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DOD AND VA

Preliminary Observations  
on Efforts to Improve  
Health Care and Disability  
Evaluations for Returning  
Servicemembers

Statement of John H. Pendleton, Acting Director  
Health Care

Statement of Daniel Bertoni, Director  
Education, Workforce, and Income Security





Highlights of [GAO-07-1256T](#), a testimony before the Subcommittee on National Security and Foreign Affairs, Committee on Oversight and Government Reform, House of Representatives

## Why GAO Did This Study

In February 2007, a series of Washington Post articles disclosed troublesome deficiencies in the provision of outpatient services at Walter Reed Army Medical Center, raising concerns about the care for returning servicemembers. These deficiencies included a confusing disability evaluation system and servicemembers in outpatient status for months and sometimes years without a clear understanding about their plan of care. The reported problems at Walter Reed prompted broader questions about whether the Department of Defense (DOD) as well as the Department of Veterans Affairs (VA) are fully prepared to meet the needs of returning servicemembers. In response to the deficiencies reported at Walter Reed, the Army took a number of actions and DOD formed a joint DOD-VA Senior Oversight Committee.

This statement provides information on the near-term actions being taken by the Army and the broader efforts of the Senior Oversight Committee to address longer-term systemic problems that impact health care and disability evaluations for returning servicemembers. Preliminary observations in this testimony are based largely on documents obtained from and interviews with Army officials, and DOD and VA representatives of the Senior Oversight Committee, as well as on GAO's extensive past work. We discussed the facts contained in this statement with DOD and VA.

To view the full product, including the scope and methodology, click on [GAO-07-1256T](#). For more information, contact John H. Pendleton at (202) 512-7114 or [pendletonj@gao.gov](mailto:pendletonj@gao.gov); or Daniel Bertoni, at (202) 512-7215 or [bertonid@gao.gov](mailto:bertonid@gao.gov).

## DOD AND VA

### Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers

#### What GAO Found

While efforts are under way to respond to both Army-specific and systemic problems, challenges are emerging such as staffing new initiatives. The Army and the Senior Oversight Committee have efforts under way to improve case management—a process intended to assist returning servicemembers with management of their care from initial injury through recovery. Case management is especially important for returning servicemembers who must often visit numerous therapists, providers, and specialists, resulting in differing treatment plans. The Army's approach for improving case management for its servicemembers includes developing a new organizational structure—a Warrior Transition Unit, in which each servicemember would be assigned to a team of three key staff—a physician care manager, a nurse case manager, and a squad leader. As the Army has sought to staff its Warrior Transition Units, challenges to staffing critical positions are emerging. For example, as of mid-September 2007, over half the U.S. Warrior Transition Units had significant shortfalls in one or more of these critical positions. The Senior Oversight Committee's plan to provide a continuum of care focuses on establishing recovery coordinators, which would be the main contact for a returning servicemember and his or her family. This approach is intended to complement the military services' existing case management approaches and place the recovery coordinators at a level above case managers, with emphasis on ensuring a seamless transition between DOD and VA. At the time of GAO's review, the committee was still determining how many recovery coordinators would be necessary and the population of seriously injured servicemembers they would serve.

As GAO and others have previously reported, providing timely and consistent disability decisions is a challenge for both DOD and VA. To address identified concerns, the Army has taken steps to streamline its disability evaluation process and reduce bottlenecks. The Army has also developed and conducted the first certification training for evaluation board liaisons who help servicemembers navigate the system. To address more systemic concerns, the Senior Oversight Committee is planning to pilot a joint disability evaluation system. Pilot options may incorporate variations of three key elements: (1) a single, comprehensive medical examination; (2) a single disability rating done by VA; and (3) a DOD-level evaluation board for adjudicating servicemembers' fitness for duty. DOD and VA officials hoped to begin the pilot in August 2007, but postponed implementation in order to further review options and address open questions, including those related to proposed legislation.

Fixing these long-standing and complex problems as expeditiously as possible is critical to ensuring high-quality care for returning servicemembers, and success will ultimately depend on sustained attention, systematic oversight by DOD and VA, and sufficient resources.

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as you examine issues related to the provision of care and services for our returning servicemembers. In February 2007, a series of Washington Post articles disclosed troublesome deficiencies in the provision of outpatient services at Walter Reed Army Medical Center, raising concerns about the care for returning servicemembers and conditions at Army facilities across the country. Deficiencies at Walter Reed included poor living conditions, a confusing disability evaluation system, and servicemembers in outpatient status for months and sometimes years without a clear understanding about their plan of care or the future of their military service.

The reported problems at Walter Reed prompted broader questions about whether the Department of Defense (DOD) as well as the Department of Veterans Affairs (VA) are fully prepared to meet the needs of the increasing number of returning servicemembers as well as veterans. Several review groups were tasked with investigating the reported problems and identifying recommendations. In February 2007, the Secretary of Defense established the Independent Review Group, which reported its findings in April 2007.<sup>1</sup> In March 2007, the President established both the Task Force on Returning Global War on Terror Heroes and the President's Commission on Care for America's Returning Wounded Warriors, commonly referred to as the Dole-Shalala Commission. The Task Force reported its findings in April 2007<sup>2</sup> and the Dole-Shalala Commission reported its findings in July 2007.<sup>3</sup> In August 2007, the President announced that he had directed the Secretaries of DOD and VA to study and implement the recommendations made by the Dole-Shalala Commission. See appendix I for a summary of selected findings from each of the review groups.

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<sup>1</sup>Independent Review Group, *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (Arlington, Va., April 2007).

<sup>2</sup>Task Force on Returning Global War on Terror Heroes, *Report to the President* (April 2007).

<sup>3</sup>President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify* (July 2007).

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The three review groups identified common areas of concern, including inadequate case management to ensure continuity of care;<sup>4</sup> confusing disability evaluation systems; the need to better understand and diagnose traumatic brain injury (TBI) or post-traumatic stress disorder (PTSD),<sup>5</sup> sometimes referred to as “invisible injuries;” and insufficient data sharing between DOD and VA of servicemembers’ medical records. Problems in these areas have been long-standing and the subject of much past work by GAO.<sup>6</sup> For example, we have reported that major disability programs, including the VA’s disability programs, are neither well aligned with the 21st century environment nor positioned to provide meaningful and timely support.<sup>7</sup> Specifically, challenges exist related to ensuring timely provision of services and benefits as well as interpreting complex eligibility requirements, among other things. In January 2003, we designated modernizing federal disability programs as a high-risk area.<sup>8</sup>

In response to Walter Reed deficiencies reported by the media, the Army took several actions, most notably initiating the development of the Army Medical Action Plan in March 2007. The plan, designed to help the Army become more patient-focused, includes more than 150 tasks for establishing a continuum of care and services, optimizing the Army Physical Disability Evaluation System, and maximizing coordination of efforts with VA. According to the Army, most of the tasks in the Medical Action Plan are to be completed by January 2008.

