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FINAL REPORT DRAFT
JULY 24 EDIT

THE PRESIDENT’S COMMISSION ON CARE FOR AMERICA’S RETURNING WOUNDED WARRIORS

FINAL REPORT – JULY 2007

“It is almost cliché now to find examples of a wounded Marine having initially been treated by a Navy Corpsman find himself medevac’ed by an Army helicopter to undergo emergency surgery at an Air Force Theater Hospital.”¹

LtCol Moore’s testimony demonstrates how the skills and resources of the U.S. military can be brought together to aid an injured service member—without regard for traditional bureaucracies and hierarchies. Under the best circumstances, the entire system smoothly joins forces to provide exactly what is needed, precisely when it is needed. His example embodies the kind of efficient care, centered on the needs of the patient, that we envision for our injured service members throughout the process of treatment, rehabilitation, and return to their military unit or home community.

In our few months of operation, we nine Commissioners—health care, disability, and housing experts, injured service members, and family—have visited 23 Department of Defense (DoD), Department of Veterans Affairs (VA), and private-sector treatment facilities. We have heard first-hand from injured service members and their families, from health care professionals, and from the people who manage military and veterans’ programs. More than 1,700 injured service members responded to a national survey we conducted,² and we received more than 1,250 letters and emails from service members, veterans, family members, and health care personnel. We have analyzed the recommendations of past commissions and task forces, including several issued earlier in 2007.³ And, we have drawn on the extensive knowledge of our fellow Commissioners.

We want to emphasize that we’ve heard time and again about the overall high quality of our military’s battlefield medicine and the care delivered in our nation’s military medical facilities

Some Definitions

“Serious injury” – a physiological condition affecting one or more body systems that has lasted or is expected to last at least 12

¹ Testimony of Air Force LtCol Andrew E. Moore, MD, at the Commission’s public hearing in San Antonio, Texas, May 4, 2007.

² Our survey was conducted from June 7 to June 19, 2007. A random sample of 5,995 active duty, reserve component, and retired, medically retired, or separated service members and veterans treated for wounds sustained in Iraq and Afghanistan that led to evacuation to the United States. The survey received responses from 1,730 individuals—a 30 percent response rate.

³ These are listed in an Appendix at the end of this report.

and the VA health system. These clinical professionals’ skill and intense commitment to the wounded is palpable. In the Vietnam era, five out of every eight seriously injured service members survived; today, seven out of eight survive, many with injuries that in previous wars would have been fatal. This is a remarkable record. The number of “seriously injured” service members on whom much of this report focuses is, without doubt, eminently manageable.

contiguous months and that precludes unaided performance of at least one major life activity (breathing, cognition, hearing, seeing, ability to bathe, dress, eat, groom, speak, use stairs or toilet, transfer, walk).⁴

“*Disability*” – a physical or mental impairment that substantially limits one or more major life activities.⁵

“*Combat-related*” – injuries and illnesses attributable to the special dangers associated with armed conflict or the preparation or training for armed conflict.⁶

The following chart compiles recent data from several sources, which don’t all use the exact same definitions and include some double-counting (some individuals have both traumatic brain injuries and amputations, for example). The data nevertheless provide a sense of the scale of the problem of seriously injured service members and the kinds of injuries being addressed in this report.

Number of deployments	2,200,000
Number of service members deployed	1,500,000
Air evacuated for illness or injuries	37,851
Wounded in action	28,000
Treated and returned to duty within 72 hours	23,270
Seriously injured (TSLGI recipients) ⁷	3,082
Traumatic Brain Injuries	2,726
Amputations	644
Serious burns	598
Polytrauma	391
Spinal cord injuries	94
Blind	48

Despite accomplishments in clinical care, problems do occur—particularly in handoffs between inpatient and outpatient care and between the two separate DoD and VA health care and disability systems. To resolve these problems, we have concentrated on ways to better:

- **Serve** the multiple needs of injured service members and their families
- **Support** them in their recovery and return to military duty or to their communities and
- **Simplify** the delivery of medical care and disability programs.

We believe our recommendations will produce a patient-centered system that fosters high-quality care, increases access to needed care and programs, promotes efficiency,

⁴ 32 CFR Sec 199.2

⁵ Americans with Disabilities Act, 1990.

⁶ DoDD 1241.01, February 28, 2004, Section E3.P5.2.2.

⁷ TSLGI (Traumatic Servicemembers’ Group Life Insurance) helps severely injured service members with a one-time payment, depending on their injury.

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supports families, and facilitates the work of the thousands of dedicated individuals who provide a gamut of health care and disability programs to injured service members and veterans. Our nation needs a system of care that enables injured service members to maximize their recovery and their opportunity to return to the mainstream of American life. Such a system not only should treat all service members—whether active duty or reserve component (that is, the National Guard and reserve)—even-handedly, but it also must be perceived as doing so.

Our Commission was established at a time of great change in U.S. health care. Many of the statements—good and bad—that we have heard about care in the DoD and VA systems could apply to the nation’s health care delivery system as a whole. While numerous aspects of U.S. medical care are excellent, problems in coordination and continuity of care are common; our nation’s hospitals and health systems are struggling to develop effective information technology systems; the stigma associated with seeking mental health care is slowly diminishing, but far from gone; our overall health system is oriented to acute care, not long-term rehabilitation; and shortages in critical staff categories are felt nationwide.

In the past few months, the health care and disability systems for our service members and veterans have been under a media microscope and the subject of several reports cited earlier. Public concern arises because Americans recognize and respect the sacrifices of our young men and women fighting in Iraq and Afghanistan and the great debt we owe those injured and killed.⁸ Many of the concerns already are being addressed by Congress and in the two Departments.

The reports published earlier this year provided invaluable background information and analyses for our work. Because they are so recent, we did not need to reiterate their findings. Rather, we focused on ways to move forward. One other difference between our Commission and previous ones is that, while they addressed discrete pieces of the DoD and VA medical care and disability systems, President Bush charged us with looking at the whole continuum of care and programs for wounded service members, as well as what is needed to assure their successful return to military duty or civilian life.

