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DOD/VA COLLABORATION AND COOPERATION TO MEET THE NEEDS OF RETURNING SERVICEMEMBERS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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JANUARY 23, 2007

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WITNESSES

DOD/VA COLLABORATION AND COOPERATION TO MEET THE NEEDS OF RETURNING SERVICEMEMBERS

TUESDAY, JANUARY 23, 2007

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:36 a.m., in room SR–418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Rockefeller, Murray, Obama, Brown, Webb, Tester, Sanders, and Craig.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. The hearing of the Committee will come to order. I want to welcome the Members who are here for this, our first hearing, and also our witnesses, and I look forward to the responses that will be forthcoming.

I want you to know that this is the Committee's first hearing for the 110th Congress, and I look forward to working with our new and returning Members for this to be a productive session. I also want to say I am delighted to continue to work with Senator Craig. We have had such a good relationship, and we will continue to work in a bipartisan manner, as we have, and I look forward to working with him and with Members of this Committee.

Today's hearing will focus on cooperation and collaboration between the Departments of Veterans Affairs and Defense. There has been strong congressional interest dating back to the 1980s on improving how the two Departments work together on improving the transition process. We hope to hear today on where the two Departments are and where they need to be.

I want to thank Secretary Mansfield from VA and Secretary Chu from DOD for joining us today. Today's hearing will establish a benchmark for future hearings and will focus on specific health and benefits issues that relate to the two Departments. Where opportunities exist for sharing resources that benefit servicemembers and veterans, they must be seized. With tens of thousands of servicemembers in harm's way, it is more important than ever that the Departments work together.

The Departments must facilitate the seamless transition of servicemembers from active duty to veteran status. Prior to separation, servicemembers must know exactly how they can obtain the

benefits and services available to them. This must be true whether someone is separating from active duty, the Guard, or Reserves. It is especially vital for those who are wounded or severely injured.

I can only imagine the stress that a new veteran with a life-altering wound or injury endures when faced with transitioning from one health care system to another while still in the process of recovery and rehabilitation. The handoff between the Departments for those who are in the greatest need must be truly seamless.

According to the Office of Management and Budget, there has been slippage since 2002 in the progress of implementing coordination of VA and DOD programs and systems. This is deeply concerning. It appears to me that much of this slippage has resulted from a failure to identify who is responsible for implementing recommended actions to improve cooperation and collaboration between the Departments. This perception is consistent with the 2003 report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans and by numerous GAO reports. VA and DOD must take advantage of local successes by implementing lessons learned on a national level.

Let me be clear. There have been successes, and I congratulate the Departments on those areas where progress has been made. I hope that our witnesses today will help us understand what areas still require work. If there are particular areas where this Committee or Congress can be of help, I ask that you let us know.

I have a longer statement that I will place in the record, and that is available at the press table. In the interest of time and to allow others to speak, I will end my remarks at this time.

[The prepared statement of Senator Akaka follows:]

PREPARED STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Good morning and welcome to the Committee's first hearing for the 110th Congress. As I said at our organizational meeting, I look forward to working with our new and returning Members, and for this to be a productive session for our Committee.

Today's hearing will focus on the current level of cooperation and collaboration between the Department of Veterans Affairs and the Department of Defense. There has been strong Congressional interest, dating back to the 1980s, on improving how the two Departments work together and improving the transition process. We hope to hear from our witnesses today, where the two Departments are and where they need to be.

I thank Secretary Mansfield from VA and Secretary Chu from DOD for joining us today to testify on this important subject. It is my hope that their testimony will establish a benchmark for future hearings that will focus on specific health and benefits issues that relate to the two Departments.

It only makes sense that, where opportunities exist for sharing resources that benefit servicemembers and veterans, we take advantage of these opportunities. As a senior member of the Armed Services Committee, I have looked at the issue of seamless transition from the vantage point of the military, and now, as Chairman of this Committee, I will look at it from the VA perspective. Today, with thousands of servicemembers in harm's way, it is more important than ever that the Departments work together.

The issue of the Departments working together goes beyond the sharing of resources. It must also include efforts to facilitate the seamless transition of servicemembers from active duty to veterans status. There is no reason why servicemembers, prior to separation, do not know exactly what VA can do for them and how they can obtain the benefits and services available to them. Given the current worldwide involvement of the total force, I believe strongly that the message needs to be consistent and universally understood by all, regardless of whether they are separating from active duty, the Guard or Reserves. This is especially true for

those who are wounded or severely injured. I can only imagine the stress that a new veteran with a life altering wound or injury endures when faced with the challenge of transitioning from one health care system to another while still in the process of recovery and rehabilitation. I am sure it would be a daunting task under the best of circumstances. We need to ensure that the hand-off between the Departments for those who are in the greatest need is truly seamless. This is an area where we cannot improve enough.

According to the Office of Management and Budget, there has been slippage since 2002 in the progress of implementing coordination of VA and DOD Programs and Systems. This is deeply concerning. It appears to me that much of this slippage has resulted from a failure to identify who is responsible for implementing recommended actions that could result in improved levels of cooperation and collaboration between the Departments. This perception is consistent with the 2003 report of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans and by numerous GAO reports. In my view, the two Departments are not making enough progress on a national level. I believe that VA and DOD can take better advantage of local successes, by implementing them on a national level.

Let me be clear—there have been successes and I congratulate the Departments on those areas where progress has been made, including the degree to which the Departments share information, cooperate on transition issues, and deliver benefits and services.

I hope that our witnesses today will help us understand what areas that still require work, and provide us with their respective Departments' strategic plans on how they intend to improve the level of coordination and collaboration between the Departments and ensure that servicemembers truly have a seamless transition to VA. If there are particular areas where this Committee or the Congress can be of help, I ask that they let us know.

Chairman AKAKA. I would like to ask our Ranking Member, Senator Craig, for his remarks.

Senator Craig?

STATEMENT OF HON. LARRY E. CRAIG, RANKING MEMBER, U.S. SENATOR FROM IDAHO

Senator CRAIG. Well, Mr. Chairman, thank you very much, and also let me apologize for being late. That will not happen again. I always appreciate, as I know you do, getting these hearings started on time.

Let me also thank you for your lead-off on this very important issue. It is clearly something that we and the Nation must focus on to make sure that those who have served and are transitioning out receive the benefits and the kind of continued treatment needs that are important.

As you know, 2 years ago we held a series of hearings on this issue. The survivors' transition hearings revealed confusion among survivors about the array of Federal benefits and services available to them and inconsistent service provided by military casualty officers.

I am particularly interested in this issue, and I look forward to the hearing on the update today from DOD on the implementation of a uniform policy of casualty assistance that all of its service branches are using and whether the customized, integrated Web site on Federal survivor benefits is eliminating survivor confusion.

Next in the series, the Committee examined the health care transition process of seriously combat-wounded servicemembers. Many of these veterans were caught in the long-term limbo awaiting discharge from the military. We learned about the specific treatment challenges, such as early intervention for mental health care and outreach to those in need of family therapy services. I remain somewhat concerned that DOD's efforts to take care of its own are

making the coordination of care and benefits between DOD and VA more difficult.

Third, we held hearings on what steps VA, DOD, and the Department of Labor were taking to ease the transition process by providing veterans benefits such as disability compensation, vocational rehabilitation, and employment placement and training services. I hope to hear today that our returning servicemembers are being made aware of these benefits, that there is adequate follow-up to ensure a successful transition, and that seriously wounded combat servicemembers are being afforded some priority of service.

And, finally, we held a field hearing following the return from Iraq of 1,700 of my fellow Idahoans with the Army National Guard 116th Cavalry Brigade. These Guardsmen and reservists did not return to an Army base in Georgia or an Air Force base in Mountain Home, Idaho. Instead, as we all know, the Guard and Reserve units returned to their homes, and to civilian lives, in some respect, and to their regular job. I hope to hear today the update on how well we are doing in that regard in relation to the transition and where VA can step in at that point once they are out of active service and make available re-employment rights or assuring that those kinds of things continue to happen, as we will probably continue to need to use Guard and Reserve for the near future.

"Seamless transition," in my opinion, is a very broad term that encompasses efforts by a number of different agencies and programs, and even includes making immediately accessible the medical records of the servicemember who is transferred from military treatment facilities to veterans' medical centers. We are all proud of how the VA handles its medical records now. We need to make sure that there is a completion of process, that there are not shortcomings there as these two agencies work to make that happen.

So I am pleased that you led with this issue, Mr. Chairman. I think it is tremendously important to our servicemen and women as they transition into civilian life or as they move from one care for their injuries to another care.

Thank you very much.

Chairman AKAKA. Thank you very much, Senator Craig.

I would like to ask Jay Rockefeller for his statement.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Mr. Chairman, if I have your permission, I will put my statement into the record.

Chairman AKAKA. Thank you very much, Senator Rockefeller.

[The prepared statement of Senator Rockefeller follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Chairman Akaka and Ranking Member Craig, I want to thank you for your dedication and commitment to oversight and bipartisanship—both are enormously important. I look forward to working closely with you. We truly have a moral obligation to meet the needs of our veterans—both those returning from combat today, and our older veterans from previous eras.

The plans and reports on DOD/VA coordination and collaboration are important and vital. I appreciate your efforts to get the formal plans and agreements in place and underway.

But, as encouraging as the testimony is today, this is not what I hear when I talk privately with West Virginia soldiers at roundtables back home. It is not what my caseworkers hear from veterans and their families in calls to our office. I believe we are making a good start, but there must be the adequate funding commitments and top leadership to make the promises of collaboration work. A promise made to veterans must be kept.

We need to push harder to help our veterans with cooperation and coordination. Given the nature of the combat and the huge stress involved, we must improve our mental health services and our outreach for such services. I support the VA effort to expand both the staff and the number of Vet Centers to serve our veterans. I also want to work with Chairman Akaka to give our National Guard and Reservists 5 years of access to VA care, instead of the current 2 years.

Plus, we must take additional efforts to help our National Guard and Reservists who in recent years have been playing a bold and extraordinary role in our Armed Services. We need to recognize this and deal with unique challenges facing our Guard and Reserves, as well as their families.

Chairman AKAKA. At this time I would like to ask Senator Murray for her statement.

STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Chairman Akaka and Senator Craig, thank you very much for holding this hearing. This is exactly the type of oversight and accountability we need to have to make sure our servicemembers get the services they need when they come home. And as I can tell you, we have got a lot of work to do. From the veterans I have talked to, it is clear that we do not offer them a seamless transition from the battlefront to the homefront, and that has really got to change.

If we have a seamless transition, why are so many veterans coming home without jobs? Why are so many veterans unable to get housing? We have new reports out today that say that up to 1,000 veterans from Iraq and Afghanistan are homeless today. That is unacceptable.

If we have a seamless transition, why are veterans having to wait 6 months to see a VA doctor for primary care? Why are so many veterans having trouble getting help with PTSD? On Friday, in fact, our Army's top medical officer said that some returning troops are not getting the help they need, and to me that is unacceptable.

If we have a seamless transition, why are so many Guard and Reserve members unable to get help from the efforts like the Transition Assistance Program? Why are our Vet Centers overwhelmed with veterans seeking help? Why do our veterans have to wait 2½ months to see a mental health care professional when they return from combat?

