

**HEARING TO RECEIVE TESTIMONY ON IMPROVEMENTS IMPLEMENTED AND PLANNED BY THE DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS FOR THE CARE, MANAGEMENT, AND TRANSITION OF WOUNDED AND ILL SERVICE MEMBERS**

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**WEDNESDAY, FEBRUARY 13, 2008**

U.S. SENATE  
COMMITTEE ON ARMED SERVICES  
*Washington, D.C.*

The committee met, pursuant to notice, at 9:32 a.m. in Room SD-106, Dirksen Senate Office Building, Hon. Carl Levin, chairman of the committee, presiding.

Committee Members Present: Levin [presiding], Kennedy, Bill Nelson, E. Benjamin Nelson, Webb, Warner, Inhofe, Sessions, Chambliss, Dole, Thune, and Wicker.

Committee Staff Members Present: Richard D. DeBobes, Staff Director, and Leah C. Brewer, Nominations and Hearings Clerk.

Majority Staff Members Present: Gabriella Eisen, Counsel, Gerald J. Leeling, Counsel, and Peter K. Levine, General Counsel.

Minority Staff Members Present: Michael V. Kostiw, Republican Staff Director, William M. Caniano, Professional Staff Member, David G. Collins, Research Assistant, Lucian L. Niemeyer, Professional Staff Member, Diana G. Tabler, Professional Staff Member, and Richard F. Walsh, Minority Counsel.

Staff Assistants Present: Fletcher L. Cork, Jessica L. Kingston, Ali Z. Pasha, and Brian F. Sebold.

Committee Members' Assistants Present: Bethany Bassett, Assistant to Senator Kennedy, Jay Maroney, Assistant to Senator Kennedy, James Tuite, Assistant to Senator Byrd, Bonni Berge, Assistant to Senator Akaka, Christopher Caple, Assistant to Senator Bill Nelson, Andrew R. Vanlandingham, Assistant to Senator Ben Nelson, Jon Davey, Assistant to Senator Bayh, M. Bradford Foley, Assistant to Senator Pryor, Gordon I. Peterson, Assistant to Senator Webb, Jennifer Cave, Assistant to Senator Warner, Sandra Luff, Assistant to Senator Warner, Anthony J. Lazarski, Assistant to Senator Inhofe, Nathan Reese, Assistant to Senator Inhofe, Lenwood Landrum, Assistant to Senator Sessions, Todd Stiefler, Assistant to Senator Sessions, Mark J. Winter, Assistant to Senator Collins, Clyde A. Taylor IV, Assistant to Senator Chambliss, Adam G. Brake, Assistant to Senator Graham, Lindsey Neas, As-

sistant to Senator Dole, Jason Van Beek, Assistant to Senator Thune, and Erskine W. Wells, III, Assistant to Senator Wicker.

**OPENING STATEMENT OF HON. CARL LEVIN, U.S. SENATOR  
FROM MICHIGAN**

Chairman Levin: Good morning, everybody. The committee meets this morning to review actions taken over the last year to improve living conditions, outpatient care, and processes to help our severely injured and ill service members as they transition to care provided by the Veterans Administration into civilian life and to discuss actions in progress or yet to commence.

Our witnesses this morning were scheduled to be: Deputy Secretary of Defense Gordon England -- and before I identify the other witnesses, let me say that I understand that Secretary Gates had a fall last night on the ice and broke his shoulder and therefore now he must be represented by Gordon England at another hearing that Secretary Gates was supposed to be at himself. Is that correct?

Mr. Geren: Yes, sir, that's correct.

Chairman Levin: It's our hope that you would express to Secretary Gates our, first of all, our hopes for a very speedy and prompt recovery. We obviously want him back in action. We understand totally, of course, why the Secretary cannot be with us this morning.

Our other witnesses are: Secretary of Veterans Affairs, Gordon Mansfield, Secretary of the Army -- excuse me, Deputy Secretary of Veterans Affairs Gordon Mansfield; Secretary of the Army Pete Geren; Under Secretary of Defense for Personnel and Readiness David Chu; the Surgeon General of the Army, Lieutenant General Eric Schoomaker.

We understand Admiral Dunne is here with you, Secretary Mansfield, this morning. We welcome you, of course, as well, Admiral.

Our Nation has a moral obligation to provide quality health care to the men and women who put on our Nation's uniform and are injured and wounded fighting our Nation's wars. On February 18, 2007, the headlines of the Washington Post read "Soldiers Face Neglect, Frustration at Army's Top Medical Facility." A series of articles by Dana Priest and Ann Hull served as a wakeup call regarding the care and treatment of our wounded warriors. The articles that appeared in the press a year ago described deplorable living conditions for service members living in outpatient status at Walter Reed, a bungled bureaucratic process for assigning disability ratings that determined whether a service member would be medically retired with health and other benefits for the member and for his family. They described a clumsy handoff from the Department of Defense to the Department of Veterans Affairs as these injured soldiers try to move on with their lives. We also learned that these problems were not limited to the Army or to Walter Reed.

A lot has been accomplished in the wake of these articles and much more needs to be done. This committee held a hearing on March 6, 2007, to address the shortfalls in the care of our wounded warriors. At that hearing we concluded that it would require the coordinated efforts of the VA Committee and the Armed Services Committee to address the issues in a comprehensive manner.

This led to a rare joint hearing of the Committee on Armed Services and the Committee on Veterans Affairs on April 12th. The committees continued to work together to pass the Dignified Treatment of Wounded Warriors Act on July 25 of 2007. This comprehensive bipartisan legislation that addressed the care and management of our wounded warriors was drafted, marked up, and passed by the Senate in record time.

This act, enhanced by provisions in the House-passed Wounded Warrior Assistance Act of 2007, became the Wounded Warrior Act that was included in the recently signed National Defense Authorization Act for Fiscal Year 2008. The Wounded Warrior Act represents major reform and was supported by veterans service organizations. It advances the care, management, and transition of recovering service members, enhances health care and benefits for families, and begins the process of fundamental reform to the disability evaluation systems of the Department of Defense and the Department of Veterans Affairs.

We require the Department of Defense in this law to use VA standards for rating disabilities and to use the VA presumption of sound condition in determining whether a disability is service-connected. We increase the disability severance pay for certain service members. We required the Department of Defense and the Department of Veterans Affairs to jointly develop a comprehensive policy on improvements to care and management of recovering service members. We established centers of excellence for traumatic brain injury, post-traumatic stress disorder, and traumatic eye injuries, and we authorized respite care for seriously injured service members.

The Wounded Warrior Act addresses nearly all of the findings of the various commissions that have examined the issues regarding the care and treatment of our wounded warriors. The most significant exception is the recommendation of the Dole-Shalala Commission to restructure the VA disability compensation system. The essence of that recommendation is a restructuring of the VA disability compensation benefit. It falls, the recommendation, primarily in the jurisdiction of the House and Senate Veterans Affairs Committees, both of whom are examining it.

The Department of Veterans Affairs has just recently awarded a contract to develop information regarding changes in the composition of disability payments, as recommended by the Dole-Shalala Commission, and some veterans service organizations have already expressed some questions about this change.

Working together in an approach that is consistent with the Wounded Warrior Act, the Departments of Defense and Veterans Affairs established a high-level senior oversight committee, co-chaired by the Deputy Secretary of Defense and the Deputy Secretary of Veterans Affairs, to oversee analysis of and changes to the DoD and VA systems, to improve the care and treatment of our injured and ill service members. We hope to learn this morning what the Departments have accomplished this far, what initiatives are in the works, and if any additional legislation is needed to accomplish their goals.

The Army has established the Army medical action plan to develop a sustainable system for the medical treatment and rehabili-

tation of injured and ill soldiers, to prepare them for successful return to duty or transition to civilian status. I'm confident that Secretary Geren and General Schoomaker will have more to say about that.

Finally, we are proud of the fact that our military doctors, nurses, and medics have courageously provided outstanding medical care to those who are wounded. This care begins on the battlefield itself, where these providers are at great personal risk as they tend to the wounded. Many service members who have died, who would have died in early conflicts are surviving injuries incurred in Iraq and Afghanistan because of the care and the loving care and the advances in battlefield medical treatment that exists now, that didn't exist before, but also, and we want to reiterate this, because of the skill and the bravery of our combat medical teams.

Seriously injured troops are rapidly evacuated to world-class medical facilities, where they receive state of the art care as inpatients.

Today's hearing is about the actions taken by the Departments of Defense and Veterans Affairs and by the Army to implement the Wounded Warrior Act and recommendations made by various commissions over the many months.

There is a vote scheduled for 10:30 this morning. I hope that we can complete our opening statements and begin questions even before the vote.

Senator Warner?

**STATEMENT OF HON. JOHN WARNER, U.S. SENATOR FROM VIRGINIA**

Senator Warner: Thank you, Mr. Chairman.

Mr. Chairman, this is a most unique piece of legislation, and one of its hallmarks is the strong bipartisan effort that's been put in on both sides of the aisle, and one of the stalwarts on our side, Senator Sessions, has been in the forefront of this. I'm going to invite him now to deliver the remarks for our side of the aisle. Senator Sessions?

**STATEMENT OF HON. JEFF SESSIONS, U.S. SENATOR FROM ALABAMA**

Senator Sessions: Thank you, Senator Warner. I do care about this deeply, as I know you do, and thank you for your leadership and that of Senator Levin.

I welcome our panel members. It's a distinguished group and I think your appearance here today represents by your very positions the commitment the Department of Defense has to fixing the problems that we've seen. Images of a mould-infested room at Walter Reed which was home to a recovering service member will not and should not be forgotten. We're all accountable for the conditions at Walter Reed and its impact on families. We're all answerable to the American people for the full and complete resolution of those problems.

There's just no doubt that when we commit our men and women to harm's way if they are injured there is a deep bond we have with them, I think, that cannot be disputed, that we will do whatever we can to assure they have the finest medical care possible.

The independent review group established by Secretary Gates in February of '07 described the situation that overwhelmed Walter Reed as a "perfect storm." It involved the confluence of an increase in operational tempo as a result of the war, the decision of the commission on BRAC to close Walter Reed, inattention by leaders to processing delays and antiquated disability evaluation processes, a breakdown in outpatient care and transition to the Department of Veterans Affairs. In addition, the Department of Defense lacked the tools to adequately identify traumatic brain injury and its overlap with post-traumatic stress disorder.

We now realize that the problems were far broader than just the Walter Reed site, and I believe that progress in addressing shortfalls in care is under way. Congress provided \$900 million in supplemental funding to DoD in Fiscal Year '07 for the purpose of aiding wounded and ill service members with traumatic brain injury and post-traumatic stress disorder. The Army has activated a new Warrior Transition Brigade focused solely on helping wounded and ill soldiers to heal. As of February 4, '08, 9,782 soldiers, both active and reserve, are assigned or attached to a warrior transition unit.

The Army now has broken ground on a new and greatly expanded hospital at Fort Belvoir, Virginia, which will be completed ahead of the BRAC schedule and will improve services for our wounded and ill military personnel, especially for orthopedic and mental health concerns. I know Senator Warner is very proud of that hospital that will be at Fort Belvoir.

It is evident by our panel today that the Department of Defense and the Department of Veterans Affairs are working together, rather than at odds. Yet, according to the DoD's recent survey of wounded and ill service members, one in four rate poorly for their experience with medical evaluation board process. One in five rates poorly for their ability to access care and appointments as soon as needed.

Studies conducted in the last year reassure the American people that the men and women who volunteer for our military and are sent into harm's way will receive the best medical care in the world. I quote from the report of the Gates panel, which said: "Through advances in battlefield medicine and evacuation care the Department has achieved the lowest mortality rates of wounded in history."

I quote also from the report of the commission appointed by President Bush, co-chaired by Senator Robert Dole and Secretary Donna Shalala: "The medical care at Walter Reed Army Medical Center and other military treatment facilities is compassionate and complete. The specialized services and programs for amputations and burns in particular are world class."

So this hearing will examine the response of our government to the shortfalls for service members who are outpatients during the long-term healing they require. The Wounded Warrior Act is itself a significant contribution toward that goal. I was privileged to be a part of that significant bipartisan effort, along with many members of this committee and the Veterans Committee.

The new law will ensure cooperation between the Department of Defense and Veterans Affairs, open new avenues of treatment for traumatic brain injury and psychological health, and begin the

process of reforming the disability evaluation system for our Nation's veterans of war, in other words achieving nearly all the goals of the Shalala-Dole Commission. So we look to the Committee on Veterans Affairs for leadership on the important work which remains, modernization of the benefits and compensation for our Nation's veterans, and in particular eliminating duplication between DoD and VA.

Senator Burr, ranking member, has announced his intention to pursue the needed reforms through legislation to create a modern, less confusing and more equitable system for today's wounded warriors. We shall forget neither the images of Walter Reed nor the stories of so many wounded veterans and their families who, as a result of a lack of care, perceived lack of fairness, lost trust in the government that they served. Nor shall we ever forget the statement of General George Washington, who said: "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the veterans of earlier wars were treated and appreciated by their country."

