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Transition

The Commission examined the policies and processes within the Departments of Defense (DoD), Veterans Affairs (VA), Labor (DOL), Health and Human Services (HHS), and the Social Security Administration (SSA) that affect military separation or retirement. Each of these entities plays a significant role in the readjustment—or "transition"—of veterans and their families to civilian life. Transition is a complex, complicated time for many service members, especially for those with disabilities. This chapter assesses transition in relation to the roles and functions of the government and the problems and risks encountered by veterans and their families.

I Transition Philosophy

Overall, the Commission is committed to seamless transition as the goal. VA and DoD must support and encourage business practices that include joint ventures, sharing agreements, and integration. If these and other operational processes are kept at the forefront of the Departments' operations, then successful transition for the service member could be more readily attainable. Because VA and DoD have separate missions and funding processes, transition policies must be well coordinated to achieve effectiveness and efficiency. Historically, there have been barriers to collaboration between VA and DoD because the two organizations lack a stable business environment, a standard process for submitting proposals, local incentives for collaboration, and a process to address agreement risk.[1] These barriers should be fully addressed with a strong emphasis on joint management by VA and DoD.

The sharing of health care information and resources by DoD and VA would significantly benefit veterans in the transition process. This practice must encompass general and specialized care, education and training, research, and administration. VA and DoD should coordinate local and national health services through direct sharing agreements, Tricare contracts, joint contracts for

[1] President's Task Force, *Final Report,* 46.

pharmaceuticals and medical and surgical supplies, information technology collaboration, and joint facility management.[2] Existing and future joint contracts should take advantage of both Departments' economies of scale and increase their purchasing power.

In FY 2006, each Department made available $9 million for resource sharing[3] (from their combined $50 billion health care budgets.) The Commission witnessed several of these initiatives:

- In Florida, the Army Community-Based Health Care Organization allows injured or ill National Guardsmen and reservists still on active duty to receive treatment at VA or private-sector facilities closer to home.
- In Georgia, VA rehabilitation services are provided for active duty members.
- In Illinois, the Great Lakes Federal Healthcare Facility is managed by VA and the Navy.
- In Texas, resources were provided for a new primary care clinic, and in San Antonio, the Intrepid Rehabilitation Center was funded by the private sector and requires that VA and DoD jointly fund its future operations.

Local facility managers view such local approaches as the best way to get things done and want the authority to negotiate memoranda of understanding, sharing agreements, and joint ventures as independently as possible. These ventures maximize resource utilization, increase market penetration, and enhance buying power for all entities involved.

The VA/DoD Joint Executive Council (JEC) Strategic Plan and its supporting activities and task forces should develop policies which require streamlining and integrating transition services to achieve success in the following areas:

- Coordination
- Case management
- Transition Assistance Program (TAP)
- Benefits Delivery at Discharge (BDD) and separation physicals
- Information technology and record management
- Family support services
- Military severely injured
- Health care

[2] Task Force on Returning*, Report,* 24.
[3] VA/DoD, *2006 Annual Report,* 30.

If not properly addressed, service members and their families are at risk for unsuccessful transitions. Today's veterans, who have to leave Tricare, submit a claim for disability compensation, apply for other benefits, enroll at a VA hospital, and have a compensation and pension (C&P) examination, find that transition is not seamless. The challenges faced by some service members who do not successfully transition from military to civilian life could result in periods of homelessness, incarceration, unemployment, divorce, and poor mental health.

I.1 Transition Risk Issues

In spite of the fact that some of the best and the brightest serve in the Armed Forces of the United States, military separation or retirement is not without its pitfalls. Engaging in such a major life change can be difficult for the most seasoned service member, to say nothing of a disabled veteran. Recent recruits are more likely to have high school diplomas, to have scored in the 50th percentile or higher of standardized aptitude tests, to come from above-average income neighborhoods,[4] and later to be recruited by Fortune 500 companies, educators, and the federal government. Even so, there are still veterans who face the complications of improper housing, lack of support, and the inability to access information.

I.1.A Homelessness

VA offers an integrated network of services for homeless veterans. The goal of the Housing and Urban Development (HUD) Veteran Resource Center is to provide veterans and their family members with information on HUD's community-based programs and services, including reintegration and vouchers at transition. This information should be included in the transition assistance program briefings.

I.1.B Unemployment

Some veterans have faced unemployment and underemployment. U.S. unemployment rates routinely fluctuate, and veterans, like everyone else, are subject to economic vacillations. However, "the unemployment rate for all Americans is now [in 2006] 4.6 percent. Veterans are doing even better—their unemployment rate is 3.5 percent."[5] Additionally, the U.S. Office of Personnel Management reported that veterans hold 25 percent of all federal jobs.[6] Yet, there are incidences of non-compliance with veterans' preference enforcement in hiring and contracting and with civilian requirements for certification and licensure.

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[4] Beland and Gilroy, *All-Volunteer Military*, A21.
[5] Craig, *Strong Employment Numbers.*
[6] Office of Personnel Management, *Veterans Continue*.