We don’t recommend merely patching the system, as has been done in the past. Instead, the experiences of these young men and women have highlighted the need for *fundamental changes* in care management and the disability system. Our recommendations address these fundamental changes. We believe they will help military service members and veterans of today and of tomorrow, as well.

Making the significant improvements we recommend requires *a sense of urgency* and *strong leadership*. The tendency to make systems too complex and rule-bound must be countered by a new perspective, grounded in an understanding of the importance of *patient-centeredness*. From the time injured service members are evacuated from the

⁸ In Operation Iraqi Freedom and Operation Enduring Freedom, the latter of which is focused primarily in Afghanistan, but has involved smaller operations in other geographic areas, as well.

battlefield to the time they go back to active duty or are discharged home to complete their education, go to work, and be active family and community members, their needs and aspirations should inform the medical care and disability systems.

Recommendations

Our recommendations will serve, support, and simplify health care and rehabilitation for injured service men and women, and return them as quickly as possible to their military duties or to civilian life. To make these recommendations a reality, the President, Congress, and Departments of Defense (DoD) and Veterans Affairs (VA) should initiate the steps described in this report.

1. Immediately Create Comprehensive Recovery Plans to Provide the Right Care and Support at the Right Time in the Right Place

Recommendation: Create a patient-centered Recovery Plan for every seriously injured service member that provides the right care and support at the right time in the right place. A corps of well-trained, highly-skilled Recovery Coordinators must be swiftly developed to ensure prompt development and execution of the Recovery Plan.

Goals: *Ensure an efficient, effective and smooth rehabilitation and transition back to military duty or civilian life; establish a single point of contact for patients and families; and eliminate delays and gaps in treatment and services.*

What it is:

The Recovery Plan should smoothly and seamlessly guide and support service members through medical care, rehabilitation, and disability programs.

The Recovery Plan will help service members obtain services *promptly* and *in the most appropriate care facilities*—whether DoD, VA, or civilian.

The Recovery Coordinator is the patient and family’s single point of contact, who makes sure each service member receives the care specified for them in the plan when they need it, and that no one gets “lost in the system.”

Action Steps:

DoD and VA should develop integrated care teams (physicians, nurses, allied health professionals from relevant specialties, social workers, and vocational rehabilitation staff). These teams would create injured service members’ initial Recovery Plans, which should start with a comprehensive clinical evaluation.

DoD and VA should direct that Recovery Plans be created for all service members seriously injured since the beginning of

The Recovery Coordinator moves injured service members through the system in a timely way, because experience shows that people recover better when treatment and services are provided promptly.

Who oversees it:

A Recovery Coordinator would oversee implementation of the Recovery Plan. Recovery Coordinators would have the authority to coordinate medical care, rehabilitation, education, and employment-related programs, as well as disability benefits. This is a difficult and complex job, and both Departments must be committed to making it work.

Recovery Coordinators would ensure that patients and families understand the likely trajectory of the service member's recovery, the types of care and services that will be needed, and how much time recovery may take.

the Afghanistan and Iraq conflicts who still would benefit from them.

DoD & VA must work with the Commissioned Corps of the Public Health Service, Department of Health and Human Services, to develop a cadre of well-trained, highly skilled Recovery Coordinators.

2. Completely Restructure the Disability and Compensation Systems

Recommendation: DoD maintains authority to determine fitness to serve. For those found not fit for duty, DoD shall provide payment for years served. VA then establishes the disability rating, compensation and benefits.

Goals: *Update and simplify the disability determination and compensation system; eliminate parallel activities; reduce inequities; and provide a solid base for the return of injured veterans to productive lives.*

The following data from our survey illustrate why we believe an overhaul is needed (Throughout this report, our survey results appear in blue):

- *38 percent of active duty, 34 percent of reserve component, and 38 percent of retired/separated service members are “very” or “somewhat” satisfied with the disability evaluation system.*
- *46 percent of active duty, 36 percent of reserve component, and 40 percent of retired/separated service members say they “completely” or “mostly” understand the military’s disability evaluation process.*
- *42 percent of retired/separated service members who filed a VA claim report that they “completely” or “mostly” understand the VA claims process.*

Department of Defense Responsibilities

Each branch of the armed services would retain

Action Steps:

authority for determining whether a service member is fit for continued military service.

If not medically fit, the service member should receive DoD annuity payments, the dollar value of which would be *based solely on rank and length of service*.

Department of Veterans Affairs Responsibilities

VA should assume all responsibility for establishing disability ratings and for all disability compensation and benefits programs.

VA should initiate its education, training, and work-related benefits *early in the rehabilitation period*.

The Department's education, training, and employment programs should include incentives to encourage veterans to participate and stay enrolled. *(Our survey found that 21 percent of demobilized reservists and 31 percent of retired/separated service members are enrolled in an educational program leading to a degree.)*

Periodic Review

The disability status of veterans should be reevaluated every three years and compensation adjusted, if their condition has worsened or improved.

Vocational Rehabilitation & Education Program (VRE)

The effectiveness of various vocational rehabilitation programs is not well established, and VA should undertake an effort to determine which have the greatest long-term success.

VA policies should encourage completion of effective programs by increasing the flexibility of scheduling for those whose disability does not permit taking a full course load. This can be done without increasing the dollar amount of the benefit.

Also, VA should develop financial incentives that would encourage completion.

Congress should clarify the objectives for DoD and VA disability systems, in line with this recommendation.

DoD and VA should create a single, comprehensive, standardized medical examination that DoD administers. It would serve DoD's purpose of determining fitness and VA's of determining initial disability level.

Service members found unfit because of their combat-related injuries should receive comprehensive health care coverage and pharmacy benefits for themselves and their dependents through DoD's TRICARE program.⁹

Congress should revise the objectives for VA disability payments to include:

1. *“transition payments”*—to cover living expenses for disabled veterans and their families. They should receive *either*
 - 3 months of base pay, if they are returning to their community and *not* participating in further rehabilitation**OR**
 - longer-term payments to cover family living expenses, if they are participating in further rehabilitation or education and training programs
2. once transition payments end, disabled veterans should receive *earnings-loss payments*—to make up for any lower earning capacity remaining after training.
3. *quality-of-life payments*—to compensate for non-work-related effects of permanent physical and mental combat-related injuries

The VA should commission a six-month study to determine the appropriate level and duration of longer-term transition payments and a separate study regarding the appropriate amounts for quality-of-life payments.

