

June 2011

DEFENSE CENTERS OF EXCELLENCE

Limited Budget and Performance Information on the Center for Psychological Health and Traumatic Brain Injury



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Why GAO Did This Study

The National Defense Authorization Act for Fiscal Year 2008 established the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCOE) in January 2008 to develop excellence in prevention, outreach, and care for service members with psychological health (PH) conditions and traumatic brain injury (TBI). DCOE consists of six directorates and five component centers that carry out a range of PH- and TBI-related functions. GAO was asked to report on (1) DCOE's budget formulation process; and (2) availability of information to Congress on DCOE.

GAO reviewed budget guidance, budget requests and performance data. GAO reviewed Department of Defense (DOD) reports submitted to Congress on PH and TBI and interviewed DOD officials.

What GAO Recommends

To enhance visibility and improve accountability, GAO recommends that the Secretary of Defense direct the Director of TRICARE Management Activity (TMA) work with the Director of DCOE to develop and use additional narrative in budget justifications, to regularly collect and review data on funding and obligations, and expand its review and analysis process. DOD concurred with GAO's recommendations. GAO understands that the expanded review and analysis process would not include realigned component centers. GAO agrees that ensuring entities external to TMA comply with regular collections of funding and obligations data could be a limitation.

View [GAO-11-611](#) or key components. For more information, contact Denise M. Fantone at (202) 512-6806 or fantoned@gao.gov.

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What GAO Found

DCOE's role in the DOD budget formulation process is limited. For fiscal year 2012, DCOE's role in budget formulation was limited to consolidating component center budget requests and providing budget requests to TMA. Further, the budget requests DCOE provided to TMA did not have complete narrative justifications. Office of Management and Budget Circular A-11 specifies that the basic requirements for a justification include a description of the means and strategies used to achieve performance goals. At the time of GAO's review, prior-year funding and obligations data and funding received by component centers from sources external to DCOE were not readily available. The absence of these data indicates that TMA and DCOE did not have benefit of this data to inform budget formulation decisions. Also, quarterly reviews conducted by DCOE that collect data on performance and resources do not include component centers. Expansion of reviews and greater access to performance information could provide DCOE an opportunity to collect information that links component center performance with resources and better informs budget decision making.

DCOE's mission and funding have not been clearly defined to Congress. At a congressional hearing, Members expressed differing visions of DCOE's mission and voiced concern about the amount of time needed to establish DCOE and achieve results. Moreover, in four congressional subcommittee testimonies, DCOE's first director and the Assistant Secretary of Defense for Health Affairs characterized DCOE as DOD's "open front door for all concerns related to PH and TBI." These statements suggest a divergent understanding of DCOE's role and bolster the importance of clear communication on DCOE's mission, funding, and activities.

Because DCOE is a relatively small entity primarily funded through the larger Defense Health Program appropriation, it falls below the most detailed level that is presented in congressional budget presentation materials. In addition, at Congress's request DOD provides mandated and ad hoc reports on PH and TBI expenditures. While these reports present information on activities and accomplishments for PH and TBI, DOD does not—and is not required to—report separately on DCOE.

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Abbreviations

CDP	Center for Deployment Psychology
CSTS	Center for the Study of Traumatic Stress
DCOE	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DHCC	Deployment Health Clinical Center
DHP	Defense Health Program
DOD	Department of Defense
DVBIC	Defense and Veterans Brain Injury Center
NDAAs	National Defense Authorization Act for Fiscal Year 2008
NICOE	National Intrepid Center of Excellence
PH	psychological health
POM	Program Objective Memorandum
RDT&E	Research, Development, Test and Evaluation
T2	National Center for Telehealth and Technology
TBI	traumatic brain injury
TMA	TRICARE Management Activity
TMA FOD	TRICARE Management Activity Financial Operations Division
USUHS	Uniformed Services University of the Health Sciences

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United States Government Accountability Office
Washington, DC 20548

June 30, 2011

The Honorable Daniel K. Inouye
Chairman
The Honorable Thad Cochran
Ranking Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable C.W. Bill Young
Chairman
The Honorable Norman D. Dicks
Ranking Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

As of June 2011, approximately 44,000 U.S. military service members have been wounded in action in conflicts in Afghanistan and Iraq. Due to improved battlefield medicine, those who might have died in past conflicts are now surviving, many with multiple serious injuries—such as amputations, burns, and traumatic brain injuries—that require extensive outpatient rehabilitation. Congress passed the National Defense Authorization Act for Fiscal Year 2008, which directed the Department of Defense (DOD) to create centers of excellence on traumatic brain injury (TBI) and post-traumatic stress disorder and other psychological health (PH) conditions to develop excellence in the prevention, outreach, and care for those with PH and TBI conditions.¹ In fiscal year 2010 DOD allotted \$638 million in operations and maintenance funding for PH and TBI activities; of these funds, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCOE) and its component centers received about \$168 million.² Congressional

¹Psychological health conditions include post-traumatic stress disorder, which is a type of anxiety disorder that is triggered by a traumatic event. Traumatic brain injury is damage to the brain that may result from a violent blow or jolt to the head, or from an object penetrating the skull.

²Because of unresolved concerns with the reliability of funding and obligations data provided by DOD, we cannot confirm the accuracy of figures related to DCOE.

committees have expressed concerns about how DCOE formulates its budget.

This is the second report we are issuing about DCOE's establishment and ongoing development. We issued a report in February 2011 examining DCOE's strategic planning and financial management.³ In that report we recommended the Secretary of Defense direct DCOE to improve its strategic plan by aligning daily activities in support of goals and improving performance measures to enable DCOE to determine if achievement of each measure fully supports attainment of its associated goal. In addition, we recommended that the Director of the TRICARE Management Activity (TMA)—under which DCOE operates—develops, updates, and maintains written procedures for proper classification and recording of DCOE obligations. DOD concurred with our recommendations.

For this report, we were asked to examine DCOE's budget formulation process and the availability of its funding and performance information to Congress. In particular, we addressed the following objectives:

1. Describe and evaluate DCOE's budget formulation within the broader DOD-wide budget process for PH and TBI and the information used to make budget decisions.
2. Evaluate the information available to Congress on DCOE's funding and activities.

To achieve these objectives, we reviewed DCOE's budget formulation for operations and maintenance funding for fiscal years 2008 through 2012. To understand DCOE's budget formulation process and the data used to inform budget requests, we reviewed documentation relevant to its budget formulation process and interviewed knowledgeable DOD officials. To understand DCOE's structure, history, and funding, we gathered and analyzed information on the creation and organization of DCOE. We also reviewed the legislative history of DCOE, DOD appropriations acts, and accompanying committee reports. We interviewed officials at Health Affairs, TMA, the Uniformed Services University of the Health Sciences (USUHS), DCOE, and DCOE's component centers about the budget formulation process, and the information used in budget decision making. We reviewed DCOE's mission, strategic goals, and performance measures.

³GAO, *Defense Health: Management Weaknesses at Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Require Attention*, [GAO-11-219](#) (Washington, D.C.: February 28, 2011).

Also, we reviewed budget request and justification documents for DCOE and its component centers. To understand how DCOE participates in DOD budget formulation processes, we reviewed DOD budget formulation guidance, including guidance specifically affecting DCOE or PH and TBI.

To determine what information is available to Congress on DCOE's funding and activities we reviewed the President's budget requests and DOD justification documents for relevant years and reports requested by Congress on DOD's effort to address PH and TBI. To identify congressional direction on information requirements, we reviewed DOD appropriations acts, accompanying committee reports, and congressional hearing records.