I.1.C Mental Illness

Major contributing factors to adjustment problems for combat veterans are posttraumatic stress disorder (PTSD), depression, anxiety, and substance abuse, any of which can lead to suicide. According to post-deployment health assessments, 15 to 17 percent of Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans have screened positive for PTSD, 20 percent for depression, and 20–25 percent for alcohol abuse.[7] Chronic and delayed PTSD are especially difficult to treat and manage, placing an even greater demand for resources on the VA health care system, especially when traumatic brain injury (TBI) is also involved.

Several epidemiological studies suggest that women are more likely to develop PTSD than males, even though males are more likely to be exposed to traumatic events.[8] IOM noted that combat exposure was an even greater precipitant to the development of PTSD and that "women veterans were nine times more likely to develop PTSD if they had a history of MSA [military sexual assault]."[9] With an increasing number of women serving in Iraq and Afghanistan, women face growing chances of being exposed to combat, witnessing death, and being assaulted or wounded, all of which can lead to life-long aftereffects. Research studies, diagnostic tools, and intervention techniques, which are predominantly designed for a male cohort, need to be redesigned to suit the experiences of women veterans.

PTSD compensation rates among all service-connected disabled veterans grew by 79.5 percent between FY 1999 and 2004. While veterans being compensated for PTSD represent only 8.7 percent of all compensation recipients, they receive 20.5 percent of all compensation payments.[10] In 2006, VA treated 345,713 veterans with PTSD (including 34,000 OIF/OEF era veterans[11]), an increase of 27,099 people over 2005. As of FY 2005, 244,876 veterans were receiving compensation for PTSD.[12]

If left unaddressed, mental disorders—especially PTSD—can have a grave impact on earnings and quality of life and may result in premature death because of risk-taking behavior, violence, overdosing, and suicide. In 1999, IOM noted that increased mortality rates among Gulf War veterans attributed to accidents

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[7] Hoge, *Mental Health, PTSD.*
[8] Foa, Keane, and Friedman, Effective Treatments for PTSD, 20.
[9] Institute of Medicine, *Posttraumatic Stress Disorder*, 39-41.
[10] VA, *Review of State Variances*, vii.
[11] *DoD/VA Cooperation and Collaboration,* statement of Gordon H. Mansfield.
[12] Veterans Benefits Administration, *Fiscal Year 2005,* 32.

were similar to those of Vietnam veterans.[13] In response to reported incidents of suicide, VA instituted a comprehensive suicide prevention program and a hotline in conjunction with the National Suicide Prevention Hotline (1-800-273-TALK) in July 2007. DoD has a risk-reduction committee and Military OneSource, and the services have suicide prevention programs.

II Coordination

To minimize the risks associated with transition, VA, DoD, HHS, SSA, DOL, and other entities such as the veterans service organizations (VSOs) and state agencies have joined forces to assist with military separation and retirement. Yet the primary responsibility for service member transition falls on DoD and VA. There have been guidelines in place for VA/DoD health care resource sharing since July 1979 (38 U.S.C. § 8111).[14] Recently, greater emphasis has been placed on sharing and transition since the inception of the Global War on Terror and the advent of the Joint Executive Council.

In 2003, Public Law 108-138 required that VA and DoD create a Joint Executive Council (JEC) to enhance coordination and resource sharing between the two organizations. JEC is co-chaired by the VA Deputy Secretary and the DoD Under Secretary for Personnel and Readiness. Reporting to the JEC are the Health Executive Council (HEC) and the Benefits Executive Council (BEC) that were created to ensure that resources and expertise are specifically directed to those crucial areas.[15] "The HEC is responsible for implementing a coordinated health care resource sharing program. The BEC is responsible for examining ways to expand and improve benefits information sharing, refining the process for records retrieval, and identifying procedures to improve the benefits claims process."[16] Seamless transition has been defined by the JEC as "an approach to health care and benefits delivery whose goal is to ensure continuity of services through the coordination of benefits, with the intended result of improving the understanding of, and access to, the full continuum of benefits and services available to service members and veterans through each stage of life."[17] Each year the JEC issues an annual report outlining its activities regarding seamless transition, health care, operations, joint readiness, information technology interoperability, and joint ventures and sharing agreements.

The congressional mandate for the JEC did not include other agencies, such as DOL and the Social Security Administration (SSA), that are major players in

[13] Institute of Medicine, *Gulf War Veterans.*
[14] VA/DoD, *2005 Annual Report,* B-1.
[15] VA Office of Policy, *VA/DoD Collaboration,* 1.
[16] *DoD/VA Cooperation and Collaboration,* Statement of David S.C. Chu.
[17] VA/DoD, *2005 Annual Report*, 2.

transition assistance programs and in seamless transition. Including DOL and SSA in the JEC in some capacity may improve coordination even further.

In reviewing the *VA/DoD JEC Strategic Plan Fiscal Years 2007–2009*, the Commission questions the detail of planning efforts. Implementation plans do not include milestones, funding requirements, and assignment of responsibilities. According to VA, "the JEC *Annual Report* includes major accomplishments as they relate to the Joint Strategic Plan" and is "not intended to be a detailed operational guide."[18] However, according to GAO, a more detailed plan with a responsible lead agent is needed by the Departments.