Mr. Chairman, thank you and I look forward to this excellent panel today.

Chairman Levin: Thank you, Senator Sessions.

Let me start with Secretary Mansfield and then we'll go to you, Secretary Chu. Are you going to be giving the statement for Secretary England?

Dr. Chu: Yes, sir, I'll be give Secretary England's prepared remarks.

Chairman Levin: Thank you.

Secretary Mansfield?

**STATEMENT OF HON. GORDON H. MANSFIELD, DEPUTY  
SECRETARY OF VETERANS AFFAIRS**

Mr. Mansfield: Thank you, Chairman Levin and members of the committee. I appreciate the opportunity to appear before you today. I'm especially pleased to be accompanied by Admiral Dunne, Secretary Geren, Secretary Chu, and General Schoomaker.

The Department of Veterans Affairs and the Department of Defense have a positive, good news report to give you today on our enhanced partnership to ensure today's active duty service members and veterans receive the benefits, care, and services a grateful Nation has promised them. They have surely earned that and I know, Mr. Chairman and members, that you and the committee members are here to make sure that it happens.

I'm especially pleased to have had the opportunity to have worked with Gordon England, the Deputy Secretary of the Department of Defense. Over the past year Gordon and I have had a unique opportunity to focus the attention of both Departments on the needs of those we serve, our service members and veterans. We have concentrated attention on the need for a seamless transition from the Department of Defense to the Department of Veterans Affairs.

I want to publicly thank him for his leadership, which has allowed us to accomplish so much. As he has said, the ties between

the two organizations have been strengthened and lines of communication are now available across the two Departments.

The Senior Oversight Council, the SOC, has been operational since May 8, 2007, but it is important to note that serious high-level cooperative efforts in the areas of health care and benefits delivery predate the SOC. VA and DoD formed a Joint Executive Council in February 2002. You later codified it in statute in November 2003. The JEC's responsibility -- and I quote from its standup document -- is "The JEC will work to remove barriers and challenges, assert and support mutually beneficial opportunities, recommend to the two secretaries the strategic directives for joint coordination and sharing efforts between and within the two Departments, and oversee the implementation of those efforts."

I believe it is important to identify some of the positives produced under the auspices of the JEC from its start. Dental care for Reserve and National Guardsmen was taken care of. The North Chicago VA and U.S. Navy cooperative effort to form the first joint Federal health care facility. The TSGLI, the Traumatic Service Group Life Insurance, which has been effective thanks to the Congress since December 1, 2005. As of January 31, we have paid 4,111 claims for a total of \$254.4 million to seriously injured service members.

Benefits delivery at discharge. We now have more than 95 MOUs covering 153 military sites. VBA counselors inserted at MTFs; data-sharing efforts; the joint incentive fund that Congress authorized to fund 66 projects for \$160 million between the two organizations.

So in short, the JEC provided a starting point for the SOC. I want to commend and thank Dr. David Chu for his past and continued efforts and cooperation as my DoD partner on the JEC.

The SOC, established by direction of the two secretaries following, as you mentioned, Mr. Chairman, hearings here on the Hill, established eight lines of action which generally defined the issues needing resolution. They include: the disability evaluation system; traumatic brain injury and PTSD, case management; data-sharing efforts; facilities; legislation and public affairs; personnel, pay, and financial support; and what we call a clean sheet review, or after we've looked at all these issues, if you were starting over how would you start and what would you build that would be different from what we have today.

Our excellent joint DoD and VA staff provided through a special office by Melinda Darby and Roger Dimsdale identified these lines of action from the issues presented in numerous reports, investigations, or commissions which reported last year, as you mentioned, Mr. Chairman -- Dole-Shalala, Gerry Scott's commission, the Marsh-West commission, and Secretary Nicholson's commission that the President directed that he take part in. All were reviewed completely to come up with a comprehensive plan of action.

Currently the SOC is overseeing the efforts to apply the decisions made from these line of action recommendations. For example, the Federal recovery coordinators or case managers' decision has resulted in VA Federal recovery coordinators standing up an office, hiring the first eight individuals, training them, placing them in

military treatment facilities, and having them start the process of fulfilling that requirement which you directed for us.

In another area, we have started a pilot project to have the VA complete one single medical exam, which will allow first DoD under their responsibility to make the decision whether this individual is fit or unfit to continue to serve on active duty, and if the individual is not fit to serve on active duty to allow the VA to use that same information to process a claim for disability benefits when the individual is discharged. This pilot has gotten one case already through the process. The examinations are taking place in the Washington, D.C., area and the cases are going to the VA office in St. Petersburg for decision. This pilot will run for approximately one year starting last November, going to November this year, and will give us the starting point for more efforts on how to make sure that this transfer from active duty to veteran status becomes seamless and the information is transferred and used by both at the same time.

We realize we have more work to do, data-sharing for example, where we move to the ability to transfer patient data between our two systems. We're doing more than we ever had before. We're sharing data. We're moving towards making it operational, and I think I can report to you that more efforts are going forward in that area than ever before. It's a hard area. There's a lot of issues to deal with, and we continue to work on that at a high level.

We're also working together on traumatic brain injury and PTSD issues -- care, research, and treatment, as we see a greater emphasis on these issues, and a new center of excellence is under construction and will be taking place at the new Bethesda location.

Currently the SOC is prepared to come together whenever required to make decisions required by the dedicated VA and DO staff which oversee the efforts on each of these lines of action. We continue to address any issues which may arise regarding cooperation between the two Departments. Gordon England and I and David Chu and I continue to discuss these issues as needed. The remaining requirements stemming from the National Defense Authorization Act passed last session will keep us focused intently on continuing improvements.

The issue of a new disability benefit system as proposed by the President through the Dole-Shalala report remains an open item. The VA has contracted for two studies which will allow us to move forward in this area. The studies are due for completion in approximately 6 months. They deal with transition payment and then compensation and quality of life issues in a to-be-proposed system.

The issue of rehabilitation medicine continues to evolve as we treat and evaluate the patients returning from the battlefield, entering acute care treatment, and initial rehabilitation and military treatment facilities before they transition to VA polytrauma centers and medical centers.

Finally, we are working to ensure better involvement and care of the family members of these individuals.

That concludes my statement and I await your questions. [The prepared statement of Mr. Mansfield follows:]

Chairman Levin: Thank you, Secretary Mansfield.  
Secretary Chu?

**STATEMENT OF HON. DAVID S.C. CHU, UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS; ACCOMPANIED BY HON. PATRICK W. DUNNE, REAR ADMIRAL, U.S. NAVY, RETIRED, ASSISTANT SECRETARY OF VETERANS AFFAIRS FOR POLICY AND PLANNING**

Dr. Chu: Mr. Chairman, I thank you for the opportunity to represent the Department of Defense this morning. Again I convey Secretary England's apologies that he could not be here. He very much looked forward to this session and asked that I present his planned opening remarks. He does have a statement for the record which I hope you will accept.

Chairman Levin: We will.

Dr. Chu: It is indeed a great privilege to join Gordon Mansfield, who has been our strong partner in the Senior Oversight Council that he described and in the Joint Executive Council established earlier. The two Departments have worked very closely, as he has outlined, and strengthened thereby the ties between the two Cabinet agencies so that we can indeed provide veterans the support that they deserve.

Gordon Mansfield has summarized the lines of action, the eight lines of action that are the mechanism through which the Senior Oversight Council exercises its responsibilities. These lines of action are jointly staffed, co-chaired by personnel from DoD and the Department of Veterans Affairs, and have created a very strong partnership between the two agencies. They have succeeded in accomplishing a great deal in a short period of time. We have, as Gordon Mansfield reported, appointed the first Federal response coordinators. We have the disability evaluation pilot begun and 120 people are in various stages of evaluation in that pilot system. We have established the Center for Psychological Health and Traumatic Brain Injury. We are I believe on track to completing by the end of this year a set of software changes that will allow existing electronic data to be shared between the two agencies, which I know has long been a subject of great concern to all.

And we have proposed to the Congress and we hope the Congress will support an accelerated and enhanced set of changes at the new Walter Reed campus in Bethesda, where the Naval Hospital is currently located.

We have benefited in these decisions from the studies that were done earlier and, of course, from the actions of the Congress. In the earlier studies there are over 400 recommendations offered to the Department, over 300 on the subjects of post-traumatic stress disorder and traumatic brain injury alone.

While a great deal has been done, we recognize that we are not finished. These lines of actions will be adding to their agendas, particularly with the additional instruction of the Congress in the Fiscal 2008 National Defense Authorization Act. We meet as necessary to accomplish these goals.

Secretary England asked that I underscore that he and Gordon Mansfield and their respective teams are completely dedicated to resolving all the issues between the two Departments and to putting the long-term care of the men and women in uniform where it should be. We view this as a partnership between the two Departments and a partnership with the Congress, the caregivers

within our Departments, and with other agencies of the Federal Government as well as agencies at the State and local level.

Secretary England did ask that I underscore one other issue which you raised, Mr. Chairman, and Secretary Mansfield touched on in his opening statement. That is, we do hope the Congress in future legislation will address a central issue raised in the Dole-Shalala proposal, and that is a new and different disability compensation system for our veterans, one that would more sharply delineate the responsibilities of the respective Departments, focusing Defense on the key military question of fitness to serve and focusing the Veterans Affairs Department on the question of support for those who cannot.

I am joined this morning by Secretary Geren and General Schoomaker, who will be ready to provide details on the progress the Army has made in its specific efforts to care for the Army's wounded personnel.

Thank you for this opportunity and I look forward to your questions.

Chairman Levin: Thank you, Secretary Chu.  
Secretary Geren?

**STATEMENT OF HON. PRESTON M. GEREN, III, SECRETARY OF  
THE ARMY**

Mr. Geren: Thank you, Mr. Chairman. Chairman Levin, Senator Warner, and members of the committee: Thank you for providing General Schoomaker and me the opportunity to come before your committee today and talk about the progress that has been made over the past year. I'd also like to thank every one of you for your unwavering support of soldiers, families, and our United States Army. Our Congress and particularly this committee are full partners in building the Army that we have today.

I also want to thank you for your Wounded Warrior Act and the initiatives which you included in last year's authorization bill. You included initiatives that will help soldiers, initiatives that will help families, and you also provided the flexibility so that the Army could continue to meet the dynamic challenges in our modern health care world, and we appreciate that. We thank you for that partnership in your legislation and the partnership over this last year.

12 months ago almost to the day, the Washington Post ran their story on the shameful conditions at Walter Reed. The report sparked outrage across our Nation, but nowhere more so than among the ranks of soldiers and veterans, nowhere equal to the outrage, the rage felt by soldiers. Soldiers take care of soldiers. Soldiers give their lives and limbs for each other. Strip away everything else and at its core that is what the Army is all about: Soldiers taking care of soldiers.

When soldiers learned that some of their own had violated their duty to our wounded, they demanded action and stepped up and took action. Today, 12 months later, we are a better Army, with good news to report to this committee, because of the good work and hard work of soldiers, but with the acknowledgment that there remains much to do.

Mr. Chairman, I'd like to ask you if I could introduce four of the soldiers who have been great leaders in this effort over the past year who have joined us today.

Chairman Levin: We'd be honored to have you do that.

Mr. Geren: Thank you, Mr. Chairman.

Colonel Terry McKendrick, who is Brigade Commander at Walter Reed -- Terry, would you please stand up -- his Command Sergeant Major Jeff Hartless; Company Commander Major Steve Gominter; and his First Sergeant, Matthew Dewsberry. They've done an outstanding job and deserve a great deal of credit for their leadership. [Applause.]

Chairman Levin: Thank you, Secretary Geren, for introducing to us these great soldiers. Again, we're honored to be in their presence.

Mr. Geren: Thank you, Mr. Chairman.

The Army, the Department of Defense, and the Department of Veterans Affairs, and the Congress's response has gone well beyond the problems identified in the Washington Post series of articles. We all realized that we had an opportunity not to just fix the problems highlighted in the articles, but transform our health care and disability system to better meet the needs of those who have borne the battle, our wounded, ill, and injured, and better support their families.

It is an opportunity to do something big, complicated, and important that does not come along very often, and together we've made progress, and we thank you for that partnership.

Today Lieutenant General Schoomaker and I will discuss the progress the Army has made and join this panel in discussing the progress the Department of Defense has made working with the Congress and particularly with this committee, and identify areas that we must continue to improve.

