Prepared Statement

of

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Chairman Chaffetz, Ranking member Tierney, and members of this distinguished Subcommittee, thank you for inviting us to testify before you on the care and transition of our wounded warriors from the Department of Defense to the Department of Veterans Affairs. Taking care of our wounded, ill and injured Service members is one of the highest priorities of the Department, the Service Secretaries and the Service Chiefs. The Secretary of Defense has said, other than the War itself, there is no higher priority. Reforming cumbersome and sometime confusing bureaucratic processes is crucial to ensuring Service members receive, in a timely manner, the care and benefits to which they are entitled. The Department's leaders continue to work to achieve the highest level of care and management and to standardize care among the Military Services and Federal agencies, while maintaining focus on the individual.

Senior Oversight Committee (SOC)

The Secretary of Defense established the Department of Defense/Department of Veterans Affairs Senior Oversight Committee (SOC) on May 3, 2007, to ensure recommendations from the Independent Review Group and the President's Commission on Care for America's Returning Wounded Warriors were promptly integrated, implemented, and resourced. Later, recommendations and requirements of the Task Force on Returning Global War on Terror Heroes, the DoD Task Force on Mental Health, the Veterans' Disability Benefits Commission, and the FY2008 and FY2009 National Defense Authorization Acts were also incorporated. The Senior Oversight Committee's purpose is to ensure inter-agency oversight to streamline, de-conflict, and expedite efforts to improve the health care process, disability processing, and the seamless transition from Service member to Veteran status. The Deputy Secretaries from the Departments of Defense and Veterans Affairs serve as committee co-chairs.

The overarching purpose of the Senior Oversight Committee is to establish a world-class, seamless continuum of care that is efficient and effective. Its membership includes senior DoD, VA, and military Service representatives. A supporting Overarching Integrated Product Team (OIPT) of joint interagency senior leadership coordinates, integrates, and synchronizes the Committee work, agenda and actions. Given the magnitude of the issues addressed and the complexity of integrating the recommendations, the SOC created the Wounded, Ill, and Injured

Senior Oversight Committee (WII SOC) Staff Office. The Staff Office provides assistance, advice, and expertise to facilitate changes to policies, procedures, and legislation in order to effectively institute program and process enhancements related to the recovery, rehabilitation, and reintegration of our wounded, ill and injured Service members, veterans, and their eligible beneficiaries.

To date, the SOC has accomplished the following in support of care for wounded warriors:

- The integration of DoD and VA into a single team.
- The implementation of new approaches to support patients and their families and/or caregivers.
- The development of new approaches to address psychological health, to include Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD).
- The worldwide expansion of the Integrated Disability Evaluation System.
- Integrated Mental Health Strategy.
- The increased sharing of health information between DoD and VA.
- Significant improvement customer care delivery.

The two Departments and the SOC are actively implementing more than 500 recommendations from six major studies, and the FY 2008 and FY 2009 National Defense Authorization Acts. The implementation is taking place through eight lines of action (LoAs), as follows:

- LoA 1 (Disability Evaluation System) developed and implemented a Disability Evaluation System Pilot aimed toward streamlining the DoD disability evaluation system with assistance from VA. Worldwide expansion of an Integrated Disability System is currently underway.
- LoA 2 (Traumatic Brain Injury and Post Traumatic Stress Disorder) efforts brought psychological health issues to the forefront, in an effort to treat and dispel the stigma associated with seeking treatment for TBI and PTSD.
- LoA 3 (Case Management) coordinated health care, rehabilitation, and delivery of services that resulted in facilitating the highest level of support ever provided to the wounded, ill, and injured.
- LoA 4 (Information Technology) increased data sharing of essential health information between the DoD and VA. (Examples: Electronic Health Record (EHR) initiative and e-Benefit portal).
- LoA 5 (Facilities) inspected and improved all Military medical facilities and housing used by the wounded, ill, and injured and their families.