To further address transition, VA created an Office of Seamless Transition with a director who reports to the Under Secretary for Health and a staff of coordinators and liaisons to work internally with the Veterans Benefits Administration (VBA) and externally with DoD's active duty, National Guard, and Reserves. There is also no counterpart to this office within DoD. Seamless transition in DoD is the responsibility of the Deputy Director of Deployment Health Support Directorate as a collateral duty who in turn coordinates with Health Affairs and Personnel and Readiness.

Recommendation 10.1

VA and DoD should enhance the Joint Executive Council's strategic plan by including specific milestones and designating an official to be responsible for ensuring that the milestones are reached.

Recommendation 10.2

The Department of Labor and the Social Security Administration should be included in the Joint Executive Council to improve the transition process.

III Case Management

For military transition to be seamless, the handoff between DoD and VA should not be adversarial, confusing, or challenging. Severely injured service members report being overwhelmed by the number of contacts and business cards collected from those who want to help. No single point of contact coordinates all of their benefits and care.

[18] VBA, *Technical Review*, 2.

An independent review group found several problems with the DoD outpatient case management process. These included an ill-defined process; differing treatment plans and medications; improper staff-to-patient ratios; lack of centralized management of staff; lack of standards, qualifications, and training of staff; unqualified contractors; and inconsistencies across the services.[19] The Task Force on Returning Global War on Terror Heroes found that "there are no formal interagency agreements between DoD and VA to transfer case management responsibilities across the military services and VA" and recommended that a system of comanagement be developed.[20] The President's Commission on Care for America's Returning Wounded Warriors recommended that there be a recovery coordinator who acts as "the patient and family's single point of contact, who makes sure each service member receives the care specified for them in the [recovery] plan when they need it, and that no one gets lost in the system."[21]

The establishment of a lead-agent case manager by VA and DoD would minimize confusion and alleviate the stress on transitioning service members and their families in tracking information and accessing services over the long term.

Recommendation 10.3

VA and DoD should jointly create an intensive case management program for severely disabled veterans with an identifiable lead agent.

IV Transition Assistance Programs

The Transition Assistance Program (TAP) and the Disabled TAP (DTAP) are the employment and benefits briefings conducted at military installations for service members in preparation for leaving the armed services. These briefings are conducted 90 to 180 days before discharge. TAP and DTAP are opportunities to address transition issues and to give veterans and their families the information, support, and assistance they will need to successfully readjust to civilian life.

According to the report of the Congressional Commission on Servicemembers and Veterans Transition Assistance, "TAP is offered at a critical juncture of the servicemembers' life at a time when he or she is getting ready to move from DoD jurisdiction to the jurisdiction of other departments and agencies, such as VA,

[19] Independent Review Group, *Rebuilding the Trust*, 11–15.
[20] Task Force on Returning, *Report*, 20.
[21] President's Commission, *Returning Wounded Warriors*, 4.

DOL, and the Small Business Administration."[22] Public Law 101-510 mandates that DoD offer TAP, and DoD Instruction 1332.36 provides guidance to the services through their community services or family support centers. The Marine Corps is the only Service to mandate attendance at the TAP classes. TAP is delivered in partnership with DOL and VA. DOL, under its Veterans' Employment and Training Services, has a lead role in the TAP process. DOL has operated the ReaLifelines program for disabled veterans since 2004, and staffs offices at military treatment facilities and within the Military Severely Injured Center.

DTAP is provided to those who intend to file a claim for a service-connected disability or an illness or injury that was aggravated by service. DTAP can begin the BDD process. At that time, applications for compensation, vocational rehabilitation and employment, and health care can be made prior to the service member's discharge. Additionally, Social Security Disability Insurance (SSDI) can be awarded to severely injured service members even while they are still on active duty.

In FY 2005, 7,500 TAP/DTAP briefings were held for 310,000 service members and their families, including 119,000 National Guard members and reservists.[23] During FY 2005, 144,965 active-duty service members were discharged.[24]

The Departments are trying to make TAP more accessible to all separating service members, especially National Guard and Reserves, and to their families. There have been issues with mandating TAP/DTAP for all service personnel as DoD does not control all of the human or fiscal resources that support this activity. On September 19, 2006, a new memorandum of understanding was signed by DoD, VA, and DOL to redefine departmental roles and responsibilities for the TAP/DTAP, which should increase class availability. To ensure that TAP is accessible to all separating service members, Congress should mandate class availability and class attendance DoD wide.

Funding for TAP has remained fairly constant for the last decade with no increases for inflation. In FY 1997, the TAP allocation was $40 million; Table 10.1 shows how those funds were distributed among the services.

[22] Congressional Commission, *Report*, 38.
[23] VA/DoD, *2005 Annual Report*, 4.
[24] Associated Press, "Numbers Leaving the Military."

Table 10.1 TAP Allocations for FY 2007

SERVICE	PERCENTAGE OF TOTAL ALLOCATION (%)	DOLLARS (thousands)
Army	**36**	**13,287**
Navy	**28**	**10,220**
Marine Corps	**11**	**4,000**
Air Force	**25**	**8,943**
Total	**100**	**36,450**

SOURCE: Applegate, "TAP funding."

Adequate funding, including increases for inflation, should be provided for the TAP and DTAP programs.