The VA should move swiftly to update

⁹ TRICARE is the Department of Defense's health care program for members of the military, their families, and survivors and serves more than 9.1 million beneficiaries worldwide.

(and thereafter keep current) its disability rating schedule to reflect current injuries and modern concepts of the impact of disability on quality of life.

To improve completion rates in its VRE program, VA should:

- allow veterans to suspend training for a time or attend part-time (for up to 72 months), with approval of their Recovery Coordinator and vocational counselor
- pay a bonus (10 percent of annual transition pay) for completing the first and second years of VRE training and 5 percent for completing the third year

3. Aggressively Prevent and Treat Post-traumatic Stress Disorder and Traumatic Brain Injury

Recommendation: VA should provide care for any veteran of the Afghanistan and Iraq conflicts who has post-traumatic stress disorder (PTSD). DoD and VA must rapidly improve prevention, diagnosis, and treatment of both PTSD and traumatic brain injury (TBI). At the same time, both Departments must work aggressively to reduce the stigma of PTSD.

Goals: *Improve care of two common conditions of the current conflicts and reduce the stigma of PTSD; mentally and physically fit service members will strengthen our military into the future.*

In our survey, around 70 percent of active duty, reserve component, and retired/separated service members report they had been asked whether they were exposed to an event or blast that caused a jolt or blow to the head.

59 percent of active duty and 52 percent of reserve component and 65 percent of retired/separated service members had been exposed to such an event.

Workforce Strategies

We recognize that augmenting DoD's mental health workforce will not be easy, because of national shortages in mental health professionals. DoD personnel requirements must take into account the expanding need for such personnel, due to the military's expanded prevention and education missions in behavioral health; and, both Departments should prepare for the expected long-

Action Steps:

Congress should enable *all* veterans who have been deployed in Afghanistan and Iraq who need PTSD care to receive it from the VA.

DoD should aggressively address its acute shortage of mental health clinicians.

term demand that may arise from chronic or delayed onset symptoms of PTSD.

Reduce Stigma

DoD should intensify its efforts to reduce the stigma associated with PTSD.

DoD should establish a network of public and private-sector expertise in TBI and partner with the VA on an expanded network for PTSD, so that prevention, diagnosis, and treatment of these two conditions stay current with the changing science base. Specifically, it should:

- conduct comprehensive training programs in PTSD and TBI for military leaders, VA and DoD medical personnel, family members, and caregivers
- disseminate existing TBI and PTSD clinical practice guidelines to all involved providers; where no guidelines exist, DoD and VA should work with other national experts to develop them.

4. Significantly Strengthen Support for Families

Recommendation: Strengthen family support programs including expanding DoD respite care and extending the Family and Medical Leave Act for up to six months for spouses and parents of seriously injured.

Goals: *Strengthen family support systems and improve the quality of life for families.*

In our survey, 33 percent of active duty, 22 percent of reserve component, and 37 percent of retired/separated service members report that a family member or close friend relocated for extended periods of time to be with them while they were in the hospital.

21 percent of active duty, 15 percent of reserve component, and 24 percent of retired/separated service members say friends or family gave up a job to be with them or act as their caregiver.

Many of the recommendations in this report serve and support families and simplify their lives. Prime examples are the Recovery Coordinator and increased availability of online resources that will be helpful to family caregivers.

DoD and VA should explore the applicability for service members and their families of innovative private-sector initiatives that have been developed and tested in the past few years.

Action Steps:

Congress should make combat-injured service members eligible for the TRICARE respite care and aide and personal attendant benefits currently provided in the Extended Care Health Option program.

DoD and VA should provide families of service members who require long-term

DoD should establish a standby plan for family support of injured service members, drawing on the experiences and model programs developed during this conflict, to enable a quicker program ramp-up in any future large deployments.

personal care with appropriate training and counseling to support them in their new caregiving roles.

Congress should amend the Family Medical Leave Act to allow up to six months' leave for a family member of a service member who has a combat-related injury and meets the other eligibility requirements in the law.

5. Rapidly Transfer Patient Information Between DoD and VA

Recommendation: DoD and VA must move quickly to get clinical and benefit data to users. In addition, DoD and VA should jointly develop an interactive “My eBenefits” website that provides a single information source for service members.

Goals: *Support a patient-centered system of care and efficient practices.*

Three Strong Caveats:

- Congress and the Departments should recognize that information technology is not the “silver bullet” that will solve various quality, coordination, and efficiency problems within the Departments’ medical and benefits systems.
- Underlying organizational problems must be fixed first, or information technology merely perpetuates them.
- Every effort must be made not to make systems unnecessarily complex, difficult to use, or redundant.

DoD and VA should make information about benefits and services available online, via a password-protected site (which we call “My eBenefits”), in which service members and veterans can securely enter personal information. Based on this profile, they would receive tailored information about relevant programs and benefits in both the public and private sectors.

Action Steps:

In order to implement our Recovery Plan recommendation, within 12 months, DoD and VA must make patient data much more accessible—to begin with, in viewable form. All essential health, administrative, and benefits data must be immediately viewable by any clinician, allied health professional, or program administrator who needs it.

DoD and VA should continue the work under way at present to create a fully interoperable information system that will meet the long-term administrative and clinical needs of all military personnel over time.

DoD and VA must develop a plan for a user-friendly, tailored, and specific services and benefits portal for service members, veterans, and family members.

6. Strongly Support Walter Reed By Recruiting and

Retaining First-Rate Professionals Through 2011

Recommendation: Until the day it closes, Walter Reed must have the authority and responsibility to recruit and retain first-rate professionals to deliver first-rate care. Walter Reed Army Medical Center has a distinguished history and, with one in five injured service members going directly to Walter Reed, continues to play a unique and vital role in providing care for America’s military.

Goals: *Assure that this major military medical center has professional and administrative staff necessary for state-of-the art medical care and scientific research through 2011.*

Approximately one in five injured service members go directly to Walter Reed, and more than 700 outpatients remain on the campus.