- LoA 6 (Clean Sheet Review) initiated actions to provide WII personnel and their families the best quality care with compassionate, fair, timely, and non-adversarial processes.
- LoA 7 (Comprehensive Legislation and Public Affairs) kept Service members, veterans, family members, the public, DoD/VA leadership, and Congress informed of new developments in care. Legislative language was introduced, as needed.
- LoA 8 (Personnel, Pay, and Financial Support) studied and developed pay and entitlement programs for Service members, Veterans, their families and their caregivers.

Continued efforts will focus on four main areas:

- Service accomplishments.
- Continuity of Care initiatives for DoD and VA to form a coordinated team approach.
- The new approach to psychological health and the anti-stigma campaign for Traumatic Brain Injury and Post Traumatic Stress Disorder.
- The revolution in customer care.

These initiatives are the core of current and future efforts to provide our wounded, ill, and injured Service members, Veterans, and family members the care and benefits they have deservedly earned. To this end, DoD and VA are making progress in key areas of weakness as identified by the SOC and the LoAs. Below specifies our major efforts to provide better transition and care of our wounded, ill and injured Service members.

Disability Evaluation System/Integrated Disability Evaluation System

The genesis of the Disability Evaluation System (DES) is the Career Compensation Act of 1949. The DES was relatively unchanged until 2007. As a result of public concern and congressional interest, the Senior Oversight Committee chartered the DES Pilot in November 2007. The SOC vision for the DES Pilot was to create a "Service Member Centric" seamless and transparent DES, administered jointly by the DoD and VA.

DoD and VA launched the DES Pilot at the three major military treatment facilities (Walter Reed, Bethesda, and Malcolm Grow) in the National Capital Region (NCR) on November 21, 2007. The DES Pilot successfully streamlined the DoD disability system with assistance from VA, and as a result, DoD and VA benefits are delivered to wounded, ill and injured Service members and to veterans as soon as legally possible. DoD and VA found the integrated DES to be a faster, fairer, more efficient system and, as a result, the SOC Co-chairs

(Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs) on July 30, 2010, directed worldwide implementation of the process beginning in October 2010 to be completed at the end of September 2011. On December 31, 2010, the first Integrated Disability Evaluation System (IDES) site became operational, which marked the end of the pilot, and the name was formally changed to the IDES.

The IDES, similar to the pilot, provides a process in which the member receives a single set of physical disability examinations conducted according to VA examination protocols, proposed disability ratings prepared by VA, and simultaneous processing by both Departments to ensure the earliest possible delivery of disability benefits. Both Departments use the VA protocols for disability examination and the proposed VA disability rating to make their respective determinations. DoD determines fitness for duty and compensates for unfit conditions incurred in the line of duty (Title 10), while VA compensates for all disabilities incurred or aggravated in line of duty during military, naval, or air service for which a disability rating of 10 percent or higher is awarded and thus may establish eligibility for other VA benefits and services (Title 38). The IDES requires the Departments to complete their disability determinations before DoD separates a Service member so that both Departments can provide disability benefits at the earliest point allowed under both titles. Service members who separate or retire (non-disability) may still apply to the VA for service-connected disability compensation.

In summary, the IDES features a Service member-centric design, simpler, faster and more consistent evaluations and compensation, single set of disability exams and proposed disability rating, seamless transition to Veteran status, disability case management advocacy, and establishment of a Service member relationship with the VA prior to separation. It also provides increased transparency through better information flow to Service members and their family and a reduced gap between separation/retirement from Service to receipt of VA benefits. Active component members completed the program 37 percent faster than a sample of legacy DES cases. As of April 11, 2011, cumulative IDES enrollment is 21,328 Service members with 6,893 completing the program by medical separation, retirement, or return to duty.

The Department of Defense is partnering closely with the Department of Veterans Affairs as we aggressively move toward IDES implementation at all 139 CONUS and OCONUS sites by 30 September 2011.