We do not need a hearing to discover if we have a seamless transition. I know that we do not. And we do not need this hearing to find out if the Pentagon and the VA are working together enough. I do not think they are. We do need to use this hearing to find out from our witnesses what they are doing about it and how they are going to fix it.

And I can tell you one thing: The veterans I talk to do not really care about Washington, DC, talk. They care about the reality they see in my State and across the Nation, whether they can get a job, whether they can get health care, whether they can get the benefits they need. And that should be the test we all use.

If we do want to make progress, Mr. Chairman, I think we need to understand how we got here so we can change course. How did we get to a point where, 4 years into this war, we have a 2-year backlog for VA benefits, mental health care that is inaccessible, and long lines to see a VA doctor? We had better understand how we got here so that we do not make the same mistakes moving forward.

Mr. Chairman, the first problem is that the Bush Administration did a miserable job planning for the aftermath of the war. The failures we have seen in the planning on the military side are mirrored by failures of planning on the VA side. We all know that the VA has some of the best employees in the world, and we are very proud of the work they do. But for too long, we have had a VA leadership that has not done an adequate job planning for the many veterans this war is creating, and the VA is still woefully behind in its projections.

Last year, the VA planned to see 110,000 veterans from Iraq and Afghanistan. It ended up seeing more than 185,000. For this year, the VA projects to see 109,000 veterans, fewer than they saw last year. That does not make sense. We need an accurate plan from the VA that spells out the real needs and how the VA intends to meet those needs.

The second problem is that the Bush Administration has never made a commitment to fund veterans' health care as an essential part of the cost of war. This war is being paid for by supplementals, but those supplementals do not include funding for veterans' health care. Funding for veterans' health care has gone up, but it is still not tied to the real needs. We need to get the VA and the White House to match the funding to what the real needs are so our veterans are not left behind.

And the third problem, Mr. Chairman, is that we have not been able to get straight answers or real numbers out of the VA. The GAO has found in report after report that VA has misled Congress, concealed funding problems, and based its projections on inaccurate models. That has to change because our veterans are paying the price.

With all due respect to our witnesses, other officials from your agencies have sat at that very same table and assured us that everything was fine, when it certainly was not. I was assured many times that the VA had the funding it needed, only to learn later that the VA had a $3 billion shortfall and the agency had falsified budget savings over many years.

So, today, Mr. Chairman, I hope we hear from Dr. Chu and Mr. Mansfield that you realize that there are serious problems on the ground and that you are committed to solving them.

We are having this hearing at a very critical moment. The President has proposed escalating our military involvement in Iraq. Just 4 days ago, the VA Secretary told the *Houston Chronicle* that sending more than 20,000 troops into Iraq will not have an impact on the VA's backlog of claims. Secretary Nicholson described the impact of the surge on the VA as "minimal."

Well, I stood here in the Senate with nine veterans last week from the Iraq war, and they had a much different picture of that. They believe that the President's escalation will further degrade

our ability to care for our veterans. Today, without the surge, veterans are waiting for the services that they have been promised. If we are not meeting the veterans' needs of today, how can we keep the promise to troops who are sent to an escalated war?

Tonight the President is going to deliver his State of the Union speech. During last year's speech, the President did not mention the word "veteran" once. I hope tonight finally he does talk about our veterans and acknowledges that our VA is overwhelmed and underfunded and outlines his plans for meeting our troops' needs when they return home.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator Brown?

STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman. Thank you for the work that you and Senator Craig have done on behalf of the 25 million veterans in this country. And, Senator Murray, thank you for your very poignant statement and what you have done for veterans in your State and in this country.

There are more than a million veterans in my State of Ohio. When I am out talking to veterans, I hear several themes stand out: one, barriers to health care and long-term care; two, claims that languish for months, as Senator Murray said, without response; three, inadequate job and educational opportunities; and, four, unfair cuts in widow and other survivor benefits.

In addition to these critical concerns, this Committee, as we have talked, Mr. Chairman, needs to pay attention to problems facing those veterans who may not come to our offices or who may not write us letters or whom we may not see as we are home in our States—those who are homeless, those who are in physical and emotional crises after sustaining a debilitating injury, those who are struggling with severe mental illness. Our Committee should spearhead efforts to fully fund the VA health care system to enhance VA mental health care and to abolish the disabled veterans tax which cuts pensions for those on disability pay.

We should work to enhance educational and housing opportunities for veterans, as envisioned in the G.I. Bill for the 21st century. We should push for tax cuts for businesses who continue to pay servicemembers serving extended tours, and we should work to ensure that Reservists and Guardsmen can enroll their families in the TRICARE program on an affordable basis.

We should advocate on behalf of widows and survivors and repeal the military families tax which reduces survivor benefits for family members of those who die of service-related injuries.

Understanding we are working under daunting budget constraints and against a host of competing Federal priorities, but our Nation has made a promise to provide key benefits and service to veterans, and no priority overrides our obligations to fulfill that promise.

Last week, I visited injured soldiers from my State at Bethesda. One of them has a pretty certain future, one of the soldiers I visited. One Marine has a pretty uncertain future, suffering from

head injury. I am not at all confident, once he leaves Bethesda, that our military and our VA will track him well enough to be able to anticipate what problems his head injury may lead to as he tries to go back to work, as he tries to live a normal life.

I am hopeful that our witnesses today can give all of us the confidence that the VA is really prepared, as this war escalates, as more troops come home with psychological and physical illnesses and injuries, that they will be ready to take care of the people to whom we have an obligation once they return to their homes.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Brown.

Senator Sanders?

STATEMENT OF HON. BERNARD SANDERS, U.S. SENATOR FROM VERMONT

Senator SANDERS. Thank you, Mr. Chairman, and I will be brief, because there is not much that I can add to what Senator Murray and Senator Brown and others have said.

When I was first elected to the Congress 16 years ago in the House, one of the things that I did was hold town meetings, many town meetings around the State of Vermont in order to inform veterans of the benefits to which they were entitled to. And the reason I did that is because we found that many, many, many thousands of veterans simply did not know the benefits to which they were entitled to such as the prescription drug program. And as a result of that, thousands of veterans entered into the VA system.

Mr. Chairman, if we go to war, I think what we have to understand is that the cost of war does not stop the day that the war ends. The cost of war stops when the last veteran stops needing the benefits and the help that they should receive as a result of their service to this country.

And let me pick up on the point that Senator Murray made, and let's be very blunt about it. We had a major problem in the VA before the Iraq war began. Before the Iraq war began, in my State and all over this country there were very long waiting lists for veterans to get into the VA system.

Now, how could that be? How could people who have put their lives on the line defending this country have to wait month after month after month to get the health care that they need? How could it happen that the Bush Administration, in order to save money, would throw hundreds of thousands of Category 8 veterans off of VA benefits entirely so that a 90-year-old veteran who calls my office who served in World War II cannot get into the VA because he is "too wealthy," earning more than $27,000 a year?

Mr. Chairman, let me go on record as saying that that is a national disgrace.

So we start off with a VA system which is inadequate to deal with the veterans from World War II, Korea, and Vietnam. And then, lo and behold, we have the war in Iraq—22,000 veterans are wounded, almost half of them seriously. And then we learn from various studies that the impact of post-traumatic stress disorder is going to be worse from the Iraq war than it was in Vietnam.

If anybody thinks that we have the resources to adequately deal with veterans who are coming back from Iraq plus all of our older veterans, they are sorely, sorely misunderstanding the situation.

And, Mr. Chairman, I hope very much and I intend to do everything that I can with you and with my colleagues to make sure that the Bush Administration, instead of giving tax breaks to billionaires, starts adequately funding the VA so we do not continue to have the disgraceful situation that we currently do.

Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Sanders.

I would like to ask for the testimony of our witnesses, and I would like for our witnesses to summarize their testimony so that we can move on with the questions. We are delighted to have you here. May I first call on the Honorable Gordon H. Mansfield, Deputy Secretary of Veterans Affairs.

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

Mr. MANSFIELD. Thank you, Mr. Chairman, and thank you, Members of the Committee. Before I start my testimony, I would like to make a statement.

When I hear words like "misled," when I hear words like "concealed" and words like "failed to deliver," it bothers me not just professionally but personally. And I would make a commitment to this body, to the Chairman and the Members, that if you have information on things like this, please contact me and I will guarantee you that I will follow up on that and make sure that nobody gets misled, nothing is concealed, and that we do not fail to deliver on issues.

There is no doubt in my mind what the status of this agency is vis-a-vis the Congress of the United States, which authorizes the laws that we follow up on and appropriates the dollars that we are given to carry out those missions, and, therefore, obviously, has the right for oversight and information. So I would just like to make that as a first statement, that I would commit to you that if you have information on that, please contact me, and I will follow up on it. And I will guarantee you that Secretary Nicholson feels the same way about these issues.

I am pleased to be here to present testimony. I am also pleased to be here with Dr. David Chu, my partner in leading the Joint Executive Council and, in effect, getting the two largest bureaucracies in the United States Government—DOD and VA—to come together and work together. Looking back, I think I can truly say that we are doing a much better job of taking care of DOD troops who will be veterans.

In the area of seamless transition, in the big picture we have moved forward in the TAP and DTAP briefing areas. We are also making sure that we get letters from Secretary Nicholson out to all servicemembers who are leaving the Service to thank them and give them a snapshot on what benefits they are entitled to, and give them information on how to proceed to get that. We also have people overseas, and even we have had folks located on Navy ships returning from deployments to give them briefings in an attempt to bring this information to them.

In the smaller, more defined seamless transition area, we have an Office of Seamless Transition, which is really devoted specifically to those troops who have been severely injured and in military treatment facility system. We have VA social workers, VA benefit workers, and others on-site in MTFs like Walter Reed or Bethesda or around the country, and they are working to make sure that the transition from those facilities to the VA facility is handled appropriately and to make sure we take care of all the needs of, not only the veteran, but the veteran's family.

We also have new outreach that we are doing, based on the fact that we have National Guard and Reserve troops coming back from the combat area. We now have MOUs or MOAs with the State Adjutant Generals to plan for and do briefings for servicemembers returning. And I can tell you, as I go around the country visiting VA regional offices where our benefits people are, or VA medical facilities where our health care providers are, I talk to our people. And everywhere I go, I know that these are folks who are spending weekends and nights going out to armories and other places in an effort to deal with National Guard troops and Reserve troops in an effort to make sure that we get them the information that they need.

Also, we have Benefits Delivery at Discharge efforts at approximately 140 sites and efforts to get the departing servicemembers scheduled for information briefings so that they can get the information they need for their benefits on record and into the system before they leave the system. Also, we get the medical service records then, and we have a better chance of doing that, and also getting the medical exams completed so that we can get a decision for these folks in a reasonable time frame. We have also consolidated these BDD sites so that two sites—one at Winston-Salem and one at Salt Lake City—are concentrating on doing these issues.

In the medical records area, which I know is of concern to the Committee, I would have to admit that there have been ups and downs. The latest JEC initiative from a year ago provided for a uniform data repository for DOD which the three services' medical Departments would feed into, and then VA could use that as a source for information we needed for either health care or benefits issues. I would leave the explanation of the AHLTA efforts that have taken place within DOD to Dr. Chu, I am sure he would want to talk about them.