We conducted this performance audit from June 2010 through June 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The National Defense Authorization Act for Fiscal Year 2008 (NDAA) directed DOD to establish centers of excellence for traumatic brain injury and post-traumatic stress disorder. Although the NDAA described responsibilities for the centers, it did not specify where the centers should be located within the DOD organization. Instead, it directed the Secretary of Defense to ensure that to the maximum extent practicable centers collaborate with governmental, private, and nonprofit entities. Senior-level DOD officials⁴ convened representatives from the Army, Navy, Air Force, Marines, and Department of Veterans Affairs to determine how to establish the centers. Informally, this group was known as the "Red Cell" and its primary mission was to address recommendations related to PH

⁴In May 2007, DOD and VA established the Senior Oversight Committee as a temporary, 1-year committee with the responsibility for addressing recommendations from multiple reports on a broad range of topics. To conduct its work, the Senior Oversight Committee established eight work groups. One work group of senior-level DOD officials focused specifically on issues related to TBI and post-traumatic brain injury. For additional information on the Senior Oversight Committee and the work groups, see GAO, *Recovering Servicemembers: DOD and VA Have Jointly Developed the Majority of the Required Policies but Challenges Remain*, [GAO-09-728](#) (Washington, D.C.: July 8, 2009).

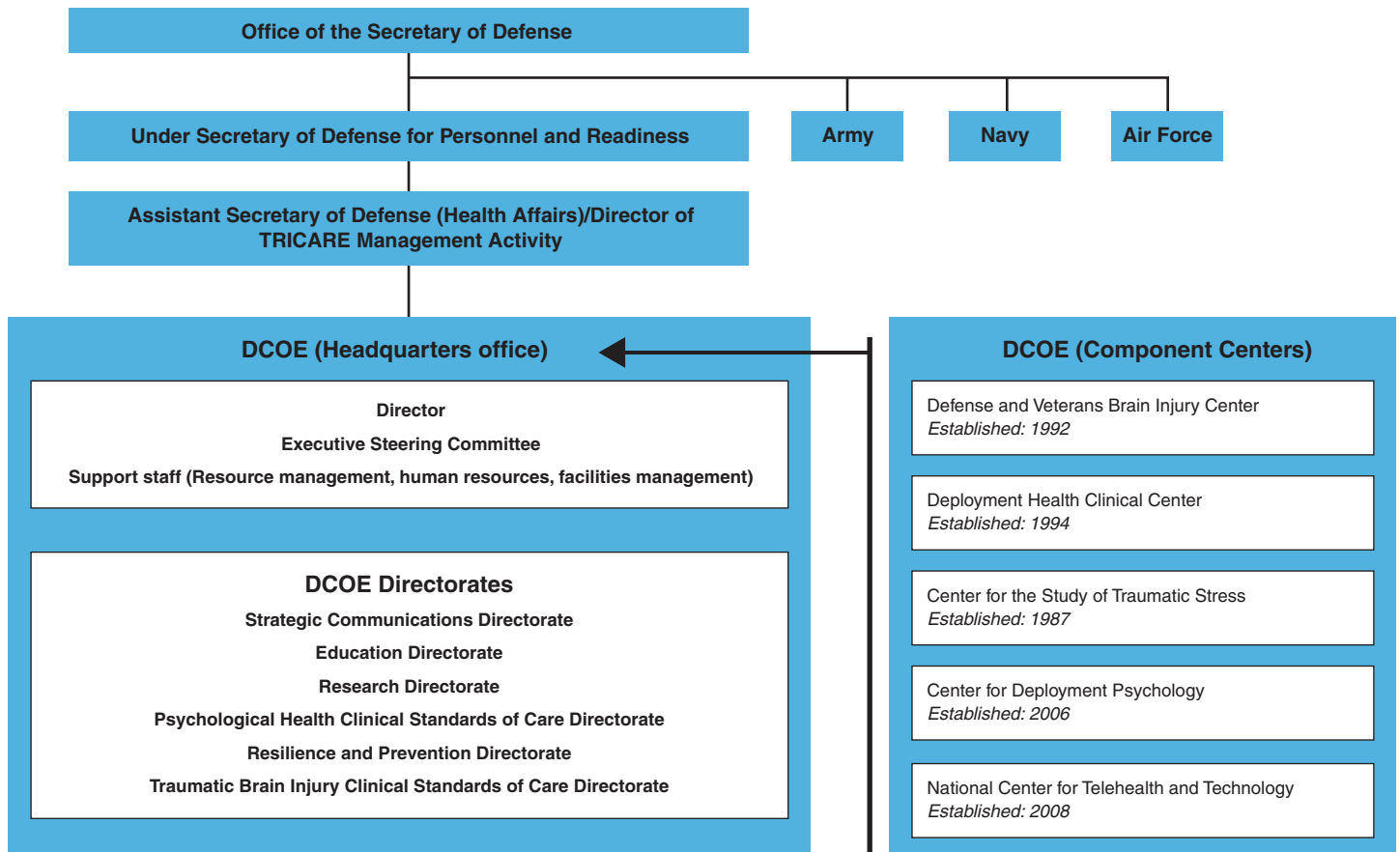
and TBI.⁵ Rather than establishing separate centers of excellence for traumatic brain injury and post-traumatic stress disorder, a combined center for both PH and TBI was created. According to one representative, the Red Cell also debated how funding would be divided between PH and TBI and across the military services. The military services, TMA, and DCOE receive PH and TBI funding through the Defense Health Program (DHP) appropriation account.

DOD Organizational Structure and the DCOE Network

Organizationally the services are led by Secretaries who have a direct relationship with the Secretary of Defense. As shown in figure 1, DCOE reports directly to the Assistant Secretary of Defense for Health Affairs/Director of TMA within the Office of the Secretary of Defense.

⁵The term “Red Cell” is normally used to denote the enemy forces in military war games. It was chosen for this group because the daunting task facing this team would likely make them the enemy of everyone else in the bureaucracy they sought to change.

Figure 1: DCOE Headquarters and Component Centers Alignment within DOD



Source: GAO analysis of Department of Defense documents.

DCOE consists of a central office and six directorates. The central office conducts multiple functions such as leadership and resource management and is responsible for DCOE’s budget formulation process. The six directorates carry out a range of activities related to PH and TBI, including operating a call center, disseminating information on DOD training programs, developing clinical practice guidelines related to PH and TBI, and identifying PH and TBI research needs. The DCOE network also includes five component centers⁶ that provide an established body of

⁶Until August 2010, DCOE also included a sixth component center, the National Intrepid Center of Excellence (NICOE), but the center has since been realigned and is transitioning to the National Naval Medical Center.

knowledge and experience related to PH and TBI. The component centers are the Defense and Veterans Brain Injury Center (DVBIC), Deployment Health Clinical Center (DHCC), Center for the Study of Traumatic Stress (CSTS), Center for Deployment Psychology (CDP), and the National Center for Telehealth⁷ and Technology (T2).

PH and TBI Funding and Allotments

Over time, PH and TBI funding evolved from DHP amounts directed specifically for PH and TBI to funding support being incorporated into the broader DHP appropriation. In fiscal year 2007, Congress appropriated approximately \$600 million specifically for TBI and post-traumatic stress disorder treatment.⁸ In fiscal year 2008, Congress specifically appropriated \$75 million for PH and TBI activities.⁹ In fiscal year 2009, funding for PH and TBI was not appropriated a specific amount, rather funding was drawn from DHP's general operation and maintenance funds—DOD had discretion over the amount and distribution of funds internally allotted.¹⁰ Beginning in fiscal year 2010, PH and TBI funding was included in the base budget request for the DHP, which established a longer-term funding stream for PH and TBI.¹¹

As shown in figure 2, in fiscal year 2010 a total of \$638 million in DHP operations and maintenance funding was allotted for PH and TBI across the military services, TMA Financial Operations Division (TMA FOD), and DCOE. The Army received the largest portion of funds, about \$279 million or 44 percent, while DCOE received approximately \$168 million or 26 percent. Of all PH and TBI funding allotted, \$96 million or 15 percent was suballotted to component centers within the DCOE network.¹²

⁷Telehealth increases access to care through information and telecommunication technologies.

