Prepared Statement

of

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Chairman Murray, Ranking Member Burr, and members of this Committee, thank you for inviting us to testify before you today. We meet at a time of historic cooperation between the Department of Defense (DoD) and Department of Veterans Affairs (VA). Thanks to President Obama's commitment to Veterans, and to delivering the care they have earned, we have established a programmatic cohesion between our Departments that is better than ever before. More so than at any time in our nation's history, soldiers who separate from the service are greeted by more comprehensive mental and physical care; by greater opportunity for education and jobs, and by a deeper societal commitment to ensuring their welfare. Especially when you compare the experience of our troops today to the generation of heroes who returned from Vietnam, the progress we have made toward a single system of lifetime care is significant.

The accomplishments to date are the result of budget increases for the VA; the personal involvement of Secretary Gates and Secretary Shinseki, and of bureaucratic spadework at every level in both Departments.

Deputy Secretary Gould and I have the distinct honor of overseeing the support systems in place to treat our wounded, ill, and injured. We accomplish this work through the Senior Oversight Committee, which the Secretaries of Defense and Veterans Affairs established in May 2007. The Senior Oversight Committee is focused on the care of our wounded warriors as they transition from the Department of Defense to the Department of Veterans Affairs. Today I would like to update you on our efforts to improve the transfer and care of our wounded warriors, including significant advances in diagnosing and addressing traumatic brain injury and mental health issues. I would also like to brief you on our progress towards establishing an electronic health record.

The 2007 revelations regarding Walter Reed were a wakeup call for us all. In the four years since, our Departments have worked in tandem to improve policies, procedures, and legislation that impacts the care of our wounded warriors. As a result of efforts in both Departments and in Congress, we have reached important milestones in improving care for our wounded veterans. These milestones include a new disability evaluation system, improved case management, the sharing of electronic health care data, and the treatment of the signature wounds of our wars today, traumatic brain injury and post traumatic stress disorder.

Disability Evaluation System

One of our main goals has been to modernize the Disability Evaluation System, which had remained relatively unchanged for decades. The revised and improved system developed by DoD and VA, known as the Integrated Disability Evaluation System (IDES), today serves over half of the approximately 26,000 people in the system. Its wide adoption is a priority of the VA and DoD leadership.

Service members using IDES receive a single set of physical disability examinations, conducted according to VA examination protocols, with simultaneous processing by both Departments. Designing the process in this way ensures the relationship between service members and VA is established before they separate from the service, and delivers disability benefits at the earliest possible time. It also leads to more consistent evaluations and a more orderly experience for service members and their families. Under IDES, duplicative requirements and misaligned timetables are reduced or eliminated. Service members who are processed through IDES also continue to receive full pay, allowances, compensation, medical

and base support care and benefits as they prepare to transition to civilian life and VA care. This is an improvement over the legacy system, which sometimes left outgoing service members with a gap before their VA benefits began.

In short, IDES is fairer, faster, and has eliminated the "benefits gap" between DoD and VA that plagued the legacy system. By the end of this year, IDES will be completely fielded and serving people at 139 sites nationwide. As a result, DoD and VA will be able to deliver benefits more expeditiously. Today's average IDES processing time is approximately 400 days from referral to post-separation, down from 540 days. The goal of IDES is to bring processing time down under 300 days, and a tiger team is currently devising means to reduce this further.

Traumatic Brain Injury (TBI)

In the Afghanistan and Iraq campaigns, we can be thankful that advances in protective equipment and battlefield medicine allow more of our warfighters to come home to their families and a grateful nation. This also means more troops are surviving who would not have done so in past conflicts – brave men and women who will need care long after the conflicts are over. Because of the prevalence of IEDs on the battlefield, more of these warriors return not only with visible wounds, but with invisible wounds that cannot be seen and are hard to treat.

We as a department have come a long way in recognizing this reality. In 2010, the Department established the National Intrepid Center of Excellence, which is dedicated to advancing our understanding of combat related psychological health and traumatic brain injury conditions. Already, we have made significant advancements in diagnosing traumatic brain injury during the past several years, including early detection and state-of-the-art treatment for those who sustain TBI.