We also have four or five Bidirectional Health Initiative pilots working under the FIP program that is funded by the JEC. Later on today Secretary Nicholson, Secretary Leavitt, and Assistant Secretary Winkenwerder from DOD will be making a joint announcement on the most important initiative in this area, and that will be at the American Health Information Council, chaired by Secretary Leavitt, a meeting that is taking place at the VA today. And this will be a move toward a single-record system which will be accessible and usable by both VA and DOD.

In the JEC arena, since 2003 we have moved forward, and I think that we have done an excellent job in the planning arena. The current plan institutionalizes our collaborative efforts across a diverse range of health care and benefits. The broad-based areas

include clinical practice guidelines in managing care, and that is both DOD and VA practitioners getting involved to develop these guidelines; in the mental health arena, specifically with PTSD; patient safety practices; in deployment health and research; in contingency planning; in financial management that addresses VA and DOD billing and reimbursement issues; in joint facility utilization, which I will talk about later; information management and information technology; in the pharmacy area; in medical materiel acquisition and procurement; in VA/DOD shared high-technology medical contracts; in shared continuing medical education and training opportunities; and also in benefits delivery.

I think one of our signature successes has been in joint facility utilization. For example, at the North Chicago VA Medical Center, which is side-by-side with the Navy training facility in North Chicago, there was previously a VA medical center and a DOD hospital right across the fence from each other, probably about a mile apart or half a mile apart. We have gone forward in a joint effort that is a pilot, and the final stage is that the VA medical center stays in business. We have added surgical suites and an emergency room to that facility, which is usable by both the VA community and the Navy community. And we are in the process of designing and building an outpatient ambulatory facility that we will have a groundbreaking for later on this spring. That ambulatory facility will be right next to the VA.

Chairman AKAKA. Mr. Mansfield, if you could wrap up.

Mr. MANSFIELD. We will then have a functionally integrated Federal health care facility that will be staffed by employees of both agencies with a single command-and-control structure. In this case, we will have a VA director of the medical facility and a Navy director of the facility.

The other area I want to comment on——

Chairman AKAKA. Mr. Mansfield, will you please wrap up as soon as you can?

Mr. MANSFIELD. I will leave it there.

Senator ROCKEFELLER. Mr. Chairman, if I can be bold and slightly unkind, this is like every other presentation made by any Government agencies that I have ever heard in 23 years here. It is all cleared by OMB. You have said absolutely nothing, except yielding on one point where there might be a problem, except good news. You are telling us all the good things that are happening, whether they are or not, you are telling them to us. If you listened to us at all, we were not interested in that. We were interested in what is happening to suicides, to mental health, to PTSD, to speed of cure and care, and all of those things. You are simply not addressing them, and I would prefer that you just not finish your statement or that David Chu not give his statement if that is going to be the approach to us, because that is totally unresponsive to the Committee, it is totally unresponsive to the veteran, and it is a farce that I am long since sick of.

Chairman AKAKA. Mr. Mansfield, would you——

Mr. MANSFIELD. I have completed my statement, Mr. Chairman.

[The prepared statement of Mr. Mansfield follows:]

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

Mr. Chairman and distinguished Members of the Committee, I am pleased to be here today to discuss the progress made by the Department of Veterans Affairs (VA) and the Department of Defense (DOD) toward improving the delivery of health care and benefits to our Nation's veterans.

Our two Departments understand that we are responsible for the same people, only at different times of their lives. We agree that we must leverage every opportunity to improve their transition from military to civilian life. And, as a result, we have cemented a relationship that works smarter in our separate but related missions. Our reinforced partnership cuts across a range of difficult issues and has reduced many of the problems encountered by previous generations of veterans.

I am pleased to provide an overview of the groundbreaking programs and pioneering initiatives VA and DOD have implemented to improve coordination between our two systems as we deliver our programs, services, and benefits.

VA/DOD JOINT EXECUTIVE COUNCIL AND STRATEGIC PLAN

First and foremost in our alliance is our Joint Executive Council (JEC). Established 4 years ago, the Council is the nexus for senior leadership management of communication, coordination, and resource sharing between VA and DOD. Today, the Council continues to direct appropriate resources and expertise to specific operational areas through its two sub-councils, the Health Executive Council and the Benefits Executive Council.

The Council's Strategic Plan is the primary means by which we advance and measure our performance and our progress. It provides a solid framework for achieving specific goals in delivering services and benefits to servicemembers and veterans alike.

The current Plan institutionalizes our collaborative efforts across a diverse range of health care and benefits. These broad-based areas include:

(1) Clinical practice guidelines in managing care for overweight and obese patients;

(2) Mental health;

(3) Patient safety practices;

(4) Deployment health and research, to include surveillance and planning activities related to depleted uranium exposure and pandemic flu;

(5) Contingency planning, as outlined in a VA–DOD Memorandum of Understanding for health care delivery during war or national emergency;

(6) Financial management that addresses VA–DOD billing and reimbursement issues;

(7) Joint facility utilization;

(8) Information management and information technology;

(9) Pharmacy;

(10) Medical materiel acquisition and procurement in new VA–DOD shared high-technology medical contracts;

(11) Shared continuing education and training opportunities; and

(12) Benefits delivery.

The Strategic Plan has materially strengthened the capability of both Departments to better serve our beneficiaries. It fosters an unprecedented level of cooperation between VA and DOD as we work to remove institutional barriers and address operational challenges. The Plan represents a quantum leap in our joint ability to improve service and access for veterans, servicemembers, military retirees, and eligible dependents.

SEAMLESS TRANSITION OF CARE AND BENEFITS

VA's efforts on behalf of veterans begins early on. Our Benefits at Discharge Program enables active duty members to register for VA health care and to file for benefits prior to separation from active service. Our outreach network ensures returning servicemembers receive full information about VA benefits and services. Each of our medical centers and benefits offices now has a point of contact assigned to work with veterans returning from service in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Many servicemembers are enrolled in the VA system even before discharge.

The staff of the Veterans Health Administration (VHA) has coordinated the transfer of over 6,700 injured or ill active duty servicemembers and veterans from DOD to VA. We hold as our highest priority those returning from the Global War on Ter-

ror and transitioning directly from DOD Military Treatment Facilities (MTFs) to VA Medical Centers (VAMCs).

In partnership with DOD, VA has implemented a number of strategies to provide timely, appropriate, and seamless transition services to the most seriously injured OEF/OIF active duty servicemembers and veterans.

VA social workers, benefits counselors, and outreach coordinators advise and explain the full array of VA services and benefits. These employees assist active duty servicemembers as they transfer to VA medical facilities from MTFs. In addition, our social workers help newly wounded soldiers, sailors, airmen and Marines and their families plan a future course of treatment for their injuries after they return home. Currently, VA Social Work and Benefit liaisons are located at 10 MTFs, including Walter Reed Army Medical Center (WRAMC), the National Naval Medical Center Bethesda (NNMC), the Naval Medical Center San Diego, and Womack Army Medical Center at Ft. Bragg.

A VA Certified Rehabilitation Registered Nurse (CCRN) is now assigned to WRAMC to assess and provide regular updates to our Polytrauma Rehabilitation Centers (PRC) regarding the medical condition of incoming patients. The CCRN advises and assists families and prepares active duty servicemembers for transition to VA and the rehabilitation phase of their recovery.

Upon notification of the Veterans Health Administration (VHA), VA's Social Worker Liaisons and the CCRN fully coordinate care and information prior to a patient's transfer to our Department. Social Worker Liaisons meet with patients and/or families to advise and "talk them through" the transition process. They register servicemembers or enroll recently discharged veterans in the VA health care system, and coordinate their transfer to the most appropriate VA facility for the medical services needed, or to the facility closest to their home.

In the case of polytrauma patient transfers, both the CCRN and the Social Worker Liaison are an integral part of the MTF treatment team. They simultaneously provide input into the VA health care plan and collaborate with both the patient and family throughout the entire health care transition process.

Case management for these patients begins at the time of transition from the MTF and continues as their medical and psychological needs dictate. Once the patient transfers to the receiving VAMC, or reports to his or her home VAMC for care, the VA Social Worker Liaison at the MTF continues to coordinate with VA to address after-transfer issues of care. Patients suffering severe injuries, or those with complex needs, receive ongoing case management at the VA facility where they receive the predominance of their care.

One important aspect of coordination between DOD and VA prior to a patient's transfer to VA is access to clinical information. This includes a pre-transfer review of electronic medical information via remote access capabilities. Video teleconference calls are routinely conducted between DOD MTF treatment teams and receiving VA PRC teams. If feasible, the patient and family attend these video teleconferences to participate in discussions and to "meet" the VA PRC team.

The Bidirectional Health Information Exchange (BHIE) allows VA and DOD clinicians to share text-based clinical data in a number of sites, including WRAMC and NNMC, the two MTFs that refer the majority of polytrauma patients to VA.

In addition to health care, Veterans Benefits Administration (VBA) counselors assigned to MTFs provide benefits information and assistance to servicemembers applying for these benefits. These counselors are often the first VA representatives to meet with servicemembers and their families and provide information about VA's full range of services, to include readjustment programs as well as educational and housing benefits.

Counselors assist servicemembers in completing claims and in gathering supporting evidence. While servicemembers are hospitalized, they are routinely informed of the status of their pending claims and given their counselor's name and contact information should they have follow-on questions or concerns. For servicemembers who are seriously disabled in OEF/OIF, compensation claims are expedited to the appropriate VA Regional Office (VARO) with a clear indication that they involve OEF/OIF claimants.

For a period of 2 years following separation from active duty, all veterans who served in combat locations are eligible for free health care services for conditions potentially related to combat service. These veterans can access VA health care, even those who have no service-connected disability. Veterans who enroll continue to be eligible for medical care after this 2-year window. This enrollment "window" applies to regular active-duty personnel who served in Iraq or Afghanistan, as well as Reserve or National Guard members who served in combat theaters.

Each VAMC and VARO has a designated point of contact (POC) to coordinate activities locally and to ensure the health care and benefits needs of returning

servicemembers and veterans are fully met. VA has distributed specific guidance to field staff to ensure that the roles and functions of the POCs and case managers are fully understood, and that proper coordination of benefits and services occurs at the local level.

In March 2005, the Army assigned full time active duty liaison officers to VA's four Polytrauma Rehabilitation Centers located at Tampa, FL; Richmond, VA; Minneapolis, MN; and Palo Alto, CA. The Army Liaison Officers support military personnel and their families from all Service branches by addressing a broad array of issues, such as travel, housing, military pay, and movement of household goods.

In addition, Marine Corps representatives from nearby local Commands visit and provide support to each of the Polytrauma Rehabilitation Centers. At VA Central Office in Washington, DC, an active duty Marine Officer and an Army Wounded Warrior representative are assigned to the Office of Seamless Transition. All DOD liaisons play a vital role in providing a wide bridge of services during the critical time of patient recovery and rehabilitation.

VA understands the critical importance of supporting families during the tumultuous time of transition. We established a Polytrauma Call Center to assist the families of our most seriously injured combat veterans and servicemembers. Initiated in February 2006, the Call Center operates 24 hours-a-day, 7 days-a-week to answer clinical, administrative, and benefit inquiries from polytrauma patients and family members. The Center's value is threefold. It furnishes patients and their families with a one-stop source of information; it enhances overall coordination of care; and, very importantly, it immediately elevates any system problems to VA for resolution.