A year ago, outpatient care in the Army was called medical hold for active duty and medical holdover for reserve components. The names themselves, "hold" and "holdover," and the fact that there were two systems give you a good sense of the problems that underlay the Army system. A year later, the Army has completely transformed outpatient care. The old system, with fragmented leadership, that was not staffed, resourced nor organized to meet even the pre-9-11 needs of outpatient soldiers, was overwhelmed by the increase in patients that came with the casualties of war. Pre-existing seams were stretched and snapped by the surge in wounded, ill, and injured. The Guard and Reserve were organized separately from the active force, with a widely held perception, if not the reality, of different standards of care. Mental health issues had not received the attention nor the resources they required, leaving the needs of many soldiers and family members unmet.

Today no more hold or holdover units. In their place, we have our wounded warriors in 35 warrior transition units located at major posts in CONUS and abroad, active, Guard, and Reserve together, one Army.

The care and support of our soldiers in our WTUs is driven by a mission statement, with leadership, officer and NCO, organized in support of that mission, with a triad of care, the squad leader,

the nurse case manager, and the primary care manager, supporting every wounded, injured and ill soldier.

Our soldiers in the WTUs are being moved into the best barracks on the post and over the last 8 months nearly 2500 personnel have been added to Medical Command to support our wounded warriors. Every WTU today has an ombudsman and now 33 and soon all of our WTUs will have a soldier family assistance center, bringing dispersed family services together into a one-stop shop for soldiers and families.

In mental health care, the Army, working with our sister services, OSD, and the VA, and with strong leadership and support from the Congress, has made investments in personnel, infrastructure, and programs to care for soldiers who suffer from TBI, post-traumatic stress, and other mental and emotional illnesses, and help their families with the challenges of supporting their soldiers suffering from these invisible wounds of war, with much left to do in this area.

In the Army, we're teaching every one of our one million soldiers how to identify symptoms of PTSD and TBI and how and where to go to get help. Every soldier is required to take that class. So far, 800,000 soldiers have received the training, and the program is available to families. It is good substantive training, but, perhaps more importantly, it is a major step forward in reducing the stigma associated with mental health care.

We're seeking to hire over 300 additional mental health professionals to meet the needs of soldiers and families, adults and children. We are short of this goal and face a challenging market for the people we need. The direct hire authority that you provided to us in your authorization bill is a big help, but we're not where we need to be in this area. We've initiated a comprehensive approach to prevent the tragedy of suicide among our soldiers, recognizing we have far to go to stem this growing challenge among our ranks, much to learn and much to do.

Cooperation between the Department of Defense, OSD, and our sister services and the Veterans Administration is strong and you will hear today about much of the progress that's been made.

Senator Levin and Senator Sessions, thank you for acknowledging the extraordinary work of our Army's health care professionals. Their selfless men and women are the very best at what they do.

In stark contrast to the shortcomings identified in the Post article are the almost miraculous recent advances in battlefield medicine, trauma care, and rehabilitation, much of which has been accomplished by the medical professionals and staff at Walter Reed and elsewhere in the Army system. Survival rates for soldiers wounded in combat are unprecedented, 94 percent, the highest in the history of warfare. Soldiers are surviving and recovering from wounds that would have been fatal in any other era and in any other health care system, thanks to the service men and women in military medicine, the Army, and our sister services.

Throughout the Army, we have leaders, officers, and NCOs, uniformed and civilian, committed to taking care of soldiers and families, demanding the best for our wounded, ill, and injured and their families. Because of that, our report today is one of progress, but

it is not and probably never will be a report of mission accomplished.

February 18, 2007 was a day our Army will not forget, a painful day, a shameful day for a proud institution, a band of brothers and sisters who look out for each other, who take care of each other, no matter the personal cost. The Washington Post helped us see something that we had overlooked and because of that Washington Post story we are a better Army today than we were a year ago, and we remain committed to continuing to improve our care and support of our wounded, our ill, and our injured soldiers and our families.

Mr. Chairman, members of the committee, thank you all for the opportunity to appear today. I look forward to answering your questions. [The prepared statement of Mr. Geren follows:]

Chairman Levin: Thank you, Secretary Geren. That was a very important statement and a very moving statement. Thank you for the preparation of it and for delivering it the way you did.

General Schoomaker?

**STATEMENT OF HON. LIEUTENANT GENERAL ERIC B. SCHOOMAKER, U.S. ARMY, SURGEON GENERAL OF THE ARMY AND COMMANDER, U.S. ARMY MEDICAL COMMAND**

General Schoomaker: Chairman Levin, distinguished members of the committee: Thank you for the opportunity to discuss the total transformation that the Army is undergoing in the way we care for soldiers and their families. We are committed to getting this right and providing a level of care and support to our warriors and their families that is equal to the quality of their service.

Secretary Geren has eloquently expressed this transformation in his testimony. The Secretary, the Chief of Staff of the Army, and the rest of the Army leadership are all actively involved with every stage of the Army medical action plan, which you, sir, alluded to in your opening comments, and to the transformation it embodies. In less than 1 year, the Army has funded, staffed, and written doctrine for a fundamental change in warrior care, a truly remarkable achievement.

For example, as Secretary Geren mentioned, we now have more than 2500 soldier leaders assigned as cadre to 35 warrior transition units that did not exist this time last February. This contrasts with fewer than 400 cadre for the same group of patients last February.

The most significant feature of these warrior transition units is this triad of care that has been alluded to, consisting of a primary care physician, a nurse case manager, and a squad leader working together to care for the needs of each individual. The regular meetings and the coordination between each leg of the triad serves to create a web of overlapping responsibility and accountability which embraces each warrior for the duration of the treatment and recovery.

Our squad leaders, many of them combat arms soldiers and former patients -- two of the officers that you were introduced to earlier have been patients at Walter Reed and have been combat injured -- are trained and responsible for the wellbeing of a small group of warriors in transition, just as any Army unit. These soldiers that you've met just a minute ago are four combat-tested

leaders and they spend their days at Walter Reed looking out for the best interests of the wounded, ill, and injured soldiers. They really are the backbone of the Army medical action plan.

Sir, with your permission I'd like to introduce two of my battle buddies in putting together this plan. I'd ask Brigadier General Mike Tucker and Colonel Jimmy Keenan just to stand up. These are two of the principal architects of the Army medical action plan. Mike is a career armor officer. We took him out of the armor school at Fort Knox. Jimmy Keenan is a career Nurse Corps officer, and they truly are the architects and executors of the Army medical action plan. We couldn't have done it without them.

Chairman Levin: Thank you for introducing them. Thank you for your service.

General Schoemaker: Another example of the difference between today and last year: One year ago, our wounded, ill, and injured soldiers believed that their complaints were falling on deaf ears within the Army. Now we've established a MEDCOM-wide ombudsman program with ombudsmen at 26 of our installations and we're hiring more each week. Everyone at our medical treatment facilities knows who the ombudsman is and how to find him or her. Many are retired NCOs and officers with experience in medical care. They work outside of the local chain of command, but they have direct lines to the hospital commander, the installation commander, the garrison commander to get problems fixed.

We've also established a 1-800 wounded soldier and family hotline that's outlined on this card that every soldier and family carries, in order to offer wounded, ill, and injured soldiers and their family members a way to share concerns on any aspect of their care or administrative support. We respond to these inquiries within 24 hours of the call. So far we've received in excess of 7,000 calls.

Another improvement in the care of soldiers over the last year is the development of multiple feedback mechanisms so that we can see ourselves from a variety of perspectives. I think this is a lesson that we learned last year. We monitor and evaluate our performance through 18 internal and external means, including the ombudsman and the hotline that I addressed earlier. But we've also got a contracted industry leader in patient surveys that we look at very carefully.

In addition, we host numerous visits from members of Congress and your staffs. In January alone we opened our WTU doors to more than a dozen Congressional visits. These visits give us a valued external perspective and allow us the opportunity to be as open and transparent in our operations as possible. Your feedback and the feedback of your staffs on these visits has been instrumental in our success.

As you well know, despite these successes, there's much progress still to be made. We still need more research on psychological health and traumatic brain injury. Congress jumpstarted us last year with supplemental funding, for which we are very grateful, but research must be a continuing priority effort.

We need to continue to look at the disability, the physical disability evaluation system and ways to make it less antagonistic, more user-friendly, and more understandable to the soldiers and

their families. I believe the pilot program that started in the National Capital Region is a good start, but, as each one of the members of the panel have mentioned, we'd like to see changes made in the physical disability and evaluation system made legislatively as aggressively as possible.

We need your continued support so that we can move forward together in 2008 much as we did in 2007. This year's National Defense Authorization Act was very consistent with how the Army is approaching wounded warrior matters. I truly appreciate the flexibility you have provided us to develop policies and achieve solutions. Your bill not only helps warriors, it helps families, it helps the health care providers caring for them. Thank you for taking the time to listen to us and to work with us.

The Army's unwavering commitment -- a key element of the warrior ethos is that we never leave a soldier behind on a battlefield or lost in a bureaucracy here at home. We are doing a better job of honoring that commitment today than we were at this day last year. In February of 2009 I want to report back to you that we've achieved a similar level of progress as we did over the last year. I'm proud of Army medicine's efforts over the past 232 years and especially over the last 12 months. I'm convinced that, in coordination with the Department of Defense, the Department of Veterans Affairs, and the Congress, we have turned the corner.

Thank you for holding this hearing and thank you for your continued support of the warriors that we are so honored to serve. I truly look forward to your questions. [The prepared statement of General Schoomaker follows:]

Chairman Levin: Thank you, General. Thank you and all the witnesses for your testimony this morning.

Let's try an 8-minute first round. We will try to work through that roll call that's coming up in 10 or 15 minutes, which some of us can just go and vote and come back, so we can try to keep it seamless. As you folks are working on seamlessness, we'll try to do the same thing here this morning.

Studies conducted by the Veterans Disability Benefits Commission concluded that the VA standard for assigning disability rating for PTSD is inadequate. These studies showed a significant discrepancy between the disability ratings assigned by the Department of Defense and the Department of Veterans Affairs for service members with PTSD. The commission found that of 1400 service members who were rated by both the Department of Defense and the VA for PTSD, the Department of Defense assigned disability ratings of 30 percent or higher to only 18 percent of that group of 1400 service members, while the VA assigned ratings of 30 percent or higher to 90 percent of that same group of individuals.

Now, that is a stunning difference. That's not a few percentage points. The same people, the same 1400, not 1400 people over here and 1400 people over there. It's 1400 people who were the same. And the DoD gave disability ratings of 30 percent or higher to 18 percent of that group and the VA gives ratings of 30 percent or higher to 90 percent of those same individuals.

Now, even before we passed the Wounded Warrior Act the law required the Department of Defense to use VA standards for rating disabilities, but in practice the services deviated from those stand-

ards, in many cases resulting in lower disability ratings than assigned by the VA for the same disability for the same person.

The Wounded Warrior Act specifically requires the Department of Defense to use the VA standard. It authorizes deviation only when the deviation will result in a higher disability rating for the service member. Now, you've described this pilot project where we're going to have a single exam followed by hopefully a single rating, and we very much welcome that. There's you said I think 120 people in that pilot project.

But in the mean time, while that project is going to take a year, we have a legal requirement now for the Department of Defense to implement the requirement now in law that restricts deviation from the VA standard to those circumstances where it benefits the service member. I think, let me ask you, Secretary Chu, how are you going to implement this requirement?

Dr. Chu: Of course, Mr. Chairman, as you have pointed out, it has been longstanding the policy of the Department we're supposed to use the VA rating schedule. There are differences in outcomes. We're aware of that. That's why we are so excited about this pilot program, which the Secretary has asked that we proliferate across the Department as soon as it's practical to absorb its lessons about the administrative issues that need to be addressed.

The ultimate safeguard -- these are basically judgments, clinical judgments reaching different conclusions. The ultimate safeguard is just to have one agency come to the conclusion, and that is the central feature of the pilot program, which is we'll use VA's disability ratings.

Now, there will still be an issue here, and this is where the Dole-Shalala proposal I think is important, because our fitness decision will be on those conditions that speak to that issue. It will not necessarily be all the conditions the individual has. We've seen already in the pilot the average person in the group that have received -- come into the program so far is ten conditions, not all of which are necessarily unfitting for service. So there is still going to be a tension there that I think we need to address.

Chairman Levin: Well, my question is, you've got a pilot --

Dr. Chu: In the mean time --

Chairman Levin: -- program over there. You say the ultimate answer is to have one rating and you're right and that's why we put it into law. But in the mean time, we can't accept that kind of a deviation.

Dr. Chu: I agree, sir.

Chairman Levin: For the same people.

Dr. Chu: I agree, sir, and we are trying to reinforce that it is one schedule. But you will still have -- I do think that the solution, as we all agree, is a single examination system, and we are moving that way.

Chairman Levin: Well, we're going to need to know what are you doing in the mean time until that system is put in place to reduce that deviation. If this were a difference between 5 percent deviation or 10 percent deviation, that would be one thing. But this is 90 percent versus 18 percent. That is totally unacceptable even as an interim differential.

