Chairman Runyon, Ranking Member McNerney, and Members of the Subcommittee:

Wounded Warrior Project (WWP) appreciates your holding this hearing and welcomes the opportunity to share our perspective on the Integrated Disability Evaluation System (IDES) – a critical, but still troubled pathway in the transition from servicemember to veteran.

I am Phil Riley, a Senior Benefits Liaison with WWP. In that capacity, it is my privilege to assist wounded, ill, and injured servicemembers in navigating the confusing road from medical evaluations to the critical benefits’ determinations associated with their military retirement or separation. As a retired Army Colonel who has worked with the disability evaluation process for some six years, including time as a veteran’s service officer, it’s my assessment – and that of WWP – that much more work is needed to close the wide gap between the goals underlying IDES and realization of those goals. We believe VA is doing its part in the IDES process. In our view, the Department of Defense (DoD) needs to do more remedial work.

IDES, of course, has its roots in the problems wounded warriors experienced under the so-called “legacy Disability Evaluation System,” the DES. Under that system service members whose injuries or medical conditions rendered them no longer fit for continued military service went through a very lengthy multi-stage processes, with both DoD and VA conducting their own separate medical evaluations and subsequent disability rating processes. Under DES, servicemembers routinely experienced many-months’ waits between discharge from service and receiving their first VA benefits payment as well as inconsistencies in how service members’ injuries were evaluated in the two systems.¹ In 2007, it took an average of 540 days under the legacy DES for a service member to clear both DoD and VA disability-evaluation processes.²

The bipartisan Commission on Care for America’s Returning Wounded Warriors (“the Dole-Shalala Commission”), formed in that year, urged that DES be overhauled. Among its findings, the Commission reported that fewer than 50% of service members understood the DoD disability evaluation system, and that only 38% of active duty and 34% of the reserve

component were “somewhat” satisfied with it.\textsuperscript{3} The Commission recommended that the two departments “create a single, comprehensive, standardized medical evaluation that DoD administers,”\textsuperscript{4} with DoD maintaining its authority to determine fitness-to-serve and VA becoming solely responsible for setting disability ratings and awarding compensation.\textsuperscript{5} Its recommendation aimed to update and simplify the disability determination and compensation process by eliminating parallel activities and to reduce inequities.\textsuperscript{6}

**Creation of IDES and the Goals of an Integrated System**

The Commission’s work was carried forward by the congressionally-established Wounded, Ill and Injured Senior Oversight Committee (SOC) which ultimately instituted a more modest reform to integrate the two systems which resulted in establishing a pilot integrated disability evaluation system. The vision was “to create a servicemember-centric, seamless and transparent DES”\textsuperscript{7} by developing a jointly-conducted military medical evaluation process under which servicemembers receive a single set of physical disability evaluations and disability ratings, conducted and prepared by VA, with simultaneous processing by both departments -- using VA protocols for disability examinations and VA disability ratings to make their respective determinations -- to ensure the earliest possible delivery of disability benefits.\textsuperscript{8} The goals of the new IDES process were to create: (1) a less complex and non-adversarial system; (2) faster, more consistent evaluations and compensation; (3) a single medical exam and a single-source disability rating; and (4) a smooth transition to veteran status.\textsuperscript{9} The IDES pilot began in the National Capital Region in November 2007 with a goal of reducing the time (from referral of a case to the DoD medical evaluation board to delivery of VA benefits) to 295 days for active duty and 305 days for reserve component service members.\textsuperscript{10} Following a phased expansion of the IDES pilot over about a year and a half period, IDES became fully operational as of October 2011.\textsuperscript{11} Under the new IDES process, a service member is to receive a full medical examination conducted by the VA, which is used as the basis for determining both fitness for continued duty in military service and entitlement to DoD benefits and VA compensation.