VA's mission is to deliver 21st century care to 21st century combat veterans. We are meeting our mandate through the life-saving and life-shaping medicine in our health care arsenal.

VA OUTREACH

Office of Seamless Transition

The Office of Seamless Transition is the lynchpin in VA's outreach efforts. Two Outreach Coordinators one a peer-support volunteer and a veteran of the Vietnam War regularly visit seriously injured servicemembers at WRAMC and NNMC Bethesda. Their visits have established a uniquely personal and trusted connection with patients and their families. Our Outreach Coordinators offer support and encouragement as patients travel the often "rough and tough" roads of rehabilitation. These individuals help identify gaps in VA services by submitting and tracking follow-up recommendations. They encourage patients to consider participating in VA's National Rehabilitation Special Events or to attend weekly dinners held in Washington, DC, for injured OEF/OIF returnees. They are first-responders in helping our injured servicemembers come to a renewed belief in themselves and in their future. In short, they are key to enhancing and advancing the successful transition of our service personnel from DOD to VA, and, in turn, to their homes and communities.

The National Guard and Reserve

VA has developed a vigorous outreach, education, and awareness program for the National Guard and Reserve. To ensure coordinated transition services and benefits, a Memorandum of Agreement (MOA) was signed with the National Guard in May 2005. Combined with VA/National Guard State Coalitions in 54 states and territories, VA has significantly improved its opportunities to access returning troops and their families. We are continuing to partner with community organizations and other local resources to enhance the delivery of VA services.

At the national level, MOAs are under development with both the United States Army Reserve and the United States Marine Corps. These new partnerships will increase awareness of, and access to, VA services and benefits during the demobilization process and as service personnel return to their local communities.

Post Deployment Health Reassessment

VA is also reaching out to returning veterans whose wounds may be less apparent. VA is a participant in the DOD's Post Deployment Health Reassessment (PDHRA) program. In addition to DOD's pre- and post-deployment assessments, DOD now conducts a health reassessment 90–180 days after return from deployment to identify health issues that can surface weeks or months after servicemembers return home.

VA actively participates in the administration of PDHRA at Reserve and Guard locations in a number of ways. We provide information about VA care and benefits; enroll interested Reservists and Guardsmen in the VA health care system; and arrange appointments for referred servicemembers. As of December 2006, an estimated 52,000 servicemembers were screened, resulting in over 13,900 referrals to

VA. Of those referrals, 32.5 percent were for mental health and readjustment issues; the remaining 67.5 percent for physical health issues.

Outreach Readjustment Counseling

Congress created the Readjustment Counseling Service (RCS), commonly known to veterans as the Vet Center Program, as the outreach element in VA's Veterans Health Administration. Program eligibility was originally targeted to Vietnam veterans; however, it now serves all returning combat veterans. The program is the undisputed "gold standard" in veterans' satisfaction (98 percent), employee satisfaction, and across other measurable indicators of quality and effective care.

The program helped form the basis for the President's New Freedom Commission on Mental Health. It is recognized as a National model for outreach and readjustment services, and emulated by other countries in their efforts to ease the readjustment of combat veterans to civilian life.

The approximate number of OEF/OIF combat veterans served by Vet Centers to date is 180,000. The Secretary of Veterans Affairs approved the hire of 100 additional OEF/OIF combat veterans to support the Program by reaching out to active, National Guard, and Reserve veterans returning from Southwest Asia. This single action advanced the continuing success of our Vet Centers in their ability to assist our newest veterans and their families. VA Vet Centers have provided bereavement services to the families of over 900 fallen warriors.

VA plans to expand its Vet Center Program. We will open 15 new Vet Centers and 8 new Vet Center outstations at locations throughout the Nation by the end of 2008. At that time, Vet Centers will total 232. We expect to add staff to 61 existing facilities to augment the services they provide. Seven of the 23 new centers will open during Calendar Year 2007.

POLYTRAUMA/TRAUMATIC BRAIN INJURY

VA Clinical Reminders for Mild Traumatic Brain Injury (TBI)

Veterans and active duty servicemembers with TBI recognized at the time of injury receive state-of-the-art, highly specialized care at both DOD and VA TBI Centers. However, less severe injuries may not become evident until military personnel return home to the care of their community physicians, DOD, or VA medical centers. Prompt diagnosis is often complicated by the fact that many who sustain mild brain injury do not recall the trauma that caused it. As a result, some patients with symptoms seemingly unrelated to mild TBI, such as headaches, sleep disturbances and depression, may go undiagnosed.

To assist clinicians in the diagnosis of mild TBI, the VA Chief of Patient Care Services stood up the Traumatic Brain Injury Clinical Reminder Work Group to develop clinical reminders to identify possible TBI in OEF/OIF veterans.

Membership is multidisciplinary and includes representatives from physical medicine and rehabilitation services, mental health, primary care, neurology, information technology, occupational and environmental health, as well as operations and management. The project's scope encompasses development of a screening instrument, appropriate follow-up for potential positive screens, and integration with VHA Health Information Systems to support system-wide implementation.

TBI Education

To ensure that all VA health care providers are well prepared to recognize brain injury sequelae, clinical management, and treatment approaches, VA's Under Secretary for Health has mandated a 4–hour continuing education course on Traumatic Brain Injury, to be completed by March 31, 2007.

VA/DOD Memorandum of Agreement

VA and DOD have in operation a longstanding MOA regarding referral of active duty military personnel who sustain spinal cord injury, TBI, or blindness to VA medical facilities for health care and rehabilitation. The MOA facilitates transfer of personnel to VA facilities that specialize in care and rehabilitation of these conditions. Effective January 1, 2007, the Assistant Secretary for Health Affairs, Department of Defense and the Acting Under Secretary for Health, Department of Veterans Affairs, renewed this MOA in support of VA/DOD resource sharing.

MENTAL HEALTH ISSUES

In Fiscal Years (FY) 2005 and 2006, VA increased funding of new and enhanced mental health programs for OEF/OIF veterans and others with Post Traumatic Stress Disorder (PTSD). VA will do so again in Fiscal Year 2007 to better meet the clinical needs of all veterans.

Additional funding initiatives are targeted to increase the mental health capacities of Community Based Outpatient Clinics and enhance telemental health capabilities in rural areas. VA's goal is to make mental health services more accessible for all we serve.

In Fiscal Year 2007, VA will fund enhanced integration of Mental Health and Primary Care services to increase our ability to provide veterans with comprehensive health care. Given the possible reluctance of some veterans to disclose emotional problems, increased mental health capacity in primary care will allow veterans to receive mental health services without actually going to an identified mental health clinic.

In Fiscal Year 2006, under the auspices of specialized and general mental health programs, VA treated 345,713 veterans with a clinical diagnosis of PTSD. This represents an increase of 27,099 individuals over Fiscal Year 2005. Of those treated in Fiscal Year 2006, 241,884 (70 percent) had a primary diagnosis of PTSD.

VA's health care system features more than 200 specialized VAMC-based PTSD programs. Every VA medical center now has specialty PTSD capability. There are over 80 VAMC-based OEF/OIF programs operating in collaboration with specialized PTSD programs, general mental health clinics, and primary care facilities. Staff training to support these programs has been developed in collaboration with DOD counterparts at the U.S. Army and U.S. Marine Corps.

Since the beginning of the OEF/OIF conflict, VA medical centers have seen nearly 34,000 veterans with a possible diagnosis of PTSD, i.e., veterans who received a PTSD diagnosis from a health care provider on at least one occasion. There has been an increase of 17,827 new provisional diagnoses of PTSD in Fiscal Year 2006.

Since hostilities began, more than 23,000 veterans received a provisional diagnosis of a depressive disorder, and 7,800 were provisionally diagnosed with alcohol or drug dependence.

VA/DOD INFORMATION SHARING

VA and DOD have made significant progress in the development of interoperable health technologies that support seamless transition from active duty to veteran status. Advances include the successful one-way and bidirectional transmission of electronic medical records between DOD and VA, and the adoption and implementation of data standards which support interoperability.

VA and DOD information sharing successes have resulted directly from implementation of the DOD/VA Joint Electronic Health Records Interoperability (JEHRI) Plan. JEHRI is a comprehensive strategy to develop collaborative technologies and interoperable data repositories, as well as adoption of common data standards.

The DOD/VA Health Executive Council, co-chaired by VA's Under Secretary for Health and DOD's Assistant Secretary of Defense for Health Affairs, manages the day-to-day implementation activities of JEHRI.

DOD and VA began implementation of the JEHRI Plan in 2002 with successful execution of the Federal Health Information Exchange (FHIE). Since then, FHIE has supported the secure one-way transmission of DOD electronic medical records to a shared repository, where records reside for review by clinicians treating veterans at VA hospitals and clinics. These same records are also available to VA claims examiners, who access FHIE data through an interface with the VBA Compensation and Pension Records Interchange (CAPRI). VA presently has access to FHIE data for more than 3.6 million unique beneficiaries.

FHIE also supports the one-way transmission of pre- and post-deployment health assessment data from DOD to VA. The Departments have recently begun the transmission and viewing of post-deployment health reassessments (PDHRA) to (1) monitor the overall health condition of troops; (2) inform them of potential health risks; and (3) work to benefit the overall health of servicemembers and veterans.

In 2004, VA and DOD leveraged FHIE technologies to develop the capability to support the real-time bidirectional exchange of electronic medical records. By using the Bidirectional Health Information Exchange, VA and DOD clinicians share text-based clinical data between medical facilities where patients (who receive care from both systems) are seen. BHIE also supports the real-time bidirectional exchange of outpatient pharmacy data, anatomic pathology/surgical reports, cytology results, microbiology results, chemistry and hematology laboratory results, laboratory order information, radiology text reports, and food and drug allergy information.

BHIE data from every VA site are available at select DOD sites where BHIE is installed. DOD is continuing to install BHIE, and system implementation has been completed at 21 major sites. These include facilities where large numbers of OEF/OIF servicemembers are seen, such as Walter Reed Army Medical Center and the

National Naval Medical Center Bethesda, the Landstuhl Regional Medical Center in Germany, and the Naval Medical Center San Diego.

As mentioned, JEHRI is a comprehensive strategy for sharing data. Where BHIE supports the bidirectional sharing of health data between legacy systems, JEHRI takes into account that both DOD and VA are modernizing their health information systems. The next phase of JEHRI, the Clinical Health Data Repository (CHDR), provides a means for VA and DOD to develop an interface between the DOD Clinical Data Repository (CDR) of DOD's AHLTA system and the VA Health Data Repository (HDR) of the next-generation VistA system, known as Health*e*Vet.

Through CHDR, DOD and VA have the groundbreaking ability to share computable data between next-generation systems featuring automatic decision support for clinicians, e.g., drug-drug and drug-allergy interaction checks. DOD and VA currently use this interface between the William Beaumont Army Medical Center and the El Paso VA Healthcare System to support care of shared patients as well as at Augusta, Georgia, and Pensacola, Florida, locations. VA and DOD are working to expand the types of clinical data available through CHDR, specifically laboratory data.