In May 2007, DOD established the Wounded, Ill, and Injured Senior Oversight Committee (Senior Oversight Committee) to bring high-level attention to addressing the problems associated with the care and services for returning servicemembers, including the concerns that were being raised by the various review groups. The committee is co-chaired by the Deputy Secretaries of Defense and Veterans Affairs, and also includes the

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<sup>4</sup>Case management is a process for guiding a patient’s care from one provider, agency, organizational program, or service to another.

<sup>5</sup>TBI is an injury caused by a blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. PTSD is an anxiety disorder that can develop after exposure to a traumatic ordeal in which physical harm occurred or was threatened.

<sup>6</sup>See the end of this statement for a list of related GAO products.

<sup>7</sup>GAO, *Federal Disability Assistance: Wide Array of Programs Needs to be Examined in Light of 21st Century Challenges*, [GAO-05-626](#) (Washington, D.C.: June 2, 2005).

<sup>8</sup>GAO, *High-Risk Series: An Update*, [GAO-07-310](#) (Washington, D.C.: January 2007).

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military service Secretaries and other high-ranking officials within DOD and VA. To conduct its work, the Senior Oversight Committee has established workgroups that have focused on specific areas including case management, disability evaluation systems, TBI and psychological health, including PTSD, and data sharing between DOD and VA.<sup>9</sup> Each workgroup includes representation from DOD, including each of the military services, and VA. The workgroups report their efforts and recommendations to the Senior Oversight Committee, which directs the appropriate components of DOD and VA to act. The Senior Oversight Committee was established for a 12-month time frame, which will end in May 2008.

Today, our remarks are based on preliminary observations drawn from our ongoing reviews as well as extensive past work. Our statement addresses the near-term actions being taken by the Army, as well as the broader efforts of the Senior Oversight Committee to address longer-term systemic problems that affect care for returning servicemembers, in the following four areas: case management, disability evaluation systems, TBI and PTSD, and data sharing between DOD and VA. We focused on efforts of the Army because it has the majority of servicemembers in Operation Iraqi Freedom and Operation Enduring Freedom, and, as a result the majority of returning servicemembers needing care and rehabilitation go to Army facilities. We also focused on the efforts of the Senior Oversight Committee because it was specifically established to address concerns about the care and services provided to returning servicemembers. Our testimony is based largely on documents obtained from and interviews with Army officials, including the Army's Office of the Surgeon General, and DOD and VA representatives of the Senior Oversight Committee. Specifically, we reviewed Army's staffing data related to the initiatives established in the Army Medical Action Plan. We did not verify the accuracy of these data; however, we interviewed agency officials knowledgeable about the data, and we determined that they were sufficiently reliable for the purposes of this statement. We visited Walter Reed Army Medical Center in August 2007 to talk with officials about how they are implementing the Army's Medical Action Plan and to obtain views from servicemembers about how the efforts are affecting their care. Our findings are preliminary and it was beyond the scope of our work for this statement to review the efforts under way in other military services or throughout DOD and VA. We discussed the facts contained in this

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<sup>9</sup>Additional workgroups are examining the condition of DOD and VA facilities as well as issues about personnel, pay, and financial support systems, among others.

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statement with DOD and VA, and we incorporated their comments where appropriate. We are conducting the work we began in June in accordance with generally accepted government auditing standards.

In summary, the Army took near-term actions to respond to reported deficiencies about the care and services provided to its returning servicemembers, and the Senior Oversight Committee is undertaking efforts to address more systemic problems. However, challenges remain to overcome long-standing problems and ensure sustainable progress in the four areas we reviewed: (1) case management, (2) disability evaluation systems, (3) TBI and PTSD, and (4) data sharing between DOD and VA.

- **Case management:** The Army has developed a new organizational structure—Warrior Transition Units—for providing an integrated continuum of care for its returning servicemembers. Within each unit, a servicemember is assigned to a team of three critical staff—physician, nurse case manager, and squad leader—who manage the servicemember’s care. As of mid-September, 17 of the 32 units had less than 50 percent of staff in place in one or more of these critical positions. To facilitate continuity of care across departments, the Senior Oversight Committee is developing a plan to establish recovery coordinators to oversee the care of severely injured servicemembers across federal agencies, including DOD and VA. This action is being taken to address a recommendation by the Dole-Shalala Commission. Although initial implementation is slated for mid-October 2007, as of mid-September, the committee had not determined how many federal recovery coordinators will be needed. This is partly because it is still unclear exactly what portion of returning servicemembers these recovery coordinators will serve.
- **Disability evaluation systems:** The Army is pursuing several initiatives to help streamline the disability evaluation process for its servicemembers—for example, by reducing the caseloads of staff who help servicemembers navigate the system—and has taken steps to help mitigate servicemembers’ confusion, such as providing additional briefings about the process and an online tool. To address more systemic concerns about the timeliness and consistency of DOD’s and VA’s disability evaluation systems, the Senior Oversight Committee is planning to pilot a joint DOD/VA disability evaluation system that may include variations of three elements: (1) a single, comprehensive medical examination; (2) a single disability rating performed by VA; and (3) a DOD-level retention board for adjudicating servicemembers’ fitness for duty. The departments initially slated the pilot to begin on August 1, 2007, but the date has slipped as DOD and VA continue to review pilot options and take steps to address

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key questions including those related to emerging legislative proposals and long-standing challenges.

- **TBI and PTSD:** To improve the care provided to servicemembers with TBI and PTSD, both the Army and the Senior Oversight Committee have efforts under way to improve screening, diagnosis, and treatment of these conditions. As part of the Army Medical Action Plan, the Army has established policies to provide training on mild TBI and PTSD to all its nurse case managers and psychiatric nurses, among others. As of September 13, 2007, 6 of the Army's 32 Warrior Transition Units had completed training for all of these staff. The Senior Oversight Committee has developed a policy for DOD and VA to establish a national Center of Excellence for TBI and PTSD that will coordinate the efforts of the two departments related to promoting research, awareness, and best practices on these conditions.
- **Data sharing:** DOD and VA have been working for almost 10 years to facilitate the exchange of medical information. The Army has service-specific efforts under way to improve the sharing of data between its military treatment facilities and VA. Also, the Senior Oversight Committee has developed a workgroup to accelerate data-sharing efforts between the two departments and to help provide for the data-sharing needs of other efforts being overseen by the Senior Oversight Committee. The need for DOD and VA to share patient data continues to be critical. For example, data sharing is important to the proposed recovery coordinators who will require timely and reliable patient information to ensure continuity of care across the many organizational seams in DOD and VA.