Recommendation 10.4

To facilitate seamless transition, Congress should adequately fund and mandate the Transition Assistance Program throughout the military to ensure that all service members are knowledgeable about benefits before leaving the service.

V Benefits Delivery at Discharge and Separation

To expedite the claims process, VA and DoD jointly developed and implemented the Cooperative Separation Process/Examination at BDD sites. The purpose of BDD is to allow service members to file VA claims prior to separation. This initiative grew out of concerns for the growing backlog at the VA regional offices as the number of pending claims increased. Veterans who do not file a claim through BDD must have their claims processed at a regional office, which adds to their wait time for a decision because of the backlog. To assist in this process, DoD is required to transmit pertinent medical information to VA.[25]

BDD is offered at 140 military facilities. VA processes those claims at two centralized locations: Salt Lake City, Utah, and Winston-Salem, North Carolina. For FY 2006, 40,600 transitioning service members went through the BDD process to file original compensation claims.[26]

[25] VA/DoD, *2005 Annual Report*, 4.
[26] VA, *2006 Annual Performance*, 1–2.

For service members to be eligible for BDD, they must have an established date of discharge and be within 180 days of discharge. Those on medical hold or on the temporarily disabled retired list are often precluded from entering BDD because they do not have established discharge dates. An authenticated electronic DD 214[27] sent by DoD to VA could also expedite this process and assist in getting service members enrolled in VA for medical care. Additionally, severely injured service members who appeared before the Commission reported being denied access to VA health care because they were still on active duty.

There have been mixed reactions to the BDD process. During site visits, the Commission heard conflicting reports on BDD. For example, in Florida, there were concerns with sending cases to the North Carolina regional office for ratings, which might increase confusion and impede follow-up. At the Boston regional office, they were relieved to not have the added workload. Additionally, veterans at town hall meetings and on panels reported varied experiences with BDD and inconsistencies in assistance. Most veterans were satisfied with the expeditious turn around in receiving VA awards; however, others who had been found unfit for duty and separated from the service, reported that they were denied VA compensation and attributed it to the BDD process being too rushed.

There are several other issues aside from BDD that influence benefits at separation. First, DoD does not currently conduct separation examinations on every service member leaving the military, but only for those who intend to file a claim for VA disability benefits. A separation examination would establish a baseline for medical conditions, so that if, and when, a veteran chooses to file a claim, information will be available on their health status at discharge. A separation examination could also be useful in reducing the VA claims backlog.

Additionally, as a result of the cost containment measures in the Omnibus Budget Reconciliation Act of 1982 (Public Law 97-253, § 401, 96 Stat. 763, 801, now 38 U.S.C. § 5111), VA is prohibited from authorizing disability compensation payments until the first day of the second month after the award is granted. Therefore, payments are delayed. This law also applies to veterans who file a claim within 1 year of discharge and whose entitlement date is the day after the date of discharge. The result is that service members do not receive any disability benefits for up to 2 months after discharge. For example, a veteran discharged on August 2, 2006, could not be paid disability benefits for the partial month of August and could not be paid September benefits until October 1. When severely injured service members testified before the Commission in January 2006, this was a primary concern. Before the 1982 statutory change, the

[27] Military discharge papers.

veteran would have received payment from the effective date, which in this example would be August 3.

Post-military employment is another separation issue. Veterans sometimes have difficulty translating their military occupational specialty (MOS) to civilian certifications and licenses, such as when an Army medic applies for a job as a civilian emergency medical technician. In response, DoD created a Web site to provide access to the Verification of Military Experience and Training VMET document, which "provides descriptive summaries of the service members' military work experience, training history, and language proficiencies" in addition to recommended college credits equivalent to military training and experiences.[28] The Army created the Credentialing Opportunities On-Line (COOL) that "helps soldiers find civilian credentialing programs related to their MOS."[29] (Navy COOL followed in 2006.)

The Task Force on Returning Global War on Terror Heroes made several additional recommendations regarding improving employment awareness at job fairs, improving certification and credentialing opportunities for transitioning service members, and spreading awareness regarding the Uniformed Services Employment and Reemployment Rights Act.[30] DoD, VA, and DOL should take additional steps to expand MOS awareness in the private sector and offer employment counseling to assist transitioning service members in documenting and describing their military experiences as assets to potential employers.

Recommendation 10.5

Benefits Delivery at Discharge should be available to all disabled separating service members (to include National Guard, Reserve, and medical hold patients).

Recommendation 10.6

DoD should mandate that separation examinations be performed on all service members.

Recommendation 10.7

Disability payments should be paid from the date of claim.

[28] *DoD/VA Cooperation and Collaboration*, 15.
[29] Ibid*,* 16.
[30] Task Force on Returning, *Report,* 54–57.

Recommendation 10.8

DoD should expand existing programs that translate military occupational skills, experience, and certification to civilian employment.

Recommendation 10.9

DoD should provide an authenticated electronic DD 214 to VA.

VI Information Technology and Record Management

Information technology (IT) interoperability is the cornerstone for successful cooperation between the Departments and a truly seamless transition for service members. Seamless transition is envisioned as a system that would "flow easily across all components of care, geographic sites, and discrete patient care incidents while protecting privacy and confidentiality…and would provide VA and DoD with insights about diseases or illnesses that could result from exposure to occupational hazards during military service and assist in epidemiological research."[31] Although most attention has focused on medical systems, electronic military personnel systems are also important to improving transition.

