

TRANSFORMATION OF THE ARMY'S PHYSICAL DISABILITY EVALUATION SYSTEM (PDES)

BY

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USAWC STRATEGY RESEARCH PROJECT

**TRANSFORMATION OF THE ARMY'S PHYSICAL DISABILITY EVALUATION
SYSTEM (PDES)**

by

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ABSTRACT

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Concerns about the processes used to evaluate disability in injured military service members continues today with the ongoing conflicts in Operation Iraqi Freedom and Operation Enduring Freedom. This study will attempt to analyze the Physical Disability Evaluation System (PDES) in the Army and make recommendations to transform and revolutionize the current system. The current Disability Evaluation System (DES) is inadequate and does not effectively support volunteer force and requires maintaining a large number of Wounded, Ill and Injured (WII) Service Members in uniform while they navigate an inefficient system of disability adjudication. The value of the study is its potential benefit for Soldiers undergoing disability review, and to the United States Army personnel and medical system. Recommendations in this study could benefit the medical community by possibly decreasing the time Soldiers remain on protracted active duty in the Military Treatment Facility without decrement in the access of quality of medical care provided to wounded, ill and injured Soldiers. Recommendations could also benefit Soldiers by enabling returning to duty or being

allowed to enter the civilian community in a more expeditious manner. Lastly, the recommendations could also positively affect the overall readiness of our Army.

TRANSFORMATION OF THE ARMY'S PHYSICAL DISABILITY EVALUATION SYSTEM (PDES)

Congress and the American people have made clear, especially following the revelations at Walter Reed Army Medical Center, that substandard care for injured service members will not be tolerated. "These men and women have stood up for our country, and we have no greater obligation than to stand with them and their families in their hours of greatest need."¹ What variables affect the adjudication and processing duration in the Army's Physical Disability Evaluation System (PDES)? For many Soldiers and commanders that have supported those Soldiers the medical disability evaluation process has been a source of significant confusion and frustration for years. The operations on the Global War on Terrorism (GWOT) in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) over the past decade has brought renewed attention to this long standing problem. More than 1.5 million troops have served in Iraq and Afghanistan. Over 41,500 troops are counted among those wounded in action. But hundreds of thousands of others have suffered injuries not recorded in the official tally, including the many veterans with serious mental health problems. These veterans are overwhelming the military and veterans' health care and disability systems. As a result, hundreds of thousands of wounded troops and veterans are being forced to wait months and even years for medical appointments and disability compensation.²

Concerns about the processes used to evaluate disability in injured military service members continue even today. Both the Department of Defense (DOD) and the Department of Veterans Affairs (VA) conduct disability evaluations and assign disability ratings. An individual's disability rating affects the scope of pay and benefits for which

he or she is eligible, and the cost to the respective department of providing such benefits. There are significant differences between the disability evaluations performed by DOD and VA, as well as civilian disability evaluations conducted by the Social Security Administration (SSA) and workers' compensation programs. Most notably, the DOD disability evaluation is focused on the effect of any disabling condition on the performance of the service member's duties in the military, while the other three systems evaluate an individual's prospects for gainful employment in the civilian economy. Congress has followed recent news reports with interest, and several legislative initiatives are under consideration. The current Disability Evaluation System (DES) is inadequate and does not effectively support volunteer force and requires maintaining a large number of wounded, ill and injured (WII) Service Members in uniform while they navigate an inefficient system of disability adjudication. This study will attempt to analyze the current PDES in the Army and recommendations to transform and revolutionize the current system. This study will also examine characteristics which significantly affect processing and adjudication duration in the physical disability evaluation system. The value of the study is its potential benefit Soldiers undergoing disability review, and to United States Army personnel and medical system.

Recommendations could benefit the medical community by possibly decreasing the time Soldiers remain on protracted active duty in the Military Treatment Facility without decrement in the access of quality of medical care provided to wounded, ill and injured Soldiers. Recommendations will benefit Soldiers by enabling returning to duty or

being allowed to enter the civilian community in a more expeditious manner. Lastly, the recommendations will also positively affect the overall readiness of our Army.