Our Departments are also collaborating on an interface between CHDR and BHIE to accelerate bidirectional data sharing and make it available at all sites of care, not solely at select DOD BHIE sites. The CHDR–BHIE Interface will make the same data elements currently in BHIE available to VA from all 138 DOD locations where AHLTA and the CDR are deployed. VA and DOD also are planning to make additional data from AHLTA available to VA, such as provider notes, procedures, and problem lists.

In addition to FHIE, BHIE and CHDR, VA and DOD have successfully developed a number of other applications that support information sharing, improve care, and support seamless transition. For example, the jointly developed Laboratory Data Sharing Interoperability (LDSI) software permits VA and DOD to serve as reference laboratories for one another. This typically occurs at locations where VA and DOD use each other's facilities to order and conduct chemistry laboratory tests and results reporting.

Our two Departments are also working to expand VA access to DOD inpatient documentation, particularly for severely wounded and injured servicemembers being transferred to VA for care. An early version of this electronic capability is currently in use between Madigan Army Medical Center and the VA Puget Sound Health Care System, where inpatient discharge summaries are exchanged.

The Departments also are cooperating to modernize imaging systems using shared technologies and to transfer improved scanned images of paper-based medical records. Both these efforts will help to ensure VA has access to significant inpatient data, especially for severely injured servicemembers about to transfer to VA for care and treatment.

VA has been widely recognized for its outstanding electronic health record. With this sharing of expertise, the two Departments will work on this initiative to benefit servicemembers and veterans, and the entire Nation as we move toward electronic medical records.

VistA, the VA electronic health record, supports ambulatory care plus a segmentable but integrated inpatient care capability. VA is planning to modernize VistA, including its inpatient module. We believe that this is an opportunity to explore a "born seamless" approach for a joint inpatient electronic health record.

It is likely that much of DOD and VA inpatient healthcare data, processes and requirements are similar. But there are some known differences. For example, the VA has no requirement for theater inpatient care and DOD does not provide long-term domiciliary care.

The analysis will identify the areas of commonality and the areas of uniqueness. This project will document and assess DOD and VA inpatient clinical processes, workflows, and requirements, determine the benefits and impacts on each Department's timelines and costs for deploying a common inpatient electronic health record solution and develop the business case analysis for alternative approaches.

Center for the Intrepid: The National Armed Forces Physical Rehabilitation Center

For the past year, the Department has been actively engaged with the Department of the Army and the Intrepid Fallen Heroes Foundation on operational plans for the Center for the Intrepid—a 65,000 square foot, state-of-the-art rehabilitation facility at Brooke Army Medical Center, Fort Sam Houston.

When the Center is dedicated on January 29, 2007, seven VHA and two VBA staff members will be working side-by-side with Army colleagues to provide the best possible rehabilitative services to severely injured servicemembers and veterans. VHA will provide physical therapy, occupational therapy, prosthetics services, social work

case management, and seamless transition liaison services. VBA will offer information and education about benefits and vocational rehabilitation services, and provide assistance with benefits claims.

We envision that the Center will provide educational and research opportunities that will better prepare VA staff for assisting our Nation's newest generation of veterans.

The North Chicago VA Medical Center/Naval Health Clinic Great Lakes Initiative

On October 17, 2005, I co-signed an MOA with the Assistant Secretary of Defense for Health Affairs that represents a historic collaboration between VA and DOD. Our joint effort "raises the bar" in standards of economy, efficiency, and management. The North Chicago VA Medical Center (NCVAMC) and the Naval Hospital Great Lakes are fully sharing all health services in one facility at North Chicago to provide all needed care to each other's beneficiaries.

The North Chicago initiative called for full modernization of NCVAMC's surgical and emergency/urgent care facilities and for VA to provide health care services to the Navy's beneficiary population treated at Great Lakes. The Naval Hospital Great Lakes was re-commissioned as the Naval Health Clinic Great Lakes. In 2006, NCVAMC began providing the Navy's beneficiary population in that area all of its emergency, surgical, and inpatient care.

The scheduled groundbreaking ceremony for the Federal Ambulatory Care Center is Spring 2007. Our working groups are continuing to develop detailed operational plans for its activation in 2010.

CLOSING

Mr. Chairman, I believe our efforts and progress speak to a new era of cooperation between the Department of Veterans Affairs and the Department of Defense. The strides we have made toward transparent and seamless transition have been recognized by both the Inspector General and the Government Accountability Office.

We have forged new ties and cast a revitalized, more productive relationship. We are working smarter to carry out our separate but related missions. We are better coordinating our overlapping infrastructure and services. We are striving to ensure more efficient use of taxpayer dollars. And we are continuing to seek out potential opportunities for partnership.

Our Departments are singularly committed to the men and women we both serve. They are our highest priority.

President Lincoln once said, "The struggle of today is not altogether for today it is for a vast future also."

Our greatest challenge, and our greatest opportunity, is to build systems that meet the needs of veterans and DOD beneficiaries for *today* and *tomorrow*. We will continue to persevere toward that goal.

Mr. Chairman, this concludes my statement. I thank you and Members of this Committee for your outstanding and continued support of our servicemembers, veterans, and their families.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA

Question 1. In July 2006, the VA Office of the Inspector General (OIG) issued a report on the "Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans After Traumatic Brain Injury Rehabilitation." The VA OIG identified problems with respect to VA and DOD coordination and collaboration that impacted the timeliness and access to rehabilitative services for servicemembers with TBI who remain on active duty status after completing their inpatient rehabilitative care at VA. What is VA doing to improve case management for veterans with traumatic brain injuries?

Response: Case management is a critical function designed to ensure lifelong coordination of services for patients with polytrauma and traumatic brain injury (TBI), and is an integral part of the system at each polytrauma care site. The polytrauma system of care (PSC) uses a proactive case management model, which requires maintaining routine contacts with veterans and their families to coordinate services and to address emerging needs. As an individual moves from one level of care to another, the case manager at the referring facility is responsible for a "warm hand off" of care to the case manager at the receiving facility closer to the veteran's home. The assigned case manager handles the continuum of care and care coordination, acts as the point of contact for emerging medical, psychosocial, or rehabilitation problems, and provides patient and family advocacy.

A polytrauma telehealth network has been established linking the four regional TBI/polytrauma rehabilitation centers and their respective network sites. This technology is an additional resource to the Department of Veterans Affairs (VA) TBI/polytrauma clinicians for patient care coordination and family support closer to home.

VHA is currently recruiting to hire 100 new transition patient advocates to assist severely injured Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans. These new transition patient advocates will serve as the liaison for veterans and their families, helping them to communicate their needs to the VHA health care team and addressing their problems and concerns. Each transition patient advocate will be assigned to work with 25–30 severely injured OEF/OIF veterans and will follow those veterans across episodes and sites of care, beginning at the point their care is transitioned from the Military Treatment Facility to a VHA health care facility. Transition patient advocates will work collaboratively with the veteran's health care team, particularly with the nurse and social worker case managers. VHA anticipates filling these positions expeditiously.

Question 2. I am encouraged by VA's implementation of its Seamless Transition Performance Measure, which monitors the transfer of injured veterans from DOD to VA facilities. As I understand it, this measure was fully implemented in early October 2006. What can you report as to its effectiveness? As a percentage, how many veterans are being contacted by a VA case manager within 7 days of VA receiving notification of their transfer from DOD?

Response: In October 2006, VA implemented a seamless transition performance measure to ensure that every severely ill/injured servicemember or veteran who is transferred from a Department of Defense (DOD) military treatment facility (MTF) to any VA healthcare facility has a case manager assigned to him or her at the receiving facility before arriving at that facility. The receiving facility has 7 calendar days after notification of transfer in which to assign a case manager to the servicemember or veteran and to call him or her to facilitate the transfer. Between October 10, 2006 and January 17, 2007, 72 severely ill or injured patients were transferred from DOD MTFs to VA healthcare facilities. During this time period, 65 (90.3 percent) of these patients were assigned a VA case manager within the 7 day standard. For the 7 cases that did not meet the performance measure, 3 exceeded the 7-day time frame to contact the patients but case managers have been assigned. For the other 4 patients, case managers have also been assigned but have been unable to contact the patients.

Question 3. To what extent have efforts been made to coordinate with the Department of Labor to assist returning servicemembers in finding meaningful employment in a timely fashion? What employment related efforts have VA made on its own accord?

Response: VA's Vocational Rehabilitation & Employment (VR&E) service and the Department of Labor's Veterans' Employment and Training Service (VETS) updated their existing memorandum of understanding (MOU) in October of 2005. VR&E and VETS adopted a team approach to job development and placement activities to improve vocational outcomes for vocational rehabilitation program participants. All veterans entering a program of vocational rehabilitation are informed of the employment assistance available through the VETS program and are encouraged to register with the State workforce agency.

The successful readjustment of disabled veterans into the civilian workforce is the mutual responsibility and concern of VA's VR&E service and the Department of Labor, VETS. Combining the services of the disabled veteran outreach program (DVOP) specialists, local veteran's employment representatives (LVER), and VR&E staff maximizes the employment services available to disabled veterans and increases the opportunities for successful placements. Both agencies are committed to working together to improve successful employment outcomes for our Nation's veterans.

Regional offices (RO) have MOUs with their State workforce agencies, which define their referral processes. Generally, the VR&E counselor provides a personal introduction to the veteran when the DVOP specialist/LVER is co-located with the VR&E. A referral form is completed and forwarded to the DVOP specialist/LVER when the DVOP specialist/LVER is not co-located.

There are 71 DVOP specialists/LVERs at 38 VA offices. Having the DVOP specialist/LVER onsite enhances the teamwork between the two agencies. Whether a DVOP specialist/LVER is co-located at a VR&E or not, these VETS employees assist VR&E staff with the following tasks:

(1) Participate in the orientation to the VR&E program.

(2) Provide initial labor market information during evaluation and planning phase.
(3) Provide "survival employment" (not necessarily "suitable employment") to the veteran to supplement finances while the veteran is receiving training/vocational services under the VR&E program.
(4) Monitor/staff the job resource labs and assist veterans with job seeking activities.
(5) Assist with locating supportive services (human service organizations) in the community when assistance outside the parameters of the VR&E program is needed.
(6) Assist veterans in obtaining and maintaining employment by providing job development and placement services.
(7) Serve as a referral source for employment services when a veteran is not eligible for the VR&E program.
(8) Provide wage information and placement data.

VA's VR&E program provides veterans with service-connected disabilities a wide range of employment assistance including, formal education needed for employment, on-the-job training, apprenticeships, and internships to meet their individual career goals. VR&E implemented the Five Tracks to Employment Process, which includes job resource labs, Web-based information resources (*http;//www.VetSuccess.gov*) and a standardized orientation. VR&E also stationed 72 employment coordinators (ECs) at ROs across the country. The primary function of the EC is to provide veterans with disabilities any necessary job readiness skills prior to and including job referral/placement. This network of ECs works closely with local employment resources, including the DVOP specialists and LVERs at the State workforce agencies. The ECs also support the Five Tracks to Employment Process.