To achieve this level of functionality, the JEC developed a Joint Electronic Health Records Interoperability (JEHRI) plan that incorporates a series of separate initiatives to connect DoD's and VA's electronic health information systems. (DoD's system is called AHLTA and VA's is called the Veterans Health Information Systems and Technology Architecture, or VistA.) This 5-year plan is overseen by the Health Executive Council. The JEHRI plan includes the development of the Federal Health Information Exchange (FHIE), which is a one-way transfer of military health data from DoD to VA's Computerized Patient Record System. Since 2002, 3.6 million patient records have been transferred, and 2 million of these veterans received care from VA. "The Compensation and Pension Records Initiative (CAPRI) electronic health records, including FHIE categories, are available to VBA employees at 57 regional offices. Access to CAPRI helped accelerate the adjudication of compensation and pension benefit claims."[32]

Using FHIE, DoD was able to transmit information to VA on its patients being treated in DoD facilities under local sharing agreements. As of September 2006,

[31] President's Task Force, *Final Report*, 7.
[32] VA/DoD, *2005 Annual Report*, 12.

1.8 million data transmissions have taken place.[33] Following the success of FHIE and building upon it, VA and DoD developed the Bidirectional Health Information Exchange (BHIE), which expanded access to patient information including pharmacy data, pathology and surgical reports, laboratory, radiology (no images), and other test results and allergy information. As of February 2006, VA could access data from nine military treatment facilities (Madigan, Beaumont, Eisenhower, Great Lakes, San Diego, Nellis, Walter Reed, Dewitt, Bethesda, and O'Callaghan) and these facilities could access VA records. DoD added the Pre- and Post-Deployment Health Assessments (PPDHA) for transitioning service members and demobilized reservists and National Guardsmen to the FHIE system. As of September 2006, over 1.4 million PPDHAs on 604,000 individuals have been transferred. DoD completed a historical data extraction and will continue to transfer these assessments on a weekly basis to VA once a referral is recorded.[34] Other military personnel data sharing plans are in process.[35]

Continued expansion of bidirectional capabilities known as the Clinical Data Repository/Health Data Repository will be a bridge between the new AHLTA and VistA. Additionally, laboratory data sharing and interoperability software will continue to leverage the Departments' abilities to work together and create standardization across systems that ensure patient safety. Despite these efforts, the AHLTA and VistA platforms are not currently compatible. AHLTA may provide a more modern platform than VistA, but significant functions in the older VA system are not available to DoD users. For example, inpatient discharge summaries and digital images from CT scans, MRIs, and x rays are part of VistA, but these records and images are not yet available in AHLTA. Therefore, DoD cannot easily transfer these types of documents to VA upon a service member's discharge without paper copies first being scanned. VA and DoD plan to share patient encounters, clinical notes, problem lists, and theater data no later than December 2007.[36]

The JEC FY 2006 *Annual Report* states, "VA and DoD will utilize interoperable enterprise architectures and data management strategies to support timely and accurate delivery of benefits and services. The emphasis will be on working together to store, manage, and share data and streamline applications and procedures to make access to services and benefits easier, faster, and more secure."[37] However, greater progress should have been made, and the 5-year strategic plan does not meet the demands of the current level of combat operations and casualties.

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[33] Ibid., 17.
[34] Ibid.
[35] Ibid., 22.
[36] Freedman, *VA/DoD Electronic Health Information Sharing.*
[37] VA/DoD, *2006 Annual Report*, A-21.

During the last decade, GAO has monitored the IT efforts of VA and DoD. GAO found that the Departments have made progress, but there is still a great deal that needs to be done in the short term and the long term. VA has achieved IT integration, but DoD still faces challenges standardizing the services' health information systems. VA and DoD have not yet properly developed an overall strategy to guide their various efforts towards achieving a comprehensive seamless exchange of health information. GAO has recommended that there be a detailed project management plan developed to guide efforts and a lead entity identified.[38]

The Task Force on the Returning Global War on Terror Heroes encouraged the Departments to expand their IT initiatives and enhance electronic health records for OIF/OEF veterans, improve patient tracking between systems, and to track TBI patients, combat veterans, and polytrauma patients. The Task Force also recommended that VA improve its electronic enrollment capabilities and to use DoD's military service information as part of VA's enrollment process.[39] The report also calls for VA to improve its IT interoperability with the Department of Health and Human Services (HHS) and Indian Health Service.[40]

The President's Commission on Care for America's Returning Wounded Warriors acknowledged that IT is not the "silver bullet," but recommended that DoD and VA rapidly transfer patient information to support an efficient patient-centered system.[41] Additionally, it advocated the development of a single federal benefits' Web site (*MyeBenefits)* where veterans can locate all necessary information, store personal records, make appointments, and apply for benefits[42]

On January 24, 2007, VA and DoD announced an agreement to create a joint inpatient electronic health record that will make inpatient medical records instantly accessible to clinicians in both Departments. However, the Departments have not committed to a completion date.