Dr. Chu: I would agree, sir. I do think I should emphasize for the record that an earlier study looked at a wider range of conditions; the average difference between the two agencies was 8 percentage points.

Chairman Levin: All right. On PTSD --

Dr. Chu: On PTSD is a particular issue, although it's also true that VA has recently revised PTSD ratings for many of the veterans involved in older conflicts, and that may be partly explaining the large differences that are reported. DoD does the rating at the time of discharge. VA may adjust that rating across the veteran's longer life history.

Chairman Levin: Secretary, these are the same 1400 people.

Dr. Chu: That's not the --

Chairman Levin: It doesn't cover veterans from older conflicts. These are the same 1400 people.

We're going to need to have a much stronger effort for this interim period until there's a single --

Dr. Chu: We understand that, sir.

Chairman Levin: And we're going to need you to tell us. We're going to give you 30 days on this one, to tell us what action's going to be taken to reduce that differential, for the reasons I gave.

Now, there's another provision in the law that requires the establishment of a board to review the DoD disability ratings of 20 percent or less. I'm wondering, is that board -- do you have plans now to appoint that?

Dr. Chu: We intend to appoint that board, sir. It is not yet appointed. But we fully understand the requirement of the statute, which is to review all the older cases since the beginning of this conflict.

Chairman Levin: Where there's 20 percent or less.

Dr. Chu: Where there's 20 percent or less.

Chairman Levin: That's a critical issue in terms of benefits and family coverage for medical care.

When will that board -- give us an estimate: 30 days, you think?

Dr. Chu: I think 1 to 2 months to get it established, yes, sir; I think that's fair.

Chairman Levin: All right.

Secretary Mansfield, has the VA updated the VA schedule for rating disabilities for PTSD?

Mr. Mansfield: It's currently under way, sir. It has to go through the Federal review process, I believe it is.

Chairman Levin: What's the timetable on that?

Mr. Mansfield: The process itself requires 30 days and then a follow-up of 30 days, and then we would act after that. So I would imagine 60 to 90 days. It has been a highlighted issue within the Department and within VBA, our benefits administration.

Chairman Levin: There was a recent series of Denver Post articles that report that 79 soldiers who were determined to be medical no-go's have been knowingly deployed to Iraq. General Schoomaker, this question is for you. The most recent article describes a soldier being taken from a hospital where he was being treated for bipolar disorder and alcohol abuse so he could be deployed to Kuwait. 31 days later he was returned to Fort Carson because health care professionals in Kuwait determined that he

should not have been sent there in the first place because of his medical condition.

These articles quoted email from Fort Carson's Third Brigade Combat Team that says: "We have been having issues reaching deployable strength and thus have been taking along some borderline soldiers who would otherwise have been left behind for continued treatment."

Are these reports accurate? What's the Army doing to address them? Maybe Secretary Geren and General Schoomaker. Let me start with you, Secretary, and then I'll go to the General.

Mr. Geren: We are looking into those issues. Sir, before a soldier deploys they are evaluated and it's a subjective process to determine whether or not they are fit for deployment, and judgment is exercised. We've had this issue come up in a number of deployment platforms around the country, in fact one this time last year that was raised down at Fort Stewart.

I guess the essential point is that the judgment is exercised at the point of deployment, and sometimes that judgment turns out to be wrong.

Chairman Levin: Is there a shortage of deployable strength that is now causing some of these decisions to be made that otherwise would not be made?

Mr. Geren: That should not be happening. I can't tell you that it's not, but it certainly should not be happening. But every soldier must be considered, whether or not he or she is fit for duty, and if not they should not be sent, and everyone understands that. I don't believe we found any evidence that the pressure has caused people to be sent that shouldn't have. Maybe cases where something was overlooked or where a mistake was made, but the commanders who evaluate these soldiers understand what the requirements are and should never send anybody that's unfit. But we look into every one of these cases.

Chairman Levin: Are you familiar with that email, that article?

Mr. Geren: Yes, sir, I am familiar with the article.

Chairman Levin: Have you checked the person who wrote that email to say that that is not an acceptable reason for deploying somebody? Could you do that?

Mr. Geren: Yes, sir, I certainly could.

Chairman Levin: Do you want to add anything to that, General?

General Schoomaker: Well, sir, I have not seen the case myself. I am familiar with the story. My understanding at this point, because the profile -- the soldiers who possess those profiles who were deployed, to include the soldier who is the centerpiece of the article, their profiles and the decision to deploy have been looked at carefully. In all the cases in which soldiers were deployed with profiles, they were placed in positions and in conditions which would be supported by their profile. The profile itself does not limit deployment. My understanding of the index soldier was that he was not hospitalized and that the opinion of outside consultants was that his condition should not limit his ability to be deployed. But I think it's still being looked at.

Chairman Levin: Well, the email itself, however, says that "We have been having issues reaching deployable strength." I mean,

that's a contemporaneous email and that should not be a factor. Would you both agree with that?

General Schoomaker: Yes, sir.

Mr. Geren: Yes.

Chairman Levin: So whoever thought that was a factor has got to be corrected, and that message has got to be made clear across the board. Would you agree with that?

General Schoomaker: I agree with that.

Chairman Levin: Thank you.

Senator Warner?

Senator Warner: Thank you, Mr. Chairman.

Gentlemen, those of us in the Senate who have had the opportunity to work on these issues have received a great deal of information, indeed support and learning, from the families of these various soldiers, sailors, airmen, and marines that have suffered these injuries. I've been particularly fortunate to have had access and brought to my attention the wives of a number of these individuals who have on their own initiative fought a very courageous battle. I'm pleased to say that in our audience this morning is Sarah Wade, whose husband in 2004, Sergeant Ted Wade, was severely injured. He's still in the process of rehabilitation, and she's accompanied by Meredith Beck, who is a very active member of an organization called Wounded Warrior Project, a nonprofit organization.

I wonder, Mr. Chairman, if we'd invite those two to stand and be recognized here. They are examples of the families that stand by their man. [Applause.]

Senator Warner: Secretary Geren, you visited with me the other day. It's interesting how forthright you are with sharing the information, good news and not so good news, with our colleagues. I feel that in discharging your responsibilities, certainly with this member of Congress, you've been absolutely forthcoming, factual.

You showed me a series of charts about the things that were concerning you. Among them was the very alarming rate of suicide. It's particularly high in the Reserve and Guard categories. I'd like to ask you to lead off what steps under your leadership the Department of the Army is taking, and then maybe we'll go to the other witnesses, who have a broader responsibility for the other departments, to the extent that the Navy, the Air Force, and the Marines are suffering some of this problem.

Mr. Geren: I'd be glad to lead off, but I'd also like to ask General Schoomaker to add as well because this is an area where the leadership of the Army has focused a great deal of attention, and not just over the last few months. We've recognized over the last few years an alarming growth in the rate of suicides. We last year experienced the highest level of suicides we've had since we started tracking suicides in 1980.

Over a year ago --

Senator Warner: So that's a period of 28 years.

Mr. Geren: Yes, sir. That's when we began tracking it. We can't tell how it compares to prior years. But we've seen a steady increase over the last 5 years, and it's something that everybody in Army leadership understands their part of the solution to that, that effort.

Every week we have a balcony group. We bring all the senior leadership in the Army together in the Pentagon Wednesday morning. One of the slides we look at is the suicide incidence over the preceding week. We want to make sure every leader in the Army recognizes that it's a part of his or her responsibility to help address this.

We have a very comprehensive effort under way right now -- and General Schoomaker can provide you greater details, but we are looking at innovative ways to approach it through different types of training for soldiers, for leaders, working with the chaplains, working with families.

I think one of the most important things we can do is overcome the stigma over getting help for mental health issues. We've got soldiers that don't come forward and ask to be helped. Until we break down that stigma, until we break down that barrier, we're going to have soldiers that are in desperate need that don't get the help they need.

This PTSD training that we're doing, it's not just PTSD and TBI, but I think it's going to break down the stigma across the whole range of mental health issues and help soldiers and family members to recognize, this soldier's got a problem, come forward and do something with it.

But we are looking at trying to understand the trends. We have seen some of these deaths associated with misuse of narcotics and other drugs that were lawfully prescribed and perhaps misused, a mix of alcohol and drugs. Most of them result from a failed relationship or some other type of traumatic event in their life, exacerbated by the stress that they're under and the pressures that they're under. Also, leaders in the Army, because the system is stressed, aren't able to put their arm around the soldier and understand what's going on with his life.

But from the lowest ranks to the most senior ranks, this is a problem that we are working to address. And I would like to ask Dr. Schoomaker -- he's done a great deal of work in this area and I think that he has much to share with the committee.

General Schoomaker: Thank you, sir.

Thanks for the question. You're right, this is -- there are two trends right now that we are watching very carefully that the Secretary has alluded to. The first is suicides within the Army at large. I think Secretary Geren has really outlined the multidisciplinary approach that we have. It starts with small unit leaders and their ability to recognize -- and fellow soldiers -- their ability to recognize a soldier who may be in trouble, that may have problems with coping with a lost relationship, which includes in some cases a loss of a relationship with the Army itself because of misconduct and the like.

It's compounded by drug or alcohol use, and certainly the families play a very critical role. We are looking at this in a multidisciplinary way. We have looked carefully across the major, the principle staff who are responsible, from the chaplains through the personnel community, through those that represent leadership at large, and then the medical community. We're prepared to come in front of the Secretary with some recommendations about how we will be approaching suicide prevention in the near future.

The other trend that we're looking at very carefully is a trend in accidental deaths, especially within our warrior transition units. Now that we have in a sense concentrated approximately 9500, almost two brigades worth, of soldiers who have illnesses or injuries, some combat-related, some other, within these warrior transition units under the care of cadre with a primary care provider and nurse case managers, we recognize now that a number of them have a constellation of drugs, drugs for anxiety, drugs for sleep, drugs for pain, which in combination, especially if used with alcohol, can be a lethal cocktail.

We have, unfortunately, lost over the last few months several soldiers. We've brought together a team. The Secretary and the Chief of Staff of the Army charged me about 10 days ago with expeditiously bringing together a team of experts to look at the factors that lead to these accidental deaths. I contrast these with suicide. I don't believe these are suicides. We've looked very carefully to separate those that are suicides from those that are truly accidental, and those that we are seeing are accidental deaths. And we've looked at the major factors and are trying to eliminate those factors.

Senator Warner: Secretary Chu, to the broader aspects of it.

Dr. Chu: Yes, sir.

Senator Warner: I don't think the other military departments are

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Dr. Chu: Yes, sir. The Marine Corps is already beginning to emulate the Army's practice of the chain teaching of mental health indicators, responsibilities at every level of command. The Secretary of Defense, to do with the stigma issue -- a small but important step -- has advocated and the administration I believe will soon decide to revise the instructions on security questionnaires so that we set aside a positive answer on have you sought mental health assistance if it has to do with PTSD or the various issues that relate to combat service.

I do think there are two issues here. One is the trend, where we are all concerned with the Army's increase. Also the level. The Department, even with this adverse trend, is approximately where civilian rates are. That doesn't mean that's where we want to be. And within the Department we do have a service that's at much lower levels, absolute levels of suicide, the Air Force. So one of the things we're doing is asking all the departments to look at what's successful about these Air Force programs that might be translatable to their circumstances.

We are very excited with this Center for Psychological Health and Traumatic Brain Injury the Congress has so generously funded. It's stood up in a provisional way, being led by an Army psychiatrist, Colonel -- soon General, I guess -- Dr. Lauri Sutton. I've asked her to focus not just on prevention after the fact, but what can we do before the fact, how can we help the resiliency of our people to deal with the stresses that military life does bring to them. Should we, for example, be asking questions all the way back at the enlistment point that we don't ask today or having screens that we don't use today?

We do, of course, use one broad screen already that is a predictor of can you stick with a military career. That's the high school diploma. That's why they're so important in our recruiting standards.

So we are trying to take a broad-based approach, ranging from the specific questions and examples to the strategic, how should we be recruiting people from American society so they can successfully serve in a very difficult environment.

Senator Warner: I actually say to this distinguished panel, we've got to have the infrastructure to carry forward all of these various initiatives, literally the bricks and the mortar and the roofs and the ceilings and so forth. Where are we with regard to, A, maintaining Walter Reed's physical plant such that it can continue to deliver that level of health care that these honorable, wonderful people are entitled? And secondly, the projections of a new facility at Fort Belvoir and the modifications to the infrastructure at the Bethesda center to take on the additional; are we on schedule? Is the budget adequate for these two construction projects?

Dr. Chu: Yes, sir.

Senator Warner: Is there anything that Congress needs to do to facilitate?

Dr. Chu: Our most important request will, of course, be to support the fiscal '09 request in this regard, which does ask for a substantial tranche of money to support a more ambitious plan for the new Walter Reed campus than we had before and a faster plan. That includes Walter Reed thought about in the large, not just Bethesda campus, but also, importantly, the DeWitt Army Hospital modernization and the refurbishment at Fort Belvoir.