\textsuperscript{3} The President’s Commission on Care for America’s Returning Wounded Warriors, July 2007, p. 6.
\textsuperscript{4} Id. at 7. Service members found unfit due to their combat-related injuries would then receive payment for years served and comprehensive health care coverage for themselves and their families through DoD’s TRICARE program. Id.
\textsuperscript{5} Id.
\textsuperscript{6} Id. at 6.
\textsuperscript{8} Id.
\textsuperscript{11} U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2013: Hearing Before the H. Committee on Veterans’ Affairs, 112\textsuperscript{th} Cong. (2012) (prepared statement of Hon. Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs).
The IDES Process

The IDES process, while differing in detail from service to service, begins with a service member's treating physician\(^{12}\) or unit commander making a referral to a Medical Evaluation Board (MEB). That board, generally composed of medical care professionals,\(^{13}\) evaluates the servicemember's injuries and ongoing treatment to determine if the Member is able to meet medical retention standards and return to full duty – and, if not, to make a recommendation (to a Physical Evaluation Board (PEB)) as to whether he or she is fit for continued service following medical treatment. From the start of the MEB referral, the servicemember is to be assigned a Physical Evaluation Board Liaison Officer (PEBLO) to help assist him/her throughout the IDES process. The PEBLO is responsible for assembling all the information included in the servicemember's DES case file: all medical records, test results, and exams performed for the MEB; letters from a service member's chain of command related to how the condition impacts duty; and other personnel records the MEB may require.\(^{14}\)

The MEB does not conduct formal hearings, and the servicemember is not afforded the opportunity to appear before the board. If the MEB determines that a service member does not meet medical retention standards, it will forward that recommendation to a PEB.\(^{15}\) The MEB results and recommendation are documented in a narrative summary (NARSUM) which becomes the single most important piece of evidence the PEB uses. After the service member receives the MEB's NARSUM, the PEBLO will review it with the service member. A service member may ask for an Independent Medical Review (IMR) and/or a Judge Advocate General (JAG) counselor to review the NARSUM to ensure it is fully developed and accurate.\(^{16}\) The service member does have the opportunity to submit a rebuttal to be considered by the MEB. Far too often, in our view, the response to the rebuttal is “no changes accepted.”

In the second phase of the process, the informal PEB (IPEB) will evaluate the service member’s fitness for duty. Generally, the IPEB is comprised of three people, with a mix of military and civilian members, including at least one physician and one nonmedical officer.\(^{17}\) Again, the service member does not attend this meeting.\(^{18}\) Using the packet compiled by the PEBLO, the IPEB will review the medical records, the NARSUM, personnel evaluations, and letters from the commander and vote as to whether the service member is fit to continue service.\(^{19}\) The PEBLO will then notify the service member of the findings of the IPEB. If the IPEB makes a determination of fitness, the service member has 10 calendar days to accept the decision and

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\(^{12}\) A doctor is to refer a case to the MEB only upon satisfaction that all has been done medically to improve the condition(s). Department of Defense, Wounded, Ill and Injured Compensation and Benefits Handbook, October 2011, 17.

\(^{13}\) Id. If a service member’s condition includes a mental health condition, a mental health care provider should be on the panel, as well. Id.

\(^{14}\) Id.

\(^{15}\) If the MEB determines a service member does meet medical retention standards (or will be able to perform full duties within one year) the service member may return to duty.

\(^{16}\) Walter Reed Army Medical Center PEBLO Office, Integrated Disability Evaluation System Quick Series Review Guide.

\(^{17}\) DoD regulations list minimum requirements for PEB membership and leaves the exact determination of who sits on the board for each military department to decide. Department of Defense, Wounded, Ill and Injured Compensation and Benefits Handbook, October 2011, 18.

\(^{18}\) Id.