Background

The Army Medical Department has a long and rich history that has been vital in supporting part of the Nation's defense. The modern American military disability system can trace its roots to the Military Pension Act, enacted in Britain by its Parliament in 1593.³ This bill recognized the need to properly provide for regular Naval officers a through pension plan. The Continental Congress of 1799 recognized a similar need after the Revolutionary War. However, due to the absence of statutes and governing bodies, the pensions granted were largely invalid pensions.⁴ Invalid pensions were called such due to their subjectiveness and often questionability in their being awarded at all. The range of subjectiveness which governed these pensions meant some/may not have been provided to those truly deserving and eligible to receive compensation for wounds, illness and faithful service. However, as speculative as these pensions may have been, they existed as an informal part of the military system for over half of a century.⁵ The debate over military pensions was a heated one in Congress for several years prior to 1861. During the War of 1812 there was a reemphasis on maintaining readiness and a fit fighting force. A regular problem in the military then was the aged officer population. Officers were staying on protracted active duty well past the period of time that they could actually perform their duties. The issue was again debated in Congress during 1838 and 1847. In 1847, Congress debated a bill that would, for the first time, allow officers to retire. Up until this time, the only method of departing the service was through resignation, cashier or death.⁶ The term "retire" was used liberally. It included those Soldiers who had received wounds incurred during service and could

no longer function to the full extent of their profession. Unfortunately, Congress adjourned before the legislation could be passed and the issue was not debated again until 1855.⁷

In 1855 the Navy established the lead in what would eventually become a successive series of mandates shaping the modern physical disability system. That year the House of Military Affairs established “An Act to Promote Efficiency in the Navy.”⁸ This mandate required that an officer no longer capable of performing their duties under field or sea conditions be expeditiously retired. These officers were then allowed to take advantage of the “invalid pensions” that existed at the time. The intent of the mandate was to promote efficiency in the Navy. However, the mandate met with considerable resistance from within several circles. Ultimately, in 1857, the law was amended to allow officers the opportunity to appeal the compulsory retirement decision.⁹

In 1861 Congress passed “An Act for the Better Organization of the Military Establishment.”¹⁰ This law provided for the separation/retirement of officers with forty years of service and for the medical separation of Soldiers who had incurred injuries while in the Line Of Duty (LOD). The separation pay was equal to 100 percent of annual pay for the highest rank held and could never be taken away. Additionally, for the first time, there is a formal organization of a board of officers whose duty it was to oversee this process. This board consisted of five to nine officers, two-fifths of whom had to be medical officers. The missions of the board was to, “decide whether, in its judgment, the said incapacity in the line of duty, from sickness or exposure therein, or from any other incident of service precluded continued service or warranted

compensation and separation”.¹¹ The current structure and function of the modern USAPDA (United States Army Physical Disability Agency), has varied little in the past 140 years in mission and design from the original founding board of officers.

The disability review boards went through several reorganizations before finally reaching some stability in 1949, through the “Career Compensation Act of Disability Retired Pay.” Dr. Richard L. Meiling, the former Assistant Secretary of Defense (Health Affairs), ASDHA, in 1951 stated “The basic reason for the existence of the military medical services is to provide support for the men who fight. Other activities, in peace and war, frequently compete for time, talent, and funds: but anything that deflects the medical services from this supporting mission is a liability against the military strength of the Nation.”¹² Today the law has changed very little and is referred to under Title 10, US Code. Title 10 consolidated disability provisions for all the military services, recognized no difference in officer or enlisted, regular or reserve, combat or non-combat related injuries (except for tax purposes) and varying length of service.

Authors studying Army disability evaluation since 1949 have concentrated more on ensuring that retirement and separation allowances maintained pace with consumer price indexes rather than analyzing adjudication duration.¹³ This trend is unfortunate, due to the fact that unfamiliarity with the disability system often leads toward a disservice to separating Soldiers. Readiness issues and personnel strength has plagued commanders of many eras in our nation’s history. The official history of World War II regarding commander’s feelings toward the disability system is as follows:

An organization commander is primarily interested in a unit which has as few substandard men as possible. From a commander’s point of view, the simplest way of disposing of substandard men during World War II was often through medical channels. In many instances the proper disposition

was an administrative separation rather than one for disability, but, because of command pressure, the latter channel was utilized.¹⁴

Similarly, some Soldiers who participated in Operation Desert Shield and Desert Storm faced the exact opposite of this trend. Soldiers afflicted with conditions which may be related to chemical exposure during the Gulf War were administratively rather than medically separated.