Given the importance of all these issues for providing appropriate and high-quality care to our returning servicemembers, it is critical for top leaders at DOD and VA to continue to implement as well as to oversee these efforts to ensure the goals of the efforts are achieved in a timely manner, particularly since there is an increasing need to provide care to servicemembers.

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## Background

DOD and VA offer health care benefits to active duty servicemembers and veterans, among others. Under DOD's health care system, eligible beneficiaries may receive care from military treatment facilities or from civilian providers. Military treatment facilities are individually managed by

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each of the military services—the Army, the Navy,<sup>10</sup> and the Air Force. Under VA, eligible beneficiaries may obtain care through VA’s integrated health care system of hospitals, ambulatory clinics, nursing homes, residential rehabilitation treatment programs, and readjustment counseling centers. VA has organized its health care facilities into a polytrauma system of care<sup>11</sup> that helps address the medical needs of returning servicemembers and veterans, in particular those who have an injury to more than one part of the body or organ system that results in functional disability and physical, cognitive, psychosocial, or psychological impairment. Persons with polytraumatic injuries may have injuries or conditions such as TBI, amputations, fractures, and burns.

Over the past 6 years, DOD has designated over 29,000 servicemembers involved in Operation Iraqi Freedom and Operation Enduring Freedom as wounded in action, and almost 70 percent of these servicemembers are from the Army active, reserve, and national guard components. Servicemembers injured in these conflicts are surviving injuries that would have been fatal in past conflicts, due, in part, to advanced protective equipment and medical treatment. The severity of their injuries can result in a lengthy transition from patient back to duty, or to veterans’ status. Initially, most seriously injured servicemembers from these conflicts, including activated National Guard and Reserve members, are evacuated to Landstuhl Regional Medical Center in Germany for treatment. From there, they are usually transported to military treatment facilities in the United States, with most of the seriously injured admitted to Walter Reed Army Medical Center or the National Naval Medical Center. According to DOD officials, once they are stabilized and discharged from the hospital, servicemembers may relocate closer to their homes or military bases and are treated as outpatients by the closest military or VA facility.

Returning injured servicemembers must potentially navigate two different disability evaluation systems that generally rely on the same criteria but for different purposes. DOD’s system serves a personnel management purpose by identifying servicemembers who are no longer medically fit for duty. The military’s process starts with identification of a medical condition that could render the servicemember unfit for duty, a process that could take months to complete. The servicemember goes through a

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<sup>10</sup>The Navy is responsible for the medical care of servicemembers in the Marine Corps.

<sup>11</sup>The system is composed of categories of medical facilities that offer varying levels of services.



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medical evaluation board proceeding, where medical evidence is evaluated, and potentially unfit conditions are identified. The member then goes through a physical evaluation board process, where a determination of fitness or unfitness for duty is made and, if found unfit for duty, a combined percentage rating is assigned for all unfit conditions and the servicemember is discharged from duty. The injured servicemember then receives monthly disability retirement payments if he or she meets the minimum rating and years of duty thresholds or, if not, a lump-sum severance payment.

VA provides veterans compensation for lost earning capacity due to service-connected disabilities. Although a servicemember may file a VA claim while still in the military, he or she can only obtain disability compensation from VA as a veteran. VA will evaluate all claimed conditions, whether they were evaluated by the military service or not. If the veteran is found to have one or more service-connected disabilities with a combined rating of at least 10 percent,<sup>12</sup> VA will pay monthly compensation. The veteran can claim additional benefits, for example, if a service-connected disability worsens.

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## While Efforts Are Under Way to Respond to Both Army-Specific and Systemic Problems, Challenges Are Emerging

While the Army took near-term actions to respond to reported deficiencies in care for its returning servicemembers, and the Senior Oversight Committee is undertaking efforts to address more systemic problems, challenges remain to overcome long-standing problems and ensure sustainable progress. In particular, efforts were made to respond to problems in four key areas: (1) case management, (2) disability evaluation systems, (3) TBI and PTSD, and (4) data sharing between DOD and VA. The three review groups identified several problems in these four areas including: a need to develop more comprehensive and coordinated care and services; a need to make the disability systems more efficient; more collaboration of research and establishment of practice guidelines for TBI and PTSD; and more data sharing between DOD and VA. While efforts have been made in all four areas, challenges have emerged including staffing for the case management initiatives and transforming the disability evaluation system.

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<sup>12</sup>VA determines the degree to which veterans are disabled in 10 percent increments on a scale of 0 to 100 percent.

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## Efforts to Improve Case Management for Servicemembers Under Way, but Human Capital and Other Challenges Are Surfacing

The three review groups reporting earlier this year identified numerous problems with DOD's and VA's case management of servicemembers, including a lack of comprehensive and well-coordinated care, treatment, and services. Case management—a process intended to assist returning servicemembers with management of their clinical and nonclinical care throughout recovery, rehabilitation, and community reintegration—is important because servicemembers often receive services from numerous therapists, providers, and specialists, resulting in differing treatment plans as well as receiving prescriptions for multiple medications. One of the review groups reported that the complexity of injuries in some patients requires a coordinated method of case management to keep the care of the returning servicemember focused and goal directed, and that this type of care was not evident at Walter Reed.<sup>13</sup> The Dole-Shalala Commission recommended that recovery coordinators be appointed to craft and manage individualized recovery plans that would be used to guide the servicemembers' care. The Dole-Shalala Commission further recommended that these recovery coordinators come from outside DOD or VA, possibly from the Public Health Service, and be highly skilled and have considerable authority to be able to access resources necessary to implement the recovery plans. The Army and the Senior Oversight Committee's workgroup on case management have initiated efforts to develop case management approaches that are intended to improve the management of servicemembers' recovery process. See table 1 for selected efforts by the Army and Senior Oversight Committee to improve case management services.

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<sup>13</sup>Independent Review Group, *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (Arlington, Va.: April 2007).

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**Table 1: Selected Army and Senior Oversight Committee Efforts to Improve Case Management**

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**U.S. Army**

- Established a new organizational structure for providing care to returning servicemembers that combines active duty and reserve servicemembers who are in outpatient status.
- Established a case management approach that includes a primary care physician, nurse case manager, and military squad leader who will coordinate the management of a servicemember's recovery process.