In terms of the personnel at Walter Reed -- and that I think is always a challenge when you close a base, how you keep everything up at the top level all the way up to the last day. We have sought and gotten from the Office of Personnel Management additional direct hire authority to make sure we can staff Walter Reed correctly, including ability to pay special retention bonuses to the personnel there.

But I would defer to Secretary Geren on additional specifics.

Mr. Geren: Well, General Schoomaker just recently left the post as commander at Walter Reed, so I'd like to ask General Schoomaker to respond.

General Schoomaker: Yes, sir. I think the Congress and the leadership of the Department of Defense and the Army sent me and my command when I commanded Walter Reed last year a very, very clear message that we were to restore Walter Reed to a world-class facility, despite the impending fusion of Walter Reed with the National Naval Medical Center in Bethesda and the formation of the new Walter Reed National Naval Medical Center that the Secretary alluded to.

And we've done just exactly that. We have given very clear orders and have had very robust support from the Department to fix all those things that need to be fixed and to maintain both the manpower as well as the clinical practices and the physical plant of the Walter Reed campus.

Senator Warner: Thank you very much.

Chairman Levin: Thank you, Senator Warner.

Senator Ben Nelson?

Senator Ben Nelson: Thank you, Mr. Chairman.

I want to thank our military men and women and those who are on the civilian side who do such an outstanding job to protect our country. Of course, nothing is more important in dealing with their needs than to make sure that the health system we provide for them is the best possible health care system. So we were all chagrined and saddened with the revelations of a year ago.

In terms of what we're working with toward public-private partnering, Secretary Mansfield and Secretary Chu, last year I met with a sergeant in Nebraska from the National Guard who suffered a traumatic brain injury as a result of his service in Iraq in 2006. When I met with him, he indicated the many challenges he had in getting the care that he required. He was lost in the system on at least two occasions, and he was finally able to get care in Nebraska through a private facility, Madonna Rehabilitation Hospital.

Receiving quality health care in rural States is obviously a challenge in many areas due to resources and geography alone. That's why I believe it's critical that we find partnership opportunities for our public institutions and private institutions to be able to make sure that we get that quality care and we integrate it.

How do you provide for that integrative care for veterans as they transition back into their communities, so that we ensure their long-term care, not simply a short-term situation, but their long-term follow-up care across a wide geographic area? I've been told that local VA hospitals have authority to contract with civilian partners, but in many instances are just very reluctant to do so and we have to continue to press to get them to be able to forge a collaboration.

But is this centralized or decentralized process from the standpoint of the VA? What are your thoughts about how we can make this system work? We talk about it being seamless. You'll have to pardon me if I find the word "seamless" between the VA and the Department of Defense an oxymoron. Perhaps "nearly seamless" might be something more, that would be more likely achievable. "Seamless" I think is beyond anyone's expectations, given a bureaucracy that is full of what I consider "we-be's": "We be here when you come, we be here when you go." And we're going to constantly find that very difficult to purge and converge those systems.

But from the standpoint of the VA first and then the DoD second.

Mr. Mansfield: Thank you for that question, Senator. First let me apologize to that individual. The idea that somebody gets lost in the system is something that we do not want, and we're doing everything we can to ensure that we take care of that. So I would apologize to that individual.

Senator Ben Nelson: Sergeant Mac Richards.

Mr. Mansfield: I'll get with you and we'll follow up on that. [INFORMATION]

Mr. Mansfield: The idea of traumatic brain injury care, serious traumatic brain injury care, started with the fact that the VA since 1992 had four brain injury treatment centers that were doing treatment, care, research, and efforts, and those four centers in Palo Alto, Minneapolis, Richmond, and Tampa became our polytrauma centers. Each one of those brain treatment centers was also co-lo-

cated with a spinal cord injury clinic, so we had a robust rehabilitation capacity in those hospitals. There's a fifth one on the way hopefully in the next budget.

What we've done since then for the effort to have more geographic representation is had each one of our VSNs, or 17 more VA medical centers, come on line as level two polytrauma treatment centers, so we can attempt to get the treatment more dispersed geographically around the country.

The issue of the private treatment is one that we've dealt with in the past in sharing agreements in various locations to get specialty care that we needed that we didn't have on staff or just couldn't provide.

Senator Ben Nelson: Excuse me. Can that be geography-related as well, not close by, so that they don't have to drive 250 or 500 miles round trip?

Mr. Mansfield: Sir, I was going to say, what we are learning and dealing with and attempting to do is deal with the individuals in an effort to bring all the conditions that would apply to bear to make the decision to go forward. I know that Dr. Cusman, the head of our Veterans Health Administration, has made the point that if the people that we're treating don't feel that they're getting the care that they need then we need to work with them in an effort.

I know that we've done that in many instances where folks are getting treatment that either VA is paying for or in some cases TRICARE I think is also taking care of the individual. But again, it's an effort that has started, is moving forward, needs the continued emphasis of the leadership, has had continued emphasis, and we will do more.

Senator Ben Nelson: Dr. Chu, Secretary Chu?

Dr. Chu: Sir, if I could just address the two issues you raise. One is the seamless transition; the other is the question of how we provide quality care to those on a geographically dispersed basis.

On the seamless transition front, we are very excited by the appointment of these first Federal integrated recovery coordinators. Their ultimate responsibility is to make sure there is a plan for that person that is really lifelong in character and that the steps are in place, the mechanisms in place, to be sure that plan's being followed. I think that's a key ingredient in getting us at least to the nearly seamless condition that you set as an immediate goal.

On the question of the geographically dispersed delivery of care, I do think this is where the central proposition of Dole-Shalala is so important. It, as you know, recommends, and the President's legislative proposal would propose to carry out, that if you're medically retired from the Department of Defense you would get -- we would end DoD deciding whether you got TRICARE coverage based on the percentage of disability. If you're medically retired you would get TRICARE coverage for you and your family.

Now, I think that's important not only for the families, but also for the issue that you described, because that does give you the right to go to any place you want, essentially, in the United States, and it would end a good deal of this problem, because it's always been a problem for the VA. In many States there may be only two or three VA hospitals and it is going to be a distance for patients to come to that hospital for care, even though the quality reviews

across the medical profession in the United States today give VA extraordinary high remarks for the quality of medical care that it delivers. It really is first class.

Senator Ben Nelson: Well, I don't think very often the question is about the quality of care or even recognizing that with the TBI situation, all the research that's going into that, that there's a general perception that we're improving the quality of care. It's availability and the seamless nature of it.

General Schoomaker, this has probably happened to others as well, but I know last week you were interviewed by NPR and you were given the example that somebody allegedly -- that Army officials told workers at the Department of the VA to stop helping injured soldiers fill out forms and so forth. So much for the idea, as I said, of seamless care and seamless relationships. Probably not the first example of embarrassment and probably not the last.

But it does point to how important it is from the top down and from the bottom up to get it right so that there isn't stovepiping or resistance to this effort to make sure that those who have done it their own way for so long don't frustrate this process by wanting to continue to do it their own way or they know best what way it ought to be done.

I wish you might comment on that. I know you did last week.

General Schoomaker: Yes, sir, and I remain personally chagrined that an effort to really reach out and ensure that the best practices that we were observing, frankly, at Fort Drum were proliferated throughout the system -- ironically, we found a system that was working extremely well and yet it was interpreted wrongly.

I will say, first of all, it's very hard for me to say anything ill about the VA. I'm a product. I'm a physician, a product of the VA system. I was trained in two VA hospitals associated with major universities. This is a great system of care. This is a national treasure. They have set the standard on good, objective outcomes-based care within the country, and I think we're better positioned than we ever have with leaders like Under Secretary Mansfield and the new Secretary of Defense, my former boss General Peat, and General Cusman and others throughout that VA system.

Our response to what we saw at Fort Drum, sir, was that Secretary Peak and Secretary Geren promptly sat down, we hammered out an agreement, a memorandum of understanding with the VA, and we've put that aside. We now have a formal memorandum that empowers VBA counselors at each one of our Army MTFs to fully counsel any soldier or family and make it very clear that they're part of the solution and that we welcome that.

Senator Ben Nelson: But it does point out that it's an ongoing process --

General Schoomaker: Yes, sir.

Senator Ben Nelson: -- that you can't measure it simply in terms of time. It's a marathon, not a spring.

General Schoomaker: Yes, sir. And I think your comments earlier about the seamlessness and Secretary Chu's comments -- I think the fact is there are seams in the system. I think the earlier comment from the chairman about disability adjudication, which for the military is based upon fitness for duty and within the VA system is based upon the whole person concept, means that you can

apply the earlier study to virtually any individual problem and you'll find the same issue there.

We adjudicate disability in the military based upon that one major unfitting condition and we turn to the VA and allow the VA to take all of those conditions that we all jointly recognize are present and adjudicate disability on the basis of the whole person. That's a seam that has to be closed.

Chairman Levin: Thank you, Senator.

Senator Ben Nelson: Thank you.

Thank you, Mr. Chairman.

Chairman Levin: Thank you, Senator Nelson.

Senator Inhofe?

Senator Inhofe: Thank you, Mr. Chairman.

Chairman Levin: Senator Inhofe, I think the vote has either started or about to start.

Senator Inhofe: How about I go ahead and start and run through my time.

Chairman Levin: Would you turn that over to the next person here, and if there's nobody here when you're here just recess until I get back?

Senator Inhofe: Okay, I will do that.

Chairman Levin: Thank you.

Senator Inhofe: First of all, General Schoomaker, I appreciate what you said and let me just drive it home, because as long as I can remember, even back when I was in the United States Army, there was complaints about the kind of treatment in the VA centers. Then when I was elected here, oh, about 21, 22 years ago, we had just some real crises. Now, maybe this is unique in our State of Oklahoma, but the treatment was not good.

I can't tell you how that's changed. I had a group in my office yesterday of the veterans and they just rave about it. I have gone to all the centers, including some of the retirement centers and others. I don't know what's accounted for it, but whatever you're doing, keep doing it that way. It's been great.

Maybe because I'm the only veteran in the Oklahoma delegation, I seem to get more calls and complaints than any of the rest of them do. And they're in three areas that have been addressed somewhat in this meeting and by your committee. One is in the disparity between the disability evaluation systems that we've had. Senator Levin talked about that. You've responded to that.

One is -- the other two are in transition areas that we've been talking about with Senator Nelson, that is transition into civilian life or into another service of our country. Many of these people who become disabled, they want to continue serving in this transition. And then the transition, of course, that we talked about from DoD to VA.

Now, I understand, from whoever wants to respond to this, that this disparity between the evaluations has been -- well, you, Dr. Schoomaker, might be the right one. This disparity has been corrected now or is in the process of being corrected in terms of disability evaluations between the various levels.

General Schoomaker: Sir, I think that's a recommendation of the Dole-Shalala Commission that's going to require legislative changes. We can -- we can smooth over the bureaucratic steps re-

quired between the military system of adjudication and the finding of fitness for duty and the VA system of adjudication of disability, but we currently are not empowered to make this a single system without further legislation.

Senator Inhofe: Are you going to be helping us in drafting the legislation?

General Schoomaker: Oh, absolutely.

Senator Inhofe: And making recommendations?

General Schoomaker: I don't want to speak for the Department, but --

Dr. Chu: Yes, sir, we'd be delighted to. General Schoomaker is absolutely correct. Until there is a change in the fundamental statute, you will always -- even if we each rate each condition with the same percentage, which is the first issue, which we can deal with and we are dealing with, the Department only rules on fitness to serve based on those conditions that affect your military career. You may have other conditions.

Senator Inhofe: Well, in terms of the evaluations, if any of the five of you don't believe it's a problem just call our office and we can provide you with some cases.

Now, in terms of the transition into civilian life or other government services, any further comments any of you want to make about that, because this has been another source of complaints?

Dr. Chu: Sir, one of the things we've done particularly with this conflict is organize a series of job fairs, particularly at medical centers, where we especially emphasize the importance of Federal agencies stepping forward, including our own, the Department of Defense.

Senator Inhofe: When did they start? When did you start doing that?

Dr. Chu: About 2 years ago we started these, and we've done about a dozen of these altogether. And they are intended to both bring civil employers as well as government agencies together to the community, not restricted to those who've been recently wounded necessarily, but that's the focus. We have worked very hard in a proactive way through the Military Severely Injured Center to help the newly injured think about the possibilities for them, what would make sense from their perspective, and how do we link them up with these agencies so they can be successful.

Senator Inhofe: Secretary Mansfield, you touched slightly on this, the transition between the DoD and VA. Could you just address this electronic transfer of data, and are we making progress there?

Mr. Mansfield: We're definitely making progress, sir. We've come further than the JEC had. We're in the process now where we can actually exchange information. The issue, though, is that we're working in an effort to make it inter-operational. Right now you can read the information, but you can't deal with it. So we are exchanging information from imaging, from clinics, from pharmacy, and from testing. So we're further along the line, but we still have a long way to go.