The impact of each stage of the IDES expansion and cumulative DES population is shown below:

- Stage I-West Coast & Southeast (October-December 2010) - (Completed) 58%
- Stage II-Rocky Mountain & Southwest Region (January-March 2011) – (Completed) 73%
- Stage III-Midwest & Northeast (April - June 2011) - 90%
- Stage IV-Outside Continental United States (OCONUS)/CONUS (July – September 2011) -- 100%

IDES constitutes a major improvement over the legacy DES and both DoD and VA are fully committed to the worldwide expansion of IDES. The Department is, however, continuously exploring new ways to improve the current system. The Secretaries of Defense and Veterans Affairs are currently exploring several options to shorten the overall length of the disability evaluation process from its current goal of 295 calendar days. In addition, the Departments are also looking closely at the stages of the disability evaluation system that are outside of timeliness tolerances and developing options to bring these stages within goal. We are committed to working closely with Congress in exploring new initiatives that can further advance the efficiency and effectiveness of the disability evaluation process.

Recovery Coordination Program

The DoD Recovery Coordination Program (RCP) was established by Section 1611 of the FY2008 National Defense Authorization Act. This mandate called for a comprehensive policy on the care and management of covered Service members, including the development of comprehensive recovery plans, and the assignment of a Recovery Care Coordinator for each recovering Service member. In December 2009, a Department of Defense Instruction (DoDI 1300.24) set policy standardizing non-medical care provided to wounded, ill and injured Service members across the military departments. The roles and responsibilities captured in the DoDI are as follows:

- **Recovery Care Coordinator**: The Recovery Care Coordinator (RCC) supports eligible Service members by ensuring their non-medical needs are met along the road to recovery.
- **Comprehensive Recovery Plan**: The RCC has primary responsibility for making sure the Recovery Plan is complete, including establishing actions and points of contact to meet the Service member's and family's goals. The RCC works with the Commander to oversee and coordinate services and resources identified in the Comprehensive Recovery Plan (CRP).
- **Recovery Team:** The Recovery Team includes the recovering Service member's Commander, the RCC and, when appropriate, the Federal Recovery Coordinator (FRC), for catastrophically wounded, ill or injured Service members, Medical Care Case Manager and Non-Medical Care Manager. The Recovery Team jointly develops the CRP, evaluating its effectiveness and adjusting it as transitions occur.
- **Reserve/Guard**: The policy establishes the guidelines that ensure qualified Reserve Component recovering Service members receive the support of an RCC.

There are currently 146 DoD trained RCCs in 67 locations placed within the Army, Navy, Marines, Air Force, United States Special Operations Command (USSOCOM) and Army Reserves. Care Coordinators are hired and jointly trained by DoD and the Services' Wounded Warrior Programs. Once placed, they are assigned and supervised by Wounded Warrior Programs but have reach-back support, as needed, for resources within the Office of Wounded Warrior Care and Transition Policy. DoD RCCs work closely with FRCs as members of a Service member's recovery team.

In the DoDI, we have codified that severely injured and ill who are highly unlikely to return to duty and will most likely be medically separated from the military (Category 3) will also be assigned an FRC. The DoDI 1300.24 establishes clear rules of engagement for RCCs. The RCC's main focus is on Service members who will be classified as Category II. A Category II Service member has a serious injury/illness and is unlikely to return to duty within a time specified by his or her Military department and may be medically separated. The FRC's main focus is on the Service members who are classified as Category III. A Category III Service member has a severe or catastrophic injury/illness and is unlikely to return to duty and is likely to be medically separated.

While defined in the DoDI, Category I, II and III are all administrative in nature and have been difficult to operationalize. The intent of the controlling DoDI is to ensure that wounded, ill, and injured Service members receive the right level of non-medical care and coordination. DoD is working with the FRCP to make sure that Service members who need the level of clinical and non-clinical care coordination provided by a FRC are appropriately referred.

Earlier this year, the Senior Oversight Committee (SOC) directed RCP and the Federal Recovery Coordination Program (FRCP) leadership to establish a DoD-VA Executive Committee on Care/Case Management/Coordination to identify ways to better coordinate the efforts of FRCs and RCCs and resolve issues of duplicative or overlapping case management. The Committee conducted its first meeting in March and its final two-day meeting will be held on May 10 – 11. The results of the Committee's efforts will be briefed to the SOC at its June meeting.