In spite of efforts by VA and DoD to use compatible electronic record systems, the goal is far from realization, and paper records will be in use well into the future. VBA continues to use paper claims folders and has no long-term plan to convert them to electronic records. Many DoD records are also still in a paper format, and need to be transferred to VA. At the St. Louis Records Management Center visited by the Commission, there is a large volume of unidentifiable and unmatched records. These missing documents can have a grievous affect on a

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[38] Melvin, *VA and DoD*, 2-4.
[39] Task Force on Returning, *Report,* 29–36.
[40] Ibid*.,* 48.
[41] President's Commission, *Returning Wounded Warriors*, *9.*
[42] Ibid*., 23.*

veteran's ability to document a claim for service connection. A joint VA/DoD task force has been established to address this situation, but resolution can take years.

Recommendation 10.10

VA and DoD should improve electronic information record transfers and address issues of lost, missing, and unassociated paper records.

Recommendation 10.11

VA and DoD should expedite development and implementation of compatible information systems including a detailed project management plan that includes specific milestones and lead agency assignment.

VII Family Support Services

DoD has an array of family assistance programs that include services for families of injured or ill service members to help keep families together. These services include family centers, child care, youth programs, family advocacy, relocation**,** transition support services, and support during mobilization and deployment (including casualty affairs).[43] At an installation's community services or family center, family members can be assisted with job placement, parenting classes, family readiness groups, and reunion and reintegration briefings, especially when a service member has been injured or becomes ill. The Family Advocacy Program intercedes in cases of domestic violence and child abuse.

There are limitations to the DoD programs such as those identified by the President's Commission on Care for America's Returning Wounded Warriors, which focused on the lack of Tricare respite care and aide and personal attendant benefits under the Extended Care Health Option program.[44]

There are further gaps in services when service members leave active duty and transfer to VA. Under title 38 U.S.C., VA has no statutory authority to treat or assist veterans' family members, other than in some very limited capacities and only when the veteran is the identified patient. DoD realizes the importance of family support and can provide significant financial assistance, travel, and housing near military treatment facilities for the families of the severely injured. There are no special VA programs or projects designed for spouses, children, or parents, grandparents, or siblings of disabled veterans. As caregivers, they do not have the travel and per diem benefits available from VA as they do when

[43] Under Secretary of Defense, *Military Community*.
[44] President's Commission, *Returning Wounded Warriors*, 8.

injured service members recuperate while on active duty, nor are they assisted with employment or health care if they need to relocate nearer to a facility that provides the level of care that the veteran requires.

Recommendation 10.12

Congress should authorize and fund VA to establish and provide support services for the families of severely injured veterans similar to those provided by DoD.

VIII Military Severely Injured

With casualties being medevaced from Iraq and Afghanistan with complex and multiple injuries, response needs to be efficient and effective. Body armor, an improved evacuation system, and coagulants are allowing an estimated 90 percent of the troops to survive battle wounds, particularly blast injuries from improvised explosive devices. Serious injuries include amputations, traumatic brain injuries, visual and hearing impairments, burns, other life-threatening conditions, and PTSD. As a result of these traumatic and multiple injuries, DoD created new programs. DoD oversees the Military Severely Injured Center (MSIC), while the services have their own programs: Army Wounded Warrior, Navy Safe Harbor, Marines4Life, and Air Force Palace Heart.

Medical hold patients at Walter Reed Army Medical Center and the National Naval Medical Center are being assigned to specific Army or Marine Corps Wounded Warrior Regiments to better assist and oversee their care. These programs link injured service members and their families to medical care and rehabilitation; education, training and job placement; personal mobility equipment; home, transportation, and workplace accommodations; individual, couple, and family counseling; and financial resources in order to return to duty or to integrate back to their home communities.[45]

It is difficult to evaluate the effectiveness of these services for the severely injured and their families, however, as there is no standard definition of the term "severely injured" and there is no common DoD database capturing service member and family workload or the services provided. It is also difficult to provide VA with a comprehensive status report on these cases for continuing treatment purposes. As a result, there are limited opportunities to identify lessons learned that could be shared within DoD or with VA, or to develop strategic plans that target funding more effectively.

[45] Military Home Front, *Severely Injured Center*.

Recommendation 10.13

DoD should standardize the definition of the term "severely injured" among the services and with VA, and create a common database of severely disabled service members.

VIII.1 Severely Injured Marines and Sailors Pilot Study

The Assistant Secretary for the Navy, Manpower and Reserve Affairs, authorized the Severely Injured Marines and Sailors (SIMS) Study as a pilot program to determine whether there were gaps in the Navy's support of injured sailors and Marines and their families, and whether changes to internal and external policies were warranted. "The purpose of SIMS is to accelerate the retirement dates of the severely injured Marines and sailors who are unlikely to return to duty within 12 months of injury and [to] enhance the compensation and benefits they are entitled to receive in order to reduce economic stressors on the family, to reduce uncertainty and fear about the future, and to increase the focus on getting better."[46] The pilot program included 25 severely injured individuals and identified the complexities and confusion they faced in navigating through the DoD, VA, DOL, and SSA benefit systems. The solution was to improve coordination between these agencies by convening an interagency working group that was composed of over 50 agency representatives.[47]

Among the SIMS study findings and recommendations were the following:

- Develop a comprehensive patient tracking system across agencies.
- Implement a master case management component that coordinates all activities.
- Develop comprehensive treatment plans before a patient is discharged that clearly delineates procedures, medications, and responsibilities.
- Create an electronic health record immediately. The patch between AHLTA and VistA is several years in the making.
- Information on Social Security Disability Insurance and its availability to injured service members while they are still on active duty must be disseminated. (This provision of SSDI is not well known, and service members do not know to apply.)
- Reassess the effectiveness of Tricare for the severely disabled. The retired disabled who are transferred under Tricare for Life to Medicare after 2 years have to pay $100 per month in premiums.