Of course, part of the issue too is that when you look at where we're starting, you have an Army record, a Navy record, and an Air Force record that needs to be consolidated, and then we get access to that through a single data access point. We're working on that.

Senator Inhofe: Secretary Geren, this is more Army sensitive than anything else. The chairman talked about some of them who were deployed who perhaps should not be deployed. But on the other end of that, there are a lot of them who want to be deployed who are not. It seems like there is a greater problem in the Army. Our 45th out of Oklahoma, that's over 2,600, they're over there in Iraq right now. I went down to Camp Gruber when they were preparing for it and, while the National Guard members, they receive TRICARE, they don't have the dental benefits. This seems to be where the problem is. I was surprised to see this, that the Department of Defense has set a service-wide goal of greater than 75 percent for fully ready to deploy service members and greater than 90 percent for partially ready service members.

Currently, five of the seven reserve components are below the 75 percent. Now, I have from your report on page 194 those seven and the two that have the great problem are the Army National Guard and the Army Reserves. Everybody else, frankly, is over the 75 percent. But these are not. These are, in the case of the Army National Guard, 45 percent; and the Air Guard, 51 percent.

Now, of those, that's just dental only problems. That seems to be the greatest problem in terms of having these people not ready for a deployment for medical purposes.

It would seem to me that -- and I talked to some of them down there at Camp Gruber before they were going -- you can't put a bridge in or do the root canal; there's not time during this transition period. And once they get over in the field of combat, they're not going to be able to do those things.

Now, wouldn't one solution that perhaps you might want to consider or you are considering is to somehow have dental benefits? There was a time when the Guard and Reserve really didn't have these overseas deployments and maybe it wasn't necessary then. But it is now, and it seems to be, of the medical -- again, I'll repeat that -- the 38 percent, is 45 percent is dental only. So that seems to be the biggest problem.

What do you think, Pete?

Mr. Geren: The experience in Oklahoma is not unique. The dental issue is something that we are looking at very carefully. One of the initiatives that the Chief and I are working on is how to do a better job of fully operationalizing the Guard and Reserve, and medical preparedness for deployment is one of the issues and the dental is always at the top of the list.

So I don't have an answer for you today, but it's something that we are looking at.

Senator Inhofe: Well, if your goal is to reach 75 percent, from the figures I have here -- this is not just Oklahoma; this is out of your report -- if you pulled the dental problem out of that, you're at 75 percent. It just seems to me like that's something that would be fairly easy to address, although it might be expensive to address because it would mean you'd have to get into --

Dr. Chu: Senator, I do know that some units in Oklahoma have adopted a best practice we'd like to see more of them use, which is to use O and M funds during periods of premobilization drill to bring mobile dental vans to the unit.

Senator Inhofe: You mean prior to --

Dr. Chu: Prior to mobilization. And the standard that you've described is what we want all units to be at all the time, so that we don't have to deal with these medical issues post-mobilization.

Senator Inhofe: I appreciate that, because I think -- and Mr. Chairman, during your absence I made comments that you talked about how there are some who didn't want to be deployed but were found deployable, but there's probably more who want to be deployed who for some reason or other can't. Or maybe that's unique to Oklahoma, but I sure have heard from a lot of people.

Dr. Chu: Again, I want to praise those units in Oklahoma that use this practice. It is a great solution. It is reasonable in terms of its cost.

Senator Inhofe: Thank you.

Mr. Geren: Real quickly, Senator, we have a group of guardsmen and reservists that advise the Chief and Army leadership on Guard and Reserve issues. They meet with us regularly, and that has been one of the issues that they've been examining and putting together recommendations in that area. We recognize that challenge. It is expensive, and there's also just some logistical issues associated with it. But we recognize the importance of it and are working through it now.

Senator Inhofe: Thank you.

Chairman Levin: Thank you, Senator Inhofe.

Senator Bill Nelson?

Senator Bill Nelson: Gentlemen, thank you for trying to correct this problem and make it right.

Secretary Chu, has Secretary Gates designated a lead agent to implement the TBI-PTSD mental health plan?

Dr. Chu: Yes, we have our Center for Psychological Health and Traumatic Brain Injury. It is the agency that will be executing the generous addition to the budget the Congress provided last year.

Senator Bill Nelson: The question was has he designated a person to implement it?

Dr. Chu: The commander is now Colonel, soon General, Dr. Lauri Sutton, Army psychiatrist.

Senator Bill Nelson: You all know the problem here and thank you for trying to correct this problem. We have excellent care, for example, for TBI once we can get them into the centers, and one of those centers is in my State, in Tampa. The problem has been getting them identified and getting them in those centers. As the other Senator Nelson pointed out in a case in his State of Nebraska, I could point out to you many cases in my State of Florida where the military person gets lost between being released from DoD and coming into the VA health care system. So thank you for working on that.

Mr. Secretary Geren, I want to go over with you what I had talked to you on the telephone about. I think it needs to come to the attention of the committee: A World War 2 veteran who was wrongly accused and incarcerated, African American, during a POW camp revolt in Italy in World War 2 and in the hysteria is swept up and incarcerated for a year. Years later, in fact just this year, so that's some 60 years later, a review of the records, the Department of Defense realizes that it made a mistake. They reversed his dishonorable discharge. They made it an honorable discharge,

acknowledged that the U.S. Army was wrong, and 60 years later returns to him the back pay that he would have earned during the 1 year of incarceration, \$720.

Now, that's just plain wrong, that someone is denied that and is given 1944 dollars without compensation for at least the cost of living adjustments, which would only be \$8,000 in today's dollars.

Chairman Levin: Senator Nelson, excuse me for interrupting. I'm going to run and vote and come back. If no one's here when you need to go, just recess.

Senator Bill Nelson: I'll recess, I will.

Chairman Levin: Thank you for raising this issue, however.

Senator Bill Nelson: Yes, sir.

Chairman Levin: It's of importance to the committee.

Senator Bill Nelson [presiding]: Of course, I appealed to you as Secretary of the Army and then you said you did not have the legal authority. I appealed to the Secretary of Defense and he said he did not have the legal authority. As a result of that, I filed a bill to correct it.

But it seems to me that under equity and fairness an issue that we are addressing here about health care for wounded warriors, that under equity and fairness, a warrior has been wounded by taking away his most prized possession, which is his honor and his liberty, and 60 years later that the U.S. Army and the Department of Defense is saying that they don't have somewhere in the bowels of the Pentagon the ability through equity and fairness to adjust \$720 back pay.

Can you share with me, Mr. Secretary, what you think we ought to do to right this wrong?

Mr. Geren: Yes, sir, I'm glad to. I reacted exactly the same way you did when I learned of this. I'd go so far as to say it's a travesty of justice. \$720 today is nothing compared to what that soldier went through and what he suffered, and certainly what \$720 would buy you in 1944 and what it would buy you today, it's no comparison at all.

When I learned of this I asked our lawyers to figure out some way to fix this, some way to address this. And they kept coming back and saying there's no way to do it. We looked at a couple of different ways and, unfortunately, they kept coming to the same conclusion, and the OSD lawyers agreed with the Army lawyers, that under the current statutory framework we're prohibited from deviating from that schedule.

So I'm glad that you've introduced a bill and I hope there's speedy consideration of it so that we can right this wrong and try to do what we can to compensate this soldier for what he suffered.

Mr. Mansfield: Senator, if I could raise an issue. If he was dishonorable discharged he would not have been eligible for VA benefits back then. So why don't we check in and see if there's some way that we can look at that situation now that it's been corrected and the VA may be able to assist him.

Senator Bill Nelson: Okay, Mr. Secretary Mansfield, we'll do that, and thank you for that suggestion.

Samuel Snow naturally is getting up there in years. He lives in Leesburg, Florida. Here's what -- I would pursue this with great vigor because this is somebody who has been wronged. But the rea-

son I'm bringing it up to you is that again it's another indicator of the cold, hard, impersonal rules and regulation on something that is obviously wrong. We've seen this in Samuel Snow's case. We've seen it in how some of these veterans have been handled. We've seen it, for example, in that veteran from Winter Haven, Florida, that was lost in the system, the military discharged him, had no indication that he had TBI because they didn't ask, they didn't probe. And so he's out there on his own, and he knows something's wrong, and he goes and gets an appointment after waiting, over at one of the VA hospitals at Bay Pines. Then he finally gets there after waiting a couple of months and then they say: Well, we can't handle this; you have to go to the Tampa Haley Hospital. And of course, that's another waiting period.

Somehow, this veteran knew to call me. And of course, the minute we found out what happened he had appointments in the Haley Hospital in the TBI center the next day.

There's something cold and hard and impersonal that we have to break through not only the subject of this hearing, on wounded warriors, but on the treatment of people like Samuel Snow 60 years ago, that his country didn't treat him right and 60 years later is giving him a check and say, go away. It's wrong. It ought to be corrected.

Mr. Mansfield: Sir, I would tell you that we've been working hard to correct that. I would agree with you that it's wrong. We, as I stated in my opening statement, need to ensure that each one of these individuals that steps up, raises their right hand, puts themselves in a position to defend this country and puts themselves at risk, deserves timely access to every benefit that this Nation has promised them. And we're working together as hard as we can to make that happen.

I would make the point, in regard to the person you mentioned, with that situation and others, we have changed the rules and regulations to make sure that people with these issues get taken in sooner and quicker and are seen.

I would tell you also that everybody that comes to us is screened for TBI and PTSD, and we're working with DoD on follow-up issues to do that.

But I would agree with you, sir: You've got two of the biggest bureaucracies in the world that need a little shaking to make sure that they know that we're dealing with people.

Dr. Chu: Sir, let me also emphasize, as you and Secretary Geren agreed, ultimately the issue with Mr. Snow is statutory. If the Congress were willing to give the Secretary of Defense discretion in cases like this, as it has given him discretion in waiving repayments, which we have used extensively, we would be able to avoid the situation.

But it is ultimately not a rule or regulation in the Snow's case; it is the law, and we are stuck.

Senator Bill Nelson: Well, if it is the law we will change it.

Dr. Chu: My plea, sir, is for broad discretion as opposed to the rifle shot, because then you can deal with the unanticipated situation just as you have advocated, and we would like to be in that position.

Senator Bill Nelson: Now, it's hard for me to believe that the Department of Defense in the enormity of its resources and rules and regulations, that there is not discretion somewhere to correct this wrong. As Secretary Mansfield has said already, there's another avenue we might explore with regard to maybe he hasn't been advised of veterans benefits that would be available to him since he had been wrongly, dishonorable discharged, and we will pursue that. I wonder why we had to come to a United States Senate hearing to get to that.

But in the mean time, since I have to recess this hearing so that I can go vote, I wish you in the recess would confer with your assistants and see if there might be any other little angle that we haven't figured out.

Mr. Geren: Sir, I can assure you we have pushed this within our legal system as hard as we can. I know you get two lawyers together, you get two opinions, but unfortunately we continue to run into the same statutory interpretation. If someone could help us see it differently, we'd be glad. I can assure you we all feel the same about that case and want to help them, and appreciate your advocacy and your interest in addressing it statutorily. We believe that's where we are, and we sent it back and sent it back and sent it back and kept getting the same answer. We want to see it fixed as well.

Senator Bill Nelson: The committee will stand in recess subject to the call of the Chair. [Recessed.]

Chairman Levin [presiding]: The committee will come back to order. Yes?

Mr. Mansfield: Could I have the privilege of speaking, please?

Chairman Levin: Sure, Secretary Mansfield. Let me just wait until everybody -- I don't know. Before, Secretary Mansfield, I call on you, let me also ask -- yes, Secretary Mansfield.

Mr. Mansfield: Sir, in reference to the last discussion about the individual wronged and the ability to deal with that and the need for legislation, I would refer you to Title 38 U.S. Code 503: "Administrative error, equitable relief. If the Secretary determines that benefits administered by the Department have not been provided by reason of administrative error on the part of the Federal Government or any of its employees, the Secretary may provide such relief on account of such error as the Secretary determines equitable, including the payment of moneys to any person whom the Secretary determines is equitably entitled to such monies."

That's what the DoD needs. That's the VA section and I think that's what DoD needs. And it would allow us to go back and look at the situation by virtue of the fact that, with that dishonorable discharge, he was not eligible for a lot of VA benefits and we could not make an adjustment based on that.

Chairman Levin: Does the mistake have to have been made under that law by the Veterans Administration?

Mr. Mansfield: No, sir. It says "on the part of the Federal Government or any of its employees." "The Federal Government."

Chairman Levin: So if there was a mistake made, which there seems to have been, by the DoD, the VA can act now under existing law?

Mr. Mansfield: Yes, sir, for VA benefits.

Chairman Levin: For VA benefits. Well, that's part of the deal, as I understand it.