Veterans Administration

On 3 July 1930, Congress established the Veterans Administration, (VA), and charged it with handling all matters of disability compensation, pensions, home and educational loan benefits, medical care, and housing for American war veterans. The law that governs how the VA will render medical care to disabled veterans is referred to Title 38, US Code. The three component agencies within the Veterans Affairs are the Veterans Health Administration, the Veterans Benefits Administration, and the National Cemetery System. Veterans Affairs quickly grew to become the largest medical system in the United States with the primary mission of caring for an aging population of veterans irrespective of disability.¹⁵ This allowed the Army to concentrate its operations and resources on providing health care for a much younger population with limited chronic medical conditions or disability. Over the years following World War II, the VA developed the reputation for providing poor medical care and lack of services. The media highlighted this point about the poor VA medical care by proclaiming, “third-rate medicine to first-rate men”.¹⁶ Further, the VA had developed a reputation for ‘institutionalizing’ veterans rather than providing adequate rehabilitative treatment.¹⁷ As a result General Omar Bradley was appointed after World War II by President Truman to lead the VA and transform its services in effort to improve the quality of health care

being delivered to injure and disabled service members. General Bradley was successful in overhauling the VA but there was still a lot of confusion in reference to what service department had ultimate responsibility in caring for the injured and disabled service members. Senior leaders in the Army were very reluctant to transfer their Soldiers to the VA system and felt that the Army medical system would ultimately ensure better care. The Career Compensation Act of 1949 carried a provision for the creation of the Temporary Disability Retirement List (TDRL) which extended the period of retention for medical treatment to five years.¹⁸ This act was in effort to allow Soldiers more time to become fully rehabilitated rather than medically retired for disability. In 1950 President Truman issued Executive Order 10122 which directed that chronic patients and those judged not likely to return to duty were the responsibility of the VA.¹⁹ President Nixon issued Executive Order 11733 in 1973 which essentially reversed President Truman's position such that the Army could choose when it would send wounded Soldiers to the VA for treatment. At that time, Vietnam wounded veterans represented less than 2% of the VA beneficiary population.²⁰

During the Cold War era the majority of Soldiers adjudicated through the DES were for medical conditions that were for the most part not related to war injuries. So there was little attention given to the DES and the complexities that remained between the DOD Medical Health System and the VA.

In a recent review of the QDR (Quadrennial Defense Review) and recent comments by Secretary Gates on future military spending it is clear that military budgets in the future continue to come under extreme scrutiny. Pressure will increase to implement better efficiencies in the military and Army Medical Department (AMEDD)

and can anticipate a reduction in the Army and AMEDD force structure. An increased observance will be placed on non deployable Soldiers and those Soldiers not capable of performing missions within designated AOCs/MOSs (Military Occupational Specialty/Area Of Concentration). Soldiers who have records being reviewed by the USAPDA will come under increased scrutiny. Commanders apprehensive of inordinate adjudication duration times in the PDES may seek alternative avenues to removing the Soldiers from organic unit assignment.

This is unfortunate, because commanders have a responsibility to take care of Soldiers assigned to their unit when these Soldiers become unable to perform designated duties due to injury or illness. Soldiers being processed through the PDES remain in a state of apprehension until such time that the process is complete. Soldiers are neither able to return to full duty nor are they able to begin new employment in the civilian sector until after they are medically retired, or separated. Normally Soldiers undergoing disability review will perform branch and rank non-specific jobs for the duration of disability processing. These jobs may be in the vicinity of the Military Treatment Facility (MTF) the soldier is receiving treatment in, or in close proximity to the soldier's unit of assignment. The soldier may also take advantage of counseling and programs which will decrease the stress of a transition to civilian employment.²¹ These assistance programs include the Army Career Alumni Program (ACAP) and the Transition Assistance Program (TAP). Both these programs can assist the soldier in developing new skills for civilian employment, if required. Lastly, it may be possible for the soldier to begin investigating educational opportunities offered under the Veterans Education Assistance Program (VEAP) or the new post 9/11GI Bill if the soldier entered

active duty after September 2001. Both VEAP and the new GI Bill can provide tuition assistance for various educational, vocational and degree programs once the soldier has been discharged or retired from military service.²²

Current System

Each year the Army Physical Disability Evaluation System (PDES) separate thousands of Soldiers who are found unfit for continued military service. The Secretary of the Army is charged with assuring the fitness of Soldiers, and separating or retiring those who become unfit to continue military service because of physical disability. The law provides benefits for eligible Soldiers whose military service is cut short due to a service-related disability incurred in the line of duty. The USAPDA manages the Army's PDES and acts on behalf of the Secretary of the Army. USAPDA is a Field Operating Agency of the Army Human Resources Command (HRC) and is headquartered in Washington DC at Walter Reed Army Medical Center (WRAMC). In addition to the USAPDA HQ at Walter Reed, the agency has three Physical Evaluation Boards (PEBs), located at Walter Reed, Ft. Sam Houston, TX, and Ft. Lewis, WA. The PEBs are administrative boards that determine whether a Soldier's disability prevents his/her continued performance in the Army. The PEB is comprised of two types of boards (Informal and Formal) that review medical and performance evidence to make determinations of fitness or unfitness to continue military service. It is important to understand that this is a performance-based system. Simply because a Soldier has a medical condition does not mean that the Soldier cannot continue to serve on active duty or in the Reserve Component. It is the impact of that medical condition upon the Soldier's ability to perform duties appropriate to his/her rank and branch/MOS/AOC, that

is important. A Soldier with a serious medical condition can be found fit within the limits of his/her profile for continued service if the evidence supports that finding.

