Honorable Togo D. West, Jr., Co-Chair, Independent Review Group, Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center

The Honorable Togo D. West, Jr.
Opening Statement
United States Senate
Committee on Veterans' Affairs
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The report by the Independent Review Group is replete with findings and recommendations covering a wide range of issues and circumstances which have come to our attention. They converge around four core concerns. Let me pose them as questions.

Firstly, who are we - as a country, as an Army, as a health care center here at Walter Reed? Unfortunately, if one considers reports we have heard from service members and their families about the lapses in support to them during their rehabilitation phase of care, we would conclude that we may be answering that question in ways that are not attractive to us as an Army or as a Nation. We say so much about ourselves by the attitudes we display towards those who look to the Nation for support during the most vulnerable times of their lives. We have included a number of findings and recommendations involving the assignment and training of caseworkers, increases in the numbers of caseworkers and adjustment of the caseworker to patient ratio, assignments of primary care physicians, and attention to the nursing shortages.

Secondly, who and what are we to become? The Base Realignment and Consolidation (BRAC) process and the A-76 process have caused incalculable dislocation in Walter Reed operations and threaten the future of both installations.

Thirdly, how are our service members doing? At every turn, the IRG has encountered service members, their families, health care professionals, and thoughtful observers who point out how challenging the traumas associated with TBI (traumatic brain injury), and PTSD (post traumatic stress disorder) have become; and how challenging they have been in terms of both DOD and Department of Veterans Affairs diagnosis, evaluation, and treatment. We believe there is a need for greater and better coordinated research in this area. We have made a detailed recommendation with respect to a center of excellence and increased attention to cooperative efforts by both the Department of Defense and the Department of Veterans Affairs.

Fourth, how long? The IRG has operated with what is, for me, a rare sense of unity and consensus in our effort. If there is one issue, on which we are even more unified than all others, it is that the horrors that are inflicted on our wounded service members and their families in the name of the physical disability review process, known in the Department of Defense as the MEB/PEB process, simply must be stopped.

It is no surprise to you on the Committee, or to us on the IRG, that each part of the governmental process can make sound arguments to defend and explain why three, and in the case of the Army four, separate Board proceedings -- with associated paperwork demands on the wounded service member and family, accompanied by delays and economic dislocation for assisting family members, and characterized prominently by inexplicable differences in standards and results -- are justified. We, however, are a Nation which values the every day good sense of the common man or woman - that is why we call it common sense. And common sense says that

from our service members' and families' point of view this must seem a wildly, incomprehensible way to settle for service members and families the question of whether the member must leave the service and, if so, under what conditions. We recommend one combined physical disability review process for both DOD and VA. (See Attachment for specific areas that require collaboration between the DOD and VA)

Virtually every finding and recommendation we make, then can be traced to these four concerns; (1) leadership and attitude; (2) the transition from Walter Reed Army Medical Center to Walter Reed National Medical Center; (3) the extraordinary use of IED (improvised explosive devices) in the current wars and their impacts on the brains and psyches of our service members; and (4) the long-standing and seemingly intractable problem of reforming the disability review process. It is important to note that at the conclusion of the IRG investigation, Army officials said the service has resolved, or is in the process of resolving, 24 of the 26 findings listed in the report.

To be sure, it was the degradation in facilities that first caught the eye of media reporters. Important as that is, however, we believe that there is far more to be dealt with here than applying paint to rooms or even in crawling around basements to deal finally with electrical problems. We had experts of every sort assigned to us, and talented and experienced health professionals as part of the Independent Review Group itself.

None of these concerns, however, is our bottom line: not BRAC, not facilities, not even the search for failures, breakdowns, or culprits. Rather our bottom line is this:

(1) We are the United States of America.
(2) These are our sons and daughters, brothers and sisters, uncles and aunts, even a grandparent or two who lie and sit wounded.
(3) Their families are our families, we are their neighbors, and we, their fellow citizens and residents.
(4) Their anguish is our anguish.
(5) We can and must do better.

Attachment

Rebuilding the Trust
Independent Review Group
Report on Rehabilitative Care and
Administrative Processes at
Walter Reed Army Medical Center and
National Naval Medical Center

April 2007

Finding:
There are inconsistencies within the Department of Defense and the Department of Veterans Affairs regulatory systems which deal with the functional loss of limb due to traumatic injury and burn. Currently, the disability system does not adequately compensate for the functional and physiological loss of limb in burn patients.