In March 2011, DoD also conducted an intense 2 ½ day Wounded Warrior Care Coordination Summit that included focused working groups attended by subject matter experts who discussed and recommended enhancements to various strategic wounded warrior issues requiring attention. One working group focused entirely on collaboration between VA and DoD care coordination programs. Another group focused on best practices within recovery care coordination and a third group focused on wounded warrior family resiliency, employment and education. Actionable recommendations are currently being reviewed, have been presented to the Overarching Integrated Product Team (OIPT) and will continue to be worked until approved recommendations and policies are implemented.

DoD is committed to working closely with the Federal Recovery Coordination Program leadership to ensure a collaborative relationship exists between the DoD RCP and the FRCP. The Military Department Wounded Warrior Programs will also continue to work closely with FRC's in support of Service members and their families.

Transition Assistance Program (TAP)

To strengthen our Transition Assistance Program (TAP) and reinforce its value to Service members and their families, the Department, in collaboration with our partners at the

Departments of Veterans Affairs (VA) and Labor (DOL), is committed to moving TAP from a traditional event-driven approach to a modern, innovative lifecycle approach. We are shifting from an end of military life-cycle event to an outcome based model that will measure success not only on the number of Service members who use the TAP process, but also on the number of transitioning service members and their families who find the TAP process beneficial in assisting them with their life goals, military career progression, and/or new careers/meaningful employment outside of uniformed service. We will be implementing this strategic plan with focuses on information technology, strategic communications, and resources and performance management. The end-state for the TAP overhaul will be a population of Service members who have the knowledge, skills, and abilities to empower themselves to make informed career decisions, be competitive in the global work force and become positive contributors to their community as they transition from military to civilian life.

As part of this effort, we launched the DoD Career Decision Toolkit in August 2010. The Toolkit was developed in collaboration with the Military Services and our TAP partners at the Department of Veterans Affairs and Department of Labor to help simplify the learning curve for transitioning Service members with the information, tools, and resources they need to succeed in the next phase of their lives. The toolkit uses the latest technology to consolidate the very best teaching materials from all the Service branches and provides thousands of on-demand resources to Service members. It is interactive, simple to use and portable. The toolkit includes:

- More than 3,000 on-demand information and planning resources
- Transition subjects such as career exploration, financial planning, resume creation, interviewing skills and compensation negotiation
- Tools that enable Service members to catalogue their military skills, training, and experience in ways that transfer to civilian sector
- Post-Service benefits and resources
- Resources that allow users to self-assess individual transition needs and plan personalized options

We are developing an "end-to-end" virtual TAP delivery vehicle delivery platform that will provide the back-bone of the transformed TAP program, integrating the Guard and reserve components, as well as expanding services available to family members.

DoD has also played a supporting role with the Office of Personnel Management on the initiative to increase hiring veterans in all federal agencies. This is now recognized as President Obama's Veterans Employment Initiative that directs all Executive Agencies to increase veteran employment. TAP is one of the programs we will use to educate and inform Service members about federal Service career opportunities.

Interagency Electronic Health Data

The collaborative Federal partnership between DoD and VA has resulted in increased integration of healthcare services to Service members and Veterans. DoD and VA spearhead numerous interagency electronic health data sharing activities and are delivering IT solutions that significantly improve the secure sharing of appropriate electronic health information.

Today's interagency health information exchange (HIE) capabilities leverage the existing electronic health records (EHRs) of each Department. Both Departments are currently addressing the need to modernize their EHRs. We are working together to synchronize EHR planning activities and identify a joint approach to EHR modernization.

Current HIE sharing capabilities support electronic health data sharing between DoD and VA. The Federal Health Information Exchange (FHIE), Bidirectional Health Information Exchange (BHIE), and the Clinical Data Repository/Health Data Repository (CHDR) support continuity of care for millions of Service members and Veterans by facilitating the sharing of health care data as beneficiaries move beyond DoD direct care to the VA. The data shared includes information from DoD's inpatient documentation system which is in use in DoD's inpatient military treatment facilities, including Landstuhl Regional Medical Center, Germany, the evacuation and treatment center Service members pass through if they have a medical problem while deployed in the current theater of operations. The health data shared assists in continuity of care and influences decision making at the point of care.