VR&E service continually seeks out and initiates new partnerships with employers and education/training institutions to meet the needs of injured returning servicemembers. Some of the recent initiatives launched by VR&E to meet the unique employment and rehabilitation needs of returning servicemembers are:

- Faith-based community initiative (FBCI), which focuses on improving veterans' employment opportunities in the nonprofit sector.
- Lockheed Martin's new supply chain management apprenticeship program.
- Federal Aviation Administration's (FAA) new agreement to train veterans at the FAA Academy in air traffic control and as airway facilities specialists.
- Federal non-paid work experience (NPWE) programs with Federal, State, and local government agencies as part of the coming home to work program.
- Veterans Health Administration's (VHA) prosthetic representative trainee program.
- Improvements to the early outreach effort by VA to inform veterans/servicemembers of their VA benefits.

Question 4. VA is in the process of moving from a decentralized to a centralized organizational structure for its Information Technology Program with IT funding and responsibility for systems development moving to the Department's Chief Information Officer. Has the realignment impacted the initiative to develop the interface between VA and DOD's health data repositories?

Response: Centralization of information technology (IT) authority under the Chief Information Officer will enhance significantly the ability of the Department to advance VA–DOD collaboration. With the central authority, VA can now assure that resources and schedules are coordinated among all stakeholders so that there is an even stronger programmatic foundation for interdepartmental collaboration for IT initiatives.

The VA CIO is committed to advancing VA–DOD collaboration; is aligned with VA strategic plan as well as VA–DOD Joint strategic plan; and supports both information interoperability to enhance service to veterans and joint development initiatives to reduce cost and time to market for new IT products.

Question 5. What measures does VA have in place to protect the personally identifiable information that is being maintained in its health data repository and how is VA securing the transfer of personally identifiable information to DOD?

Response: Personally identifiable information maintained in the health data repository (HDR) is controlled through the standard Veterans health information systems and technology architecture (VistA) legacy security controls, which includes authentication using standard access and verification codes, and user access is controlled using Kernel security's option and menu management and security keys. HDR completed certification and accreditation requirements per National Institute of Standards and Technology (NIST) and received authority to operate in August 2006.

HDR does not transfer any data to DOD; that is accomplished through the Clinical/Health Data Repository (CHDR) system. Medical information data exchange for patients that are using both VA and DOD health care is done via machine-to-machine exchange, which does not involve end users. Data transmission is accomplished using a virtual private network (VPN) two-way communication channel that is compliant with DOD security standards.

Question 6. The 2003 Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) recommended that the Administration direct HHS to declare the two Departments to be a single health care system for purposes of implementing HIPAA regulations. How did VA and DOD respond to the recommendation? How have the HIPAA requirements impacted your health information exchange efforts?

Response: VA's response to the President's Task Force (PTF) to Improve Health Care Delivery of Our Nation's Veterans indicated VA's agreement with the intentions of reducing data sharing impediments between the agencies. VA, however, maintained its belief that there are sufficient authorities within the Health Insurance Portability and Accountability Act (HIPAA) legislation to allow sharing of protected health information without becoming one single entity.

In general, the HIPAA privacy final rule prohibits the nonconsensual disclosure of protected health information (PHI). This rule, however, includes a special exemption pertaining to DOD's sharing data with VA. This exception, 45CFR 164.512(k)(1)(ii), allows DOD to "disclose to Department of Veterans Affairs (DVA) the protected health information of an individual who is a member of the Armed Forces upon the separation or discharge of the individual from military service for the purpose of a determination by DVA of the individual's eligibility for or entitlement to benefits under laws administered by the Secretary of Veterans Affairs." In addition, there are several other authorities provided in the privacy rule that allow DOD and VA to share IIHI, including treatment purposes for which no patient authorization is required, pursuant to a signed authorization from the patient and other authorities that allow the covered functions in both organizations to share PHI for various other purposes. VA and DOD HIPAA, privacy and general counsel staffs worked diligently to resolve any differences in interpretation of these authorities. In the end, DOD and VA were able to implement a data-sharing MOU that outlines these agreed-upon authorities.

The HIPAA privacy rule has not impacted VA's health information exchange efforts as ample authority exists under this rule for the exchange of health information both with DOD and private and public health care providers.

Question 7. I understand that VA maintains eight full-time and two part-time VA/DOD liaison positions at DOD hospitals. How were the DOD facilities selected and does VA plan to expand this program in Fiscal Year 2007 and beyond?

Response: VA currently has nine full-time and three part-time VA/DOD Liaisons stationed at 10 MTFs located throughout the United States. Two new sites were added in 2006—Naval Medical Center, San Diego and Womack Army Medical Center, Fort Bragg, NC. DOD facilities were selected based on their workload of returning Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans. VA continues to monitor the volume of returning veterans and will expand the program as needed.

Question 8. In 2003, the PTF recommended that, there should be a mandatory physical exam for all separating servicemembers. I understand that currently a separation physical is only mandatory for those who are retiring. Do you believe that a separation physical should be mandatory for all personnel leaving the military?

Response: We defer to DOD for details on their requirements of physical examinations for all separating servicemembers; however, we understand that all active duty members are provided with periodic health assessments. Individuals retiring from active duty or those returning from deployment and leaving service receive separation physicals. All other separating members are given a health screening questionnaire to determine whether a follow-up assessment is needed.

Question 9. For VA and DOD, the Joint Executive Council Strategic Plan is the primary way by which you advance and measure performance and progress. What specific measures are in place to evaluate the effectiveness of your efforts?

Response: The VA/DOD Joint Strategic Plan for Fiscal Year (FY) 2007–2009 has 34 specific performance measures in place to evaluate the effectiveness of the Joint Executive Council (JEC). Measures are linked to six broad goals:

(1) Leadership commitment and accountability;
(2) High quality health care;
(3) Seamless coordination of benefits;
(4) Integrated information sharing;

(5) Efficiency of operations; and
(6) Joint medical contingency/readiness capabilities.

While some measures are single event milestones, 17 are outcome measures designed to promote progress over time. Future strategic plans will include mostly outcome oriented measures.

Two examples of performance outcome measures in the current Joint Strategic Plan are provided for the Health Executive and the Benefits Executive Councils (HEC/BEC).

1. HEC, Graduate Medical Education Working Group, will examine opportunities for greater VA/DOD collaboration and with implementation of four initiatives the expected result will lead to a 50 percent increase in the number of military trainees applying for positions in VA-affiliated residency programs within 2 years.
2. BEC will oversee an increase in the percent of original claims filed within the first year of release from active duty at a BDD site (prior to a servicemembers discharge) achieving 57 percent in Fiscal Year 2007; 61 percent in Fiscal Year 2008; and 66 percent in Fiscal Year 2009.

Progress is monitored at quarterly meetings of the JEC. Results achieved are presented in the JEC Annual Report to Congress.

The President's Management Agenda is a joint initiative that is focused on activities intended to institutionalize increased sharing and coordination between DOD and VA. The Proud To Be (PTB) and President's Management Scorecard are a focused subset of initiatives that are managed through the Joint Executive Council (JEC). OMB provides oversight for the PTB and scorecard documents.

Specifically, the PTB has identified two strategic areas of focus intended to indicate the institutionalization of processes related to information technology (IT) and process changes to overcome technical and administrative barriers.

The specific strategic areas in each subset are:

1. Use of Information Technology to Institutionalize Processes

Health IT

1. Real-Time Bi-Directional Electronic Patient Medical Records
2. Consolidated Health Informatics

Benefits IT

1. VA/DOD Military Personnel Data Sharing
2. Process Changes to Overcome Administrative Barriers.

Structure

1. Establish National Defense Authorization Act 2003 Pilot Projects
2. Cooperative Separation Process/Exam

People

1. Develop Joint Graduate Medical Education (GME) Pilot Program
2. Increase non-GME Training and Education Sharing

Procurement

1. Joint Purchasing of Non-Drug Medical Supplies and Equipment

Question 10. I understand that VA's Overseas Military Services Coordinators are only available in Europe for 9 months a year and that they are stretched too thin, with only 2 persons covering all of Europe at any given time. Is this a function of funding or a perceived lack of need, and what can be done to improve overseas transition assistance?

Response: VA's overseas military services program was implemented in 1994 under a memorandum of agreement with DOD. Under this agreement, VA provides overseas military service coordinators, and DOD provides logistical support and travel funding. Since the beginning of the program, coverage has been less than 12 months; however, VA is extending this coverage in Fiscal Year 2008. Beginning Fiscal Year 2007, VA will be funding the travel cost for the program, estimated at $489,000 for Fiscal Year 2007.

The number of coordinators serving overseas has continued to increase. During Fiscal Year 2006, 7 coordinators were assigned to Europe and Asia for 9 months. In addition, Korea is covered on a full-time basis by veterans service representatives assigned to our BDD site at Yongsan Army Base. Approximately 500 benefits briefings were conducted by our overseas coordinators and attended by about 12,000 active duty personnel and family members. The coordinators personally interviewed over 3,000 individuals in conjunction with these briefings. Seven overseas coordinators will provide services from mid-January until the end of September 2007, and will be assigned as follows: two in Germany, who also serve Belgium and the Neth-

erlands; one in England, who also serves Bahrain; one in Italy, who also serves Spain and Portugal; two in Japan; and one in Okinawa. VA benefits briefings will be conducted at about 70 overseas military facilities.

Effective in Fiscal Year 2008, VA will provide coverage 12 months a year with 7 counselors covering the locations outlined above.

Question 11. In September 2005, DOD issued a policy memo to the Services Secretaries directing them to provide VA with the names of servicemembers entering DOD's Physical Evaluation Board process. I understand that in May 2006, this initiative was put on hold because of DOD concerns about data security compliance. Why was the initiative put on hold and what is its current status? Are there any issues related to the May 2006 VA data theft that have affected VA's and DOD's ability to share data?

Response: From October 2005 through May 2006, DOD was e-mailing a list of servicemembers entering DOD's physical evaluation board (PEB) process via a password-protected Excel spreadsheet. In May 2006, VA asked DOD to cease sending the list in this manner, as it didn't meet VA's heightened security requirements. Transmission of the data was halted until VA and DOD could implement a secure method of transmitting the data between Departments. Currently VA and DOD are evaluating transmitting the data electronically via a Federal Information Processing Standards (FIPS) 140–2 compliant secure file transfer protocol (FTP) server or one of the existing VA/DOD data feeds, such as the Federal Health Information Exchange (FHIE).

Additional factors have delayed the use of the PEB data. In conjunction with addressing the secure transfer, VA staff has been addressing PEB file quality issues that vary widely with each file and are therefore, difficult to mitigate. Further, the VA data incident in May 2006 created significant delays and disruption in the data exchange and process.

DOD has suggested that they will seek a way to automate the collection of the PEB list. DOD made extra efforts to make this data available to VA for outreach; however, due to the issues noted, the use has been limited thus far.

Question 12. In May 2005, VA and the National Guard signed a memorandum of agreement that formalized a partnership between the National Guard Bureau and VA to enhance the ability for VA to have access to troops, and brief returning servicemembers and their family members. Please describe the impact of this agreement. Also, please describe how VA is working with the other Reserve components.

Response: In order to support better communication between the National Guard Bureau (NGB) and VA, a MOA was developed between VA and NGB to institutionalize this partnership. The national MOA between VA and the NGB was signed in May 2005 outlining how the two organizations would work together to identify and solve problems, and collaborate to improve communication and information flow about VA healthcare/benefits for Guard and Reserve members.