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**Senior Oversight Committee**

- Developed policy requiring DOD and VA to establish a joint Recovery Coordinator Program no later than October 15, 2007, to integrate care and service delivery for returning servicemembers and their families. The recovery coordinators are to be provided by VA.
- Mapped the case management process across the military services and developed common roles and responsibilities for case managers for an integrated DOD and VA approach and joint standards of practice and training.
- Planning to develop DOD/VA oversight metrics to ensure accountability and continuous process improvement.

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Sources: Army and Senior Oversight Committee.

The Army's approach includes developing a new organizational structure for providing care to returning active duty and reserve servicemembers who are unable to perform their duties and are in need of health care—this structure is referred to as a Warrior Transition Unit. Within each unit, the servicemember is assigned to a team of three key staff and this team is responsible for overseeing the continuum of care for the servicemember.<sup>14</sup> The Army refers to this team as a “triad,” and it consists of a (1) primary care manager—usually a physician who provides primary oversight and continuity of health care and ensures the quality of the servicemember's care; (2) nurse case manager—usually a registered nurse who plans, implements, coordinates, monitors, and evaluates options and services to meet the servicemember's needs; and (3) squad leader—a noncommissioned officer who links the servicemember to the chain of command, builds a relationship with the servicemember, and works along side the other parts of the triad to ensure the needs of the servicemember and his or her family are met. As part of the Army's Medical Action Plan, the Army established 32 Warrior Transition Units, to provide a unit in every medical treatment facility that has 35 or more eligible

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<sup>14</sup>The Warrior Transition Unit also includes other staff, such as human resources and financial management specialists.

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servicemembers.<sup>15</sup> The Army's goal is to fill the triad positions according to the following ratios: 1:200 for primary care managers; 1:18 for nurse case managers; and 1:12 for squad leaders. This approach is a marked departure for the Army. Prior to the creation of the Warrior Transition Units, the Army separated active and reserve component soldiers into different units.<sup>16</sup> One review group reported that this approach contributed to discontent about which group received better treatment.<sup>17</sup> Moreover, the Army did not have formalized staffing structures nor did it routinely track patient-care ratios, which the Independent Review Group reported contributed to the Army's inability to adequately oversee its program or identify gaps.

As the Army has sought to fill its Warrior Transition Units, challenges to staffing key positions are emerging. For example, many locations have significant shortfalls in registered nurse case managers and non-commissioned officer squad leaders. As shown in figure 1, about half of the total required staffing needs of the Warrior Transition Units had been met across the Army by mid-September 2007. However, the Army had filled many of these slots thus far by temporarily borrowing staff from other positions.

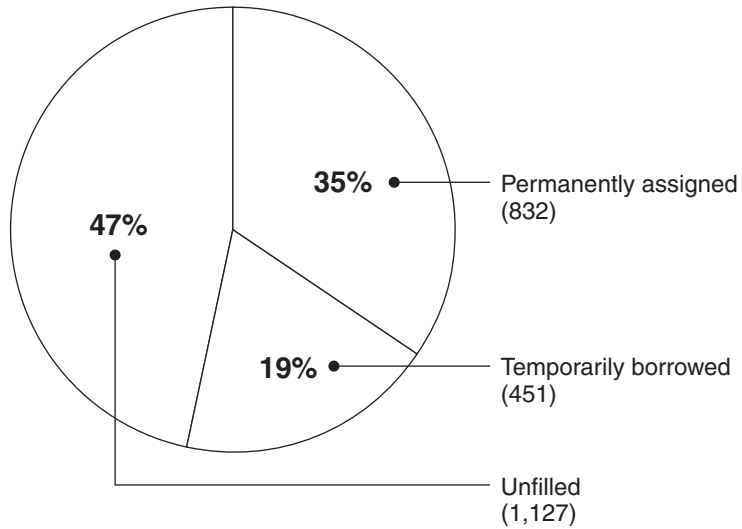
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<sup>15</sup>The Army also established three Warrior Transition Units in Germany.

<sup>16</sup>Active-duty servicemembers were typically placed in Medical Hold units, while Reserve and National Guard servicemembers were placed into separate Medical Holdover units.

<sup>17</sup>Independent Review Group, *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center*.

**Figure 1: Status of Warrior Transition Unit Staffing, as of September 13, 2007**



Source: GAO analysis of Army data.

Note: Percentages do not add to 100 percent due to rounding.

The Warrior Transition Unit staffing shortages are significant at many locations. As of mid-September, 17 of the 32 units had less than 50 percent of staff in place in one or more critical positions. (See table 2.) Consequently, 46 percent of the Army's returning servicemembers who were eligible to be assigned to a unit had not been assigned, due in part to these staffing shortages. As a result, these servicemembers' care was not being coordinated through the triad. Army officials reported that their goal is to have all Warrior Transition Units in place and fully staffed by January 2008.

**Table 2: Locations Where Warrior Transition Units Had Less Than 50 Percent of Staff in Place in One or More Critical Positions, as of September 13, 2007**

Location	Total number of servicemembers at location <sup>a</sup>	Critical positions		
		Physicians	Nurse case managers	Squad leaders
Fort Hood, Texas	743		x	x
Fort Lewis, Washington	617	x	x	
Fort Bragg, North Carolina	586		x	
Fort Gordon, Georgia	546	x		x
Fort Knox, Kentucky	430			x
Fort Carson, Colorado	394	x	x	x
Fort Campbell, Kentucky	328			x
Tripler, Hawaii	237			x
Fort Stewart, Georgia	223		x	
Fort Riley, Kansas	209		x	x
Fort Eustis, Virginia	128			x
Fort Sill, Oklahoma	127			x
West Point, New York	99			x
Fort Leonard Wood, Missouri	78			x
Fort Wainwright, Alaska	51		x	
Fort Jackson, South Carolina	45		x	x
Redstone Arsenal, Alabama	4	N/A <sup>b</sup>	N/A <sup>b</sup>	x

Source: GAO analysis of Army data.

Note: Warrior Transition Units also include other positions, such as social workers, occupational therapists, and administrative staff.

<sup>a</sup>Total number of servicemembers includes those in outpatient care—assigned to a Warrior Transition Unit as well as in the Medical Evaluation Board process and who have not been assigned to a Warrior Transition Unit.

<sup>b</sup>No staff were authorized for this position.