⁸Pub. L. No. 110-28, 121 Stat. 119, 134 (May 25, 2007). The appropriations specified that the \$600 million available for the treatment of traumatic brain injury and post-traumatic stress disorder was to remain available until September 30, 2008.

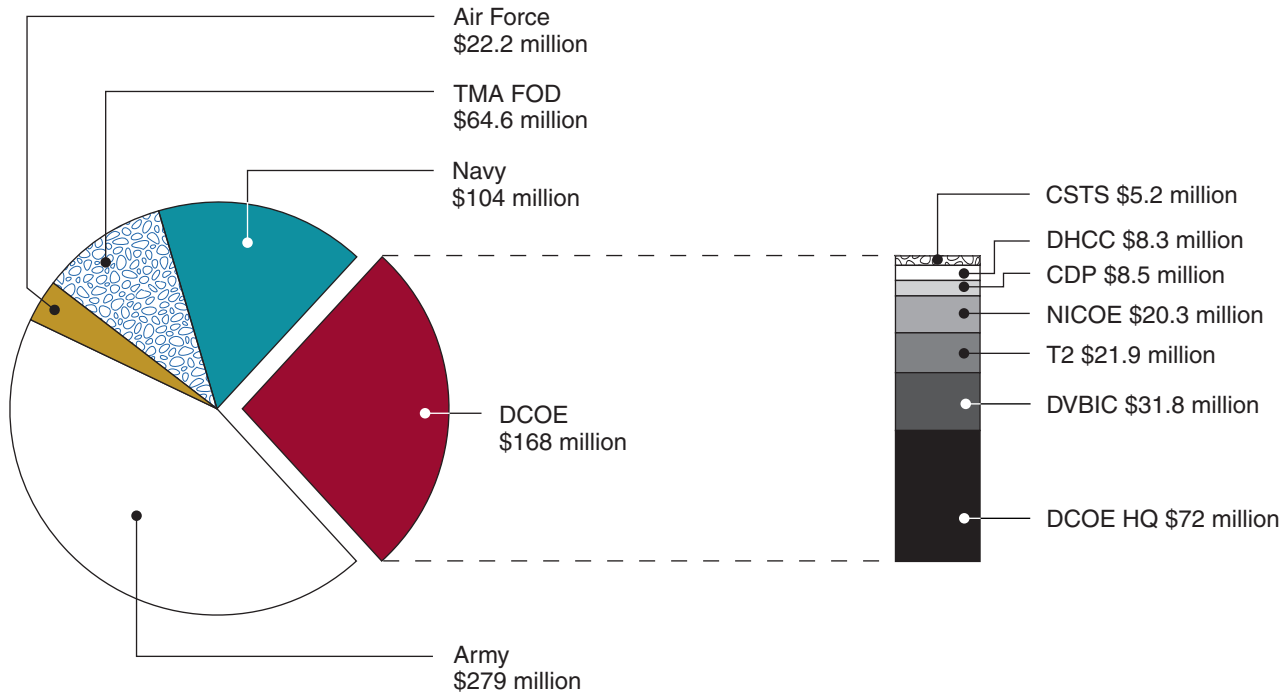
⁹Pub. L. No. 110-252, 122 Stat. 2323, 2403 (June 30, 2008). Amounts appropriated for PH and TBI purposes remained available for two fiscal years, expiring September 30, 2009.

¹⁰See Pub. L. No. 110-329, 122 Stat. 3574, 3617 (Sept. 30, 2008).

¹¹See Pub. L. No. 111-118, 123 Stat. 3424 (Dec. 19, 2009); Pub. L. No. 111-212, 124 Stat. 2310 (July 29, 2010).

¹²Because of unresolved concerns with the reliability of funding and obligations data provided by DOD, we cannot confirm the accuracy of figures related to DCOE.

Figure 2: Beginning of Fiscal Year 2010 Allotment of DHP Operations and Maintenance PH and TBI Funding Across DOD, Including DCOE and DCOE Component Centers



Source: GAO presentation of Department of Defense data.

Notes:

Because of unresolved concerns with the reliability of funding and obligations data provided by DOD, we cannot confirm the accuracy of figures related to DCOE.

Figures do not include funds allotted from the DHP Research, Development, Test and Evaluation appropriation account for PH and TBI activities. In fiscal year 2010, Army, Air Force, and Navy were allotted Research, Development, Test and Evaluation funds. Army received approximately \$179 million, the Air Force received approximately \$900 thousand, and the Navy received approximately \$16 million.

DOD Budget Formulation Process

Budget formulation for DOD occurs as part of the Planning, Programming, Budgeting and Execution Process, which projects near-term defense spending. The system is intended to provide defense decision makers with the data they need to make trade-offs among potential alternatives; thus resulting in the best possible mix of forces, equipment, and support to accomplish DOD's mission. Specifically, DOD budget formulation occurs in the programming phase of the Planning, Programming, Budgeting and Execution Process, and begins with the development of a program objective memorandum (POM). The POM reflects decisions about

resource allocations and proposed budget estimates and is used to inform the development of the President's Budget and DOD Congressional Justifications. Because DCOE is only one, relatively small entity receiving funds through the broader DHP appropriation, it is not visible in DOD budget presentation materials. The POM covers six fiscal years and is developed in even fiscal years, for example fiscal year 2008 and fiscal year 2010.¹³ DOD develops the POM approximately 18 months in advance of the first fiscal year the POM covers.

While DCOE's Role in the Budget Formulation Process Is Limited, More Complete Information Would Be Helpful

DCOE Does Not Make PH and TBI Budget Formulation Decisions, and Its Input to the Process Is Limited

DCOE had a limited role in budget decision making for the fiscal year 2012 POM process. Ultimately, senior DOD officials,¹⁴ including the Health Affairs Deputy Assistant Secretaries of Defense, decided to fund 1 of 18 PH and TBI requests, which did not include DCOE's. For this POM, DCOE headquarters solicited and received budget requests from component centers. Ultimately, DCOE accepted and incorporated all component center requests into its budget request. However, in some instances DCOE officials said they requested additional justification from component centers. PH and TBI budget requests from across DOD, including DCOE, were collected for consideration in the fiscal year 2012 POM. A working group of PH and TBI subject matter experts within DOD reviewed and prioritized requests for funding above the fiscal year 2010 base budget from across the department. According to a DCOE official, DCOE's

¹³The multiyear POM process is used to develop the President's annual budget request. For the purposes of this report we refer only to the first year of the POM. Effective April 2010, the DOD began to implement the process annually.

¹⁴The DOD senior officials are referred to as the Super Integrating Council. The Super Integrating Council is composed of Deputy Surgeons General of the Air Force, Navy and Army, and Commander Joint Task Force National Capital Region Medical Command, the Joint Staff Surgeon, and the Health Affairs Deputy Assistant Secretaries for Defense.

interests were represented by TMA officials who contributed to the prioritization of these requests; however, the final decisions were not formally communicated to DCOE.

DCOE had a limited role in budget formulation for the fiscal year 2010 POM¹⁵ because it was still in its first year of operation. According to a senior DOD official, no limits were imposed on PH and TBI budget requests and no trade-off decisions were made. Nevertheless, this year was significant because it was the first year that DCOE's budget was considered in the DHP baseline budget request. According to DCOE officials, because DCOE had only recently been established, it had limited staff. In addition, component centers were still being realigned under DCOE and both the relationship between component centers and DCOE and the missions of two component centers, T2 and the National Intrepid Center of Excellence (NICOE), were unclear. For the fiscal year 2008 POM process, the newly established DCOE had no role in budget formulation. Instead, the Red Cell convened to determine how the centers of excellence would be implemented and provided recommendations on DCOE's original budget, which the Senior Oversight Committee approved.¹⁶ Because the POM process occurred on a biannual basis in even fiscal years, DOD did not have a budget formulation process in fiscal years 2009 and 2011.