Mr. Mansfield: That would be one way to make him whole, to look at what he would have -- what he would have been eligible: home loan or education or compensation.

Chairman Levin: Well, I'm sure Senator Nelson will pursue that. But what you're doing is opening up the avenue that, even though you don't think the DoD has that power -- we'll check that in a second -- that the VA has power if there's a mistake made by any governmental agency that affected the benefits of the VA, that you can make that -- you may not be able to make that soldier whole, but you'll be able at least to take care of the VA part of doing it under that law.

Mr. Mansfield: I'll bet you we could make him pretty damn near whole.

Chairman Levin: Okay. Well, that's better yet.

Mr. Mansfield: Or pretty well whole.

Chairman Levin: And I'm sure Senator Nelson, I assume he's aware of that and will pursue that. But if not, thank you for bringing that to our attention.

Mr. Mansfield: We'll notify him. But DoD needs legislation --

Chairman Levin: Let me follow that up now. Do you know, Secretary Chu, if DoD has that same power?

Dr. Chu: I don't believe so, sir, but obviously we'd want to doublecheck.

Chairman Levin: Well, we'll raise it in the authorization bill this year, then. There's no reason why the DoD should not have the same power that VA has to correct mistakes. So my staff I know is following this and we will pursue that, unless, Secretary Geren, do you know whether the DoD has that power?

Mr. Geren: We looked as hard as we could to figure out a way to address this situation and Army -- we looked at it, looked at everything that we had that was discretionary. We could not find a way for it to fit. We went to OSD's lawyers to see if there would be a way to do it at the OSD level. They could not find a way. We kept coming to the same conclusion, that there was a statutory block that kept us from doing it, and we certainly would support an effort to provide the flexibility to redress it.

Chairman Levin: Well, Secretary Mansfield, thank you for bringing that to our attention.

Mr. Mansfield: Thank my excellent staff here, sir.

Chairman Levin: We thank your excellent staff. We appreciate that. We all rely on our staff, more than we like to admit.

Mr. Mansfield: I'll admit it today, sir.

Chairman Levin: Well, every other day we admit it, too. But at any rate, thank you, and that will be pursued.

There's nobody here who hasn't had a first round, so let me start a second round here. The Senior Oversight Committee has been working diligently on a number of these issues, as we've heard here this morning and were aware of even before this morning. But the question is whether or not the issues that we are discussing will have -- remain a priority over time, talking about transitions and seamless transitions, since there will be a change of administrations in January. What steps are you taking to ensure that these

issues will remain a priority during the transition period from this administration to the next?

Secretary Chu, why don't I ask you first and then Secretary Mansfield.

Dr. Chu: We are planning to use -- and Secretary Mansfield and I have already begun discussing that issue -- the now statutorily chartered Joint Executive Council, which is a similar partnership between DoD and VA, to make sure that there is no backsliding, no ground lost, no lessening of commitment to these initiatives. We are determined to see them through past the transition using that already existing mechanism.

I think it's already produced, as Secretary Mansfield indicated, important successes in other areas. I point to North Chicago as a prime example of that, that agenda succeeding, and I'm confident it can carry forward into the next administration.

Chairman Levin: Secretary Mansfield?

Mr. Mansfield: Sir, one point I would make is that everything that we've discussed that we're putting into action are becoming VA directives that will be on the books as we leave. The other point I would make is in the course of a transition there is normally a discussion with the incoming and the outgoing of the highlights of what the outgoing administration looks at and wants to put in -- give their attention to the folks coming in, I'm sure would be a part of this effort.

Chairman Levin: Is there a permanent structure, a joint structure that's now in place, to evaluate these changes that we've talked about and to monitor systems and to make further recommendations for process improvement? Is there that structure and if so what is it?

Mr. Mansfield: Sir, I would say that, again, the statutorily mandated JEC with its benefits subgroup and its health care subgroup have been working for 4 years now --

Dr. Chu: 5 years.

Mr. Mansfield: -- 5 years now, in an effort to put processes in place that we can measure what is required and be able to make a decision at the end of each year what we've done, what we need to do.

Chairman Levin: Now, who are the members of the JEC?

Mr. Mansfield: Currently it's myself and Dr. Chu and Secretary Chao from Labor has asked us to include a member from there, the Veterans Employment and Training Service, which is responsible for veterans employment, and we've agreed to bring somebody from there on board. Then you have, in the benefits arena you have the Under Secretary for Benefits from the VA and the equivalent OSD and DoD folks. In the health arena you have the Under Secretary for Veterans Health and the equivalent folks from the services in DoD.

Chairman Levin: Now, you two are political appointees.

Mr. Mansfield: Yes, sir.

Chairman Levin: Are the ones, those under secretaries, are political appointees, are they?

Dr. Chu: They are political appointees.

Mr. Mansfield: Yes.

Dr. Chu: But the council, the Joint Executive Council, is, thanks to your efforts, a statutory body. So whoever succeeds, either acting for or confirmed by the Senate, will succeed to that responsibility. And the career staff understands that this agenda has to go forward using this mechanism.

Mr. Mansfield: Under secretaries in the VA are political appointees, but they are on 4-year terms, which would overlap this administration.

Chairman Levin: Would you make sure that the career staff not just tells your successors, assuming that you're not reappointed, about this, but that somehow or other, can they be acting during a period that there is a gap?

Mr. Mansfield: Sir, the career staff, the leading senior career staff in each agency, are heavily involved in this and understand very well the need for them to be --

Chairman Levin: Are they authorized to meet during a transition period without you?

Mr. Mansfield: As part of the JEC?

Chairman Levin: Yes.

Dr. Chu: I see no reason they could not. I don't want to get in the general counsel's way here on the Vacancies Act issue, but I see no reason that those performing the duties of these officials, which would be the last resort, could not in fact convene a meeting and have --

Chairman Levin: Will you let us know whether that can happen?

Dr. Chu: I will do that, sir.

Chairman Levin: And if it can't happen, let us know what would be required to make that happen legislatively?

Mr. Mansfield: We will provide that information, sir.

Chairman Levin: That would be great. Thank you.

Secretary Geren, last week you announced a program called the Wounded Warrior Education Initiative. Could you tell us what that's about?

Mr. Geren: Yes, sir. We announced it at Leavenworth, Kansas. In September the chancellor of the University of Kansas came to meet with me and with Dr. Gates to propose an initiative where Leavenworth would partner with Kansas University in developing a graduate degree program for wounded warriors, for specifically wounded warriors. It's a program where the wounded warriors would either stay on active duty or, if they have left active duty, be supported in some type of an internship role, attend a 2 years master's program at Kansas University, then return to the military and serve in either a teaching capacity or a support capacity at our colleges at Leavenworth.

A very innovative program, and we were able to, work with Kansas, over a period of just several months pull it together, and last week we announced that we have eight soldiers accepted into the program; hope to build on it. I think it's a model that could be used elsewhere.

Chairman Levin: Yes, if it works I assume you will expand it.

Mr. Geren: Yes, sir.

Chairman Levin: Now, some have proposed giving veterans a plastic card that they could take to any health care provider to pay

for their health care. Can you give us your view on that proposal, Secretary Mansfield?

Mr. Mansfield: I don't think it's a good idea.

Chairman Levin: Why is that?

Mr. Mansfield: The VA is set up -- I have to go into, the VA is set up to be able to be the primary care provider for the individuals in the system and keep track of what their needs are and follow them throughout the system. Part of what you're looking at is taking us away from that, where we wouldn't know what's going on with the care, what the quality is, what they need, what they don't need.

The other part of it is it would make us in effect a insurer, a Medicare-type payor for the system, and I don't know what kind of a requirement we would have for the back office, that we'd have to replicate the Medicare system to get the bills, figure out what the bills, whether they were reasonable or not, whether the treatment was reasonable, and then make a payment.

Chairman Levin: Do veterans groups generally favor this kind of approach, do you know, or not, service organizations?

Mr. Mansfield: I don't think they do favor it, sir. I think they would look at it as unraveling, starting to unravel the VA. As was mentioned here earlier, we now have reached a point where we are regarded as providing pretty good care and taking pretty good care of these individuals that are in our system.

Chairman Levin: One of you mentioned the electronic health record system which we're trying to develop between the two entities. I've forgotten, was it Dr. Chu? Were you doing it? You made that reference? What's the timetable for that?

Dr. Chu: Sir, we anticipate by the end of this year having all existing electronic information interchangeable between, viewable, as I understand the computer community phrase it, between the two institutions, so if you are a VA doctor you can see the DoD record and vice versa. We already have the pharmacy data at that stage. We have the laboratory data to that stage, the first discharge summaries to that stage, etcetera.

It's a very significant project. It's been ongoing for a number of years. The recent Senior Oversight Committee effort has given extra energy to it and I think we'll get to that goal by the end of this year.

It doesn't necessarily make the data, as the computer community would phrase it, computable. In other words, you can't manipulate it inside the program. I can look at it. For that, eventually what we need to do is have a common electronic health record between the two Cabinet agencies, and we are committed to doing that. That is a multi-year project. That's not going to be overnight. It allows us to replace our aging existing inpatient electronic records.

We do have in DoD a worldwide, essentially web-based, although that's not actually the vehicle used, it's on servers that we control, outpatient electronic record now, which is part of what we're making available to the VA physicians for outpatient treatment. But we need to modernize our inpatient software, replace it basically. The VA eventually will have the same need. So we are committed jointly. The first exploratory effort has begun to getting to that com-

mon, essentially identical, electronic health record for the future. But that is a multi-year project.

Chairman Levin: If it's an identical record, then each agency would be able to add to that record?

Dr. Chu: Exactly.

Chairman Levin: And manipulate the information.

Dr. Chu: And manipulate the information. And DoD's ambition is to mirror for that what we can now already for ourselves do for outpatients, which is wherever you are, at least in theory, I can call up what's been done to you as an outpatient, on an outpatient basis. That's important because our people, as you know well, move around the world so much. So we don't want something that's site specific in character. So these data are now on servers that allow worldwide access.

Chairman Levin: Did we require that by law?

Dr. Chu: You required in statute that we make it interoperable.

Chairman Levin: But not the second step?

Dr. Chu: Not the second stage. It's a multi-year project. We will be coming to you in this and future budgets.

Chairman Levin: But we haven't already mandated it?

Dr. Chu: I don't believe so, sir.

Chairman Levin: You've got to come up -- you and I both used the word "manipulate" and I think we've got to find a different verb.

Dr. Chu: Yes, sir. They like to say "computable."

Chairman Levin: Yes. I shouldn't use that word because some people would understand that to be a pejorative word, that we are somehow or another manipulating data for some nefarious purpose, rather than --

Dr. Chu: No nefarious purpose intended.

Chairman Levin: No, no. I used the word, too. But I don't know what the new verb is. "Computable," is that it?

Dr. Chu: "Computable" is my understanding.

Chairman Levin: Make it computable.

Okay. I think Senator Chambliss. Yes, Senator Chambliss, you are next.

Senator Chambliss: Thank you very much, Mr. Chairman.

Gentlemen, thank you, first of all for being here, your excellent testimony this morning. But thanks for what you do. Thanks for being concerned about our brave men and women who wear the uniform.

And please to convey our thoughts and prayers to the Secretary. Gee, Pete; what did you do to him over there? Rough morning at the Pentagon. Actually, it was pretty slippery in my neighborhood, too. Tell him we're thinking about him.

Let me thank all of you for your efforts over the last year to improve our health care and transition programs for our wounded warriors. I've personally seen how the warrior transition units and our health care professionals have made great strides in caring for and treating our wounded service members. I have been to both Fort Gordon, I've been to Fort Benning, where I've seen firsthand what's happening with respect to our men and women who are coming back with injuries.

We're doing a great job of helping them re-integrate into the military and the community, and I appreciate the hard work each of you have done to get us to this point.

I note in Secretary England's statement that he focuses on the recovery coordination program. This program is designed to identify and integrate care and services for wounded service members, veterans, and their families, obviously. Establishing recovery coordinators to serve as the patient and family single point of contact during their recovery and transition period was discussed in the number one recommendation of the Dole-Shalala Commission, and I'm pleased to see that the Department is taking steps to implement this very important recommendation.

Training for the recovery coordinators is obviously very important if they're going to perform their jobs effectively. Augusta, Georgia, has developed a very unique collaboration in the area of wounded warrior care. The City of Augusta is home to the Eisenhower Medical Center at Fort Gordon, formerly operated under the great leadership of General Schoomaker. We miss you there. Your successor General Bradshaw is certainly doing a great job.

Part of what I'm going to talk about here and ask you about is something that began under your leadership, and we thank you for your continued attention to the care for our wounded warriors.