The Senior Oversight Committee’s approach for providing a continuum of care includes establishment of recovery coordinators and recovery plans, as recommended by the Dole-Shalala Commission. This approach is intended to complement the military services’ existing case management approaches and place the recovery coordinators at a level above case managers, with emphasis on ensuring a seamless transition between DOD and VA. The recovery coordinator is expected to be the patient’s and family’s single point of contact for making sure each servicemember receives the care outlined in the servicemember’s recovery plan—a plan to

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guide and support the servicemember through the phases of medical care, rehabilitation, and disability evaluation to community reintegration.

The Senior Oversight Committee has indicated that DOD and VA will establish a joint Recovery Coordinator Program no later than October 15, 2007. At the time of our review, the committee was determining the details of the program. For example, the Dole-Shalala Commission recommended this approach for every seriously injured servicemember, and the Senior Oversight Committee workgroup on case management was developing criteria for determining who is “seriously injured.” The workgroup was also determining the role of the recovery coordinators—how they will be assigned to servicemembers and how many are needed, which will ultimately determine what the workload for each will be. The Senior Oversight Committee has, however, indicated that the positions will be filled with VA staff. A representative of the Senior Oversight Committee told us that the recovery coordinators would not be staffed from the U.S. Public Health Service Commissioned Corps, as recommended by the Dole-Shalala Commission. The official told us that it is appropriate for VA to staff these positions because VA ultimately provides the most care for servicemembers over their lifetime. Moreover, Senior Oversight Committee officials told us that depending on how many recovery coordinators are ultimately needed, VA may face significant human capital challenges in identifying and training individuals for these positions, which are anticipated to be complex and demanding.

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## Efforts Are Under Way to Improve Disability Evaluation Processes, but Challenges Remain in Transforming the Overall System

As we have previously reported, providing timely and consistent disability decisions is a challenge for both DOD and VA. In a March 2006 report about the military disability evaluation system, we found that the services were not meeting DOD timeliness goals for processing disability cases; used different policy, guidance and processes for aspects of the system; and that neither DOD nor the services systematically evaluated the consistency of disability decisions.<sup>18</sup> On multiple occasions, we have also

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<sup>18</sup>GAO, *Military Disability System: Improved Oversight Needed to Ensure Timely and Consistent Outcomes for Reserve and Active Duty Service Members*, [GAO-06-362](#) (Washington, D.C.: Mar. 31, 2006).

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identified long-standing challenges for VA in reducing its backlog of claims and improving the accuracy and consistency of its decisions.<sup>19</sup>

The controversy over conditions at Walter Reed and the release of subsequent reports raised the visibility of problems in the military services' disability evaluation system. In a March 2007 report, the Army Inspector General identified numerous issues with the Army Physical Disability Evaluation System.<sup>20</sup> These findings included a failure to meet timeliness standards for determinations, inadequate training of staff involved in the process, and servicemember confusion about the disability rating system. Similarly, in recently-issued reports, the Task Force on Returning Global War on Terror Heroes, the Independent Review Group, and the Dole-Shalala Commission found that DOD's disability evaluation system often generates long delays in disability determinations and creates confusion among servicemembers and their families. Also, they noted significant disparities in the implementation of the disability evaluation system among the services, and in the purpose and outcome of disability evaluations between DOD and VA. Two reports also noted the adversarial nature of DOD's disability evaluation system, as servicemembers endeavor to reach a rating threshold that entitles them to lifetime benefits. In addition to these findings about current processes, the Dole-Shalala Commission questioned DOD's basic role in making disability payments to veterans and recommended that VA assume sole responsibility for disability compensation for veterans.

In response to the Army Inspector General's findings, the Army made near-term operational improvements. For example, the Army developed several initiatives to streamline its disability evaluation system and address bottlenecks. These initiatives include reducing the caseloads of evaluation board liaisons who help servicemembers navigate the disability evaluation system. In addition, the Army developed and conducted the first certification training for evaluation board liaisons. Furthermore, the Army increased outreach to servicemembers to address confusion about the process. For example, it initiated briefings conducted by evaluation board

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<sup>19</sup>For additional information on VA disability claims processing, see GAO, *Veterans' Disability Benefits: Long-Standing Claims Processing Challenges Persist*, [GAO-07-512T](#) (Washington, D.C.: Mar. 7, 2007); and GAO, *Veterans' Disability Benefits: Processing of Claims Continues to Present Challenges*, [GAO-07-562T](#) (Washington, D.C.: Mar. 13, 2007).

<sup>20</sup>Office of the Inspector General, Department of the Army, *Report on the Army Physical Disability Evaluation System*, (Washington, D.C.: Mar. 6, 2007).



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liaisons and soldiers' counsels to educate servicemembers about the process and their rights. The Army also initiated an online tool that enables servicemembers to check the status of their case during the evaluation process. We were not able to fully assess the implementation and effectiveness of these initiatives because some changes are still in process and complete data are not available.

To address more systemic concerns about the timeliness and consistency of DOD's and VA's disability evaluation systems, DOD and VA are planning to pilot a joint disability evaluation system. DOD and VA are reviewing multiple options that incorporate variations of the following three elements: (1) a single, comprehensive medical examination to be used by both DOD and VA in their disability evaluations; (2) a single disability rating performed by VA; and (3) incorporating a DOD-level evaluation board for adjudicating servicemembers' fitness for duty. For example, in one option, the DOD-level evaluation board makes fitness for duty determinations for all of the military services; whereas in another option, the services make fitness for duty determinations, and the DOD-level board adjudicates appeals of these determinations. Another open question is whether DOD or VA would conduct the comprehensive medical examination.<sup>21</sup> Table 3 summarizes four pilot options under consideration by DOD and VA.

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<sup>21</sup>On August 31, 2007, the Senior Oversight Committee directed DOD and VA to create by October 1, 2007 a single, standardized examination to be used by DOD to determine fitness for all seriously injured servicemembers and by VA to determine disability ratings, but it did not specify which agency will be responsible for conducting the examinations.

**Table 3: Summary of Pilot Options under Consideration by DOD and VA**

	<b>Comprehensive medical examination</b>	<b>Single disability rating done by VA</b>	<b>DOD-level evaluation board</b>
Option 1	Done by VA	Yes	Makes fitness determinations.
Option 2	Done by DOD	Yes	None. Services make fitness determinations.
Option 3	Done by VA	Yes	Adjudicates appeals of services' fitness determinations.
Option 4	Done by VA	Yes	Conducts quality assurance reviews of services' fitness determinations.

Source: GAO analysis of information provided by DOD.

Note: DOD and VA explored these options at pilot planning exercises conducted in August 2007, but are also considering variations of these options including combining portions of them. For example, one option may be to have DOD conduct comprehensive medical examinations and to have a DOD-level evaluation board make fitness determinations.