Discussion:
The Code of Federal Regulations, Title 38, Part IV (Veterans Affairs Schedule for Ratings and Disabilities) does not address specific disability ratings for burn injuries. It does thoroughly cover amputations. It also addresses many skin injuries such as scarring, disfigurement and dermatitis. There exists a gap for addressing issues specific to burn injuries. Burned skin needs extra protection from the sun and elements; it does not sweat normally and needs extra precautions (for example: ultraviolet protective clothing and salves) for warm/hot environments. Because there are not specific disability ratings for burn patients, they do not qualify for home or vehicle modification as an amputee patient would.

Recommendations:
1. The Secretary of Defense should request the Secretary of Veterans Affairs to update the Code of Federal Regulations, Title 38, Part IV to account for the unique disabilities and needs of traumatic amputees and burn victims, focused on a loss of function and post-service needs. This would require an expedited process for publishing the change.
2. The Secretary of Defense should review the Physical Evaluation Board determinations of all burn cases, dating back to 2001, within one year after the update to United States Code 38.

Finding:
When an amputee leaves the Department of Defense medical system, the follow-on care, the amputee receives, may not be as technologically advanced outside the military medical system.

Discussion:
The Department of Defense, from clinical necessity, has been on the cutting edge of prosthetic replacement for traumatic amputation. The Department of Veterans Affairs has largely been focused on patients who lost a limb (or limbs) through disease or accident instead of combat. In addition, many amputees in the Veterans Affairs system are much older than those who have suffered an amputation due to combat.

The Sun-Times News Group recently reported, MAJ (RET) Tammy Duckworth, currently the Director of the Illinois Department of Veterans Affairs, testified before the US Senate Committee for Veterans Affairs on March 27, 2007 and stated, "The US Department of Veterans Affairs is absolutely not ready to treat amputee patients at the high tech levels set at Walter Reed. Much of the technology is expensive and most of the Veterans Affairs personnel are not trained on equipment that has been on the market for several years, let alone the state-of-the-art innovations that occur almost monthly in this field. I recommend that the VA expand its existing SHARE program that allows patients to access private prosthetic practitioners. There is simply not enough time for US Department of Veterans Affairs to catch up in the field in time to adequately serve the

new amputees from Operations Iraqi and Enduring Freedom during these critical first two years following amputation. Perhaps after the end of current wars in Iraq and Afghanistan, the VA will have time to advance its prosthetics program."
Travel for prosthetic care also includes Department of Defense beneficiaries follow up post amputation patients often requires travel to medical centers with competent prosthetics departments. Often a patient does not live in a geographic area where TRICARE Prime is offered. The TRICARE Prime travel benefit covers per diem and travel if a patient is referred to care more than 100 miles away from their home. TRICARE Standard does not offer a travel benefit.

Recommendations:
1. The Secretary of Defense should pursue partnerships with the Secretary of Veterans Affairs to provide treatment; promote education and research in prosthesis care, production, and amputee therapy.
2. The Secretary of Defense should pursue a partnership with the Secretary of Veterans Affairs to expand the Department of Veterans Affairs' existing program to allow patients to access the military health system and private prosthetic practitioners.
3. Review TRICARE regulations (CFR 199.17) and update specifically to change them so that the geographic home of the patient does not limit access to benefits for prosthetic care and treatment.

Finding:
There are serious difficulties in administering the Physical Disability Evaluation System due to a significant variance in policy and guidelines within the military health system.

Discussion:
There is much disparity among the Services in the application of the Physical Disability Evaluation System that stems from ambiguous interpretation and implementation of a Byzantine and complex disability process. It is almost as if a peacetime, draft-era program is being applied to an all-volunteer force engaged in war.