It's home to, also, the Charlie Norwood VA Medical Center and the Medical College of Georgia, particularly the school of nursing. These three institutions are already collaborating in the treatment of wounded warriors and the Charlie Norwood VA hosts the only active duty rehab facility for military personnel in a VA medical center. The Medical College of Georgia school of nursing has an existing program for training and certifying clinical nurse leaders. These clinical nurse leaders are basically the civilian equivalent of DoD's wounded warrior recovery coordinators and perform many of the same tasks.

As a means of extending the collaboration and treatment of wounded warriors in the Augusta area, the Medical College of Georgia school of nursing has proposed a short certificate program which would take advantage of classes and faculty already resident in their clinical nurse leader program to help train and certify DoD's recovery coordinators. I understand from statements from several of you that DoD is conducting some training, including web-based training, for your recovery coordinators. But I'm wondering if you would consider taking advantage of this proposal that the Medical College of Georgia is offering, to determine if it could be an effective means of helping to train your recovery coordinators and if it would provide a value-added addition to the Department's establishment of a wounded warrior recovery program.

I'll direct that to whoever wants to respond first, but Dr. Chu, Mr. Secretary.

Dr. Chu: Yes, sir. We always value new ideas. We'd be delighted to look at this one.

Mr. Mansfield: Sir, I would add that it's interesting you mentioned Fort Gordon, because we have at the present time a program with VA and DoD that goes back I think to 2004, where the VA is actually doing rehab for active duty soldiers down there. So that cooperative effort is already in place down there, and we can

look at going forward and, as Dr. Chu mentioned, doing something new and better.

Senator Chambliss: Anyone else have a comment? [No response.]

Senator Chambliss: Well, I know that the personnel at the Medical College of Georgia school of nursing would be willing to modify their proposal in order to meet any specific training requirements, as well as the necessary time frame that DoD might require for training their recovery coordinators, and whatever will be helpful to the Department and the college from a discussion standpoint. These folks are ready and willing to offer any services necessary.

General Schoomaker, you know firsthand the great job that Dr. Romm and the folks over at the Medical College do, as well as the folks at the VA Medical Center. I've had the pleasure of visiting any number of our patients there at the VA Center over the last several years and the work that we're doing, particularly with our severely injured folks, is truly amazing there. Thanks again, General Schoomaker, for your leadership and role at Eisenhower in establishing it as certainly the premier in my opinion recovery unit for our wounded warriors out there.

General Schoomaker: Thank you, sir. Frankly, I get the credit for the terrific work of a team at the Augusta VA Medical Center and at Eisenhower. We had a very farsighted group in both communities who recognized very early in the war that the nature of the injuries that our soldiers and sailors, airmen, and marines were suffering, the long experience that the Augusta VA Medical Center and many VA's throughout the system have in rehabilitative medicine, especially with blind and deaf and traumatic brain injury and post-traumatic stress disorder, which Secretary Mansfield has talked about already, I think was resident within those communities, and they reached out to us, just as we reached to them, and we had a very -- continue to have a very collegial and cooperative relationship.

It's important to note that this was built on a relationship of cooperative agreements that go back in neurosurgery, that go back in cardiothoracic surgery between the two organizations, which set the framework for what you have there today.

We really truly support, appreciate the support that you have given to this, that Senator Isakson has given, that Congressman Norwood, the late Charlie Norwood, gave to it, and now Congressman Broun give to that.

Senator Inhofe said something earlier that I think is very important and that is that his own -- the revelation, the epiphany that he has experienced in going back into the VA system and seeing that this is such a high quality system. That insight, frankly, is one that all of our soldiers and their families need to recognize. Relationships such as we have at the Augusta VA Medical Center, but all our polytrauma units, if you've been to see them, tell us every day as well -- it allows our soldiers and families, even if they come back into uniform, fully recovered and rehabilitated, it gives them an insight into what the VA medical system provides for them and much greater confidence through working knowledge of the VA. So these kinds of relationships are just absolutely fundamental.

Thank you, sir.

Senator Chambliss: Thank you, Mr. Chairman.

Chairman Levin: Senator Chambliss, thank you.  
Senator Warner?

Senator Warner: Thank you, Mr. Chairman.

The Army really has on its own initiative established this warrior transition brigade. As I understand it, this fine officer was introduced as the brigade commander, is that correct?

General Schoomaker: Yes, sir. He's the first brigade commander, sir, for the warrior transition unit. Colonel McKendrick is the commander of the only brigade within the WTUs. We have 34 other warrior transition units at the battalion and company level.

Senator Warner: And they're staffed accordingly to the need in that geographic jurisdiction?

General Schoomaker: Exactly, sir, on a standard Army document that provides staff in accordance with the number of patients and the severity of patients.

Senator Warner: Then, General, do you find it desirable if Congress were to recognize this in legislation at all? Or do you prefer to just leave it as it is right now?

General Schoomaker: I guess, sir, I need a little clarification as to how Congress wants to recognize it.

Senator Warner: Well, now, wait a minute. I'm not suggesting that Congress move in. This is an Army initiative.

General Schoomaker: Yes, sir.

Senator Warner: And it's working. You may not need anything in there by Congress. But every now and then organizations need a little structural recognition in the law to stay alive after passage of time and other priorities begin to encroach on Army needs and so forth.

General Schoomaker: Yes, sir. I believe in the NDA '08 you gave us the right structure and the right imperative, without giving us -- without giving us such directive ratios of soldiers and patients, that we have the latitude to really make the judgments that we need to make, sir.

Senator Warner: Now, what about your staffing? Are there individuals -- are you looking for volunteers to take this on? Is it career-enhancing? As you well know, that's got to be somewhere in the residual recesses of every Army mind as he or she is moving up: Is this assignment going to help me move on to my next goal in the Army?

General Schoomaker: Yes, sir. What we have done is, first of all we have codified the units in Army doctrine so that they have -- they have all of the necessary administrative tools to have an enduring presence within the Army. We have funded them. The Army has stepped forward very aggressively and put manpower against them. Despite a war and the challenges of deploying soldiers, they have placed 2500 soldiers against them. And these are not traditional medics, many of them.

What we see happening is that these positions represent for the cadre that fill those roles an opportunity for them to take a knee from constant deployment or recruiting duties or training duties and other things. We've also put special pays in for the NCO leadership. These are all signs that these are important jobs for the Army, and I think the visibility it's given for the senior Army lead-

ership and the emphasis that the Chief of Staff and the Secretary have given to this I think are all signs of the importance.

Senator Warner: What about Reserve and Guard members? They will be on equal par?

General Schoomaker: They are, sir.

Senator Warner: Do you have a quota for so many regular Army and so many who are Army Reservists and so forth?

General Schoomaker: Absolutely, sir, to mirror the composition of the warrior transition units, so guardsmen and reservists are also present there, especially because of the special needs of the Guard and Reserve with respect to administrative and pay and travel issues and the like.

Senator Warner: Let's go back to the family support, the parents, the spouses, so forth. Do they have access to this organization to help get support?

General Schoomaker: Oh, yes, sir. Of course, the Army family is one of the cornerstones of the Army. You may be familiar with the Army covenant that the Secretary of the Army --

Senator Warner: Oh, Secretary Geren has read that before this committee in years past.

General Schoomaker: We feel very strongly about the need to support our families. We have created soldier and family assistance centers at every one of our sites.

Senator Warner: But I mean, is this brigade also part of that infrastructure that the families can access?

General Schoomaker: Oh, absolutely, sir.

Senator Warner: The wife, parent, can walk right in and say, look, my soldier husband or son is just not able to get here today; I want to try to get this for him, and so forth?

General Schoomaker: Yes, sir. The nurse case managers that are providing administrative oversight of the needs of that soldier I think also provide ingress for that.

Have I depicted that correctly there?

Mr. Geren: Yes, sir.

Senator Warner: And you're satisfied that the budget and everything else is adequate to help the family members as they try to continue their roles of support for their spouses or sons as the case may be?

General Schoomaker: Yes, sir. As we've identified challenges to these families to travel, for example, or to be there, be present and provide support for a wounded son or daughter or husband or wife, even non-marriage, non-medical attendance, we have reached out to them and have found the necessary funds to support their travel and presence.

Senator Warner: To our distinguished Secretary of Veterans Affairs, indeed I look back over your personal record of achievements. You've certainly served this Nation well. Thank you for continuing, Secretary Mansfield, in your role today.

Mr. Mansfield: Thank you.

Senator Warner: Have we covered here this morning -- some of us in the course of votes missed some testimony -- the disability rating for service members, the pilot program? Have you testified about that this morning?

Mr. Mansfield: We talked about it generally sir. The pilot started. It's up and running. We've had the first case run through the system. It'll be running until November and we'll be taking periodic looks at it.

Senator Warner: So that the record this morning has adequate testimony with regard to that very important program?

Mr. Mansfield: I believe so, sir.

Dr. Chu: Yes, sir, I agree.

Senator Warner: Thank you very much.

How about the improvements in the DoD disability evaluation system? Have we covered that adequately this morning?

Dr. Chu: Yes. That's part and parcel of the same effort.

Senator Warner: All right. Well, Mr. Chairman, I think you've conducted a very good hearing this morning. I have seen part of it.

Mr. Geren: Mr. Chairman, could I just make one point in response to Senator Warner's?

Chairman Levin: Please, Secretary Geren.

Mr. Geren: When the legislation was being developed for the Wounded Warrior Act there were those, many of them who were in the other body, that did advocate a fairly prescriptive approach to setting ratios and using statutes to set up these warrior transition units or systems to meet the needs of wounded warriors. We worked with this committee and you gave us the kind of flexibility that we felt was very important for us to be able to shape these units so that they were able to adjust to the dynamic situation that they're asked to work in. And we appreciate very much how this committee worked with us and provided us that kind of flexibility.

We think that's one of the success stories in this legislation that you passed, is it does give these Army leaders the opportunity to be somewhat entrepreneurial. They did create this in a very short time out of whole cloth, a totally different approach, and they continue to adjust it. They continue to make improvements.

General Schoemaker talked about this task force that he's heading up to look at how do we start accommodating the needs of some of these soldiers who are particularly vulnerable, that have all been brought together in these warrior transition units. He will continue to fine-tune this, as well as General Tucker and the others that are working in the area. So the flexibility that you gave us I think is very important as we shape this over the coming years, and we appreciate very much how you've given these great Army leaders the opportunity to be entrepreneurial, do something that has not been done before. It's a work in progress today, great progress, but a work in progress.

Senator Warner: The group of Army veterans -- well, actually they're active duty -- is almost 10,000; is that correct?

Mr. Geren: Yes, sir. In the warrior transition units?

Senator Warner: Yes.

Mr. Geren: That's active, Guard and Reserve, but they're all currently on active duty. It's about 9600 right now.

Senator Warner: And these, they go all the way from where they're still getting treatment to this transition group, trying to integrate them back into the U.S. Army and find an MOS and a responsibility that they can fulfil in the Army commensurate with

such limitations as they might have as a consequence of their wounds; is that correct?

Mr. Geren: Yes, both to give them the opportunity and prepare them to return to duty or, if they're going to transition to civilian life, to make sure that they are well equipped to be productive citizens and anything we can do to prepare them for that.

Senator Warner: And a number of these are accessing health care both within the regular Army and accessing it within the veterans organization; is that correct?

Mr. Mansfield: That's correct, sir.

Senator Warner: You've worked out a system how that can be done.

These are really dramatic changes, Mr. Chairman, in the small period of a year's time. You're to be commended, each and every one of you.

Dr. Chu, in the old Navy we used to get a red hash mark for every couple of years service. How many years service have you been coming before this committee?

Dr. Chu: If I include my prior service, with my break in service here, it's getting close to 20 years.

Senator Warner: 20 years.

Chairman Levin: How many Purple Hearts have you been awarded -- [Laughter.]

Senator Warner: For wounds inflicted by Congress.

Chairman Levin: I hadn't finished the sentence, but he got it.

Senator Warner: That's quite a record, Dr. Chu.

Dr. Chu: Thank you, sir.

Senator Warner: That's quite a record.

Well, give your Secretary our best. Tell him you stood in very well for both the Deputy and Secretary Gates. I don't know. All of us went home on that ice last night. It's an experience. It could happen to anybody.

Chairman Levin: Well, give our best to Secretary Gates. Tell Secretary England we didn't miss him, you did fine. That will make his day, I'm sure.

Secretary Geren, you made reference to flexibility. We did work with you very closely to give you flexibility and I think you and the others understand that that flexibility goes to how you accomplish the requirements, not whether --

Mr. Geren: Yes, sir.

Chairman Levin: -- the goal is achieved. I think it was the right thing to do and we're more than happy to work with you, because we think you and the other witnesses and the Department is as determined as we are to get these changes made. So that's what we're relying on. That's what our troops are relying on, their families.

We thank you for your testimony. We thank the soldiers for their service, for coming here this morning, and their families for the kind of support that they give, which is so essential to these programs working.

With that, we will stand adjourned.

[Whereupon, at 12:04 p.m. the hearing was adjourned.]