As recent pilot planning exercises verified, in addition to agreeing on which pilot option to implement, DOD and VA must address several key design issues before the pilot can begin. For example, it has not been decided how DOD will use VA's disability rating to determine military disability benefits for servicemembers in the pilot. In addition, DOD and VA have not finalized a set of performance metrics to assess the effect of the piloted changes. DOD and VA officials had hoped to begin the pilot on August 1, 2007, but the intended start date slipped as agency officials took steps to further consider alternatives and address other important questions related to recent and expected events that may add further complexity to the pilot development process. For example, the Senior Oversight Committee may either choose or be directed by the Congress to pilot the Dole-Shalala recommendation that only VA and not DOD provide disability payments to veterans. Implementing this recommendation would require a change to current law, and could affect whether or how the agencies implement key pilot elements under consideration. In addition, the Veterans' Disability Benefits Commission, which is scheduled to report in October 2007, may recommend changes that could also influence the pilot's structure. Further, the Congress is considering legislation that may

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require DOD and VA to conduct multiple, alternative disability evaluation pilots.<sup>22</sup>

DOD and VA face other critical challenges in creating a new disability evaluation system. For example, DOD is challenged to overcome servicemembers' distrust of a disability evaluation process perceived to be adversarial. Implementing a pilot without adequately considering alternatives or addressing critical policy and procedural details may feed that distrust because DOD and VA plan to pilot the new system with actual servicemembers. The agencies also face staffing and training challenges to conduct timely and consistent medical examinations and disability evaluations. Both the Independent Review Group and the Dole-Shalala Commission recommended that only VA establish disability ratings. However, as we noted above, VA is dealing with its own long-standing challenges in providing veterans with timely and consistent decisions.<sup>23</sup> Similarly, if VA becomes responsible for servicemembers' comprehensive physical examinations, it would face additional staffing and training challenges, at a time when it is already addressing concerns about the timeliness and quality of its examinations. Further, while having a single disability evaluation could ensure more consistent disability ratings, VA's Schedule for Rating Disabilities is outdated because it does not adequately reflect changes in factors such as labor market conditions and assistive technologies on disabled veterans' ability to work. As we have reported, the nature of work has changed in recent decades as the national economy has moved away from manufacturing-based jobs to service- and knowledge-based employment.<sup>24</sup> Yet VA's disability program remains mired in concepts from the past, particularly the concept that impairment equates to an inability to work.

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<sup>22</sup>H.R. 1538, as passed by the Senate on July 25, 2007, Sec. 154.

<sup>23</sup>To help address processing challenges, VA hired about 1,000 new disability claims processing employees since January 2007.

<sup>24</sup>GAO, *High-Risk Series: An Update*, [GAO-03-119](#) (Washington, D.C.: Jan. 1, 2003) and *SSA and VA Disability Programs: Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity*, [GAO-02-597](#) (Washington, D.C.: Aug. 9, 2002).

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## Efforts Under Way to Improve Screening, Diagnosis, and Treatment for TBI and PTSD

The three independent review groups examining the deficiencies found at Walter Reed identified a range of complex problems associated with DOD and VA's screening, diagnosis, and treatment of TBI and PTSD, signature injuries of recent conflicts. Both conditions are sometimes referred to as "invisible injuries" because outwardly the individual's appearance is just as it was before the injury or onset of symptoms. In terms of mild TBI, there may be no observable head injury and symptoms may overlap with those associated with PTSD. With respect to PTSD, there is no objective diagnostic test and its symptoms can sometimes be associated with other psychological conditions (e.g., depression). Recommendations from the review groups examining these areas included better coordination of DOD and VA research and practice guidelines and hiring and retaining qualified health professionals. However, according to Army officials and the Independent Review Group report, obtaining qualified health professionals, such as clinical psychologists, is a challenge, which is due to competition with private sector salaries and difficulty recruiting for certain geographical locations. The Dole-Shalala Commission noted that while VA is considered a leader in PTSD research and treatment, knowledge generated through research and clinical experience is not systematically disseminated to all DOD and VA providers of care. Both the Army and the Senior Oversight Committee are working to address this broad range of issues. (See table 4.)

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**Table 4: Selected Army and Senior Oversight Committee Efforts to Improve Screening, Diagnosis, and Treatment of TBI and PTSD**

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### **U.S. Army**

- Providing mild-TBI and PTSD training for social workers, nurse case managers, psychiatric nurses, and psychiatric nurse practitioners.
- Exploring ways to track incidents on the battlefield (e.g., blasts) that may result in TBI or PTSD.
- Examining procedures for screening servicemembers for mild TBI and PTSD prior to an involuntary release from the Army to ensure that servicemembers are not inappropriately separated for behavioral problems.

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### **Senior Oversight Committee**

- Developed policy requiring DOD and VA to establish a national Center of Excellence for TBI and PTSD no later than November 30, 2007.
- Establishing common educational and training materials and screening processes for mild TBI and PTSD, as well as consistent definitions for mild-TBI diagnosis.

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Sources: Army and Senior Oversight Committee.

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The Army, through its Medical Action Plan, has policies in place requiring all servicemembers sent overseas to a war zone to receive training on recognizing the symptoms of mild TBI and PTSD. The Army is also exploring ways to track events on the battlefield, such as blasts, that may result in TBI or PTSD. In addition, the Army recently developed policies to provide mild TBI and PTSD training to all social workers, nurse case managers, psychiatric nurses, and psychiatric nurse practitioners to better identify these conditions. As of September 13, 2007, 6 of the Army's 32 Warrior Transition Units had completed training for all of these staff.

A Senior Oversight Committee workgroup on TBI and PTSD is working to ensure health care providers have education and training on screening, diagnosing, and treating both mild TBI and PTSD, mainly by developing a national Center of Excellence as recommended by the three review groups.<sup>25</sup> This Center of Excellence is expected to combine experts and resources from all military services and VA to promote research, awareness, and best practices on mild TBI as well as PTSD and other psychological health issues. A representative of the Senior Oversight Committee workgroup on TBI and psychological health told us that the Center of Excellence would include the existing Defense and Veterans Brain Injury Center—a collaboration among DOD, VA, and two civilian partners that focuses on TBI treatment, research, and education.<sup>26</sup>

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## Efforts Under Way to Facilitate Data Sharing between DOD and VA

DOD and VA have been working for almost 10 years to facilitate the exchange of medical information. However, the three independent review groups identified the need for DOD and VA to further improve and accelerate efforts to share data across the departments. Specifically, the Dole-Shalala Commission indicated that DOD and VA must move quickly to get clinical and benefit data to users, including making patient data immediately viewable by any provider, allied health professional, or program administrator who needs the data. Furthermore, in July 2007, we reported that although DOD and VA have made progress in both their long-

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<sup>25</sup>VA has a national Center on PTSD that was required to be established by the Veterans' Health Care Act of 1984. This center advances the clinical care and social welfare of veterans through research, education, and training of clinicians in the causes, diagnosis, and treatment of PTSD.