\(^{19}\) The PEB will determine a service member’s disposition – return to duty, separation, or permanent or temporary retirement. Department of Defense, Wounded, Ill and Injured Compensation and Benefits Handbook, October 2011, 18.
return to duty or offer a rebuttal and request a formal PEB. If the IPEB determines a service member is unfit, he/she has 10 calendar days to decide on a course of action; the options are (1) to accept the decision, (2) accept the decision but request a reconsideration of the VA disability rating, (3) offer a rebuttal and request a formal PEB, or (4) request both a formal PEB and reconsideration of the VA disability rating.\(^{20}\) If a service member requests a formal PEB, he/she is allowed to appear before the board with legal representation. The formal PEB hearing must conduct a *de novo* review— all factual questions must be addressed as if for the first time. The formal PEB’s decision may change from the IPEB. The formal PEB will then notify the appropriate service headquarters of its determination. Once service headquarters receives the final PEB determination, the service member may be separated, medically retired, or returned to duty.\(^{21}\)

A service member found to be unfit by the PEB will still receive two separate disability ratings under the new IDES process: (1) a rating by the PEB that evaluates only those conditions deemed to make the servicemember unfit for duty (which determines whether or not the servicemember will qualify for medical retirement and what benefits the service member is eligible to receive from DoD), and (2) a VA rating of all service-connected conditions (whether the conditions make the servicemember unfit for duty or not). Both the DoD and VA ratings are to be based on the VA Schedule for Rating Disabilities (VASRD).

**IDES Goals versus IDES in Practice**

In our view, IDES should be judged by reference to the goals it was to achieve – a less complex, non-adversarial system that operates more quickly and with greater transparency and consistency to provide a smooth transition to veteran status. Even today, however, our Wounded Warriors still encounter great difficulty in navigating a system they find to be highly complicated, difficult to understand, unnecessarily contentious, and often ponderously slow. We at WWP who have been representing these servicemembers see a serious lack of quality-control in a system often marked by inconsistent practices, decisions based on incomplete or inaccurate medical records, and wide variability in the reliability of information and advice furnished to servicemembers confronting difficult, life-changing circumstances.

**Case Examples**

The experiences of two warriors, with whom we at WWP have worked, illustrate the kinds of problems we’re describing. In both instances, these warriors are at a sensitive stage of the process and requested that we omit reference to their names.

**The Officer:** The first, an Army officer sustained a penetrating head injury in Iraq. He has had a long remarkable rehabilitative journey, and his wife was by his side through the course of his painfully slow recovery. As he gradually regained lost function, the couple could begin to think and worry about the future. As she explained it, given her role as a full-time caregiver, his injury deprived two college-educated people of the ability to work. “Don’t worry,” he was told, “you’ll be 100%; you’ll be fine.” That misplaced expression of confidence reflected a widespread misconception that injured soldiers would collect both retirement pay and VA disability

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\(^{20}\) Walter Reed Army Medical Center PEBLO Office, Integrated Disability Evaluation System Quick Series Review Guide.

\(^{21}\) Id. If the Service member appeals the formal PEB findings, the appropriate military department considers the appeal and returns to duty, separates, retires, or assists the service member to complete an inter-Service transfer, if appropriate and approved. Under Secretary of Defense, Integrated Disability Evaluation System Directive-Type Memorandum 11-015, Dec. 2011.
compensation. But, as they ultimately learned -- with VA compensation offsetting military retired pay – a 100% disability rating represented only 60% of his monthly military income. The couple faced a very confusing choice as to whether to elect to receive military retirement pay or Combat Related Special Compensation. Making a prudent decision required understanding the relationship between, and the calculations regarding, (1) DoD military retirement, (2) VA compensation, (3) VA special monthly compensation, and (4) DoD Combat Related Special Compensation. The couple came to realize that Army personnel who help the wounded navigate the system are not necessarily knowledgeable on the interrelationship between those financial pieces, and at times those advising them were not helpful. In fact, their JAG, finance office, and PEBLO gave the couple conflicting information on the critical point: would a wounded soldier receive both military retired pay and VA compensation concurrently? Each was unaware of how the above four compensation programs offset each other. Confusion on such a basic point of information highlights the dilemma facing servicemembers with often severe multiple injuries.