The Governing Statute, implementing publications and regulatory guidelines: Code of Federal Regulation: Title 10, USC chapter 61, provides the Secretaries of the Military Departments with the authority to retire or separate members for physical disability. Code of Fed reg Title 38, provides the authority for the VA. DoD Directive 1332.18, Separation or Retirement for Physical Disability; DoD Instruction 1332.38, Physical Disability Evaluation; DoD Instruction 1332.39, Application of Veterans Affairs Schedule for Rating Disabilities, and applicable service specific regulations or instructions set forth the polices and procedures implementing the statute. 80
For each respective service, the governing service specific guidelines include: Department of the Air Force, AFI 36-3212, Physical Evaluation for Retention, Retirement, and Separation; Department of the Army, AR 635-40, Physical Evaluation

for Retention, Retirement, or Separation; Department of the Navy, SECNAV Instruction 1850.4E and Department of the Navy Disability Evaluation Manual.
A Government Accounting Office (GAO) Report (2006), acknowledged the differences among the services and recommended improved oversight of the physical disability evaluation system, to which the Department of Defense agreed and indicated an intent to implement.

"The Government Accountability Office noted that eligibility criteria for disability programs need to be brought into line with the current state of science, medicine, technology and labor market conditions."

During the course of its review, the Independent Review Group identified no less than five Government Accountability Office reports and one Presidential Task Force report that noted deficiencies and made recommendations to improve the physical disability evaluation system. These reports include:

- November 2004 Government Accountability Office Report: VA and DoD Health Care: Efforts to coordinate a single physical exam process for servicemembers leaving the military

- September 2005 Veterans Affairs and Department of Defense Health Care: VA has policies and outreach efforts to smooth transition from DOD Health Care, but sharing of Health Information remains limited.

- June 2006 Government Accountability Office Report: VA and DOD Health Care: Efforts to provide seamless transition of care for OEF and OIF servicemembers and veteran's.

- March 2006 Military Disability System: Improved oversight needed to ensure consistent and timely outcomes for reserve and active duty service members.

- March 2007 Government Accountability Office Report: DOD and VA Health Care: Challenges encountered by injured servicemembers during their recovery process.

- 2003 President's Task Force to Improve Health Care Delivery for Our Nation's Veterans.

Despite the comprehensive findings and recommendations in these reports, the Group found little evidence of action on the recommendations.

Recommendations:
1. The Secretary of Defense should provide recommendations to Congress to amend Title 10 United States Code, Chapter 61, and Title 38 United States Code, to allow the ‘fitness for duty' determination to be adjudicated by the Department of Defense and the disability rating be adjudicated by the Department of Veterans Affairs.

2. Following the changes to the United States Code, the Secretary of Defense, should quickly promulgate regulatory guidelines and policy to the Service Secretaries.

Finding:
The current Medical Evaluation Board/Physical Evaluation Board process is extremely cumbersome, inconsistent, and confusing to providers, patients, and families.

Discussion:
The physical disability evaluation system is the means by which servicemembers are retired or separated due to physical disability in accordance with the aforementioned references. The Department of Defense Directive (DoDD) 1332.18, Section 3.2 outlines four elements of the physical evaluation disability system: the physical evaluation; appellate review; counseling; and final disposition. According to the Department of Defense regulations, the physical evaluation process consists of the Medical Evaluation Board and the Physical Evaluation Board. The Department of Defense and the Department of Veterans Affairs use the Veterans Administration Schedule for Rating Disabilities.
The Veterans Administration Schedule for Rating Disabilities (VASRD) is primarily used as a guide for evaluating disabilities resulting from all types of diseases and injuries encountered as a result of, or incident to, military service.

Not all the general policy provisions set forth in the rating schedule apply to the military. Consequently, disability ratings consistently vary between the Department of Defense and Department of Veterans Affairs. The Services rate only conditions determined to be physically "unfitting," compensating for loss of a military career. The Department of Veterans Affairs may rate any service-connected impairment, thus compensating for loss of civilian employability. Additionally, the term of rating is different among the Department of Defense and the Department of Veterans Affairs. The Services' ratings are permanent upon final disposition. The Department of Veterans Affairs ratings may fluctuate with time, depending upon the progression of the condition. Further, the Services' disability compensation is determined by years of service and basic pay; while Veterans Affairs compensation is a flat amount based upon the percentage rating received.

Recommendations:
1. The Under Secretary of Defense (Personnel & Readiness) should completely overhaul the physical disability evaluation system to implement one Department of Defense level Physical Evaluation Board/Appeals Review Commission with equitable Service representation and expand what is currently the Disability Advisory Council.