Transmission of Data from Point of Separation: At separation, the Federal Health Information Exchange (FHIE) provides for the one-way electronic exchange of historic healthcare information from DoD to VA for separated Service members since 2001. On a monthly basis

DoD sends: laboratory results; radiology reports; outpatient pharmacy data; allergy information; discharge summaries; consult reports; admission/discharge/transfer information; standard ambulatory data records; demographic data; pre- and post-deployment health assessments (PPDHAs); and post-deployment health reassessments (PDHRAs). DoD has transmitted health data on more than 5.6 million retired or separated Service members to VA. Of these 5.6 million patients approximately 2.1 million have presented to VA for care, treatment, or claims determination. This number grows as health information on recently separated Service members is extracted and transferred to VA monthly.

Access to Data on Shared Patients: For shared patients being treated by both DoD and VA, the Departments maintain the jointly developed Bidirectional Health Information Exchange (BHIE) system that was implemented in 2004. Unlike FHIE, which provides a one-way transfer of information to VA when a service member separates from the military, the two-way BHIE interface allows clinicians in both Departments to view, in real-time, health data (in text form) from the Departments' existing health information systems. Accessible data types include allergy, outpatient pharmacy, inpatient and outpatient laboratory and radiology reports, demographic data, diagnoses, vital signs, problem lists, family history, social history, other history, questionnaires and Theater clinical data, including inpatient notes, outpatient encounters and ancillary clinical data, such as pharmacy data, allergies, laboratory results and radiology reports.

Use of BHIE continues to increase. The number of patients, including Theater patients, available through BHIE increased during FY 2010 by approximately 400,000 shared patients. There are more than 4.0 million shared patients including health data for over 243,000 Theater patients, available through BHIE.

To increase the availability of clinical information on a shared patient population, VA and DoD collaborated to further leverage BHIE functionality to allow bidirectional access to inpatient discharge summaries from DoD's IDS. Use of the IDS at Landstuhl Regional Medical Center plays a critical role in ensuring continuity of care and supporting the capture and transfer of inpatient records of care for wounded warriors. Information from these records is accessible

stateside to DoD providers caring for injured Service members and inpatient discharge summaries are available to VA providers caring for injured Service members and Veterans. As of April 2011, discharge summaries are available for all DoD inpatient beds. IDS is now operational at all 59 DoD inpatient sites.

Recent improvements to BHIE include the completion of hardware, operating system, architecture, and security upgrades supporting the BHIE framework and its production environment. This technology refresh, completed in January 2011, resulted in improved system performance, and reliability.

Exchange of Pharmacy and Allergy Data: The Clinical Data Repository/Health Data Repository (CHDR) supports interoperability between AHLTA's CDR and VA's HDR, enabling bidirectional sharing of standardized, computable outpatient pharmacy and medication allergy data. Since 2006, VA and DoD have been sharing computable outpatient pharmacy and medication allergy data through the CHDR interface. Exchanging standardized pharmacy and medication allergy data on patients supports improved patient care and safety through the ability to conduct drug-drug and drug-allergy interaction checks using data from both systems.

In FY 2010, the Departments exchanged computable outpatient pharmacy and medication allergy data on over 250,000 patients who receive healthcare from both systems. This was a more than 400 percent increase from the 44,000 patients whose computable pharmacy and medication allergy data was being exchanged in FY 2009. By the second quarter of FY 2011 the Departments have exchanged computable outpatient pharmacy and medication allergy data on over 741,000 patients who receive healthcare from both systems.