DCOE's Budget Request Did Not Have Complete Narrative Justification

For the fiscal year 2012 POM, DCOE provided limited narrative support for its budget justification. TMA requested that DCOE complete and submit a spreadsheet template with cost estimates and narrative for resource requests above the prior-year baseline. The narrative portion asked for four elements: (1) background, (2) requirements summary, (3) impact to other programs, and (4) the risk if not funded. DCOE and its component centers did not provide this template in a complete manner. Not all of the requested narrative elements were provided. For example, the impact to

¹⁵POM planning begins approximately 18 months prior to the start of the fiscal year.

¹⁶The Senior Oversight Committee was established in May 2007 by DOD and VA as a temporary 1-year committee with the responsibility for addressing recommendations from multiple reports on a broad range of topics, including TBI and post-traumatic stress disorder. The committee is co-chaired by the Deputy Secretaries of DOD and VA and includes military service Secretaries and other high-ranking officials within both departments. According to DOD officials, although the Senior Oversight Committee was established as a temporary committee it remains in existence.

other programs was not discussed for half the requests DCOE submitted.¹⁷ In addition, the DCOE headquarters request was calculated with a 3.5 percent inflation factor versus the 1.7 percent prescribed in POM guidance, but DCOE did not explain why it needed to use a higher inflation rate.

Two years earlier, for the 2010 POM, DCOE provided no narrative support for its budget justification. TMA requested that DCOE provide completed spreadsheets that did not include a narrative component. For this POM, DCOE differentiated the amounts it requested by PH or TBI strategic initiatives and by commodity,¹⁸ but did not provide narrative justifications for these amounts. Guidance contained in OMB Circular A-11 specifies that the basic requirements for a justification include a description of the means and strategies used to achieve performance goals. Means can include human resources, information technology, and operational processes. Strategies may include program, policy, management, regulatory, and legislative initiatives and approaches and should be consistent with the agency's improvement plans.¹⁹ According to OMB, a thorough description of the means and strategies to be used will promote understanding of what is needed to achieve a certain performance level and increase the likelihood that the goal will be achieved. To develop a comprehensive departmentwide budget submission to OMB, a thorough description of means and strategies in justifications is needed at all levels within an agency.

DCOE already collects information that could improve its budget justifications. DCOE requests that both directorates and component centers prepare "fact sheets," which contain detailed information including mission, activities, relevant legislation, staffing, performance metrics, and resource requirements.²⁰ Information like that in the fact

¹⁷The DCOE request was comprised of a request for DCOE headquarters, DHCC, CSTS, CDP, T2, and DVBIC.

¹⁸DOD strategic initiatives for PH and TBI include: access to care; quality of care; surveillance and screening systems; leadership and advocacy; resilience promotion; transition and coordination of care; and research. DOD commodities include Civilian Pay, Contracts, Equipment, Pharmacy, Supplies, Travel, and Other.

¹⁹OMB Circular No. A-11, Preparation, Submission, and Execution of the Budget, pt. 2, § 51 (July 2010).

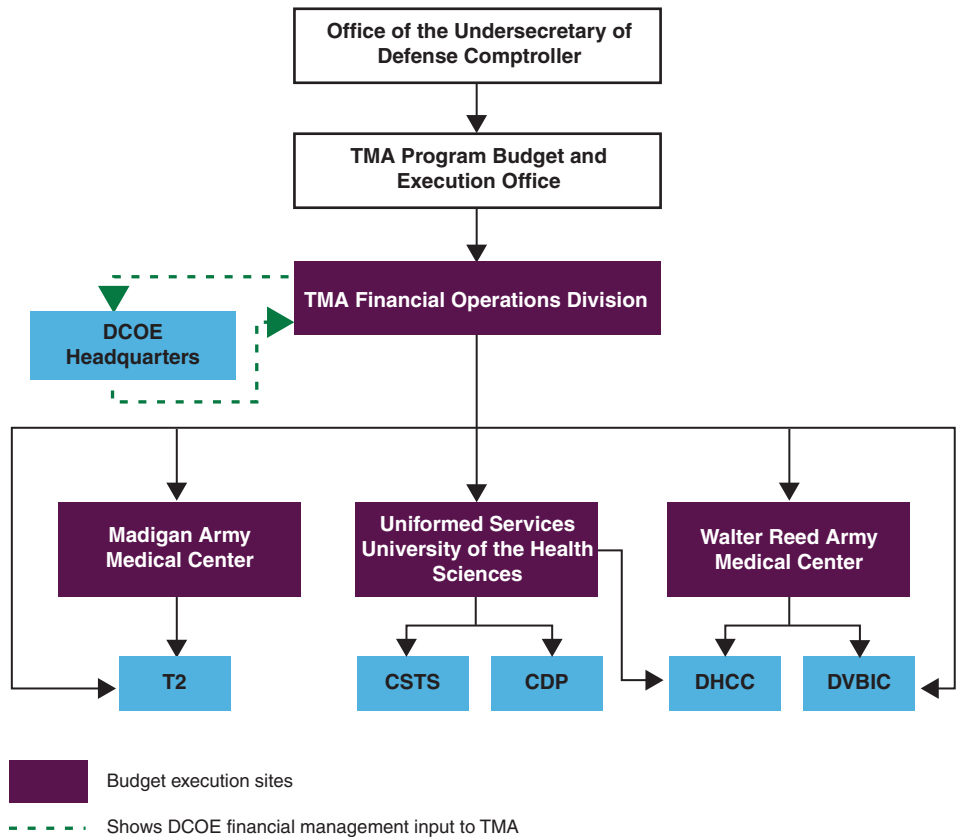
²⁰According to DCOE officials, fact sheets are updated at least once a year, although some component centers have chosen to update their fact sheets more frequently.

sheets provides an expanded discussion of performance information. DCOE and TMA could leverage this existing information to improve budget justifications and resulting decisions.

Key Information Was Not Readily Available to Inform Budget Formulation

Decision making for DCOE's budget formulation could be facilitated by key information, such as funding and obligations data, additional non-DCOE funding received by its component centers, and performance information resulting from internal reviews. This information could also help DCOE justify and prioritize its budget requests. However, DOD required more than 3 months to query numerous sources and provide us with prior-year data on funding and obligations for DCOE and its component centers. The absence of readily available, comprehensive historical funding and obligations data indicates that TMA and DCOE did not have benefit of these data to inform budget formulation. Furthermore, DCOE and TMA FOD do not have access to systems that track funds authorized for execution on behalf of the DCOE component centers because component center budget execution is conducted at multiple sites that maintain separate financial systems. According to TMA and DCOE officials, DCOE has limited responsibility for budget execution activities. TMA FOD and DCOE must request and compile obligations data for funds administered by budget execution sites. For example, as shown in figure 3, once DCOE requests that TMA FOD authorize funding for T2, the funds are provided to T2's host entity, Madigan Army Medical Center. At this point, TMA and DCOE can no longer monitor the execution of T2's funds through TMA's financial reporting systems and must request that information. TMA FOD's financial system contains data on spending it administers for DCOE headquarters and component centers. DCOE and TMA should use comprehensive historical funding and obligations data to inform budget formulation and justify requests. OMB Circular A-11 directs agencies to present prior-year resource requirements in budget justification materials.

Figure 3: Flow of PH and TBI Funds to DCOE and Component Centers



Source: GAO presentation of Department of Defense data.