Not only is it active today, but Walter Reed is scheduled to continue operation for at least four more years and must have the resources—professional and otherwise—to continue its historic role as a vital tertiary care and research center until the day it actually ceases operation.¹⁰

Action Steps:

DoD must assure that Walter Reed has the resources it needs to maintain a standard of excellence in both inpatient and outpatient care.

DoD must implement tailored incentive packages to encourage civilian health care and administrative professionals to continue working there and to enable recruitment of new professionals, as needed.

A System that Serves

America has recognized the nation’s responsibility to care for injured soldiers ever since the early days of the War of Independence. More than 80 years later, near the end of the Civil War, Abraham Lincoln reaffirmed that responsibility, admonishing the country to strive “to care for him who shall have borne the battle . . .” And, today, a huge and generally well regarded infrastructure has developed to sustain this commitment to our service members, veterans, and their families:

- 68 military treatment facilities
- 154 military outpatient clinics
- 153 VA medical centers and
- 875 VA outpatient clinics.

The nation also has developed non-medical programs for those injured during military service—not just disability compensation, but a wide array of supporting programs and

¹⁰ The decision to close Walter Reed came from the Department of Defense’s Base Realignment and Closure Commission (BRAC).

benefits to help veterans and their families with recovery, transition to civilian life, education, and employment. Federal and state government programs are augmented by more than a thousand private-sector, community, volunteer, and faith-based initiatives that help injured service members and their families meet housing, transportation, and short-term financial needs.

“The rehabilitation of disabled veterans and their reintegration into useful economic and social life should be our primary objective.”—The Bradley Commission, 1956

In 1956, the President’s Commission on Veterans’ Pensions, chaired by General of the Army (Ret.) Omar N. Bradley, concluded that there was “no clear national philosophy of veterans’ benefits.” That Commission developed a philosophy and guiding principles that remain relevant today. Not only did it assert a national responsibility “to do justice by those who were injured or disabled as a consequence of their military service,” but it also laid out a rationale for disability programs. Despite the Bradley Commission’s urging, neither Congress nor the Executive Branch has established clear overall objectives, such as those we recommend, for the constellation of veterans’ benefits the government offers. To this day, lack of a specific objective hinders the design, coordination, and evaluation of

both individual veterans’ programs and the disability system as a whole. We recommend that these objectives should include recognition of the degree of disability, effects on quality of life, and earnings loss, and should facilitate participation in education, training, and employment programs to maximize life recovery.

A Continuum of Care

The majority (68 to 80 percent) of individuals in our survey are “very” or “somewhat” satisfied with inpatient care.

Our Vision:

A care system that continually strives to offer injured service members the highest standard of quality.

The acute medical care that injured service members receive in the field and in military hospitals back home is consistently and demonstrably of high quality. Clearly, today’s skilled medical corps and our military surgeons, physicians, and critical care teams save many lives. But DoD never intended to provide the long-term, rehabilitative programming now understood as necessary to optimal recovery. Rehabilitation and long-term care were a VA specialty. What is needed now is to improve the continuity and integration of medical and rehabilitation programming across the two Departments.

Injured service members receive clinical care in many settings. It may be provided in military hospital inpatient units and outpatient departments, in the private practices of physicians and mental health care professionals, and in various physical rehabilitation programs connected with the hospital, the nearby community, the VA, or back home in their own communities. They also are eligible for numerous education, training, and employment programs that, although not clinical, depend for their effectiveness on service members’ level of physical and mental functioning.

We recommend that DoD and VA medical care, support ***A Patient-Centered Recovery Plan***

programs, vocational rehabilitation programs, and disability benefits for seriously injured service members be integrated under a *comprehensive, patient-centered Recovery Plan* that sets goals for recovery and facilitates transitions across settings and programs. Development of the plan should begin as soon as possible during the acute care phase of a service member’s recovery.

The initial plan should include a *complete clinical evaluation* by a team that includes physicians, nurses, mental health and allied health professionals, rehabilitation and vocational rehabilitation specialists, and social workers, as appropriate. The plan should take into account the *goals of the patient* with respect to future activities—including return to military duty, community, education, or employment—and it would be adjusted periodically, as appropriate. Because families are so important to the recovery of individuals with serious injuries, Recovery Plans should, insofar as possible, address family needs, too. In short, the Recovery Plan should be designed to move seriously injured service members efficiently through treatment and rehabilitation.

- Should:**
- Identify patient goals for: post-acute, outpatient, and rehabilitation care; and return to military duty, home community, or into education, training, and employment programs
 - Specify all resources—clinical and other—needed to meet these goals
 - Specify milestones and estimates of time for recovery phases
 - Assess where these clinical and rehabilitative needs can be most appropriately addressed
 - Evaluate and provide for family needs
 - Monitor for timeliness of receipt of care and patient progress

Well-trained and highly skilled Recovery Coordinators should oversee the implementation of service members’ Recovery Plans. Recovery Coordinators would work with existing case managers involved in discrete aspects of care, engage family members, arrange for support programs, make sure care is timely, and advocate for service members across systems. Working across departments, benefits programs, and both public and private sectors, is enormously difficult and will require energy and tenacity.

“We are now training our seventh case manager.” – family member, Washington, DC

To make this system work, Recovery Coordinators need considerable authority and to be paid accordingly. Recruitment, training, and oversight by a new unit of the U.S. Public Health Service’s Commissioned Corps, in the Department of Health and Human Services, should be strongly considered.

Our vision:
A system in which families of seriously injured service members would have a primary point of contact to coordinate their care.

Recovery Coordinators would manage many more issues than case managers currently do in the DoD and VA systems. Now, patients typically have several case managers, each concerned with a different component of their care. We heard reports of high turnover among case managers and that some are not adequately trained. (In particular, some families of patients with traumatic brain injury and post-traumatic stress disorder believed that case managers did not well understand these conditions, the issues they present, and how they should be managed.)

The Recovery Plan concept also requires cross-Departmental health information exchange that does not exist at present. Every health care and rehabilitation professional

working with injured service members, as well as the administrative personnel involved with various benefits programs, would need access to relevant information regarding those individuals—not just “read-only” access, but also the ability to add information to the record.