[46] Severely Injured, *Interim Report,* 1.
[47] Ibid., 2.

- Review invitational travel orders for nonmedical attendants to return the disabled to the military treatment facilities for follow-up care.
- Review the combat stress control program and the lessons learned from OIF/OEF.
- Track TBI patients for present and future symptoms.
- Coordinate family services and support.
- Allow prorated retirement pay for severely injured personnel whose service was interrupted by injury.
- Require a durable power of attorney for all deploying service members and have three people designated for invitational travel orders..
- Allow severely injured service members to receive support in the form of "gifts" from nonprofits, under certain circumstances, and convene a task force on this ethical issue.
- Transmit DoD information to the states, especially in relation to treatment of PTSD and TBI and employment.
- Allow adaptive housing grants to be used more than once.
- Amend the Family and Medical Leave Act (FMLA) to include parents of injured troops over the age of 18.
- Allow rehabilitating severely injured personnel to attend military schools to obtain certification and training in occupations that are in higher demand than their current military occupational specialty and that translate more readily to the civilian sector.[48]

VIII.2 Army Wounded Warrior Survey

To capture the issues and challenges of its severely injured soldiers and families, the Army Wounded Warrior (AW2) program conducted a survey and held symposiums. The most recent survey and symposium discovered the following information:[49]

The top five priority issues were

1. retired wounded soldiers' eligibility for combat-related special compensation;
2. inadequate medical retirement pay for wounded warriors;
3. compensation for PTSD, TBI, and uniplegia;

[48] Severely Injured Marines and Sailors, *Final Report*,
[49] US Army, *Wounded Warrior.*

4. a benefit package (under Tricare) for nondependent primary caregivers of severely wounded; and
5. career opportunities for wounded warriors in government positions.

The top five transition concerns were

1. financial stability,
2. finding a job,
3. strain on loved ones,
4. inconsistencies in treatment and services by VA, and
5. low disability ratings from the Army.

The five most helpful sources of assistance were

1. spouse, family, and friends;
2. faith;
3. Army Wounded Warrior programs and services;
4. nonprofit organizations; and
5. VSOs and other veterans.

Other issues that did not make the top five, but were greatly discussed related to

- support and education for families, especially children;
- Medical Evaluation Board/Physical Evaluation Board education and case management assistance;
- access to specialty care (including women's health) at VA medical centers or outpatient clinics with improved case management;
- reimbursement of VA beneficiary travel expenses and accommodations; and
- SSDI eligibility for wounded warriors with less than the required quarters. (There are soldiers who have not worked long enough to be eligible before they were injured.)

Recommendation 10.14

DoD should consider the findings of the Severely Injured Marines and Sailors Program and the Army Wounded Warrior Survey.

Recommendation 10.15

DoD and VA should make transitioning service members aware of Social Security Disability Insurance.

Recommendation 10.16

Congress should consider eliminating the Social Security Disability Insurance minimum required quarters for severely injured service members.

IX Health Care

The Commission views health care as a primary benefit (along with compensation). Health care should be provided to disabled veterans to facilitate their rehabilitation, improve their quality of life, and expand their capacities to engage in usual life activities. A guiding principle of the Commission is that service-connected veterans should have access to a full range of health care at no cost, and their level of priority for receiving health care should be based on their degree of disability. Access to health care was often mentioned by veterans and their families during the public comment sessions of the Commission's meetings. It was also discussed in Commission meetings with VA and DoD leadership and field staff. The Commission visited VA centers for polytrauma, blindness, spinal cord injury, burns, amputee care, TBI, and PTSD. The health care budget of VA and DoD combined is $51.5 billion, with 1,982 point-of-care sites, 333,000 staff, and 16.9 million beneficiaries (not unique users).[50]

The mission of DoD Health Affairs is "to provide, and to maintain readiness to provide, health care services and support to members of the Armed Forces during military operations."[51] DoD Health Affairs also provides care to eligible family members and retirees. The military health system is composed of 70 medical treatment facilities, over 800 clinics, and the Tricare network. The system has 9.2 million beneficiaries, and a $20 billion budget.[52]

Tricare is the DoD health care coverage program for active duty and retired uniformed services and their families. Tricare brings together the health care

[50] Data was compiled from the DoD AHLTA briefing provided to the Veterans' Disability Benefits Commission on November 17, 2006, and from VA's *Organizational Briefing Book*, 2006, and the VA *FY 2006 Performance and Accountability Report*.
[51] Health Affairs Organization, *Responsibilities and Functions*.
[52] DoD, "Tricare Management."

resources of the Army, Navy, Air Force, and Coast Guard with a network of civilian health care professionals.