Prior to our review, DCOE did not collect information on the sources and amounts of funds component centers received in addition to allotments from DCOE, and therefore did not have benefit of these data to help inform budget decision making.²¹ In some cases, component centers receive significant amounts of non-DCOE funding. For example, Deployment Health Clinical Center received about \$8.3 million in funding from DCOE in fiscal year 2010, while it was awarded about \$3.3 million from external sources.²² Standards for internal control in the federal

²¹Component centers receive funds in addition to allotments from DCOE, such as through Congressionally Directed Medical Research Programs, the National Institutes of Mental Health and direct research funds provided by the Services.

²²Because of unresolved concerns with the reliability of funding and obligations data provided by DOD, we cannot confirm the accuracy of figures related to DCOE.

government state that information should be recorded and communicated to management and others within the entity who need it.²³ Without information on non-DCOE funding, when DCOE and TMA make trade-off decisions, they cannot consider all the resources available to component centers. While DCOE has begun collecting information on component centers' non-DCOE funding, it has not had an opportunity to use that data to inform budget formulation and requests because the fiscal year 2012 POM process already occurred.

Additionally, DCOE could obtain more performance information to better prioritize and justify its budget requests. In the middle of fiscal year 2010, DCOE began to hold quarterly meetings to evaluate directorates' performance and reallocate resources used for DCOE's daily activities.²⁴ However, component centers are not included in this process. A DCOE official said component centers are excluded because DOD is reviewing the governance structure of all DOD centers of excellence, and this could affect the organizational structure of DCOE.²⁵ But if DCOE included the component centers in this process, it could collect information that links component center performance with resources and enhance future budget decision making.

Limited Information Is Available on DCOE's Mission, Funding, and Activities

DCOE's mission has not been clearly defined to Congress. For example, in one hearing of the House Committee on Armed Services,²⁶ Members expressed differing visions of DCOE's mission. One Member expressed frustration that DCOE had not become an "information clearinghouse" and the "preeminent catalogue of what research has been done," as had been envisioned. A second Member described his vision of DCOE being an overarching body that "coordinates, inspects, and oversees the

²³GAO, *Internal Control: Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

²⁴GAO, *Defense Health: Management Weaknesses at the Defense Centers of Excellence for Psychology Health and Traumatic Brain Injury Require Attention*, GAO-11-219 (Washington, D.C.: February 2011).

²⁵One DCOE official asserted that any expansion of the review and analysis process would most likely begin with component centers more closely aligned to DCOE headquarters, that is, DHCC, DVBIC, and T2. These three centers have established memorandums of agreement that define their relationship with DCOE.

²⁶Hearing on *Department of Defense Medical Centers of Excellence*, U.S. House Armed Services Committee, April 13, 2010.

tremendous amount of good work being done across the nation.” Members also voiced concern about the amount of time needed to establish DCOE and achieve results. In four congressional subcommittee testimonies, DCOE’s first director and the Assistant Secretary of Defense for Health Affairs characterized DCOE as DOD’s “open front door for all concerns related to PH and TBI.”²⁷ These statements suggest a divergent understanding of DCOE’s role and bolster the importance of clear communication on DCOE’s mission, funding, and activities.

DCOE is a relatively small entity and it does not typically appear in DOD DHP budget presentation materials and falls below the most detailed level that is presented—the Budget Activity Group level.²⁸ DCOE has only appeared in DOD’s budget presentation materials for fiscal year 2010, when PH and TBI funding was first included in the DHP base budget request.²⁹ In the request, DOD did not specify that DCOE’s individual budget request for 2010 was only about \$168 million³⁰ of the \$800 million requested. Specifically, the request stated “\$0.8B to fund operations of the Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury, and to ensure that critical wartime medical and

²⁷Testimony by Colonel Loree K. Sutton, Special Assistant to the Assistant Secretary of Defense for Health Affairs for PH and TBI, before the Personnel Subcommittee of the U.S. Senate Armed Services Committee (Mar. 5, 2008), *Findings and Recommendations of the Department of Defense Task Force on Mental Health, the Army’s Mental Health Advisory Team Reports, and Department of Defense and Service-wide Improvements in Mental Health Resources, Including Suicide Prevention for Servicemembers and their Families*; Testimony by The Honorable S. Ward Casscells, M.D., Assistant Secretary of Defense for Health Affairs, before the Subcommittee on Military Personnel, U.S. House Armed Services Committee, March 14, 2008, Military Health Issues (Mar. 14, 2008); Testimony by General Loree Sutton, Special Assistant to the Assistant Secretary of Defense for Health Affairs for PH and TBI, before the Defense Subcommittee of the U.S. House Appropriations Committee, March 3, 2009, *Psychological Health and Traumatic Brain Injury Programs* (Mar. 3, 2009); and Testimony by Loree K. Sutton, Director, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, before the Personnel Subcommittee of the U.S. Senate Armed Services Committee, *Testimony on the Incidence of Suicides of United States Servicemembers and Initiatives within the Department of Defense to Prevent Military Suicides* (Mar. 18, 2009).

²⁸Examples of Budget Activity Groups include “In-House Care,” “Consolidated Health Support,” “Information Management,” “Management Activities,” “Education and Training,” and “Base Operations Communications.”

²⁹Future year funding for DCOE was mentioned explicitly for information technology projects under DHP’s RDT&E account, totaling approximately \$1 million for fiscal years 2011 and 2012.

³⁰Because of unresolved concerns with the reliability of funding and obligations data provided by DOD, we cannot confirm the accuracy of figures related to DCOE.

health professionals are available to provide needed mental health services by improving hiring and retention bonuses and offering targeted special pay.”

DOD provides supplemental reporting on PH and TBI expenditures through reports mandated in the National Defense Authorization Act for Fiscal Year 2008, as well as ad hoc reports at Congress’s request. While these reports present activities and accomplishments by strategic initiative, DOD is not required to separately report on DCOE in its annual reports. Thus, while PH and TBI information is reported to congressional decision makers, DCOE specific funding and activities are not visible. The Government Performance Results Act (GPRA) Modernization Act of 2010³¹ further requires agencies to consult with the congressional committees that receive their plans and reports to determine whether they are useful to the committee. Table 1 summarizes selected mandated and ad hoc reports DOD provided to Congress.

³¹Pub. L. No. 111-352, § 11, 124 Stat. 3866, 3881-82 (Jan. 4, 2011).

Table 1: Selected DOD Reports to Congress on PH and TBI Activities

Report title	Report details		Report content
Comprehensive Plan on Prevention, Diagnosis, Mitigation, Treatment, and Rehabilitation of, and Research on, Traumatic Brain Injury, Post-Traumatic Stress Disorder, and other Mental Health Conditions in Members of the Armed Forces	Mandate	NDA 2008 Section 1618b	Summarized DOD's program to address PH and TBI needs, including program capabilities by strategic initiative
	Reporting Frequency	Once	
	Date Provided to Congress	October 2008	Outlined DCOE's focus areas and described gaps in DCOE's capabilities at the time
Report on the Establishment of the Centers of Excellence	Mandate	NDA 2008 Section 1624	Described the background, mission, and structure of DCOE
	Reporting Frequency	Once	
	Date Provided to Congress	November 2008	Assessed DCOE's progress, plans, and objectives with examples of DCOE collaborations and activities by strategic initiative
Annual Report on TBI and Post-Traumatic Stress Disorder Expenditures	Mandate	NDA 2008 Section 1634b	Described activities, PH and TBI DOD priorities, and a progress assessment
	Reporting Frequency	Annually through 2013	
	Dates Provided to Congress	May 2008 June 2010 ^a	Reported expenditures for DVBC; all other expended funds are listed by DOD-wide strategic initiatives, not by entity
Senate Appropriations Committee reports	Mandate	n/a	Displayed expenditures by strategic initiative, budget activity group, and commodity ^b for PH and TBI activities within the DHP
	Reporting Frequency	Monthly	
	Dates Provided to Congress	Provided monthly in 2009	

Source: GAO analysis of reports provided to Congress by DOD.