Today, we better understand blast dynamics, have improved the detection of biomarkers used in the diagnosis of concussion, and can make quicker and more accurate diagnoses. This in turn drives the development of new treatments. We are also helping increase awareness of the signs and symptoms of TBI and when and how to undergo an evaluation. Materials aimed at line commanders, providers, and service members themselves as well as our Online Family Caregiver Curriculum are now widely available.

One of the emerging findings from the body of research on TBI is the importance of beginning treatment early. So we are aggressively working to improve the diagnosis and treatment of TBI in-theater. Steps we have taken include deploying a rapid field assessment of mild TBI and requiring, since 2010, the comprehensive evaluation of service members who are exposed to potential concussive events.

Overall, we have made great strides in finding TBI, tracking TBI, and treating TBI. We are now working to prevent TBI through developing better protective equipment and operational procedures. And in a sign of our recognition of TBI as the signature combat injury of our times, we accord those who suffer from it and mild TBI with the oldest commendation given by our military, the Purple Heart.

Mental Health

Despite our efforts to date, a tragic number of our service members and veterans commit suicide. DoD and VA have developed a mental health strategy that ensures our suicide prevention efforts fully complement one another. We have consolidated reporting of suicide events and standardized the measure of risk and protective factors. A web-based clearinghouse

now serves as a tool for research and analysis. We have also developed new clinical guidance for depression, substance abuse, mild TBI, and co-occurring psychological disorders. Clinical tools such as the VA/DoD Major Depressive Disorder Toolkit and the Co-occurring Conditions Toolkit help providers used evidence-based approaches to treating mental and physical illness.

Because not every veteran or service member lives near a facility that can provide the needed level of care, we are exploring the use of telehealth services and establishing a network of practitioners to serve rural locations. We have developed Mobile Telehealth Units, a web-based assistance program, smart phone applications to aid in the management and treatment of PTSD, and the Virtual PTSD Experience, an immersive, interactive activity that educates users about combat-related stress.

We have long known at the Defense Department that when you enlist a serviceperson, you effectively enlist a family. And when it comes to mental health, families are a crucial link. Our efforts to support families include a 24/7 phone line, online chat, and email; online self-help tools; and inTransition, a coaching and assistance program to bridge gaps in behavioral health support during transitional periods. Many of you have seen the Sesame Workshop programs that help children cope with deployments and injured parents or read one of the 190,000 copies of "A Handbook for Family and Friends of Service Members." The mental and emotional health needs of military children are among the least attended to, but most important, aspects of our current tempo of operations.

We are also seeking to break the cycle of silence around mental health issues. Public education initiatives, including the Real Warriors Campaign, encourages service members and veterans grappling with psychological health concerns to seek treatment. The campaign's public service announcements, which reach over 1.5 million service members each week, feature

service members who have reached out, obtained care, and continue to lead productive military and civilian careers.

Advances in Case Management

We have also made significant progress in how the cases of individual veterans are managed. Thanks to legislative changes in FY2008 National Defense Authorization Act and the December 2009 Department Instruction 1300.24, non-medical care provided to wounded, ill, and injured service members has been standardized across military departments.

Today, Recovery Care Coordinators develop a comprehensive recovery plan for each service member's non-medical needs. This plan includes tracking actions and points of contact to meet the goals of the service member and his or her family. Recovery Care Coordinators then work with commanding officers and medical care providers to implement the plan. Service members with injuries of a catastrophic nature are further assisted by a Federal Recovery Coordinator. These coordinators are also assigned to severely injured and ill service members who are highly unlikely to return to duty and who will most likely be medically separated from the military.

Within DoD there are currently 146 Recovery Care Coordinators in 67 locations placed within the Army, Navy, Marines, Air Force, United States Special Operations Command and Army Reserves. The Care Coordinators who work out of these centers are hired and jointly trained by the Department and the Services' Wounded Warrior Programs. To ensure cases are managed so as to avoid duplication, we are striving to better coordinate their efforts. There also

currently are 22 Federal Recovery Coordinators at 12 medical treatment facilities and VA medical centers around the country.