Serious Injuries of the Afghanistan and Iraq Conflicts

“We’re thinking about what this person will be like five or ten years from now.” – Chief, Brooke Army Medical Center Burn Center

Our Vision:
A patient-centered, integrated care model that addresses the needs of the “whole patient.”

Tremendous strides in military medicine have led to markedly reduced mortality rates among U.S. service members—many of whom require lengthy hospital stays and extensive rehabilitation. Those with serious burns, for example, need several years of treatment in order to reach their maximum functioning. State-of-the-art burn care, such as that provided at Brooke Army Medical Center in San Antonio, often requires a year in the hospital, multiple rounds of surgical reconstruction, and two to four years of rehabilitation. Likewise, amputees require numerous fittings and trials of different artificial limbs. Some of the world’s most advanced prosthetic technologies are available at Walter Reed Army Medical Center. It also has the highly trained staff needed to fit prostheses properly and help service members learn how to use them. For service members with these types of injuries, military treatment facilities are often their best choice.

Our military personnel in Iraq and Afghanistan are constantly at risk for car bombs, suicide bombers, and improvised explosive devices. They face difficult military operations, largely carried out in crowded urban environments, where civilians are active players and anyone—young or old—might be a suicide bomber. The stress is enormous. These battlefield conditions have highlighted two particularly challenging consequences of combat:

- post-traumatic stress disorder (PTSD)—an anxiety disorder that develops in reaction to traumatic events—and
- traumatic brain injury (TBI)—a physical injury to the brain, often caused by exposure to one or more explosions, or other blows to the head. Injuries can be penetrating or closed, and the latter can be mild, moderate, or severe.

A sizeable fraction of service members returning from Iraq and Afghanistan suffer from PTSD. Best estimates are that PTSD of varying degrees of severity affects 12 to 20 percent of returnees from Iraq and 6 to 11 percent of returnees from Afghanistan. To date, 52,375 returnees have been seen in the VA for PTSD symptoms. Severe and penetrating head injuries are readily identified, but cases of mild-to-moderate TBI can be more difficult to identify and their incidence harder to determine. A recent report indicated that when some 35,000 returnees believed to be healthy received a screening test, ten to 20 percent had apparently experienced a mild TBI during deployment. Many have both PTSD and TBI. Multiple deployments increase the risk.

In an attempt to increase resilience and prevent PTSD, the military has developed new ways of training service members, and it has deployed mental health personnel with battle units in order to de-stigmatize mental health issues and facilitate early identification of individuals with problems. Post-deployment, the military services try to identify individuals with PTSD and mitigate its effects. For example, post-deployment health assessments include mental health screening questions, and a reassessment process has been added, in order to identify cases that develop over time. However, we heard many reports that service members, believing that revealing psychological symptoms will delay their return home or jeopardize their careers, do not report them. By contrast, some service members will report PTSD symptoms to “game the system,” in order to avoid deployment or to receive disability benefits.

For both PTSD and TBI, prompt, correct treatment improves the chances for recovery. DoD is working to increase its medical professionals’ expertise in treating TBI, although clinical guidelines are needed for rehabilitation. Because the VA recognized that injury to the brain often occurs at the same time as other, more visible injuries and should be treated as aggressively, it designated four Polytrauma Rehabilitation Centers¹¹ to tackle such multidimensional care. These Centers, although within the VA system, accept patients from the active-duty military.

56 percent of active duty, 60 percent of reserve component, and 76 percent of retired/separated service members say they have reported mental health symptoms to a health care provider.

“The biggest thing you could do is to beat down the stigma of being treated.” -- PTSD patient, Brooke Army Medical Center

Our Vision:
A military that focuses on strengthening warrior resilience and preventing PTSD, TBI, and their consequences and

The VA has a long history of treating combat-related PTSD. Yet, clinicians are not necessarily informed about state-of-the-art treatment or available resources, public and private. Other mental health-related problems, including substance abuse, depression, suicide, and family disruption, often co-occur with PTSD and likewise merit attention. The VA recently announced a major expansion of mental health services, to increase their availability system-wide.

The military’s laudable efforts to prevent mental health problems and identify symptoms more quickly have severely stretched its already thin mental health program staff. Multiple deployments of uniformed mental health professionals have increased the rate at which they are leaving military service. Hospitals located in geographically isolated or less “desirable” areas report great difficulty recruiting civilian staff.

However, for PTSD, the larger problem may be cultural, not clinical. Many service members believe it unmilitary or a sign of weakness to betray the symptoms of psychological distress. As recently as last month, a DoD Mental Health Task Force concluded that the stigma attached to mental health problems remains pervasive.

¹¹ These Centers are at the James A. Haley Veterans Affairs Medical Center, Tampa, Fla.; Minneapolis Veterans Affairs Medical Center; Veterans Affairs Palo Alto Health Care System, Calif.; and Hunter Holmes McGuire Veterans Affairs Medical Center, Richmond, Va.

gives mental health and physical health the same importance.

Concentrating specialized care—like burn and amputee care—at specific centers makes sense not only for reasons of economy, but, more important, for quality of care. A hospital needs enough patients in a specific category in order to attract specialized staff, keep their skills sharp, and maximize patient outcomes. By contrast, service members with relatively common conditions, like mild traumatic brain injury and post-traumatic stress disorder, should find high-quality care *regardless of where they are treated*.

Medical Rehabilitation

67 to 70 percent of active duty and reserve component members are “very” or “somewhat” satisfied with rehabilitative care; as are 60 percent of those retired or separated.

Rehabilitation of injured service members is geared to restoring patients to their highest possible level of functioning. It takes place in a wide variety of inpatient and outpatient facilities, in DoD, VA, and community settings, and is provided by an array of health care specialties, depending on the nature of an individual’s injuries. As noted, DoD’s specialized centers provide initial care for the most seriously injured. This approach enables DoD to offer the most expert care, but it can conflict with the desires of service members—especially those from the reserve components—to be cared for closer to home and to reduce the burden on their families.