Not only are key decisions facing a warrior in the course of the IDES process confusing, but the information from which critical determinations are made is often incomplete or even inaccurate. In the officer’s case, for example, the NARSUM failed to include any description of his day-to-day functional impairment, but simply set out a list of his medical conditions. Even at that, one of those conditions – loss of use of an arm – was omitted from this critical document. An Independent Medical Review was, in fact, critical of the NARSUM and included the reviewing physician’s observation regarding a section listing residuals from TBI –

“[It] is hard to read and almost incomprehensible to the military physician: it is crucial to remember that these reports are intended for the audience of the PEB and servicemember. The writing should be unequivocal and precise, which is not the case here.”

While the MEB accepted some of the officer’s points of rebuttal, the Board did not rewrite the NARSUM, which was ultimately the basis of the PEB’s determination.

While IDES was intended to foster a smooth transition, it is subject to troublingly disruptive pressures. For example, the Warrior Transition Unit to which the officer was assigned worked intrusively and applied pressure – to include harassing the PEBLO -- to hurry the process along. Similarly, while the IDES process provides appeal rights, their experience was that the WTU actively discouraged him from appealing the PEB decision, as that would slow the process down. These weren’t isolated experiences. Earlier in the course of his rehabilitation, the couple was subjected to pressure to sign papers that resulted in cutting short still-needed rehab care (against medical advice) and rushing him into the MEB process.

While IDES was designed to achieve greater timeliness, the officer’s experience was but the officer’s experience in that regard was of a heavy-handed military attempting to push him through prematurely where that early haste led to errors, culminating in a lengthy appeal process that was compounded by long delays in getting needed VA examinations.

This mature, college-educated couple’s rough journey through the IDES process certainly calls into question how well a much less sophisticated young warrior with similar injuries and without expert representation might have fared.

**The Master Sergeant:** An Army Reserve Master Sergeant with a 24-year military career sustained multiple severe physical injuries, a traumatic brain injury, and developed chronic post-traumatic stress disorder after the Humvee under his command was hit by a roadside bomb in Iraq in 2005. This servicemember endured a long, rough road to recovery that included 26
surgeries and over a hundred medical procedures, and that (among other disabling conditions) resulted in loss of function in the dominant hand due to severed nerves.

Given the voluminous body of medical records that had been compiled by the time the MEB process was initiated in 2010, the Sergeant made sure to bring those records – which filled a large suitcase – to the meeting with the PEBLO and asked for the opportunity to review the MEB packet before it was forwarded to the Board. This packet was not made available for the Sergeant to review. Moreover, the VA physician who carried out the MEB physical exam had been provided only with a single medical record file, and even expressed frustration about the inability to conduct the physical exam properly without further records. Upon contacting the PEBLO about the missing medical records, the Sergeant was told, “if additional records are needed, the VA doctors will request them from the MTF.”

In February 2011, the Sergeant received a 137-page NARSUM; despite its length, it omitted several service-connected conditions. The Sergeant was overwhelmed by having to review this very lengthy technical document in seven days. This was compounded by not being able to get a face-to-face meeting with the PEBLO. A JAG officer whom the Sergeant asked for help provided only a limited review of the case that didn’t allay the concerns; an effort to secure additional JAG assistance at another installation was rebuffed. The Sergeant was later referred to another JAG officer, who seemed stretched thin with a large backlog of cases, but who did eventually assist in drafting a request for an independent medical review (IMR), but the IMR wasn’t done because the PEBLO failed to accurately explain the IMR process to the local primary care Air Force doctor who was to conduct the IMR. An IMR was finally done in April 2011, but involved only a review of the NARSUM without any review of the Sergeant’s medical treatment records, and resulted simply in upholding the flawed NARSUM. Although the extended process appeared to be nearing an end, the Sergeant was informed by the PEB doctor in July 2011 that disability ratings could not be completed without additional pictures of the injuries. It was only in January 2012 that the Sergeant got notice that VA had "recommended" a 100% rating but with a final decision deferred pending review of medical records regarding service-connection for other medical conditions. The adjudicative process was completed with assignment of a 100% rating 24 months after the Sergeant’s unit commander requested MEB initiation.