The Army disability review system is composed of three separate elements: The Medical Evaluation Board (MEB), the Physical Evaluation Board and the final reviewing and adjudicating authority, USAPDA.²³ The emphasis of this research will begin with the initial day the soldier received an exam initiating the MEB and end with final review by the USAPDA. First, it is necessary to understand the incremental steps necessary for a soldier's record to be forward to the USAPDA for final adjudication review. Table 1 highlights these echelons.²⁴

Echelons of Disability Processing

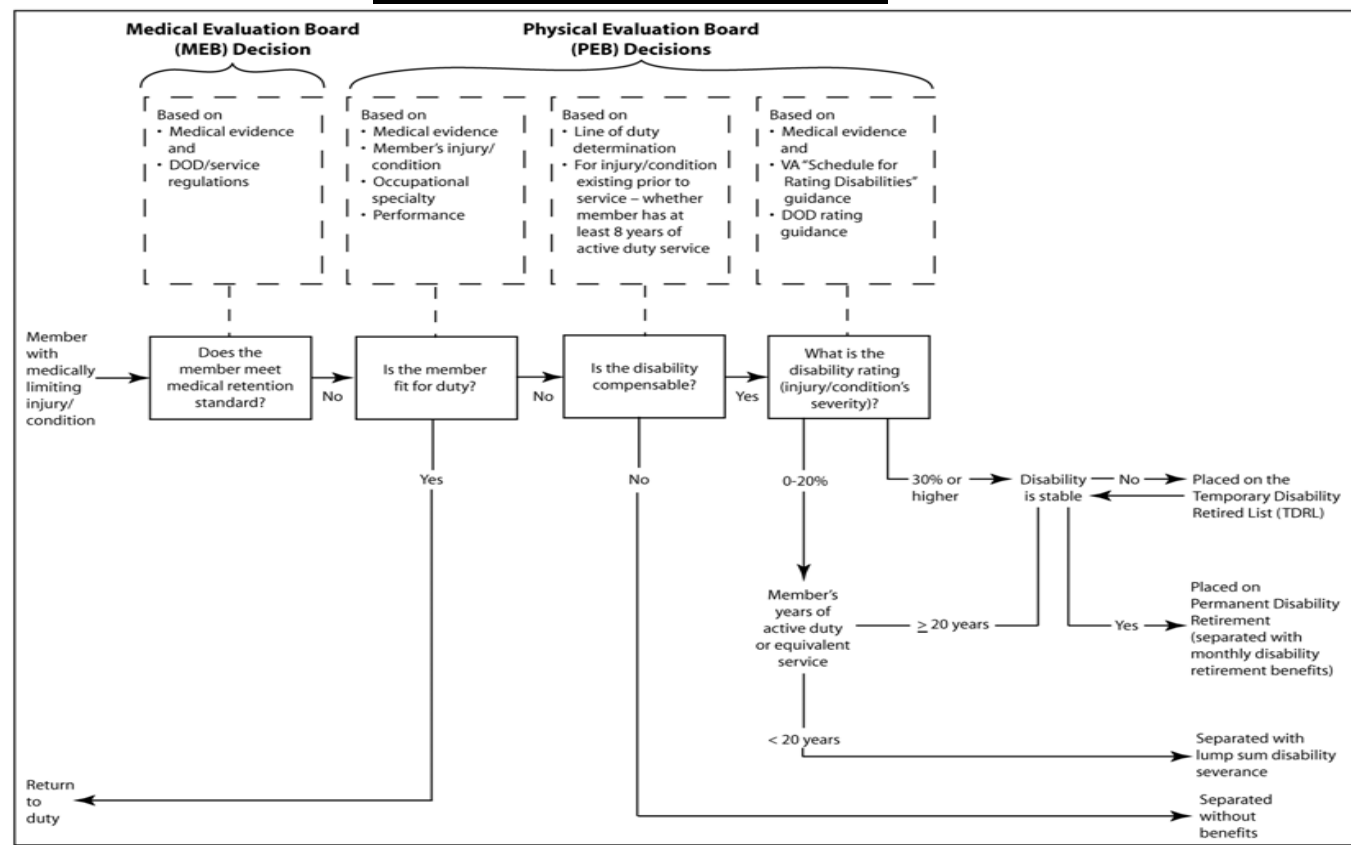


Table 1:

The MEB is completed by at least two physicians who have expertise in the medical conditions affecting the soldier. The MEB is completed at the local medical treatment facility (MTF). The physicians complete DA Form 3947, (Medical Evaluation Board Proceedings) and a brief but complete clinical history of the patient's medical status referred to as the Narrative Summary or NARSUM. These forms generally complete the MEB dictation. In most cases, the soldier's physician will complete the MEB dictation alone, and then discuss the findings with the chief of the clinical department prior to the final preparation of the document. The soldier and the physician will then discuss the contents of the MEB dictation. If there are no concerns that need to be addressed in the MEB dictation by the soldier or physician, both will sign the document. Then, one of four things will happen:²⁵

- The soldier will return to full duty because the MEB found the soldier has met medical retention standards in accordance with AR 40-501, Standards of Medical Fitness, Chapter 3.
- The soldier will be returned to duty with limitations based on permanent "two" profile that was assigned.
- The soldier will be returned to duty with a permanent "three" profile. The parent organization will be responsible for coordinating a Military Occupation Specialty (MOS) Medical Review Board (MMRB) to determine if the soldier is still capable of performing his or her designated MOS, if applicable.
- The soldier does not meet medical retention standards. The MEB dictation is forwarded to the PEB for a medical retention determination.

The PEB is a board which is more commensurate with the standard Army board. Unlike the MEB which is prepared by one physician and concurred with by a more senior physician, the PEB is composed of designated board members, who adjudicate cases equally irrespective of rank. The composition of this board is arranged in accordance with Army Regulation's 40-501 and 635-40. Evaluation is by a three member board composed of a Colonel as President, a Personnel Management Officer (PMO) and a physician who may be civilian or military. The President and PMO may be any branch except medical. The PMO is usually a Reserve Component.²⁶ In some cases, enlisted Soldiers in the grade of E-7 or above may be present on the board at the soldier's request. The board must always have an odd number of voting members to prevent ties in the adjudication process. Additionally, the PEB reviews MEBs either informally or formally. Finally, the board has the authority to make fitness determinations and in some instances compensation awards. After review by the PEB, the board is forwarded to the USAPDA with a final recommendation. The USAPDA has the authority to accept or modify the PEBs findings, if applicable.²⁷

The informal PEB, only the soldier's MEB records appear before the board. Once the MEB has been received by the PEB, the PEB determines if the soldier meets retention standards or is medically unqualified for continued service. If medically unqualified, the soldier's physical limitations are "rated" based on the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD).²⁸

The VASRD is an algorithm that the board members follow in order to objectively rate the soldier's condition. For example, if the soldier experienced an amputation; was it an arm or a leg? If arm, turn to page "X." Was it the soldier's

dominant arm? Was the amputation above or below the elbow? Once all the questions have been answered, the VASRD results in a objective disability rating. Once the board completes adjudication, the soldier has the opportunity to concur or disagree with the board's finding. If the soldier does not concur with the finding of the Informal PEB, the soldier can request a Formal PEB.²⁹

The Formal PEB, affords the service member, legal and medical record to the soldier's MEB record, and permits him/her to appear before the board in order to express concerns over the board's original finding. The legal advisor may be one that is appointed or one that the soldier retains independently at no expense to the government. The legal advisor is not part of the board and is present to assist the soldier in the appeal. The soldier may also appear alone before the board or may have someone appear on his or her behalf. Lastly, the soldier may simply make a written appeal to the board instead of a personal appearance. After a second look at the soldier's record, the board members may change the fitness recommendation or compensation award.³⁰ Under Governing Statutes, Title 10 Chapter 61, after final review by one of the three regional PEBs, the soldier's record is forwarded to the centralized USAPDA for final medical/administrative review.³¹

Chapter 61, Title 10, US Code provides the Secretaries of the Military Departments with the authority to retire or discharge a member if he or she finds the member unfit to perform duties due to a disability. The USAPDA, under the operational control of the Commander, Human Resources Command (HRC), is responsible for operating the physical disability evaluation system and executes Secretary of the Army decision-making authority as directed by Congress in Chapter 61, Title 10 US Code,