Tricare divides the country into three regions with a fourth region overseas. The regions are covered by different insurance contractors whose competitive contracts come up for bid every few years. Transferring to other regions can be difficult. In areas where Tricare has military treatment facilities and an extensive network, access and quality is not as much an issue. In remote or rural areas, this can mean difficulty finding providers who will accept Tricare patients and are competent with military health issues. Many wounded soldiers have had to pay some of the costs of treatment for their combat-related wounds, a requirement that has been described as "adding insult to injury."

Recommendation 10.17

DoD should remove Tricare requirements for copays and deductibles for the severely injured service members and their families.

In FY 2006, VA had 156 medical facilities, 877 clinics, 136 nursing homes, a staff of over 201,000 and a $31.5 billion budget. It had over 7.7 million enrollees and treated 5.5 million unique patients, of whom 184,500 were OIF/OEF veterans.[53] (Vet Center contacts are not included in this data.) Since FY 2002, there have been 631,174 OIF/OEF veterans who have left active duty and became eligible for VA.[54] Enrollment in VA health care is not automatic for all separating service members. They must first make an application to the nearest VA facility and have their eligibility determined. OIF/OEF veterans have 2 years of open enrollment. There has been proposed legislation to extend this period to 5 years, since many medical conditions have a delayed onset or increase in severity. Extending enrollment would also allow those veterans who were unaware of or misunderstood their VA benefits at the time of their discharge more time to access the health care system.

Based on the current OIF/OEF VA user population, one prediction places the number of OIF/OEF veterans accessing VA care in 2014 at over 730,000 (of 1.5 million assumed discharges). This would also result in a projected increase in cost from $1 billion to $6.8 billion during that same time period.[55] Financial stresses will continue to be placed on the system as it has to provide quality long-term care, mental health, and polytrauma rehabilitation to several generations of disabled veterans with varying needs.

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[53] VA, *2006 Annual Performance*, 1–2.
[54] VHA, *Analysis of VA Health Care*, 4.
[55] Bilmes, *Soldiers Returning*, 14.

Instituted in 1979, the Vet Centers provide readjustment counseling at 209 community-based locations nationwide with over 400 mental health providers. Readjustment counseling provides a wide range of services to all eras of combat veterans and their families to facilitate transition from military to civilian life. Services include individual, group, marital, family, PTSD, and bereavement counseling. Counselors also provide medical referrals, assistance in applying for VA benefits, employment counseling, alcohol and drug assessments, military sexual trauma counseling and referral, outreach, and community education.[56] In FY 2005, Vet Centers provided services to 125,737 veterans (67.4 percent being from the Vietnam era) who made more than a million visits.[57]

In 2003, the VA Secretary extended Vet Center eligibility to OEF/OIF veterans. Subsequently, the Vet Centers hired 100 additional Global War on Terror (GWOT) outreach coordinators to encourage OIF/OEF veterans to come into the Vet Centers, network with members of the National Guard and Reserves and their families, and to provide post-deployment briefings in areas where units have returned from Iraq and Afghanistan. Since 2003, Vet Centers have provided services to a total of 156,787 OIF/OEF veterans, (outreach with 115,708, and treated 41,079) and provided grief counseling to 1,213 family members of approximately 800 service members killed on active duty.[58]

The complex nature of some injuries and multiple body system damage being seen in Iraq and Afghanistan veterans has led VA to provide levels of care that are unprecedented and revolutionary. These programs are crucial to successful readjustment after military injury or illness, but they are resource intensive as they require a multidisciplinary approach with case managers and liaisons.

VHA is in the difficult position of having to balance the needs of a younger, sometimes severely injured population with the needs of its preexisting and aging patient population. This diversity places an even greater demand on resources in areas that already are resource intensive. Such diversity also requires staff to expand their expertise and perspective in treatment planning and program design to include issues such as technological assistance and job success strategies. Future veterans will need to continue to depend upon this diversity of care.

Recommendation 10.18

Maintain the accessibility and stability of quality health care for all disabled veterans.

[56] Vet Center, *Services Councilors Provide*.
[57] Batres, Interview.
[58] Batres, *Treatment of PTSD.*

Recommendation 10.19

VA and DoD should fund research in support of the needs of veterans from Operation Iraqi Freedom and Operation Enduring Freedom.

X Conclusion

Seamless transition is an admirable concept, but it does not fully exist at the present time. Transition has been described as needing to be seamless, integrated, and transparent to service members, veterans, and their families. But these concepts are elusive as the Departments and agencies that support the transition process have very different missions and statutory authorities. Successful readjustment boils down to the veteran needing services that are coordinated, complementary, and well communicated. A wide variety of health care and benefits are needed to help disabled veterans and their families with transition from military to civilian life. These services include medical and psychiatric care, housing, rehabilitation, employment services, compensation, education, and family support, particularly for the severely injured. Effective service delivery must be well coordinated and lead agents identified to ensure gaps are closed and duplication of effort is avoided. The ultimate vision of transition should be the continuation and fulfillment of a quality life for our nation's veterans, especially for those disabled while on active duty.

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