**Timeliness and Lack of Quality-Control**

IDES was intended to improve the timeliness of the disability-evaluation process, but rather than realizing the 300-day goal for moving a servicemember through the system, the process is apparently taking an average of nearly 400 days. To assess IDES solely by reference to timeliness, however, is to overlook the dangers inherent in moving too quickly – and in doing so, foreclosing the servicemember from getting needed medical care and increasing the risk of prejudicial error. In fact, the IDES process is particularly vulnerable to what amounts to quality-control issues -- incomplete examinations, examination reports that fail to include new diagnoses, incomplete or insufficient NARSUMs, and missing critical documentation. Such problems – sometimes attributable to pressures to move cases along – ultimately contribute to delay and adversely affect the ultimate disability rating determination. WWP often hears from warriors, especially those in Reserve and National Guard units, who cite long delays in the system, and of having to fight to get needed medical treatment.

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Delays encountered during the MEB process can have a compound effect, resulting in medical exams “expiring” or no longer being accurate, requiring nurse case-managers and PEBLOs to order new exams. Too often warriors’ medical and mental health conditions are incompletely diagnosed or not even assessed during medical exams, resulting in incomplete exam summaries and delays in needed care. As a result, examiners must take extra time to clarify the summaries, and in some cases, redo the exam.\textsuperscript{23}

While substituting a VA evaluative medical examination for what had been duplicative separate DoD and VA exams under the legacy system was to have saved time, IDES has not eliminated sharp differences of view between the two departments.\textsuperscript{24} On that point, my experience and that of others representing servicemembers is aptly captured by the following observations:

“The MEB places no value in the results of the VA examination. There are many cases in which VA has diagnosed PTSD and other conditions as moderate to severe, and the MEB disregards the findings and bases it on their own evaluation. MEB review of the Service Member’s medical treatment records is also not thorough in many cases. The system is full of cases where the treating Psychiatrist and the Examining Psychiatrist at the VA are overruled by the Doctors on the MEB. Often the same thing is done in Orthopedic departments. VA documents the severity of the Service Member’s disability by reference to its effect on a variety of normal daily activities including ability for exercise, sports and effect on a job. The MEB consistently disregards these findings and minimizes them in the so-called ‘Consolidation of Inconsistencies.’ What is obvious is that the MEB has reached a decision often prior to the VA examination and refuses to take the VA examination into proper consideration.”\textsuperscript{25}

Given the MEB’s mode of operation, the Board findings – documented in the NARSUM -- are often flawed. While the NARSUM is the single most important document describing a warrior’s physical and mental limitations, it is rarely fully developed, comprehensive, or accurate. Too often the MEB process either fails to identify and fully document in the NARSUM all of the warrior’s medical conditions, or it minimizes them. It is particularly troubling, in this regard, that MEBs routinely fail to take the time to review a servicemember’s complete medical records or to research those records in depth. In addition, the military seldom affords servicemembers the complete physical examination required by regulation.\textsuperscript{26} By law, the armed forces are required to document all service-connected medical conditions, medically acceptable for a VA disability rating.\textsuperscript{27} However, MEBs, in preparing the NARSUM, routinely fail to include the servicemember’s medically acceptable conditions, and focus only on those conditions affecting the service member’s ability to serve. The upshot of that narrow focus and resultant omissions is to make it more difficult for the servicemember to establish service-connection for disabilities that are incurred in service but simply not noted in the NARSUM. These failures also have an impact “downstream” – increasing the number of appeals in the already-backlogged VA adjudication system.