^aDOD did not provide an annual expenditure report to Congress in 2009.

^bDOD commodities include Civilian Pay, Contracts, Equipment, Pharmacy, Supplies, Travel, and Other.

Conclusions

DCOE faces numerous challenges, such as recruiting staff and shaping relationships with its component centers and military services. Nonetheless, DCOE could take additional steps to make better informed budget decisions and justify resource requests. DCOE lacks key information, such as comprehensive funding and obligations data for component centers and does not make full use of performance data. Better leveraging of such information could enhance DCOE's ability to influence component centers' progress towards achievement of positive outcomes for wounded service members. For DCOE to achieve its mission and goals it must have access to and consider information needed to prioritize its activities and communicate its role to stakeholders. As DOD reviews the governance structure of its centers of excellence, such as DCOE, it has an

opportunity to ensure that these centers have the tools needed to promote success.

Recommendations for Executive Action

To enhance visibility and improve accountability, we recommend that the Secretary of Defense direct the Director of TMA to work with the Director of DCOE on the following three actions:

1. develop and use additional narrative, such as that available in component center fact sheets, in budget justifications to explain the means and strategies that support the request.
2. establish a process to regularly collect and review data on component centers' funding and obligations, including funding external to DCOE.
3. expand its review and analysis process to include component centers.

Agency Comments and Our Evaluation

We provided a draft of this report to the Secretary of the Department of Defense for official review and comment. The Assistant Secretary of Defense of Health Affairs and Director of TRICARE Management Activity provided us with written comments, which are summarized below and reprinted in appendix III. DOD also provided technical comments that were incorporated into the report as appropriate. DOD concurred with all of our recommendations. Specifically, DOD concurred with our recommendation that the Director of TRICARE Management Activity (TMA) work with the Director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCOE) to develop and use additional narrative, such as that available in component centers' fact sheets and budget justifications. DOD also concurred with our recommendation to establish a process to regularly collect and review data on component centers' funding and obligations, including funding external to DCOE. However, DOD stated that one limitation in executing this recommendation is ensuring entities external to TMA comply with the request to regularly report funding and obligations data. We agree that this limitation presents challenges for DCOE's and TMA's oversight of obligations and funding data. However, a complete understanding of this information is important to fully review the resources that affect DCOE's operations.

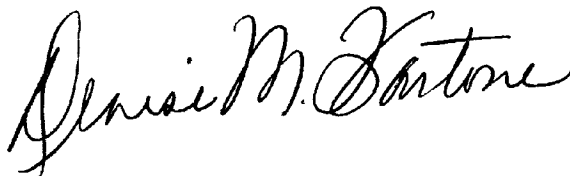
DOD stated that DCOE is appropriately informed of budget execution data through formal systems, as well as informal coordination and managerial reporting. In addition, TMA stated that it executes a majority of the total operations and maintenance funding that DCOE and its component centers receive and that TMA, DCOE, and the Services have instituted

numerous internal controls to monitor planned and actual expenditures. Despite the level of oversight described by DOD, it was not readily able to provide us with disaggregated information on DCOE's funding and obligations. Although TMA does execute and oversee the majority of operations and maintenance funding for DCOE and its component centers, additional funding remains outside of its oversight, including approximately 18 percent of operations and maintenance funding.

The data provided for fiscal year 2010 remain incomplete and the information provided has not been sufficient to confirm its accuracy or reliability. Furthermore, DOD was unable to describe the process used to identify and resolve errors in source data from multiple financial systems, and TMA stated that it could not confirm the accuracy of data from financial systems it does not administrate. This raises questions about DCOE and TMA's oversight and use of these data to inform budget formulation. Lastly, DOD agreed with the recommendation to expand its review and analysis process to include component centers, but that it did not plan to include two component centers, the Center for the Study of Traumatic Stress and the Center for Deployment Psychology, which are in the process of formally aligning under the Uniformed Services University of the Health Sciences.

We are sending copies of this report to the Secretary of Defense and appropriate congressional committees. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact Denise M. Fantone at (202) 512-6806 or fantoned@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.



Denise M. Fantone
Director, Strategic Issues

Appendix I: Scope and Methodology

We reviewed the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCOE) budget formulation for fiscal years 2008 through 2012. To understand DCOE's budget formulation process and the data used to inform budget requests, we reviewed documentation relevant to its budget formulation process and interviewed knowledgeable Department of Defense (DOD) officials. To understand DCOE's structure, history, and funding, we gathered and analyzed information on the creation and organization of DCOE, such as the report on the outcomes of the Red Cell, and memorandums of agreement between DCOE and component centers. We also reviewed the legislative history of DCOE, DOD appropriations acts from fiscal years 2007, 2008, 2009, and 2010, and accompanying committee reports.

Initially, we sought to obtain funding and obligations data from fiscal years 2007 through 2011; however, DOD was unable to provide these data in a timely manner, and ultimately provided data that we determined were not sufficiently reliable for presenting funding and obligations figures. As a result, the team reduced the scope of our data request to only include fiscal year 2010. Through interviews and responses to written questions, DOD provided additional information about the process used to generate and validate this data. However, as of May 5, 2011, the data provided for fiscal year 2010 remain incomplete, and the information provided has not been sufficient to confirm the accuracy or reliability of all detailed funding and obligations data. Because such data are necessary to fully understand the budget process for psychological health (PH) and traumatic brain injury (TBI), the team decided to present these data, but to note that we have not confirmed their accuracy.

We reviewed DCOE's mission, strategic goals, and performance measures. Also, we reviewed budget request and justification documents for DCOE, and its component centers for fiscal years 2010 and 2012, and documents that support the development of budget requests, such as component center fact sheets. To understand how DCOE participates in DOD budget formulation processes we reviewed DOD budget formulation guidance, including TRICARE Management Activity (TMA) and Program Objective Memorandum (POM) guidance for fiscal year 2010 and 2012 that specifically affects DCOE. The Defense Health Program appropriation includes three accounts, Operations and Maintenance, Procurement, and Research, Development, Test and Evaluation (RDT&E). We focused our review on the budget formulation process for Operations and Maintenance funding because DCOE and DCOE component centers do not receive any baseline funding for Procurement and RDT&E, which are obtained through separate budget processes. We interviewed officials at Health

Affairs, Force Health, Protection and Readiness, TMA, the Uniformed Services University of the Health Sciences (USUHS), DCOE, and DCOE's component centers about the budget formulation process, and the information used in budget decision making.

To determine what information is available to Congress on DCOE's funding and activities, we reviewed the President's budget requests and DOD's justification documents for fiscal years 2010, 2011, and 2012. In addition, we reviewed reports mandated by the 2008 National Defense Authorization Act on PH conditions and TBI, and reports requested by the Senate Appropriations Committee on PH and TBI expenditures. To identify congressional direction on information requirements, we reviewed DOD appropriations acts from fiscal years 2007, 2008, 2009, and 2010, accompanying committee reports, and congressional hearing records.

We conducted this performance audit from June 2010 through June 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Description of Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Directorates and Component Centers

Six directorates carry out a range of activities related to psychological health (PH) conditions and traumatic brain injury (TBI).