Department of Defense (DOD) Directive 1332.18 and Army Regulation 635-40. There is no single organizational structure or formal framework of rules which the USAPDA arranges its lines of authority and communications for the reviewer's of PEBs in the USAPDA.³² Historically, the reviewers in the USAPDA generally consist of at least three personnel: A physician, lawyer and branch immaterial field grade officer. Reviewers in the USAPDA will examine the soldier's records independent of each other. If questions or concerns occur while circulating the record between reviewers, the members will meet to discuss the case and reach consensus on a resolution.³³ Upon satisfactory review of the soldier's record and affirmation of the regional PEBs adjudication, the USAPDA makes the final fitness determination and forwards its results to the Commander, HRC. The soldier's status is then changed from a patient undergoing disability review to either active duty soldier, a retired or separated classification.³⁴ If issues are identified by the reviewers which preclude satisfactory examination of the soldier's record, the USAPDA may return the record to the regional PEB or local MTF with instructions for re-submission.

According to Dr. Ronald Grubb with the PEB at WRAMC collecting data on the disability system, the average was 220 days to complete satisfactorily all requirements for soldier disposition from MEB dictation to final determination by HRC.³⁵ Recent efforts by the Army has reduced the processing time to 159 days as of the end of fiscal year 2009. Table 2, below, profiles the echelons of control in the physical disability system.³⁶

ACTION	WHO	CONTROL
MEB Dictation	Physician at the local MTF	Clinical Dept of MTF
MEB Processing	Physical Evaluation Board Liaison Office (PEBLO) at MTF	PEBLO of MTF
PEB: Both Formal & Informal	One of Three Regional PEBs	President, Regional PEB
Review	USAPDA Adjudication Board	Deputy Commander, HRC

Table 2: Hierarchy of Control in Disability Processing

DOD–VA Disability Evaluation Pilot

The Integrated Disability Evaluation System (IDES) pilot program was implemented on 26 November of 2007 that was designed to assist wounded service members by improving the efficiency and effectiveness of completing disability determinations.³⁷ Central to this effort is the use by both DOD and VA of a single medical examination with which to make determinations. The IDES pilot consolidates DoD and VA disability systems to the degree allowed by law. The IDES Pilot did not implement the full recommendations of the President's Commission on Care for America's Returning Wounded Warriors or Dole - Shalala Commission, which called for a more complete restructure of the DoD and VA systems. In simple terms, the Dole – Shalala proposal would allow the DOD to concentrate on maintaining a fit, battle-ready force while the VA to focuses on what it does best, evaluating, treating, and compensating Wounded, Ill and Injured veterans. The Dole - Shalala disability system would remove the DOD from the disability compensation process, thereby eliminating the frustrating and confusing circumstances of differing disability ratings, disability

evaluations, and appeal and compensation practices by DOD. DOD acknowledged and supported efforts to implement the full recommendations regarding these aspects of the disability system however changes in legislation would be needed to enact full implementation of the Dole-Shalala Commission.

In February 2007 the media exposed deficiencies at Walter Reed Army Medical Center. This brought public attention to the housing and PDES for Wounded Warriors who were wounded or injured in combat. The primary issue criticized was the PDES which was described as complex, confusing and cumbersome.³⁸ The Department of the Army Inspector General (DAIG) conducted a report that highlighted 41 observations and findings for corrective action covering the policies, procedures, and practices related to the PDES.³⁹ BG Michael Tucker, commander of the Warrior Transition Unit (WTU), organized a formal review of the PDES under Lean Six Sigma. The result of this formal review resulted in a number of redundant forms being eliminated and a number of the required forms being significantly reduced.⁴⁰ Significant efforts were made by BG Tucker and his staff to inform Soldiers and educate them on the PDES process. In effort to provide more personalized service to Soldiers the AMEDD increased the number of nurse Case Managers and MEB Physicians. The most significant change was the creation of WTUs to which medically impaired Soldiers were assigned.⁴¹ This change eliminated the AMEDDs medical holding companies and these new WTUs were modeled on the traditional Army unit structure with a Commander and complete support staff. These WTUs were co-located with the MTFs with the sole mission for the assigned Soldiers to recover from their injuries and either return to duty or be processed for transition to civilian life.

