiary health information, including pre- and post-deployment health assessments and medical records, will be accessible from a centralized database with the full implementation of the Composite Health Care System II and its Clinical Data Repository (CDR). DoD (Health Affairs) will be responsible for maintaining the CDR and the Services are responsible for maintaining the quality of the data. DoD electronic health information is currently shared with the VA through the Federal Health Information Exchange (FHIE). FHIE permits the transfer of electronic health information from DoD to VA at the point of a Service member's separation. VA providers nation-wide and Veterans Benefits Administration personnel have access to this data which are being utilized in the delivery of health care and adjudication of disability claims. To provide a more robust capability and institute a two-way exchange of information, DoD and VA are working on interoperability between DoD's CDR and VA's Health Data Repository, which will be functional in Fiscal Year 2005. Currently, all pertinent DoD paper health records, including copies of the pre- and post-deployment health assessments that are filed in the individual's permanent medical record, are currently available to VA hospitals caring for former Service members.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Lane Evans
Witness: Mr. Wyatt
Question # 5

Question: Explain any impediments to allowing mobilized aid stations from routinely rolling information about in-theater health utilization into a centralized database. Are they administrative? Technological? Explain the status of the Theater Medical Information Program. What is this program intended to test? How many unique individuals are tracked?

Answer: The Theater Medical Information Program (TMIP) integrates components of various medical information systems to ensure timely and interoperable medical information support for rapid mobilization, deployment, and sustainment for theater forces. This system is supporting health care delivery of Operation Iraqi Freedom forces at numerous combat support hospitals, area support medical battalions, area support medical companies, and forward surgical teams. TMIP transmits medical data collected in theater to a central repository providing medical surveillance and command and control information to the warfighter. Electronic medical information collected in theater will be transferred to the Composite Health Care System II Central Data Repository. The placement of our Service members electronic health record in a single, centralized location will provide DoD an unprecedented opportunity to maintain a comprehensive, computer-based patient record, which will enhance the effectiveness and efficiency of military healthcare. TMIP functional capabilities include medical command and control, medical logistics assemblage management, blood management, immunization tracking, structured text clinical encounter, battle injuries, disease and non-battle injury, post-deployment surveys, and occupational health/radiation exposure. Operational testing will include TMIP's ability to transmit medical data generated at battlefield locations to a central database, track and report patient location during evacuation from theater to stateside, and also permit trend analysis. Unified processes have been established to address challenges as they arise.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Lane Evans
Witness: Mr. Wyatt
Question # 6

Question: What is DoD doing to relieve the stigmatization associated with troops seeking mental health services? How is it helping with troops who have problems after recent deployments?

Answer: Each Service has proactively addressed mental health issues by providing the full spectrum of metal health services for the continuum from pre-deployment to return from theater and reintegration back into normal routine. Key to this effort has been involvement of command leadership in the effort to make attention to mental health a priority. The Services have also emphasized education about what are expected reactions to the stresses of deployment and combat, the coping mechanisms exhibited, and resources available for those desiring or needing assistance. All efforts are made to maintain confidentiality within the confines of current statutes and policy. The Services report considerable success in identifying affected individuals early, intervening and, most importantly, being able to return Service members to their units as effective members of the combat team.

It is difficult to quantify how effective these efforts have been in reducing/removing the stigma of seeking mental health services. Measuring whether attitudes have changed and to what extent is an imprecise science, and it is too early to make any generalizations about the effectiveness of the Department's efforts. However, the combination of 1) appropriate education of our personnel; 2) command involvement and interest in stress management and early identification and treatment of those at high risk for developing problems during or after deployment; and 3) ready access to mental health services focused upon treatment and return of the Service member to full service as quickly as possible are expected to be effective in destigmatizing mental health services.

Hearing Date: October 16, 2003
Committee: HVAC
Member: Lane Evans
Witness: Mr. Wyatt
Question # 7

Question: I understand that some Air Guard and Air Force Reserve Units process members for deployment and deploy directly from the venue of their host unit. From a health care perspective, how does the DoD assure that the deployment and redeployment processes are standardized and how does DoD assure compliance by these geographically dispersed units?

Answer: Service policies direct the mobilization, deployment, and redeployment processes that are developed to meet their specific requirements. DoD policy standardizes deployment health surveillance programs that include pre-deployment and post-deployment health assessments with copies archived in the Defense Medical Surveillance System. This validates individuals' medical readiness to deploy, ensures complete immunizations and other protective measures, and addresses health concerns upon their return. Through the Assistant Secretary of Defense (Health Affairs) quality assurance program, DoD monitors the electronically archived pre- and post-deployment health assessments at the Army Medical Surveillance Activity to assure compliance and that indicated referrals on the post-deployment health assessment are being conducted.