Directorates include:

- **Strategic Communications Directorate**—To strategically inform and disseminate to multiple audiences and stakeholders; providing relevant and timely information, tools, and resources for warriors, families, leaders, clinicians, and the community that empowers them, supports them, and strengthens their resilience, recovery, and reintegration.
- **Psychological Health Clinical Standards of Care Directorate**—To promote optimal clinical practice standards to maximize the psychological health of warriors and their families.
- **Research Directorate**—To improve PH and TBI outcomes through research; quality programs and evaluation; and surveillance for our service members and their families.
- **Resilience and Prevention Directorate**—Assist the military services and the DOD to optimize resilience; psychological health; and readiness for service members, leaders, units, families, support personnel, and communities.
- **Education Directorate**—To assess training and educational needs in order to identify, and promote effective instructional material for stakeholders resulting in improved knowledge and practice of PH and TBI care.
- **Traumatic Brain Injury Clinical Standards of Care Directorate**—To develop state of the science clinical standards to maximize recovery and functioning and to provide guidance and support in the implementation of clinical tools for the benefit of all those who sustain traumatic brain injuries in the service of our country.

The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCOE) network also includes five component centers¹ that provide an established body of knowledge and experience related to PH and TBI. Component centers include:

¹Until August 2010, DCOE also included a sixth component center, the National Intrepid Center of Excellence (NICOE), but the center has since been realigned and is transitioning to the National Naval Medical Center.

Appendix II: Description of Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Directorates and Component Centers

- **Defense and Veterans Brain Injury Center (DVBIC)**—With a focus on TBI, DVBIC was created as a collaboration between DOD and Department of Veterans Affairs that serves military personnel, veterans, and their families by providing clinical care, conducting research, and providing education and training to DOD providers.
- **Deployment Health Clinical Center (DHCC)**—Focused on deployment-related health concerns, including PH, DHCC serves military personnel, veterans, and their families by providing outpatient care, conducting research, leading the implementation of a primary care screening program for post-traumatic stress disorder and depression, and information to military health system providers.
- **Center for the Study of Traumatic Stress (CSTS)**—By addressing a wide scope of trauma exposure that includes the psychiatric consequences of war, deployment, disaster, and terrorism, CSTS serves DOD, and collaborates with federal, state, and private organizations. Activities include conducting research, providing education and training to military health system providers, and providing consultation to government and other agencies on preparedness and response to traumatic events.
- **Center for Deployment Psychology (CDP)**—Covering both PH and TBI, CDP trains military and civilian psychologists and other mental health professionals to provide high quality deployment-related behavioral health services to military personnel and their families.
- **National Center for Telehealth² and Technology (T2)**—Addressing both PH and TBI, T2 serves military personnel, veterans, and their families by acting as the central coordinating agency for DOD research, development, and implementation of technologies for providing enhanced diagnostic, treatment, and rehabilitative services.

²Telehealth increases access to care through information and telecommunication technologies.

Appendix III: Comments from the Department of Defense

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUN 3 2011

Ms. Denise Fantone
Director, Strategic Issues
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Ms. Fantone:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-11-611, "Limited Budget and Performance Information on the Center for Psychological Health (PH) and Traumatic Brain Injury (TBI)," received on May 13, 2011, (GAO Code #450844). Overall, I concur with recommendations made in the draft report. I would like to clarify some information, however, in order to better describe financial controls and processes currently in place to support the Defense Centers of Excellence (DCoE) for PH and TBI budget activities. First, I would like to emphasize the components of DCoE's budget formulation and execution processes that support thoughtful investment decisions, as well as accountability and reliability in managerial data collection. Second, in preparation for the Fiscal Year (FY) 2010 Program Objective Memorandum (POM) and the Future Years Defense Budget (FYDP), DCoE has been involved fully in program justification within the DoD system. Finally, DCoE has maintained open and responsive communications with Congress in reference to its ongoing achievements in the field of PH and TBI.

DCoE is a new organization, established in FY 2008 with an initial PH/TBI Operations and Management (O&M) budget of \$45 million. DCoE's program requirements and corresponding budget growth in FY 2009-2010 were informed by existing projects, as well as proposed activities in compliance with legislative and task force guidance. A baseline funding plan was established during the FY 2010 program review (\$180 million in O&M dollars). Formulation of the budget and FYDP, by DCoE staff, followed established Department and Military Health System guidance, including review and endorsement by the Senior Military Medical Advisory Council consisting of the Service Surgeons General. The program review and budget process have been followed by DCoE since the establishment of the base budget.

While DCoE does not have a standalone financial system, TMA oversight of obligations and expenditures has kept the DCoE Director appropriately informed of budget execution data. This information has been reported through formal systems, as well as informal coordination and managerial reporting between TMA Program Budget and Execution, TMA Financial Operations Division (FOD), DCoE, and the Uniformed Services University of the Health Sciences (USUHS). In fact, in FY 2010 TMA FOD executed 82 percent (\$137 million) of the total O&M funding identified for DCoE and its CCs. Adding the USUHS data (\$21 million in funding authorization documents (FADs)), a total of \$158 million (94 percent) of DCoE and its CC

See comment 1.

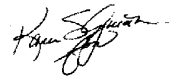
See comment 1.

FY 2010 PH/TBI O&M funding are auditable at the TMA level. In addition, DCoE, TMA, and the Services have instituted numerous internal controls to monitor planned and actual expenditures covering the remaining 6 percent of support costs. With respect to Research Development Test and Evaluation (RDT&E) appropriations, grant dollars are separately reviewed, distributed, and accounted for outside of TMA. While central oversight of RDT&E activities could be improved, it is important to note that the DCoE portfolio was not originally structured to manage DCoE CC research projects.

In relation to the reliability of DCoE/TMA funding data (Figure 2 in Draft Report), DCoE took the time to verify obligation and FAD data so that all responses were auditable with regard to the \$168 million reported. Recently, TMA FOD was audited as part of GAO engagement #290826 for all FY 2009 DCoE obligations. For the current audit, the process of collecting and providing information was complex and lengthy. The data call was a dual request for audit engagements #450844 and #351513, including all appropriations data (O&M, RDT&E, and procurement) from multiple sources within DoD (e.g., Services, TMA, and USUHS) for FY 2007–2010. Although the GAO sought a singular DoD representative for this data, the report was a coordinated effort due to the segmentation of financial systems. Given the complexity, several meetings were held during the audit to clarify the data call request to ensure that DCoE and GAO defined terms in the same way. As a result of guidance from GAO, DCoE submitted revised versions of the funding spreadsheet to ensure GAO received the information according to their specific business rules. DCoE acknowledges that this was a lengthy process but is confident in the reliability of the information provided to GAO.

Finally, as the report included several comments in regard to DCoE's relationship with Congress, it is important to note that DCoE, since its inception, has worked to inform Members of Congress about its mission. The information shared was refined in accordance with DCoE's organizational growth and maturity. DCoE has continued to make subject matter experts available to Members upon request to discuss such topics as TBI, PH, and overall DCoE activities. In 2011, DCoE leadership met with several congressional committees, using the opportunity to clarify DCoE's role and obtain input from congressional stakeholders to better align expectations.

Thank you for the opportunity to review and provide comments. The points of contact on this issue are Ms. Anne Giese (Functional) and Mr. Gunther Zimmerman (Audit Liaison). Ms. Giese may be reached at (301) 295-3687 or Anne.Giese@tma.osd.mil. Mr. Zimmerman may be reached at (703) 681-4360 or Gunther.Zimmerman@tma.osd.mil.



Jonathan Woodson, M.D.

Enclosures:
As stated

**GAO DRAFT REPORT—DATED MAY 13, 2011
(GAO CODE #450844/GAO-11-611)**

**“LIMITED BUDGET AND PERFORMANCE INFORMATION ON THE CENTER FOR
PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY”**

DEPARTMENT OF DEFENSE COMMENTS TO THE RECOMMENDATIONS

To enhance visibility and improve accountability, we recommend that the Secretary of Defense direct the Director of TRICARE Management Activity (TMA) to work with the Director of the Defense Centers of Excellence (DCoE) on the following three actions:

RECOMMENDATION #1: Develop and use additional narrative, such as that available in Component Centers’ fact sheets and in budget justifications, to explain the means and strategies that support the request.