<sup>26</sup>In April 2007, VA established policy requiring all Operation Iraqi Freedom and Operation Enduring Freedom veterans receiving care within the VA system to be screened for TBI. Additionally, if the screen determines that the veteran might have TBI, then the veteran must be offered further evaluation and treatment by providers with expertise in this area.

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term and short-term initiatives to share health information, much work remains to achieve the goal of a seamless transition between the two departments.<sup>27</sup> While pursuing their long-term initiative to develop a common health information system that would allow the two-way exchange of computable health data,<sup>28</sup> the two departments have also been working to share data in their existing systems. See table 5 for selected efforts under way by the Army and Senior Oversight Committee to improve data sharing between DOD and VA.

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**Table 5: Selected Army and Senior Oversight Committee Efforts to Improve DOD and VA Data Sharing**

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**U.S. Army**

- Army Medical Department is developing a memorandum of understanding regarding sharing of medical data between Army military treatment facilities and VA.

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**Senior Oversight Committee**

- Developed policy requiring DOD and VA to develop a plan to execute a single Web portal to support the care and needs of servicemembers and veterans by December 31, 2007.
- Developed data sharing policies requiring DOD and VA to (1) develop a plan for interagency sharing of essential health images, such as radiology studies, by March 31, 2008; (2) ensure that all essential health and administrative data are made available and viewable to both departments, and requiring that progress be reported by a scorecard no later than October 31, 2008.

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Sources: Army and Senior Oversight Committee.

As part of the Army Medical Action Plan, the Army has taken steps to facilitate the exchange of data between its military treatment facilities and VA. For example, the Army Medical Department is developing a memorandum of understanding between the Army and VA that would allow VA access to data on severely injured servicemembers who are being transferred to a VA polytrauma center. The memorandum of understanding would also allow VA's Veterans Health Administration and Veterans Benefits Administration access to data in a servicemember's medical record that are related to a disability claim the servicemember has filed with VA. Army officials told us that the Army's medical records are

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<sup>27</sup>GAO, *Information Technology: VA and DOD Are Making Progress in Sharing Medical Information, but Remain Far from Having Comprehensive Electronic Medical Records*, [GAO-07-1108T](#) (Washington, D.C.: July 18, 2007).

<sup>28</sup>Computable data are data in a format that a computer application can act on—for example, to provide alerts to clinicians of drug allergies.

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part paper (hard copy) and part electronic, and this effort would provide the VA access to the paper data until the capability to share the data electronically is available at all sites.<sup>29</sup>

Given that DOD and VA already have a number of efforts under way to improve data sharing between the two departments, the Senior Oversight Committee, through its data sharing workgroup, has been looking for opportunities to accelerate the departments' sharing initiatives that are already planned or in process and to identify additional data sharing requirements that have not been clearly articulated. For example, the Senior Oversight Committee has approved several policy changes in response to the Dole-Shalala Commission, one of which requires DOD and VA to ensure that all essential health and administrative data are made available and viewable to both agencies, and that progress is reported by a scorecard, by October 31, 2008. A representative of the data sharing workgroup told us that the departments are achieving incremental increases to data sharing capabilities and plan to have all essential health data—such as outpatient pharmacy, allergy, laboratory results, radiology reports, and provider notes—viewable by all DOD and VA facilities by the end of December 2007.<sup>30</sup> Although the agencies have recently experienced delays in efforts to exchange data, the representative said that the departments are on track to meet all the timelines established by the Senior Oversight Committee.

A Senior Oversight Committee workgroup on data sharing has also been coordinating with other committee workgroups on their information technology needs. Although workgroup officials told us that they have met numerous times with the case management and disability evaluation systems workgroups to discuss their data sharing needs, they have not begun implementing necessary systems because they are dependent on the other workgroups to finalize their information technology needs. For example, the Senior Oversight Committee has required DOD and VA to establish a plan for information technology support of the recovery plan to be used by recovery coordinators, which integrates essential clinical (e.g., medical care) and nonclinical aspects (e.g., education, employment, disability benefits) of recovery, no later than November 1, 2007. However,

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<sup>29</sup>Officials from Walter Reed Army Medical Center told us that Walter Reed already has the capability to share this data electronically.

<sup>30</sup>DOD facilities in combat zones may not have this capability because they operate in a different environment with different informational technology capabilities.

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this cannot be done until the case management workgroup has identified the components and information technology needs of these clinical and nonclinical aspects, and as of early September this had not been done. Data sharing workgroup representatives indicated that the departments' data sharing initiatives will be ongoing because medications, diagnoses, procedures, standards, business practices, and technology are constantly changing, but the departments expect to meet most of the data sharing needs of patients and providers by end of fiscal year 2008.

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## Concluding Observations

Our preliminary observations are that fixing the long-standing and complex problems spotlighted in the wake of Walter Reed media accounts as expeditiously as possible is critical to ensuring high-quality care for our returning servicemembers, and success will ultimately depend on sustained attention, systematic oversight by DOD and VA, and sufficient resources. Efforts thus far have been on separate but related tracks, with the Army seeking to address service-specific issues while DOD and VA are working together to address systemic problems. Many challenges remain, and critical questions remain unanswered. Among the challenges is how the efforts of the Army—which has the bulk of the returning servicemembers needing medical care—will be coordinated with the broader efforts being undertaken by DOD and VA.

The centerpiece of the Army's effort is its Medical Action Plan, and the success of the plan hinges on staffing the newly-created Warrior Transition Units. Permanently filling these slots may prove difficult, and borrowing personnel from other units has been a temporary fix but it is not a long-term solution. The Army can look to the private sector for some skills, but it must compete for personnel in a civilian market that is vying for medical professionals with similar skills and training.

Perhaps one of the most complex efforts under way is that of redesigning DOD's disability evaluation system. Delayed decisions, confusing policies, and the perception that DOD and VA disability ratings result in inequitable outcomes have eroded the credibility of the system. Thus, it is imperative that DOD and VA take prompt steps to address fundamental system weaknesses. However, as we have noted, key program design and operational policy questions must be addressed to ensure that any proposed system redesign has the best chance for success and that servicemembers and veterans receive timely, accurate, and consistent decisions. This will require careful study of potential options, a comprehensive assessment of outcome data associated with the pilot, proper metrics to gauge success, and an evaluation mechanism to ensure



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needed adjustments are made to the process along the way. Failure to properly consider alternatives or address critical policy and procedural details could exacerbate delays and confusion for servicemembers, and potentially jeopardize the system's successful transformation.