\textsuperscript{24} Id.
\textsuperscript{25} Interview with Jerry Johnson.
\textsuperscript{26} “A complete physical examination must be recorded in the MEB.” AR 40-400 (27 January 2010); “The overall effect of all disabilities present in a soldier whose physical fitness is under evaluation must be considered.” AR 635-40, sec. 3-1b.
In contrast to the many instances in which warriors experience long delays in moving through the MEB/PEB process, we see instances such as discussed above, where warriors are seemingly rushed through the process, many of them National Guard and Reserve members. These circumstances inevitably create problems ranging from incomplete treatment to erroneous disability ratings. WWP is working with several warriors who were referred to the MEB while still undergoing treatment or had developed new medical problems, and as a result received an incomplete NARSUM. In such instances, the MEB process should be delayed or stopped. All medical conditions should be diagnosed and treated before the MEB process even begins.

Dual-Adjudication Undercuts the Goal of a Timely, Streamlined System

One of the most critical barriers to a timely, streamlined system is that IDES retains the redundancy of a dual-adjudication process. Army Surgeon General, LTG Eric Schoomaker, in testifying before the Senate Appropriations Subcommittee on Defense, acknowledged that the system “remains complex and adversarial,” and warriors “still undergo dual adjudication where the military rates only unfitting conditions and the VA rates all service-connected conditions.”28 At the same hearing, the then-Undersecretary of Defense for Personnel and Readiness described the ideal system as one that would produce "a single evaluation based upon one medical record."29 Eliminating this redundancy would represent an important reform, but would not alone eradicate the range of problems warriors encounter in moving through the disability evaluation system. Substantive errors in decision-making go unaddressed in those many cases when the PEBLO assisting the warrior is not adequately trained and the warrior is either lacks representation or is not effectively represented.

IDES Leaves Too Many Ill-informed and Unrepresented

Generally, warriors and their family members are uninformed or do not understand the IDES process. The system’s complexity leads some to become cynical, as in the case of one Wounded Warrior who commented, “they make it convoluted and you get so frustrated that you want to give up. I’ve never been as stressed out as I am in this process.”30 Servicemembers’ lack of understanding of the process also contributes to flawed case-adjudication. With the failure to inform servicemembers at the outset of the MEB referral of the importance of their medical records and the need for supporting documentation, many are wholly unprepared for the challenge associated with establishing service-connection.

In theory, the military’s assignment of a PEBLO to each servicemember undergoing the IDES process should close the information-gap. Beginning with an initial briefing before the service member’s first physical examination for the MEB, the PEBLO’s role is to inform the service-member of what to expect at various phases of the process, assist the servicemember in gathering medical information and documentation, and review the MEB and PEB determinations with the servicemember. The reality, however, is that some of these officers do not fully understand the system or have such large caseloads they can’t provide each servicemember adequate instruction and assistance. While the nature of the process requires the PEBLO to maintain an ongoing flow of information to the servicemember, warriors often report that they rarely hear from their PEBLO. But even under the best of circumstances, the PEBLO acts as the servicemember’s counselor and liaison, but that officer is not the servicemember’s advocate before the MEB or PEB.

29 Id.
30 Beldock
Servicemembers do have access to JAG representation\textsuperscript{31}, and some efforts have been made to provide training for the JAGs. In our view, however, there is wide variability in the level of expertise on IDES issues among JAGs, and certainly not enough JAGs have the necessary expertise. Servicemembers themselves often express reluctance to avail themselves of the assistance of a JAG officer, often based on the perception that a military/government lawyer may not represent their best interests.