DOD RESPONSE: Concur.

RECOMMENDATION #2: Establish a process to regularly collect and review data on Component Centers’ funding and obligations, including funding external to DCoE.

DOD RESPONSE: Concur. DCoE will develop a process to enhance its existing funding data collection for Component Centers, including funding external to DCoE. The only limitation in the execution of this recommendation is the degree to which the receiving entities outside of TMA comply with the request to regularly report out on the funding and obligations data.

RECOMMENDATION #3: Expand its review and analysis process to include Component Centers.

DOD RESPONSE: Concur. DCoE will expand its current review and analysis process to include the Defense and Veterans Brain Injury Center, the Deployment Health Clinical Center, and the National Center for Telehealth and Technology. As the Center for the Study of Traumatic Stress and the Center for Deployment Psychology are in the process of formally aligning under Uniformed Services University of the Health Sciences, DCoE does not plan to include these two organizations in the review and analysis process at this time.

GAO DRAFT REPORT—DATED MAY 13, 2011
(GAO CODE #450844/GAO-611-11)

“LIMITED BUDGET AND PERFORMANCE INFORMATION ON THE CENTER FOR
PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY”

DEPARTMENT OF DEFENSE COMMENTS

Technical Comments:

Now on p. 3.

• Page 9 (Paragraph 4). The term “Senior level DoD officials” should refer to the Line of Action Two (LOA2) leads, not the Senior Oversight Committee (SOC). The SOC established the eight Lines of Action. **Recommend** re-wording the sentence and Footnote 4 to indicate the appropriate group. In addition, **recommend** clarifying the Red Cell’s role, noting that its primary mission was to address 400-plus recommendations related to Psychological Health (PH) and Traumatic Brain Injury (TBI), which included developing a conceptual framework for a Center of Excellence for PH and TBI.

Now on p. 4.

• Page 10 (Paragraph 1). In a Decision Memorandum, dated August 7, 2007, the SOC directed the Department of Defense (DoD) and Department of Veterans Affairs to establish a center of excellence no later than November 30, 2007. **Recommend** replacing “Red Cell” with “SOC,” as they were the officials that directed the establishment of a combined center for PH and TBI.

Now on p. 5.

• Page 11 (Figure 1). In the chart, the first DCoE Directorate listed, “Strategic Management Directorate,” is incorrect. **Recommend** replacing “Strategic Management Directorate” with “Strategic Communications Directorate.”

Now on p. 6.

• Page 12 (Paragraph 2). Regarding the reference to the “additional \$75 million for PH and TBI activities” in FY 2008, this statement is incorrect. The \$75 million was originally FY 2007/2008 appropriated funding subsequently rescinded and re-appropriated in FY 2009. **Recommend** deleting the sentence referencing 2008 dollars. Regarding the FY 2009 reference to Operations and Management (O&M) funds “without a specific amount,” this statement also is incorrect. **Recommend** noting that FY 2009 Defense Health Program (DHP) O&M funds totaled \$585 million, consisting of the \$75 million re-appropriated from FY 2007/2008, \$300 million in supplemental funds, and \$210 million in Congressional add-ons.

Now on p. 6.

• Page 12 (Paragraph 3). Regarding the “\$638 million [that] was allotted for PH and TBI,” **recommend** noting that this amount refers to O&M funding, as explained in Figure 2.

See comment 1.

• Page 13 (Figure 2). In the chart, the dollar amounts listed for DCoE and its Component Centers are incorrect. **Recommend** changing the amounts listed in Figure 2: Beginning of Fiscal Year Allotment of Operations and Maintenance PH and TBI Funding as follows: the amount for DCoE should be listed as \$180.2 million; the amount for the Center for the Study of Traumatic Stress (CSTS) should be listed as \$5.2 million; the amount for the Deployment Health Clinical Center (DHCC) should be listed as \$9.8 million; the amount for the Center for Deployment Psychology (CDP) should be listed as \$5.7 million; the amount listed for the

National Intrepid Center of Excellence(NICoE) should be listed as \$21.7 million; the amount listed for the Center for Telehealth and Technology (T2) should be listed as \$20.3 million; the amount listed for the Defense and Veterans Brain Injury Center (DVBIC) should be listed as \$31.9 million; the amount listed for DCoE Headquarters (HQ) should be listed as \$85.6 million. For additional background information, please refer to the original funding spreadsheet that was submitted to the GAO Strategic Issues Team by DCoE on February 15, 2011.

Now on p. 9.

- Page 15 (Paragraph 1). DCoE does not have any evidence that the final decisions of the PH and TBI working group were published. Therefore, **recommend** changing the language to note that the final decisions were not “formally” communicated to DCoE.

Now on p. 9.

- Page 15 (Paragraph 2). The Red Cell provided recommendations to the LOA2 leads as to how the FY 2008 PH/TBI O&M dollars, a \$600 million Congressional appropriation (page 12), should be allocated across DoD components, including the Services and DCoE. Their recommendations did not include an initial budget for DCoE, but rather suggested an initial portion, approximately \$45 million, of the total \$600 million. Final allocation decisions were made by the SOC. **Recommend** changing the existing language to note that the Red Cell did not form DCoE’s original budget, but rather provided recommendations pertaining to DCoE’s original O&M allocation for FY 2008.

Now on p. 14.

- Page 20 (Paragraph 2). DCoE did not appear in the DoD DHP budget presentation materials not because of its “small” size, but rather DoD Program Objective Memorandum materials are presented according to programs. Therefore, presentations are not detailed out by organizations such as DCoE. **Recommend** noting that DCoE was not listed in the DoD DHP budget presentation materials, as these documents report out by program, not specific organizations.

See comment 1.

- Page 21 (Paragraph 1). Per the technical comment for page 13 (Figure 2), the \$168 million noted in this sentence is incorrect. **Recommend** deleting “\$168 million” or replacing “\$168 million” with “\$180.2 million.”

GAO Comments

The following GAO comments on the Department of Defense's letter dated June 3, 2011, supplement those that appear in the text of the report.

1. While DOD stated that DCOE is appropriately informed of budget execution data through formal systems, as well as informal coordination and managerial reporting, DOD was not readily able to provide us with basic information on funding and obligations. Furthermore, the data provided for fiscal year 2010 remain incomplete and the information provided has not been sufficient to confirm its accuracy and reliability. This raises questions about DCOE and TMA's oversight and use of these data to inform budget formulation. Accurate and reliable status of funding data should be used as the starting point to inform, justify, and prioritize future budget requests. Although DOD stated that funding data provided to us on February 15, 2011, should be reported on, we continue to believe that these data do not reflect specific psychological health and traumatic brain injury funding that DCOE provided to component centers. Service-level data provided on that date were not subsequently revised. However, data for DCOE and its component centers were revised multiple times after receiving initial data on February 15, 2011. We continued to work with DCOE and TMA to address inconsistencies, incorporate new data, and establish a common understanding of budget terminology, such as allotments and obligations. Moreover, DOD provided numerous revisions to data provided after February 15, 2011, and continued to do so even in comments to the draft of this report. While DOD believes that the data provided are reliable, DOD was unable to describe the process used to identify and resolve errors in source data from multiple financial systems, and TMA stated that it could not confirm the accuracy of data from financial systems it does not administrate.

Appendix IV: GAO Contacts and Staff Acknowledgments

GAO Contact

Denise M. Fantone, (202) 512-6806 or fantoned@gao.gov

Acknowledgments

In addition to the individual listed above, Carol M. Henn, Assistant Director; Erinn L. Sauer; Michael Aksman; Alexandra Edwards; Robert Gebhart; Jyoti Gupta; Chelsa Gurkin; Felicia Lopez; and Steven Putansu made major contributions to this report.

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