- According to a Government Accountability Office report, a problem with the current organization is that the Council only "aims" to meet quarterly, but did not meet for a full year, to discuss issues raised by the Services. This recommended concept would have consolidated operational oversight and responsibility of the Physical Evaluation Board process, including the current the Service level Physical Evaluation Board and Appeals Review levels of jurisdiction. This action allows for streamlining of personnel and resources, and eliminates the intra and inter-Service disparities of the disability ratings and provides a forum for implementing immediate corrective action. This recommended concept incorporates Veterans Affairs representation and ensures a seamless transition from the Department of Defense into the Department of Veterans Affairs health system.

2. The Under Secretary of Defense (Personnel & Readiness) should conduct a quality assurance review all (Army, Navy/Marine Corps, and Air Force) Disability Evaluation System decisions of 0, 10, or 20 percent disability and Existed Prior to Service (EPTS) cases since 2001 to ensure consistency, fairness, and compliance with applicable regulations.

3. The Secretary of Defense and the Secretary of Veterans Affairs should establish one solution. Develop and utilize one disability rating guideline that remains flexible to evolve and be updated as the trends in injuries and supporting medical documentation/treatment necessitate. Revise the current process of updating the disability ratings system to include an operation update that pushes changes to the field on a weekly, or as needed basis.

Finding:
A common automated interface does not exist between the clinical and administrative systems within the Department of Defense and among the Services, causing a systemic breakdown of a seamless and smooth transition from Department of Defense to the Department of Veterans Affairs.

Discussion:
Servicemembers should not be burdened with the arduous navigation requirements of our current system. The complexity of the physical disability evaluation system is further perpetuated as the servicemembers transition into the Veterans Affairs system. Currently there is not a seamless transition.

A "seamless transition" from military service to veteran status is especially critical in the context of healthcare, where readily available, accurate, and current medical information must be accessible to health care providers.

For the administrative aspects of this process, no one system currently exists. The Department of Defense does not have an integrated automated system that supports the standardization of the clinical and administrative requirements of the physical disability

evaluation system. Absent a corporate solution, the Services have created individual systems to track the service members within the physical disability evaluation system. This exacerbates the process variation.

The Air Force currently does not have an automated system. The Army currently uses the Medical Evaluation Board Internal Tracking Tool (MEBITT). The Navy uses the Medical Board On Line Tri-Service Tracking System (MedBOLTT). Each system serves its Service independently for Medical Evaluation Board processing; yet do not interface with the next step of the Physical Evaluation Disability System, or Physical Evaluation Board.

The Army Physical Evaluation Board uses the Physical Disability Case Processing System (PDCAPS) to track Army cases once they enter the Physical Evaluation Board stage of the process. Using the Army as an example of the lack of interface between systems, during the Medical Evaluation Board phase of the process, the Medical Evaluation Board Internal Tracking Tool is used. During the Physical Evaluation Board phase, the Physical Disability Case Processing System is used. These two systems, unique to one Service, result in numerous disparities within the Army since the systems do not interface. From a clinical perspective, all medical documentation should be available to the servicemembers' providers throughout the entire process. This includes the transition into the Veterans Affairs system where there is no continuity other than what records the servicemember carries to the Veterans Affairs. This issue has been continually addressed without resolution.

"The Department of Veterans Affairs and the Department of Defense should develop and deploy, by fiscal year 2005, electronic medical records that are interoperable, bidirectional and standards-based". [Refer to Recommendation 3:1 of President's Task Force. (2003) Final report to improve health caredelivery for our nation's veterans. Washington, DC] The same report recommends a single separation physical and electronic transmittal of the Department of Defense Form 214 (DD214) to the Department of Veterans Affairs. These recommendations have yet to come to fruition and as a result, there is a significant amount of redundancy is still required at this point starting at the physical examination.

Recommendation:
The Secretary of Defense, in conjunction with the Secretary of Veterans Affairs, should direct the transition process be streamlined for the servicemember separating from the Department of Defense and entering the Department of Veterans Affairs.

- As already identified in the Government Accountability Office report (2004), implement the single physical exam. Review the 1998 Department of Defense memorandum of understanding (MOU) between the Department of Defense and Department of Veterans Affairs, implement a common physical for use by the Services and the Department of Veterans Affairs for those servicemembers in the physical disability evaluation system, and allow flexibility in the timelines test or procedures that would eliminate redundant efforts.

Rapidly develop a standard automated systems interface for both clinical and administrative systems that allows bilateral electronic exchange of information. Review and implement the recommendations of the 2003 President's Task Force.