Our Vision:

A system that lets injured service members and their families concentrate on healing, not dealing with bureaucracy.

We observed that the supply and demand for medical rehabilitation care are not well balanced. Some facilities—like the VA’s Polytrauma Rehabilitation Centers—are not being optimally used, whereas others—like Walter Reed’s outpatient units—are over capacity. An overall, coordinated plan for use of existing DoD and VA facilities is needed, with attention to where private sector facilities may fill gaps. Because seriously injured service members’ rehabilitation needs can be very long term, their individual Recovery Plans should consider whether these needs can be met close to home.

A System that Supports

More than 3,000 service members have been seriously injured during operations in Iraq and Afghanistan. In virtually every case, a wife, husband, parent, brother, or sister has received the heart-stopping telephone call telling them that their loved one is sick or injured, halfway around the world. While recovery from most injuries is relatively quick, and service members soon return to their units, one telephone call has changed the lives of many service members’ families forever.

Family or close friends stayed to assist recovery of almost 66 percent of active duty and

The most seriously injured service members and their families are embarking on a long journey together, one that may require family to temporarily relocate to a different part of the country to be near the facility where their loved one is being treated. Relocation may

54 percent of reserve component service members.

“Even though things went relatively smooth for us, it’s a lot. We basically do not have a life any more.” – father of a severely wounded soldier

Our Vision:
A restructured, more flexible system of benefits for addressing the multiple needs of families—especially those who must take on a major, long-term caregiving role.

require them to give up the lives they know—jobs, school, homes—and live for an uncertain period far from their existing network of friends and family.

Family support is critical to patients’ successful rehabilitation. Especially in a prolonged recovery, it is family members who make therapy appointments and ensure they are kept, drive the service member to these appointments, pick up medications and make sure they are taken, provide a wide range of personal care, become the impassioned advocates, take care of the kids, pay the bills and negotiate with the benefits offices, find suitable housing for a family that includes a person with a disability, provide emotional support, and, in short, find they have a full-time job—or more—for which they never prepared. When family members give up jobs to become caregivers, income can drop precipitously.

Military families are changing. The majority of spouses work. The Iraq and Afghanistan conflicts rely more heavily than in the past on the reserve components. The husbands, wives, and parents of these troops are distributed across many communities, not concentrated in and around the large installations where military treatment facilities and family support programs are located.

Temporary Housing

50 percent of active duty, 24 percent of reserve component, and 26 percent of retired/separated service members say their family members staying with them were provided with comfortable, convenient housing.

Our Vision:
A system better integrated with private-sector care facilities for service members who want care closer to home.

When family members receive the call telling them that their service member has been injured, their first thought is “How fast can I get there?” Only after they arrive at the medical treatment facility do they begin to think through all of the day-to-day logistics of being at their loved one’s bedside.

One of the first issues to resolve is housing. Every major military medical center and a number of VA medical centers have Fisher Houses on their grounds—residential facilities built with private money, then donated to and operated by the government. Fisher Houses are available free of charge to family members of hospitalized service members and those receiving intensive outpatient care. The nation’s 38 Fisher Houses serve approximately 8,500 families a year, with more houses slated for construction.

When the number of injured service members with long recuperation times has occasionally stretched the capacity of temporary lodging facilities at some military installations, additional housing is arranged

on base or in the community.

Support Programs

“Returnees tell me ‘It’s like drinking out of a fire hose’ when all these programs are described to them.”

– transition coordinator, Ft. Bragg

Our Vision:

Simple, user-friendly ways for service members and families to learn about benefits, when and where they are needed.

Support programs for injured service members and their families help in meeting a wide variety of needs: temporary housing, transportation, financial assistance, meals, counseling, and information about benefits.

Family Service Centers exist on every military installation. These Centers provide referrals to a wide range of programs—from child care to employment assistance. In partnership with community-based organizations, the Centers provide families a “safety net” during long hospital stays. Ironically, the sheer number of overlapping support programs, public and private, and their varying requirements and benefits can at times be overwhelming.

Having a coordinated Recovery Plan and the Recovery Coordinator as a single point of contact may make it easier for families to figure out which programs are most appropriate for them, at what point during recovery. DoD, VA, and private entities have made an effort to put information about their resources online.¹² Families comfortable with accessing and acting upon Web-based information may find these compendiums a promising start. In the long run, online resources will be of greatest help if they can provide information specific to service members’ home communities and tailored to their specific questions and needs.

Employment, Education, and Training

Employment is the dominant concern of most service members reentering civilian life. VA vocational rehabilitation programs—such as vocational assessment, education, retraining, development of alternative employment plans, identification of assistive technologies, and assistance with job-seeking skills—focus on helping veterans with disabilities enter a different job or career. For severely disabled veterans for whom paid employment is not an option, these programs focus on enhancing the ability to live more independently in their homes and communities. Further, an array of federal, state, and private-sector programs and employer incentives promotes employment opportunities for veterans in general and disabled veterans in particular. Education and training assistance also is widely available.

¹² For example, the military’s online resource and telephone hotline, Military OneSource; the DoD’s “America Supports You,” which compiles information on many charitable organizations; and an Army website currently under development, MyArmyBenefits.mil.

21 percent of demobilized reserve component and 31 percent of retired/separated service members are enrolled in an educational program leading to a degree.

33 and 36 percent of these groups are “very” or “somewhat” satisfied with VA employment services.

73 and 44 percent of these groups are working at a paid job.

Participation in vocational rehabilitation programs can significantly increase employment and quality of life for people with disabilities. Unfortunately, the VA does not—and should—routinely track vocational rehabilitation participants over time to evaluate program outcomes and identify factors associated with success. As a result, it is impossible to determine which programs work best. Research does show that vocational rehabilitation and employment programs should be provided as early as possible after the onset of the disability, in order to have the greatest impact on the service member’s likelihood of returning to work; likewise, the sooner an injured person can return to regular activities, the more successful the transition is.

Veterans who qualify for and complete VA’s Vocational Rehabilitation and Employment program achieve good results in the short run. However, of the 65,000 veterans who apply for the program each year, only half qualify for it; of these, less than 40 percent complete either the education or independent living tracks. Including a vocational rehabilitation component in the Recovery Plan should increase the number of participants and program completion rates. Financial incentives also could increase program retention.