Sharing Healthcare Data Electronically

One of the most promising areas of collaboration between our Departments is electronic health records. To ensure the continuity of care, health care data must be shared. At present, a number of information systems share data. The Federal Health Information Exchange provides for the one-way electronic exchange of historic healthcare information from DoD to VA for separated service members. The Bidirectional Health Information Exchange (BHIE) allows clinicians in both Departments to view health data on shared patients. The Clinical Data Repository/Health Data Repository (CHDR) enables bidirectional sharing of outpatient pharmacy and medication allergy data. The DoD and VA have created a service called the "Blue Button" that, once complete, will allow beneficiaries to safely and securely access personal health data at TRICARE Online, the Military Health System's Internet point of entry. And to support our most severely wounded and injured service members, Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Brooke Army Medical Center are providing scanned records and radiology images for patients transferring to VA Polytrauma Rehabilitation Centers in Tampa, Richmond, Palo Alto, and Minneapolis.

To work toward a true integrated electronic health record (iEHR), DoD and VA have agreed to implement a joint common platform with compatible data and services, data centers, interface standards, and presentation formats. Our joint approach will utilize commercially available components whenever possible. It will be led by a Program Executive and Deputy

Director selected by the Secretary of Defense and Secretary of Veterans Affairs and overseen by an advisory board co-chaired by the DoD Deputy Chief Management Officer and the VA Assistant Secretary for Information and Technology.

We are also working with the private sector on the Nationwide Health Information Network and the Virtual Lifetime Electronic Record. These efforts will enable the Departments to view a beneficiary's healthcare information not only from DoD and VA, but also from other participants in the network. To create a virtual healthcare record, data will be pulled from existing electronic healthcare records and exchanged using data sharing standards and standard document formats. A standard approach will not only improve the long-term viability of how information is shared between VA and DoD. It will also enable the meaningful exchange of information with other government and private sector providers. Both DoD and VA are currently executing pilots to demonstrate the value of this approach.

These various systems, while incredibly important to patient care, do not yet constitute a fully electronic health record. Such a record will contain all relevant health information from accession through end of life for all service members and veterans, improving patient outcomes while reducing cost.

As we go about this ambitious program that has such potential benefit for our service members, it is important to keep in mind the difficulty of what we are trying to accomplish. Developing large-scale IT systems is difficult for any organization, public or private. Jointly developing an interoperable system across two major federal departments is more difficult still. Secretaries Gates and Shinseki appreciate this. They remain personally involved, and have directed us to approach this project bearing several lessons in mind. To the extent that other large joint IT systems have succeeded, they have based on a common data foundation, common

service bus, and common service broker. We are closely observing these lessons and are confident they will lead to the best possible outcome.

Finally, the James A. Lovell Federal Health Care Center in North Chicago, Illinois has combined the missions of the Naval Health Clinic Great Lakes and the North Chicago VA Medical Center into a single organizational structure. This unique DoD/VA effort operates under a single line of authority, integrating management of the full spectrum of health care services. Through this effort, we are demonstrating just how compatible our two Departments' clinical processes and business rules are, which will help to enable the implementation of a joint, common electronic health record platform. In standing up this effort, the Departments developed reusable capabilities such as joint patient registration, medical single sign on with context management, and orders portability. These capabilities are in demand throughout our respective enterprises, and will be fully leveraged as we develop electronic health records**.**

Conclusion

These measures, taken together, substantially and materially affect the experience of our men and women in uniform, and the families who support them. Our work to improve the care of wounded warriors, especially as they transition from DoD to VA, is the core of our efforts to provide those who have sacrificed so much the care and benefits they are owed. I cannot overstate how far DoD has come with our VA partners in the four years since our leaderships have made working jointly a standard operating procedure.

Despite the significant achievements I have highlighted in this testimony, we should not underestimate what remains to be done as we care for a new generation of veterans who have

served under such difficult circumstances, for such sustained periods. We will continue to work with our colleagues at VA and throughout the government to do everything we can to provide our service members with the absolute best care and treatment. Taking care of our wounded, ill and injured service members is one of the highest priorities for the Department, the Service Secretaries, and the Service Chiefs. As the Secretary Gates often remarks, other than the wars themselves, we have no higher priority.

Mr. Chairman, thank you again for your support of our Wounded, Ill, and Injured Service members, Veterans and their families. I look forward to your questions.