On December 8, 2005, a letter and copy of that agreement was sent to all RO directors as well as Veterans Integrated Service Network (VISN) directors and VA medical center (VAMC) directors. The letter outlined how each RO director and VISN/VAMC director should begin to work with the National Guard to develop a similar local MOA with related state and local services and organizations. The purpose of this effort was to develop regional and local partnerships between VA leadership, National Guard Adjutants General, and State directors of Veterans Affairs and community agencies to enhance access and services for returning veterans and to integrate the delivery of services for VA benefits and healthcare services through the development of state coalitions.

In late 2005, the NGB hired 54 National Guard transition assistance advisors (TAAs) (formerly called State benefits advisors)—one for each of the 50 states and 4 territories. With the expansion of their role, additional TAAs have been hired for Texas and California. The total number of TAAs is 57.

The primary function of the TAA is to serve as the statewide point of contact and coordinator, to facilitate education and awareness for Guard and Reserve members and their families on VA benefits and services, and to assist in resolving access issues for VA healthcare, benefits, and TRICARE. VA hosted the first training conference in February 2006 on VA healthcare services, Veterans Benefit Administration (VBA), National Cemetery Administration (NCA) and TRICARE. The goal of this partnership between VA and National Guard is to educate all Guard members and their families on VA benefits and to assist with access to VA benefits and services. While the program was primarily set up to take care of Guard members and their families, TAAs provide critical support and facilitate the integration of VA and community services to *all* members of the active, Guard and Reserve components returning home to the State.

VA has implemented a robust outreach program with VA staff participating in family day events, reunions, freedom salute and drill weekends with PDHRA screening events. These events provide opportune time for VA staff to provide one-on-one consultation to soldiers requesting information on VA services/benefits.

TAAs assist National Guard and Reserve members with access to care and enrollment at VA healthcare facilities near their home of record. Additionally, they work with other Joint Forces Headquarters staff members and directors of State family programs to build a State coalition of support with VA and community organizations for Guard members and their families to access in their local community.

Additionally, the TAAs were charged with working locally to develop and maintain State coalitions to tie together the resources of DOD, VA and NGB and State and local community resources in an effort to ensure Guard and Reserve members and their families receive the benefits and support when they return home. The State coalition provides a community-based support network of VA, State and community resources to assist Guard and Reserve members at the local level.

As of December 2006, there were 25 signed local VA/NGB MOAs and another 21 states reported that they were in the process of developing a local MOA in 2007.

An MOA is currently in the final phases of development with the Army Reserve that will further support effective joint work and sharing to serve Army Reserve component soldiers returning home. Plans are in process for MOAs with the USMC, Navy and Air Force similar to those MOAs developed with the National Guard and Army Reserve.

In February 2007, VA again participated in the training for the TAAs in Phoenix, Arizona, in partnership with the National Guard family programs. This joint conference provided networking with the NGB State family programs to support the special needs of returning troops and families when spouses are deployed or returning home.

With the strong support for families and existing infrastructure within the NGB, one of the best methods of working with the Reserve components has been using the TAAs as a primary point of contact for both the returning Guard and Reserve personnel. Many TAAs work directly with the Marine, Navy and Coast Guard units in their State.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV

Question 1. Overall Funding Issues. Whenever I can, I try to host a roundtable in West Virginia to talk to newly returned soldiers, including National Guard and Reservists. I learn a great deal from these heroes. I fully support the goals of DOD and VA in improving the transition, and many of the policies sound good. But when I talk to West Virginia veterans, I do not hear about these policies, I hear about problems getting care and delays in service.

Question 1(a). What is the level of new funding committed to these important policies? What are top officials in DOD and VA doing to train staff and deliver on the good intentions and commitments?

Response: VA has wide range of training and educational programs to ensure that VA clinicians and administrative staff have the tools they need to respond to the unique and sometimes complex healthcare needs of returning combat veterans. Our existing training and education initiatives include:

VETERANS HEALTH ADMINISTRATION

Tools for points of contact (POC), case managers and other front line staff:

- VHA published three Directives in 2006 clearly stating VA's expectations regarding returning OEF/OIF veterans. The three directives cover case management of OEF/OIF veterans, the PEB process, and the PDHRA program.
- VHA communicates policies, guidance and tools to assist front line employees via the seamless transition Intranet Web site.
- VHA hosts a monthly conference call for the VISN OEF/OIF POCs to discuss issues relating to OEF/OIF veterans.
- VHA maintains two e-mail groups: one for VISN POCs and one for VAMC POCs and case managers to facilitate dissemination of information on OEF/OIF veterans and discussion of issues relating to OEF/OIF veterans.
- VHA trained over 260 VAMC POCs and case managers to use the MTF tracking system (MTF2VA), which tracks servicemembers transitioning from MTF to VAMCs. The training also included VHA's expectation on the seamless transition performance measure.
- VHA developed and distributed outreach toolkits to assist VA staff participating in National Guard and Reserve outreach programs as well as PDHRA events.

• VHA in partnership with employee education service (EES) implemented an awareness campaign to educate VA employees on the seamless transition process. The awareness campaign kits, distributed in October 2006, contained EES brochures containing a list of educational products geared toward treating OEF/OIF veterans, seamless transition brochures, handout cards depicting the transition process and a video showing transition from the battlefield to VA to the community.

Tools for VA healthcare providers:

• VA and DOD developed clinical practice guidelines to assist clinicians treating combat veterans.

• "A Guide to Gulf War Veterans Health" was originally on health care for combat veterans from the 1991 Gulf War. The product, written for clinicians, veterans and their families, remains very relevant for OEF and OIF combat veterans as many of the hazardous exposures are the same.

• "Endemic Infectious Diseases of Southwest Asia" provides information for health care providers about the infectious disease risks in Southwest Asia, particularly in Afghanistan and Iraq. The emphasis is on diseases not typically seen in North America.

• "Health Effects from Chemical, Biological and Radiological Weapons" was developed to improve recognition of health issues related to chemical, biological and radiological weapons and agents.

• "Military Sexual Trauma" was developed to improve recognitions and treatment of health problems related to military sexual trauma, including sexual assault and harassment.

• "We are Women Veterans" provides a personal view of the military experience of women.

• "Post-Traumatic Stress Disorder: Implications for Primary Care" is an introduction to post traumatic stress disorder (PTSD) diagnosis, treatment, referrals, support and education, as well as awareness and understanding of veterans who suffer from this illness.

• "Traumatic Amputation and Prosthetics" includes information about patients who experience traumatic amputation during military service, their rehabilitation, primary and long-term care, prosthetic, clinical and administrative issues.

• "Traumatic Brain Injury" presents an overview of TBI issues that primary care practitioners may encounter when providing care to veterans and active duty military personnel.

• All are available in print, electronic format, and on the Web at *http://www.va.gov/VHI*.

Taken as a whole, these programs add up to a rigorous, thorough and systematic education and training program to ensure VA staff are knowledgeable about the programs and policies in place as well as the tools to assist them in providing care and services to OEF/OIF veterans. In the June 2006 the Government Accountability Office (GAO) report, GAO complimented VA's numerous educational activities and online clinical tools to ensure VA medical providers and other staff are aware of and recognize the healthcare needs of OEF/OIF servicemembers and veterans.

VETERANS BENEFIT ADMINISTRATION

We are currently increasing staffing levels to reduce the pending claims inventory and providing the level of service expected by the American people. We began aggressively hiring additional staff in Fiscal Year 2006, increasing our on-board strength by over 580 employees between January 2006 and January 2007.

It is critical that our employees receive the essential guidance, materials, and tools to meet the ever-changing and increasingly complex demands of their decisionmaking responsibilities. To that end, VBA has deployed new training tools and centralized training programs that support accurate and consistent decisionmaking.

New hires receive comprehensive training and a consistent foundation in claims processing principles through a national centralized training program called "Challenge." After the initial centralized training, employees follow a national standardized training curriculum (full lesson plans, handouts, student guides, instructor guides, and slides for classroom instruction) available to all regional offices. Standardized computer-based tools have been developed for training decisionmakers (69 modules completed and an additional 8 in development). Training letters and satellite broadcasts on the proper approach to rating complex issues are provided to the field stations. In addition, a mandatory cycle of training for all Veterans Service Center employees has been developed consisting of an 80-hour annual curriculum.

Our plan is to continue to accelerate hiring and fund additional training programs for new staff this fiscal year. However, because it requires an average of 2 or 3 years for our decisionmakers to become fully productive, increased staffing levels do not

produce immediate production improvements. Performance improvements from increased staffing are more evident in the second and third years. We have therefore also increased overtime funding this year and recruited retired claims processors to return to work as reemployed annuitants in order to increase decision output.

Since the onset of the combat operations in Iraq and Afghanistan, VA has provided expedited and case-managed services for all seriously injured OEF/OIF veterans and their families. This individualized service begins at the military medical facilities where the injured servicemembers return for treatment, and continues as these servicemembers are medically separated and enter the VA medical care and benefits systems. VA assigns special benefits counselors, social workers, and case managers to work with these servicemembers and their families throughout the transition to VA care and benefits systems, and to ensure expedited delivery of all benefits.

The Secretary of Veterans Affairs recently announced a new initiative to provide priority processing of all OEF/OIF veterans' disability claims. This will allow all the brave men and women returning from the OEF/OIF theatres who were not seriously injured in combat, but who nevertheless have a disability incurred or aggravated during their military service, to enter the VA system and begin receiving disability benefits as soon as possible after separation.

Question 1(b). Will DOD and VA be seeking additional funding to meet the health care needs of our returning veterans?

Response: For Fiscal Year 2007, VA will have the funding it needs to support the health care needs of our returning veterans and all veterans seeking care.

Question 2. Mental Health and Suicide. Last year, I cosponsored legislation with Senator Harkin and others to address the tragedy of suicides among our returning veterans. There have been too many tragedies, including ones in Iowa and West Virginia.

Question 2(a). I realize that OMB prevents direct comments on legislation, but we all know that mental health care is an enormous need given the overwhelming stress of serving in Iraq and Afghanistan. We know there is a stigma about seeking mental health care. Some estimate that only 26 percent of veterans get formal mental health care.

Response: VHA is implementing a comprehensive program to prevent veteran suicides that is analogous in many respects to the programs proposed in both the House and Senate. It includes initiatives to further enhance the capacity, access and quality of overall mental health programs as well as activities that directly focus on suicide prevention. One of the major components will be funding for suicide prevention coordinators in each medical center as of the third quarter of Fiscal Year 2007.

Question 2(b). GAO says that $100 million of VA funding for mental health went unspent. This is wrong. Why aren't we doing more on mental health care, and particularly suicide prevention and awareness?

Response: When GAO stated that VA funding for mental health went unspent, they were referring to delayed spending of approximately $86 million of $200 million that was available to enhance mental health services last year. This figure represents 3.6 percent of the total $2.4 billion spent for mental health services last year. It represented a slowed rate of enhancement, not a decrease in services. The delay was related to education, training, and both program and staff development activities that were necessary to ensure that funds, when spent, would be used effectively and efficiently to improve care. For Fiscal Year 2007, VHA is allocating $306 million to enhance mental health programs, with still more increases projected for Fiscal Year 2008.