A Simpler System

Many aspects of the DoD and VA medical care, support program, and disability systems have become tremendously complex over the years. As various needs have arisen, the Departments have undertaken initiatives to augment or clarify existing policy and programs. Often these initiatives are—or were—good solutions for limited problems, but ripple through the entire system in undesirable ways. Unplanned and uncoordinated programmatic evolution creates redundancies, while gaps are unfilled. It adds layers of complicated policies and rules. Then, because different individuals, offices, and military service branches interpret rules differently, the result can be real or perceived inequities.

The patchwork of programs, rules, and regulations affecting injured service members is mirrored in the complicated, uncoordinated information technology systems that support these activities. Efforts to streamline IT have to be built on a more coherent underlying structure. As stated earlier in this report, although IT systems are important, they cannot by themselves solve all the information flow and quality problems the Departments face. They are a means to an end, not the end itself.

Consequences for Families of a Complex System

“We cannot begin piecing our lives back together or caring for ourselves until our loved ones are cared for first.”—wife of a severely injured soldier

Families thrust into stressful new situations by a loved one’s serious injury understandably are confused and anxious. They cannot be expected to know about care or benefits available, and they may feel incapable of determining the best course. Our recommendation for a Recovery Coordinator should ease this burden.

Our Vision:

An easier return to normal life for service members and families.

Complexity in Disability Determination & Compensation Systems

Less than half of service members understand the DoD’s disability evaluation process.

Just 42 percent of retired/separated service members who had filed VA claims understand that process.

The DoD’s disability determination system focuses on whether service members are fit or unfit to perform their primary military duties. DoD’s disability ratings determine how much service members will receive in military disability compensation and whether this compensation is lifelong or one-time-only. It determines whether they and their families receive lifetime TRICARE medical benefits or coverage for only 180 days after discharge. Similarly, the VA’s disability ratings determine the amount of VA compensation veterans receive and their eligibility for an array of vocational rehabilitation and other benefits that help them recover.

The DoD and VA each have their own complicated disability rating processes that take several months to complete. If a service member appeals the rating decision, the case may not be resolved for several years (for the VA, an *average* of 657 days). A positive step is a joint VA/DoD initiative—the Benefits Delivery at Discharge Program—intended to provide medically separating or retiring service members a smoother transition into the VA health care system and prompt receipt of VA disability compensation.

Research confirms that there are indeed differences in ratings, depending on which military service determines the DoD rating and which regional office determines the VA rating. Disability ratings assigned by DoD are scored differently and are usually lower than those assigned by the VA.

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Despite their disability systems' different intents, processes, and outcomes, DoD and VA use the same outdated rating schedule to establish a service member's percent disability.¹³ The rating schedule has not been completely revised since 1945, although portions have been updated over the past 20 years. The schedule is problematic for service members injured in Iraq and Afghanistan, because of:

- the number of injuries that are new or for which diagnostic criteria are changing rapidly, such as traumatic brain injury
- a new appreciation of the disabling impact of other conditions, such as post-traumatic stress disorder and
- advances in medical care and rehabilitation that change the prognosis for certain conditions, such as serious burns and amputations.

Future conflicts may produce their own “signature conditions,” and at the same time clinical treatment continues to advance. This dynamic situation requires that the VA review and adjust the disability rating system *at frequent and regular intervals*.

As long as injured service members remain in the military, they receive their military pay. Once their disability rating is established and they leave the military, they receive disability compensation and may be eligible for health care and other programs. For most injured service members, military pay is more than their disability pay will be. Service members may therefore believe it is to their advantage to stay in a “pending” category for as long as possible, continue to receive their military pay, and not face the uncertainties of the disability rating system.

Once they do leave the military, most veterans with disabilities will end up with the higher of either DoD or VA disability compensation pay. Since 2004, individuals with more than 20 years of military service who have a 50 percent or greater VA disability rating for combat-related injuries may receive payment from both systems.¹⁴

In DoD, the objective of the disability payment system is not well-defined and, once again, it is governed by a complex set of rules and procedures. In part, DoD disability payments appear intended to compensate injured service members for the premature end to their military careers—in effect, a “retirement benefit” for those unable to reach actual retirement. The VA's system, as noted above, is intended to replace lost earnings capacity. A 21st century view acknowledges a disability's effects not just on earnings, but also on social, family, and community participation. The current system touches on these issues indirectly, not by explicit policy.

As long ago as the Bradley Commission, we were warned about the debilitating potential of policy aimed merely at income replacement. Such a focus reduces recipients' incentives to work, to obtain education and training—in short, to get on with life. In line with our belief that the goal of the disability system should be to return disabled veterans

¹³ Institute of Medicine. *A 21st Century System for Evaluating Veterans for Disability Benefits*. Washington, DC: National Academies Press, 2007.

¹⁴ Receiving both benefits is called “concurrent receipt.” Almost all other government programs have rules requiring that people eligible for the same type of benefit from different programs to choose one or the other; they cannot receive both.

to normal activities, insofar as possible, and *as quickly as possible*, strong incentives to encourage education, training, and employment are urgently needed.

A Streamlined DoD/VA Retirement & Disability Compensation System

At any point in time, disabled veterans would receive three types of payments:

Point of Discharge

Point of Retirement

	Throughout the “working years,” veterans would receive	After Retirement Age	
1. DoD’s Military Annuity Payments	\$ amount based on rank and years of military service		
2. VA Quality of Life Disability Payments	\$ amount based on impacts on quality of life		
3. Transition payments*		4. Followed by ...	5. Followed by . . .
▶ EITHER	Long-term living expense support while in school/VRE	Earnings loss payments when employment begins**	Social Security
▶ OR	3 months	Earnings loss payments when employment begins**	Social Security

*To help veterans become established and move into work or, if unable to work, to enable independent living.

**These payments would contribute to veterans’ earnings for Social Security eligibility; the amount would be recalculated periodically as veterans’ condition or earnings change.