Recommended Changes to the System

The goal of DOD disability policy is that the physical disability evaluation process will be conducted in a “consistent and timely manner.”⁴² Soldiers deserve a disability system that is efficient and fair. It should focus on the rehabilitation to their maximum capability and promote reintegration into the workforce. However, DOD has given the each of the services the latitude to set up their own processes and procedures, so inconsistencies are likely inevitable. While standards or common schedules such as the VASRD are used, these may be open to interpretation or possibly misapplication. DOD leaders have also established timeliness standards for case initiation and complete processing. All service members must be referred for evaluation within one year of the diagnosis of their condition if they are unable to return to duty. In addition, DOD allows 30 days to complete the MEB process and 40 days to complete the PEB process. GAO has found that DOD has not monitored compliance by the services with DOD directives on disability evaluation, or exercised oversight over the training of disability program staff.⁴³ The Army Inspector General, in a recent inspection of the Army disability system, found that the Army was not meeting the DOD timeliness standards.⁴⁴

The challenge of the PDES as it exists is that it was not developed to support an Army that is engaged in persistent conflict. It is time to embark on complete reform of the PDES that is consistent with the current operational needs. First our senior leaders need to understand in order to pass legislation that changes U.S.C. Title 10, which governs the DOD DES, and Title 38, Part II, Chapter 11, Service-Connected Disability Compensation, which governs the VA DES, there needs to be a national debate on this issue. Changes to the current DES are helpful, however have not gone far enough. The current system remains complex, adversarial, with the primary focus on disability..

Service members undergo dual adjudication by the military and VA based on the laws, legal opinions, and policies specific to each, often resulting in vastly different outcomes. Dual adjudication is confusing to Soldiers, and creates the perception the Army does not recognize their complete medical condition in an effort to minimize disability compensation and limits access to other valued benefits. DOD must eliminate dual adjudication from DES. The clear line of delineation should be such that: DOD determines fitness for duty and compensates for service; and the VA determines medical limitations and compensates for disability. Perhaps another recommendation would be for the Army and the VA to look jointly at redundancies within the current PDES.

The author would argue that it could perhaps eliminate the MEB all together and fortify the PEB with medical resources to coordinate directly with the VA. With the recent implementation of the DOD-VA pilot program the PEB has been relegated to determining if the Soldier is fit or not fit for duty. The Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) processes have been streamlined under the pilot program and paperwork requirements reduced to more efficiently move a Soldier's disability package through the adjudication process. With additional resourcing the PEB could complete this determination and work directly with the VA for final determination of a percentage of disability. To be sure the devil is always in the details and elimination of the MEB would put greater responsibility on the PEB and the VA. However there is evidence that in doing so it could have potential benefits by further cutting down on the adjudication and processing times for the Soldiers. The military services should focus on fitness determination, providing the maximal medical treatment

that encourages continued service. This will disengage the Army from the adjudication process that promotes conflict with Soldiers. In this regard, once a Soldier is found not fit for duty, both the Army and the VA would need to support needed legislative changes for an equitable service-related compensation package to assist Soldiers through the transition process. Determination of disability by the VA follows a natural course given that the VA is the statutory agency that provides life-long medical care for disabled veterans. Additionally, there should be provisions that will guarantee continued healthcare benefits for the families of disabled Soldiers.

Key Recommendations in Transforming and Revolutionizing the DES

- Near-Term –
 - PEB determines Fitness
 - VA provides disability rating for all service-connected conditions
 - PEB uses VA's Combined Rating of all service-connected conditions to make its disposition decision
- Long-Term –
 - Make legislative changes to reform the DES
 - Military determines fitness and VA determines disability rating as part of member's transition
 - Military compensates for loss of career due to disability based on Years of Service
 - VA compensates for disability
 - Include transition payments with continued eligibility for TRICARE and VA quality of life payments

In order to realize these changes assistance is needed from DOD, the VA and Congress. DOD needs to support policy and legislative changes allowing for the creation of a streamlined disability system with continuous DoD / VA coordination for health care, compensation, and benefits .

New process would flow from Service Medical Department (e.g., Medical Retention Determination Point) to Service Physical Evaluation Board for fitness decision. If a Soldier is found unfit, VA would then evaluate and adjudicate disability rating for all service-connected conditions. This would eliminate the back-and-forth handoffs between the Military and VA to make the determination in the current IDES. It would also eliminate the PEB from having to evaluate every condition when making its fitness decision. The Service PEB would make its decision in less than 30 days. Then turn disability processing over to VA on a BDD (Benefits Delivery at Discharge), like model. When VA has completed its evaluation, the Service would use VA's combined rating to make its disposition decision. A potential road block for implementation of these changes is the ability of the VA to conduct exams and rating in a timely manner. In order to mitigate this issue, once a Soldier is found to be unfit for military service he or she should start other transition processes and make use of VA rehabilitation and education services. As long as military uses a disability rating to make disposition decision (compensation for loss of career, and access to other valuable benefits), the Services will be tied to a long process of evaluating the extent of all disabilities. Therefore, the Services need legislative reform to change basis of compensation in Years Of Service (YOS). These combined changes will ensure our Nation's commitment to Soldiers and their families.