Wounded Warrior Image Transfer: To support our most severely wounded and injured Service members transferring to VA Polytrauma Rehabilitation Centers for care, DoD sends radiology images and scanned paper medical records electronically to the VA Polytrauma Rehabilitation Centers. Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Brooke Army Medical Center are providing scanned records and radiology images electronically for patients transferring to VA Polytrauma Rehabilitation Centers in Tampa, Richmond, Palo

Alto, and Minneapolis. From 2007 to the present, images for more than 375 patients and scanned records for more than 470 severely wounded warriors have been sent from DoD to VA at the time of referral.

Virtual Lifetime Electronic Record: The Departments are firmly focused on enhancing our electronic health data sharing and expanding capabilities to share information with the private sector through Nationwide Health Information Network (NwHIN) and the Virtual Lifetime Electronic Record (VLER). NwHIN will enable the Departments to view a beneficiary's healthcare information not only from DoD and VA, but also from other NwHIN participants. To create a virtual healthcare record—and achieve the VLER vision—data will be pulled from EHRs and exchanged using data sharing standards and standard document formats. A standards based approach will not only improve the long-term viability of how information is shared between the Departments, but will also enable the meaningful exchange of information with other government providers and with civilian providers, both of which account for a significant portion of care delivered to the Departments' beneficiaries.

The VLER pilot projects are demonstrations of exchanges of electronic health information between VA, DoD and participating private sector providers. The pilots continue to provide evidence of the power and effectiveness of coordinated development between the Departments for increasing the secure sharing of electronic health information while leveraging existing EHR capabilities. DoD's VLER pilots are underway in San Diego, California; Tidewater, Virginia; and Spokane, Washington. The fourth and final pilot will be launched in Puget Sound, Washington in late FY 2011. In addition, VA is participating in seven other pilots with the private sector to expand the VLER capability. Those pilots are in Asheville, NC, Richmond, VA, Rural Utah, Indianapolis, IN and three other sites that have not yet been publicly announced. By September 2011, VA will be operational in a total of 11 pilot sites, with at least 50,000 Veterans participating who have provided written consent to share records with the private sector.

Modernizing the EHR – The Foundation for Interagency Data Sharing: The Departments are collaborating on a common framework and approach to modernize our EHR applications.

The Secretary of Defense and Secretary of Veterans Affairs affirmed we will continue to synchronize our EHR planning activities to accommodate the rapid evolution of healthcare practices and data sharing needs, and to speed fielding of new capabilities. The Departments have already identified many synergies and common business processes, including common data standards and data center consolidation, common clinical applications and a common user interface. VA is evaluating open source management options, and DoD is working with the VA to identify opportunities to contribute and participate in the open source collaboration. As the open source communities mature, DoD and VA will continue to analyze open source components that fit the architectural construct for use in the future EHR.

World-Class Medical Care in the National Capital Region

The Base Realignment and Closure (BRAC) construction projects at Bethesda and Fort Belvoir will provide nearly three million square-feet of new world-class clinical and administrative space, cutting-edge technology, and Americans with Disability Act lodging to meet the rehabilitation needs of Wounded, Ill, and Injured service members. The new facilities will improve the infrastructure for casualty care and services and better align healthcare delivery with the population centers of the National Capital Region (NCR) beneficiaries. The projects are on schedule to receive patients and clinical functions from Walter Reed Army Medical Center (WRAMC) by September 15, 2011, while casualty care and patient safety remain the top priorities related to the move. The majority of the BRAC construction at both sites is complete and patient care is being provided in the new inpatient and outpatient pavilions at Bethesda. The Department is paying close attention to the timeliness and milestones necessary to achieve the final moves.

The BRAC projects are only part of the larger transformation of Military Medicine in the NCR. The NCR contains a mix of nearly 40 Army, Navy, and Air Force Medical Treatment Facilities (MTFs), has almost 550,000 eligible beneficiaries, and runs on an annual operating budget of almost $1.5 Billion. Its most important patients are the casualties returning from the war and their families. The Department is taking the opportunity to substantially enhance and transform this multi-Service military healthcare market to provide effective and efficient world-class healthcare. The Joint Task Force National Capital Region Medical (JTF CapMed) is a

standing JTF that was established to oversee the rationalization and realignment of medical infrastructure to achieve greater effectiveness and cost efficiency through the integrated delivery of healthcare.