Our recommendation regarding the disability rating and compensation system for injured service members would accomplish the following:

- DoD and VA should create a single, comprehensive, standardized medical examination that DoD administers. It would serve DoD’s purpose of determining fitness and VA’s of determining initial disability level.
- The service branches would remain in charge of determining whether an injured service member is fit for duty
- If not, he or she would be separated from the military and receive a lifetime annuity payment, based on military rank and years of military service
- Service members’ disability rating would be determined by the VA and continued eligibility for payments and benefits reassessed periodically (at least every three years)
- All disability-related payments and benefits for veterans would be obtained through the VA. Veterans would be eligible for compensation that would reflect three components, as shown in the accompanying chart:
 - a. *transition payments* after they leave military service—either:
 - *short-term*, to help with expenses related to their return to the community or

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- *longer-term*, to cover family living expenses while they participate in education and training programs or prepare for independent living
- b. *earnings-loss payments* to make up for any reduced earning capacity and
- c. *quality-of-life payments* to compensate for permanent losses of various kinds.
- Service members found unfit because of their combat-related injuries should receive lifetime, comprehensive health care coverage and pharmacy benefits for themselves and their dependents through DoD's TRICARE program.

This recommendation gets the DoD completely out of the disability business. It eliminates the confusing, parallel systems of ratings and compensation and the notion of “concurrent receipt.” The objective of the DoD system would be to maintain a fit force and acknowledge years of military service, and the objective of the VA system would be to compensate for disability.

Information Technology (IT)

The design of information systems must be driven by the needs of an organization for effective management, operations, and support programs. The current information technology (IT) systems within DoD and VA are fragmented and compartmentalized. Information is collected and stored in isolated yet overlapping data systems that are rarely integrated. Some parts of the system collect more information than needed; others duplicate information available in other parts of the system, increasing opportunities for errors and inconsistencies. We were told that users of these complex data systems often do not know what data are already available to them.

The DoD and VA are working to facilitate the exchange of medical information and the sharing of personnel and disability information. At present, they do not fully integrate health care data with benefit information. Understanding organizational needs and simplifying the processes are the first priority. Meanwhile, congressional or departmental reform efforts should resist imposing new requirements that may result in duplicative or uncoordinated electronic systems and, instead, encourage the streamlining of today's systems and facilitate communication across them.

With our proposed comprehensive Recovery Plan, patient records would need to be electronically available to the Recovery Coordinator, health care professionals, and program staff across the continuum—from acute care, to rehabilitation, to long-term support, education, and employment programs, if needed. The system must be secure and designed so that various professionals have access to the information germane to their work.

Drawing information from these systems, an interactive web portal, such as the prototype “My eBenefits” page shown above, could provide tailored information to each service member and veteran, specific to their situation, and enable them to make appointments, do financial planning, maintain confidential personal health records, and apply for various benefits programs. Today, in order to find such information, armed service

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members and veterans must navigate a disparate, confusing, and cumbersome array of websites. First-rate content exists online for service members and their families; however, the presentation and organization of this information simply have not evolved to meet the needs and expectations of the next generation of service members.

There is a timely and unmistakable need for the VA and DoD to work together to create a single, one-stop “information shop.” As we envision it, a site such as “My eBenefits” would be consumer-friendly, interactive, evolving, fully customizable and personalized information portal. It would host almost every type of data important to a patient’s Recovery Plan. It also would include tailored, up-to-date information on federal and state benefits, in-patient and out-patient care, disability evaluation and application status, local and national resources from veterans service organizations and community organizations, area employment opportunities, doctors’ names and contact information, news, and the ability to connect easily with other armed service members and veterans.

A Gratifying Accomplishment . . .

Sometimes Commission work can seem long-term or theoretical. This time, we already have something good to report. In the course of our work with veterans and their families, we learned that service members’ remaining enlistment bonuses were not being paid when they were injured and medically retired or separated from active duty.

The DoD was applying a rule that enlistees who leave the service early cannot receive their full enlistment bonus. We were confident that this rule was surely not intended to apply to service men and women whose combat-related injuries forced them to leave the military.

Upon learning about the problem, we contacted the Department of Defense and received assurances that these payments will be made to all applicable injured service members, retroactive to 2001.

Implementing Our Recommendations

The following chart summarizes the locus of responsibility for implementing the action steps that support our recommendations.

<i>Recommendation Action Steps</i>	<i>Congress</i>	<i>DoD</i>	<i>VA</i>	<i>Other</i>
1. Implement comprehensive Recovery Plans				
▪ Develop integrated care teams		X	X	
▪ Create Recovery Plans		X	X	
▪ Develop corps of Recovery Coordinators		X	X	PHS
2. Restructure disability and compensation systems				
▪ Clarify the objectives of DoD and VA disability programs	X			
▪ Create a single, comprehensive medical exam		X	X	
▪ Provide lifetime TRICARE benefits for combat-injured	X			
▪ Revise objectives for VA disability payment system	X			
▪ Determine appropriate length and amounts of transition payments			X	
▪ Determine appropriate quality-of-life payment amounts			X	
▪ Update and keep current the disability rating schedule			X	
▪ Develop flexibility within Vocational Rehabilitation and Education (VRE) program			X	
3. Improve care for people with post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI)				
▪ Enable all Iraq & Afghanistan veterans who need PTSD care to receive it from the VA	X			
▪ Address shortage in mental health professionals		X		
▪ Establish and expand networks of experts in PTSD and TBI		X	X	
▪ Expand training regarding PTSD and TBI		X	X	
▪ Develop or disseminate clinical practice guidelines		X	X	
4. Strengthen support for families				
▪ Expand eligibility for TRICARE respite care and aide and attendant care	X			
▪ Expand caregiver training for families		X	X	
▪ Cover family members under the Family Medical Leave Act	X			
5. Transfer patient information across systems				
▪ Make patient information available to all personnel who need it, initially in readable form		X	X	
▪ Continue efforts for fully interoperable information system		X	X	
▪ Develop a user-friendly single web portal for service members and veterans		X	X	
6. Support Walter Reed until closure				
▪ Assure adequate resources		X		
▪ Strengthen recruitment and retention of needed administrative and clinical staff		X		

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