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Mr. Chairman, this completes my prepared remarks. We would be happy to respond to any questions you or other members of the subcommittee may have at this time.

For further information about this testimony, please contact John H. Pendleton at (202) 512-7114 or [pendletonj@gao.gov](mailto:pendletonj@gao.gov) or Daniel Bertoni at (202) 512-7215 or [bertonid@gao.gov](mailto:bertonid@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made major contributions to this report are listed in appendix II.

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# Appendix I: Selected Issues Identified by Three Review Groups following the Reporting of Deficiencies at Walter Reed

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In the aftermath of deficiencies identified at Walter Reed Medical Center, three separate review groups—the President’s Commission on Care for America’s Returning Wounded Warriors, commonly referred to as the Dole-Shalala Commission; the Independent Review Group, established by the Secretary of Defense; and the President’s Task Force on Returning Global War on Terror Heroes—investigated the factors that may have led to these problems. Selected findings of each report are summarized in table 6.

**Appendix I: Selected Issues Identified by  
Three Review Groups following the Reporting  
of Deficiencies at Walter Reed**

**Table 6: Selected Findings of Review Groups Reporting on Walter Reed Army Medical Center Deficiencies**

Review groups	Findings
President’s Commission on Care for America’s Returning Wounded Warriors (Dole-Shalala Commission) (July 2007)	<ul style="list-style-type: none"> <li>• A patient-centered recovery plan is needed for all seriously injured servicemembers.</li> <li>• Department of Defense’s (DOD) disability and compensation systems need to be “completely restructured.”</li> <li>• DOD and the Department of Veterans Affairs (VA) must work to aggressively prevent and treat post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) and reduce perceived stigma of both conditions.</li> <li>• Support for servicemembers’ families must be strengthened, including expanding DOD respite care and extending the Family and Medical Leave Act for up to six months for spouses and parents of the seriously injured.</li> <li>• DOD and VA should work together to quickly share clinical and administrative data with each other. A “My eBenefits” page for servicemembers should be established.</li> <li>• DOD and VA must assure that Walter Reed Army Medical Center has the clinical and administrative staff it needs, until its closure in 2011.</li> </ul>
Secretary of Defense’s Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center (April 2007)	<ul style="list-style-type: none"> <li>• Comprehensive care, treatment, and administrative services not provided to the outpatient in a collaborative manner at Walter Reed Army Medical Center.</li> <li>• Lack of clear, consistent standards for qualifications and training of outpatient case managers across the Army, Navy, and Air Force.</li> <li>• Lack of early identification techniques and comprehensive clinical practice guidelines for TBI and its overlap with PTSD, within the military health system, results in inconsistent diagnosis and treatment.</li> <li>• Serious difficulties administering the Physical Disability Evaluation System due to significant variance in policy and guidelines among the military services. The current process is cumbersome, inconsistent, and confusing to providers, patients, and families.</li> <li>• No common automated interface exists between the clinical and administrative systems within DOD and among the services, or between DOD and VA.</li> </ul>
President’s Task Force on Returning Global War on Terror Heroes (April 2007)	<ul style="list-style-type: none"> <li>• DOD’s and VA’s disability evaluation systems are confusing, time consuming, and sometimes inconsistent among the services and between DOD and VA.</li> <li>• No formal agreements for how active duty servicemembers should be managed when they receive services from both DOD and VA.</li> <li>• No agreements on definition of case management, functions of case managers, or how DOD and VA case managers should transfer patients to one another to assure continuity of care.</li> <li>• Servicemembers with mild to moderate TBI can be particularly difficult to diagnose given the lack of easily visible symptoms.</li> <li>• While VA provides a comprehensive medical benefits package for enrolled veterans, the current paper and online versions of the required paperwork for certain benefits packages do not allow for identification of Operation Enduring Freedom / Operation Iraqi Freedom veterans. Further, the online application does not provide e-authentication or e-signature capabilities thereby requiring veterans to submit signed applications and complete the entire form, including some data they have already supplied VA.</li> </ul>

Sources: President’s Commission on Care for America’s Returning Wounded Warriors, the Independent Review Group, and the President’s Task Force on Returning Global War on Terror Heroes.

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# Appendix II: GAO Contacts and Staff Acknowledgments

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## GAO Contacts

John H. Pendleton at (202) 512-7114 or [pendletonj@gao.gov](mailto:pendletonj@gao.gov) or  
Daniel Bertoni at (202) 512-7215 or [bertonid@gao.gov](mailto:bertonid@gao.gov)

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## Acknowledgment

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# Related GAO Products

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*DOD Civilian Personnel: Medical Policies for Deployed DOD Federal Civilians and Associated Compensation for Those Deployed.* [GAO-07-1235T](#). Washington, D.C.: September 18, 2007.

*Global War on Terrorism: Reported Obligations for the Department of Defense.* [GAO-07-1056R](#). Washington, D.C.: July 26, 2007.

*Information Technology: VA and DOD Are Making Progress in Sharing Medical Information, but Remain Far from Having Comprehensive Electronic Medical Records.* [GAO-07-1108T](#). Washington, D.C.: July 18, 2007.

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*Veterans' Disability Benefits: Long-Standing Claims Processing Challenges Persist.* [GAO-07-512T](#). Washington, D.C.: March 7, 2007.

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*VA and DOD Health Care: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans.* [GAO-06-794R](#). Washington, D.C.: June 30, 2006.

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*VA and DOD Health Care: VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited.* [GAO-05-1052T](#). Washington, D.C.: September 28, 2005.

*Federal Disability Assistance: Wide Array of Programs Needs to be Examined in Light of 21st Century Challenges.* [GAO-05-626](#). Washington, D.C.: June 2, 2005.

*Veterans' Disability Benefits: Claims Processing Problems Persist and Major Performance Improvements May Be Difficult.* [GAO-05-749T](#). Washington, D.C.: May 26, 2005.

*DOD and VA: Systematic Data Sharing Would Help Expedite Servicemembers' Transition to VA Services.* [GAO-05-722T](#). Washington, D.C.: May 19, 2005.

*VA Health Care: VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services.* [GAO-05-287](#). Washington, D.C.: February 14, 2005.

*VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services.* [GAO-04-1069](#). Washington, D.C.: September 20, 2004.

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