DoD's Comprehensive Master Plan (CMP) for the NCR, provided to Congress last year, outlined how JTF CapMed will implement an Integrated Healthcare Delivery System (IDS) to provide this world-class healthcare cost effectively. The Department has provided JTF CapMed with command and fiduciary authorities to manage MTFs in the NCR and directed that the new hospitals at Bethesda and Fort Belvoir become joint commands subordinate to JTF CapMed to develop best practices, enhance interoperability and patient safety, and combine shared services such as contracting, personnel, and consolidated information technology – ultimately improving the *patient and family experience*. An example of clinical transformation is in the direct care pharmacy system that will facilitate prescriptions and refills no matter where in the NCR they are presented, provide refills to Six Sigma quality standards, and alleviate traffic concerns at NCR BRAC sites.

The Department has requested $109M in the President's 2012 budget ($762M between FY12 - FY16) to recapitalize medical facilities at Bethesda that the BRAC did not address and provide the new space required to convert to single patient rooms and expand support for the operating suites. These facility projects and the implementation of the NCR IDS by JTF CapMed are part of the Department's commitment to providing "world-class" healthcare in the NCR and fulfilling the requirements under section 2714 of the FY10 NDAA.

Conclusion

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to do. We have, thus, positioned ourselves to implement these provisions and continue our progress in providing world-class support to our warriors and veterans while allowing our two Departments to focus on our respective core missions. Our dedicated, selfless service members, veterans and their families deserve the very best, and we pledge to give our very best during their recovery, rehabilitation, and return to the society they defend.

Mr. Chairman, thank you again for your generous support of our wounded, ill, and injured service members, veterans and their families. I look forward to your questions.

Lynn C. Simpson

Performing the Duties of the Principal Deputy Under Secretary of Defense for Personnel and Readiness

Ms. Lynn Simpson became a career member of the Senior Executive Service in August 2008 when named the Director of Human Capital and Resource Management for the Under Secretary of Defense for Personnel and Readiness. In April 2010, she was assigned to perform the duties of the Principal Deputy Under Secretary of Defense for Personnel and Readiness (P&R). She brings executive level leadership and oversight to Human Capital Management within the OUSD (P&R). She effectively implements Human Capital initiatives and leads human capital management improvements within the OUSD (P&R) including increased focus on SES lifecycle management, proactive management and development of the workforce, and attracting and retraining a high performing workforce.

Ms. Simpson has been a federal civil service employee since 1985. Prior to her executive appointment, she was Director of Administration for the OUSD (P&R) where she transformed customer service delivery to the OUSD (P&R) employees and streamlined processes for security management, human resource recruitment, financial management, and administration and management services. Prior to returning to the Department of Defense in June 2007, Ms. Simpson served as an Executive in the Department of Health and Human Services as the Office of the Secretary Executive Officer. She served the Secretary and his staff organizations by providing critical assistance on resource management, budget and financial services, human resources, administration and management, information management, equal employment opportunity, and project management. Through an exceptional combination of skills, she led the organization to provide centralized, cost-effective service delivery to client organizations and provided solutions to their business requirements.

Ms. Simpson is an accomplished public service professional with extensive leadership and change transformation expertise in two Executive Departments and the Legislative Branch. She is known for her understanding of administration and management issues in the context of the strategic mission of the organization, which ultimately deliver specific services to citizens, stakeholders, and internal government customers.

Ms. Simpson earned a Masters of Public Administration degree from the American University in the Key Executive Program in Washington, D.C and a Bachelor of Science degree in Education from the University of Wisconsin, LaCrosse, Wisconsin. She is a member of the Pi

Alpha Alpha National Honor Society Public Administration, the American Society for Public Administration and the Senior Executive Association. Her awards include the Secretary of HHS Exceptional Civilian Service Award, Secretary of Defense Exceptional Civilian Service Award, Secretarys Award for Distinguished Service; Special Act Awards, and the OIG Employee of the year.