Conclusion

In his 27 January 2009 testimony before Congress, Secretary of Defense Robert M. Gates reaffirmed his commitment to caring for the men and women of the armed forces who have become wounded, ill or injured in service to their country. Over the past two years, the Army has made tremendous progress in transforming how it provides health care to its Soldiers, with improvements impacting every aspect of the continuum of care. The Warrior Care and Transition Program is an example of the strong commitment by the Army to adapt and improve its ability to provide the best care possible to its wounded, ill and injured warriors. Implementing the DOD-VA Integrated Disability Evaluation Pilot program Army-wide is another example. However, significant challenges in the PDES remain that will require legislative changes in the relationships between DOD and VA if lasting improvements are to be realized. Senior military leaders must examine a way to jointly formulate a strategic communication plan to facilitate a national debate so that positive legislative changes can be enacted to reform the current DES. Further complicating matters is the lack of VA facilities in overseas locations which delay processing and adjudication of cases. Any changes in legislation that place greater responsibility on the VA would require increased VA funding. DOD and Congress need to eliminate dual adjudication and allow the military health care system to focus is on fitness, treatment, and smooth seamless transition to VA. In the words of several of our Senators “These men and women have stood up for our country, and we have no greater obligation than to stand with them and their families in their hours of greatest need”.⁴⁵ To be sure, our Soldiers will continue to face illness and injury that will precluded their further service to our nation. We owe it to them to

transform our disability system that is less complicated and cumbersome as they transition into civilian life.

Endnotes

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²² Budahn, P.J. *Veterans Guide To Benefits*. Stackpole Books, PA. 1994, 103

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²⁴ Warrior Transition Unit Consolidated Guidance (Administrative), Department of the Army WTU Consolidated Guidance , 20 Mar 2009 pg. 67.

²⁵ Army Regulation (AR) 40-3, *Medical, Dental and Veterinary Care*, Headquarters, Department of the Army, Washington, DC, 30 July 1999. Army Regulation (AR) 40-501, *Standards of Fitness*. Headquarters, Department of the Army, Washington, DC, 12 April 2004. Army Regulation (AR) 635-40, *Physical Evaluation for Retention, Retirement or Separation*. Headquarters, Department of the Army, Washington, DC, 8 February 2006.

²⁶ Information Paper on *Overview of Physical Disability Evaluation*, (TAPD-ZB), United States Army Physical Disability Agency, FT Bragg, NC, 15 December 1996.

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³⁵ Interview. *Meeting on Average Length of Stay in the Disability System*, Notes as taken by James R. Andrews in discussion with Dr. Ronald Grubb, Walter Reed Army Medical Center, October 2010.

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³⁷ The DES Pilot commenced on 26 November 2007 in the National Capital Region (NCR) which included Walter Reed Army Medical Center. Pilot Expansion began in October 2008 which as of May 2009 included: Fort Belvoir, Fort Mead, Fort Stewart, Fort Polk, Fort Richardson, Fort Wainwright, and Fort Drum.

³⁸ Multiple independent groups made recommendations to revamp the Disability Evaluation System. The most prominent was, "The President's Commission on Care for America's Returning Wounded Warriors" often referred to as the Doe-Shalala Report released in July 2007. In that report 6 major recommendations were made of which was to completely restructure the Disability and Compensation System (pp. 5-6). Data collected by that commission revealed that less than 50% of the respondents surveyed understood the process, and less than 40% were satisfied.

³⁹ Memorandum for Under Secretary of the Army, 6 March 2007, "Report on the Army Physical Disability Evaluation System (APDES)", Executive Summary.

⁴⁰ "Army Medical Action Plan", MEDCOM NOW, Vol 1, No. 1, 14 May 2007, 1.

⁴¹ Gary Sheftick and Franz Holzer, "Army to Establish "Warrior Transition Units", October 9, 2007, <http://www.military.com/features/o.15240.152058.00html>.

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⁴³ GAO, *Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members*, GAO-06-362, March 31, 2006.

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⁴⁵ Letter from Senators Boxer, Obama, Bond, Lieberman, Clinton, and Kerry to the Honorable Robert M. Gates, http://bond.senate.gov/press_section/record.cfm?id=277467, June 21, 2007, 1