Not only is the servicemember generally unrepresented but that individual is not afforded the opportunity to appear before the MEB to discuss his health status. Accordingly, the MEB’s development of a narrative summary is based, and dependent, on the medical records available to the MEB, and its interpretation of those records. Lack of representation is especially problematic at the point that the service member receives the MEB determination, because the individual is given just seven working days to review and appeal the NARSUM before it is forwarded to the PEB for a determination of fitness, separation, or military retirement. This is an unreasonably limited period of time for an individual to obtain reliable advice or counsel, particularly in the often complex cases that involve multiple severe injuries, let alone enough time for many warriors to review and comprehend NARSUM findings and the significance of omissions or inaccuracies in that document. The servicemember has only an additional five days within which to seek an IMR to challenge the NARSUM before the case moves to the PEB, and is not afforded the option of providing evidence from a specialist of his/her own. In contrast, the IMR - generally performed by a physician under contract to DoD -- is less than “independent,” and is seldom a specialist able to address specific issues. In our experience, very few such reviews come back with any change in determination; yet our own reviews often show strong bases for an IMR to challenge the findings.

WWP’s representation of growing numbers of Wounded Warriors through this process has highlighted problems under IDES, but has also led us to develop solutions. We offer the following recommendations in the belief that the IDES system can and must be materially improved, and urge this Committee to work with the Armed Services Committee to spur the Executive Branch to make needed changes.

**WWP Recommendations**

1. Direct DoD and VA to provide (i) better instruction and outreach on IDES for warriors and their caregivers, and (ii) better instruction on IDES for warrior transition unit and other pertinent staff who work with warriors and their families and caregivers.

2. Direct DoD to re-engineer, and institute quality-controls on, the “front-end” of the IDES process to –

   (a) Provide procedures and safeguards to protect servicemembers, and particularly National Guard and Reserve members, from being pushed into and rushed through the MEB process.

   (b) Ensure that the MEB process is not begun until optimum medical care has been provided and the servicemember’s conditions have been diagnosed, and that such process will be deferred under circumstances where a significant new medical condition develops.

\textsuperscript{31} In our experience, at least one JAG officer and a paralegal are stationed in the military treatment facilities to assist when MEBs take place.
(c) Ensure that NARSUMs are fully developed and accurately document all service-connected medically acceptable conditions of a warrior, to include (i) requiring MEBs to review thoroughly all medical records, and (ii) providing opportunities for the servicemember to meet with the MEB.

(d) Allow ample time for a warrior to review his/her NARSUM with the assistance of an advocate and/or a medical provider (to include additional time for servicemembers with multiple, severe injuries).

(e) Provide substantially improved avenues for effective assistance to and representation of servicemembers undergoing physical and mental health disability evaluations, including expanding the number – and improved training -- of PEBLOs and JAGs, and encouraging the use of certified veterans’ service officers throughout the IDES process.

(f) Provide servicemembers the opportunity and sufficient time to obtain a review of the NARSUM and all pertinent medical records by a specialist(s) of the servicemember’s choosing, and the opportunity to present such specialist findings in rebuttal.

(3) Adopt the key recommendation of the Dole-Shalala Commission by establishing a single adjudication system with a single agency responsible for disability evaluation that would not only provide needed consistency, but help realize a more streamlined, timely process.

(4) Ensure leadership and oversight at the highest level to achieve the required system re-engineering and quality-control measures to realize the goals of IDES.

**Conclusion**

WWP believes that, whatever the injury, every warrior going through the IDES process should receive comprehensive medical treatment, full and fair adjudication of their medical conditions and disability evaluation, and accurate compensation for service-related health conditions. Today, almost five years after a bipartisan commission called for streamlining the complicated disability evaluation system that so poorly served Wounded Warriors, the goals envisioned for that system have yet to be realized. WWP recognizes that VA and DoD staffs have devoted much time and effort to improving the disability evaluation process, but more must be done to produce a system worthy of our Wounded Warriors and the sacrifices they have made. We call for a re-engineering of IDES processes, and institutionalization of quality-controls along with continuing Congressional oversight, as the pathway to meeting this obligation to our warriors.