Question 3. Timely Access to Care for National Guard and Reservists. I have heard from West Virginia National Guard personnel of several instances in which the standards you established in your October 2003 policy regarding timely access to care have not been met for Guard soldiers returning to the civilian world from deployment in Iraq and Afghanistan. It appears that the major injuries are usually taken care of prior to discharge from active duty, but then after they return home, the soldiers slip through the cracks for care recommended by their doctors for less critical combat injuries.

Question 3(a). What are you doing to ensure that these combat veterans receive all of the care that they need and that their doctors have recommended, and that they receive it on a timely basis? Have you established an effective quality control system?

Response: All Guard/Reserve soldiers, sailors, airmen and Marines separating from active duty to continued Reserve status or to civilian status have the oppor-

tunity to attend the transition assistance program (TAP) briefings at each of the demobilization sites. In this program they first learn about VA healthcare services (and how to enroll in care), VA benefits and how to file for disability claims with VA. This is the first opportunity to learn about healthcare services, the 2 years of eligibility for VA healthcare (also 180 days of continued TRICARE healthcare) and 90 days to receive dental care at VA. While still at the demobilization station, all servicemembers while on active duty complete the PDHA and they are also given the opportunity to see a DOD healthcare provider for care prior to leaving the demobilization station for home and being separated from active duty.

Once the veteran is home, they schedule a VA primary care clinic appointment after enrolling in VHA care and will in most cases receive a VA appointment within 30 days for evaluation of their deployment-related condition. While they attend the clinic appointment, a series of screening exams are performed such as for PTSD, depression, alcohol abuse, military sexual trauma, etc. Additional referrals are made for specialty care as the primary care provider requests follow-up of any medical condition which has been identified in the screening or physical examination. These times for receiving primary care appointments are tracked as national performance measures to ensure that Guard/Reserve members receive the care that they need in a timely manner and for all the conditions that have been caused or aggravated through their combat deployment.

An additional program that offers screening for physical/mental health conditions occurs at the unit or use of a call center for screening exams for lingering mental health/physical conditions that are experienced at 90–180 days when they return home. This is a coordinated effort between VA and DOD (specifically the Guard/Army Reserve) to offer a screening exam and schedule appointments to VA, TRICARE or private physicians for further evaluation of these deployment-related conditions. VA staff members are present at the unit to accept referrals and schedule appointments to the local VA for follow-up evaluation for any physical or mental health condition. Again, Guard/Reserve members will receive appointments for primary care within 30 days and Vet Centers. Guard/Reserve members may choose to visit a civilian provider through TRICARE or use their private insurance from their civilian employer.

Question 3(b). Is there an appeal or grievance process through the Veterans Affairs system?

Response: For healthcare services, each VAMC has a patient advocate to assist with complaints for care or issues concerning eligibility. At each VAMC there is also an OEF/OIF coordinator who is an ombudsman for the Guard/Reserve or active duty servicemember requesting healthcare. Since many of the Guard/Reserve members are new to VA, they are frequently escorted to the eligibility clerk at the VAMC who will begin the enrollment process and facilitate appointments.

Question 3(c). What can be done to meet the health insurance needs of our medically retired National Guard members and their families?

Response: The medically retired veteran will continue to receive healthcare at the local VAMC and Vet Center for the condition of their disability as well as other conditions that may appear later. These members may also be eligible for DOD benefits; however, we defer to DOD for additional information.

Question 4. Information Sharing. What can be done to facilitate a more efficient flow of communication between military medical facilities, to include Community Based Health Care Organization (CBHCO) and Military Treatment Facilities (MTF), and the individual state Adjutant General when an injured soldier transitions from one duty status to another?

(From the National Guard's point of view, there should be a point of contact clearly identified or established at every military medical facility, including CBHCOs and MTFs, who would be responsible for notifying the soldier's Adjutant General when the soldier is admitted, discharged or transported to another facility. The Adjutant General would then assure the delivery of transitional benefits access and counseling to include Veterans Affairs healthcare options, TRICARE programs that may be available, VA benefits counseling such as home loan guarantee, education benefits, and or vocational rehabilitation services.)

Response: Each of the 10 MTFs where the large number of severely injured servicemembers receive their initial care, have VA/DOD liaisons and VBA counselors embedded with DOD staff to facilitate the transition from DOD to VA to the community. Case managers in Medical Holdover and the eight community based healthcare organizations (CBHCO) are activated Guard Nurses who notify the Adjutant General or the J–1 staff in each State about the health and transition status of the active duty servicemembers in these programs. The TAAs in each State work for the Adjutant General and are trained by VA experts to assist the State director

of Veterans Affairs in notification of returning servicemembers to the State. They coordinate with the J–1 staff in the State for updates of those returning servicemembers/veterans back to the State. They also help to facilitate the briefings to returning soldiers to ensure that they receive Federal and State veterans benefits when they transition from active duty to veteran status. The TAAs work collaboratively with the State family program directors to provide VA information to them for their retiring spouse.

The Adjutant General, TAA and J–1 staffs assure access and counseling on transitional benefits to include VA healthcare options, TRICARE options, VA benefits such as home loan guarantee, education benefits, and vocational rehabilitation services. State directors of Veterans Affairs, county service officers, veterans' service officers as well as VA staff from the hospital and regional office participate in the PDHRA events to provide outreach information to new veterans.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BARACK OBAMA

Question 1. Electronic Health Records. As part of last October's Defense Authorization Bill, Congress required a report on the feasibility of providing each servicemember with a secure electronic copy of their health and service records. I was hoping you could discuss the importance of the DD214 form to veterans applying for benefits and healthcare and the potential advantages of giving veterans more specific data about their service and medical histories through an individual electronic health record.

Response: VA and DOD have made significant progress in sharing electronic health information and lead the Nation in sharing electronic health data between two large medical enterprises. Veterans' benefits claims adjudicators have electronic access to the DD214 by using the VA personnel information exchange system to connect to the Defense personnel records retrieval system portal to the official military personnel files maintained by the services. The DD214 is a part of that official military personnel file and is an essential document for all veterans when they apply for VA benefits

Veterans also have increasing access to their own medical information and other important health data through My Health*e*Vet (MHV). VA has currently deployed MHV as the eHealth portal and personal health record (PHR) for veterans and VA employees. MHV continues to release new iterations, and now includes a robust self-entered PHR, Internet prescription refill capability, and targeted clinical health information for conditions and healthy living. Participants can enter information about their health, conditions, medications, and care providers in one secure electronic eVAult; track health readings (e.g., blood pressure and blood sugar); keep health journals (e.g., food and activity journals); and print out summaries for their various health care providers. In December 2006, VA launched the second generation of the PHR. Veterans who receive care in the VA system may now choose to upgrade their account by undergoing a face-to-face authentication at an authorized VA care facility. They then can elect to receive more identifiable health information from VA's VistA electronic health records, such as their appointments, medication names and laboratory results. The rollout of this VistA electronic health records information to MHV PHR is expected to take place over the coming year, and will include training for clinicians and patients, as specified by the VA clinical and patient education community. The use of information technology to improve the Veteran experience is a high priority. VA is actively working to help lead the Nation into a future of patient-centered health information.

Question 2. Aggregate Health Data. I am concerned that the military is not giving VA enough concrete data to help them conduct long-term planning. Let's take mental health as an example. The Army's Mental Health Advisory Team found that soldiers who deployed to Iraq for a second time were more likely to suffer mental health problems. Absent that data, what kind of data is VA using to anticipate the demand for mental health care? Did VA anticipate that 36 percent of Iraq/Afghanistan veterans entering the VA would require mental health treatment?

Response: In additional to available data to project current demand for mental health services from servicemembers from OEF/OIF, VA looks at historical medical treatment trends from past periods of war. VA also considers capacity needs to meet that demand by conducting reviews of literature, past VA and DOD epidemiological studies, and utilization records. Based on our reviews, we anticipated that a proportion of OEF/OIF veterans would require mental health services.

VA anticipated that 36 percent of OEF/OIF veterans entering VA would require mental health treatment based on review of the research conducted since the time of the Vietnam War, which found that increasing exposure to war zone stressors can

result in an increase in vulnerability to PTSD and associated mental and emotional problems. Data from various studies of veterans of previous wars suggested that overall, the rate of mental problems can be in the range of 15–26 percent, or higher in certain populations exposed to extreme stress such as prisoners of war. That the number of veterans coming to VHA has a rate of mental problems in the 30 percent range has been evident since we began tracking the utilization rates for VHA services for returning OEF/OIF veterans in Fiscal Year 2002.

Question 3. Falling through the Cracks. In an average year, 10,000 to 20,000 servicemembers are separated from the military through the Medical Evaluation Board and Physical Evaluation Board Process. These are soldiers who, because of a physical or mental health problem, are unfit to be deployed.

Question 3(a). How many of these troops had benefits claims filed before they discharged?

Response: Servicemembers undergoing medical evaluation board (MEB) or PEB proceedings with a discharge date are currently included in the BDD program. There were approximately 36,000 claims filed through the BDD program in Fiscal Year 2006. VBA does not separately track MEB/PEB cases; rather, all BDD cases are tracked and handled expeditiously.

Question 3(b). How many had their first VA medical appointment scheduled before they discharged?

Response: Medical appointments are made according to the patient's clinical need. For the seriously injured patients requiring inpatient rehabilitation and transfer from a DOD MTF to a VAMC, medical appointments are made prior to hospital discharge in all cases. Patients who are discharged from the DOD treatment facility to outpatient status elect where they will get their outpatient medical care. That care may or may not be provided by a VA treatment facility. If the patient elects to receive his or her care in the VA system, the VA personnel in the DOD treatment facility coordinate the appointment prior to discharge.

Question 3(c). What kind of comprehensive case management is being offered to these troops?

Response: Each VAMC has designated an OEF/OIF clinical case manager to provide ongoing case management services to returning OEF/OIF servicemembers, veterans and their families. Although many OEF/OIF patients may not require intensive case management, VA requires the case manager to conduct an initial assessment to identify and assist with immediate needs. Patients with severe injuries or having complex needs will receive ongoing case management as their medical and psychosocial needs dictate. The case manager is accessible to the patient and family should additional needs arise in the future. In addition, VA requires that polytrauma patients receiving treatment at one of VA's four polytrauma rehabilitation centers receive social work case management services at a ratio of one social work case manager for no more than six OEF/OIF polytrauma inpatients.

VBA counselors and VHA social worker liaisons have been established at MTFs. ROs have established liaison with local MTFs to ensure contact with seriously injured OEF/OIF veterans. VBA counselors at key MTFs or VA medical facilities meet with every injured OEF/OIF servicemembers when medically appropriate. The servicemembers are made aware of all potential VA benefits and services as well as other benefits and services available through other sources. They are assisted in completing their claims and gathering supporting evidence. While servicemembers are hospitalized, they are routinely informed about the status of all of their pending claims. Servicemembers are given a business card that contains the VBA counselors name and contact information such as a telephone number.

Question 3(d). Concerning the 631,000 total Iraq/Afghanistan veterans, wounded or otherwise, what kind of one-on-one transition assistance did these veterans receive?

Response: VA provides outreach to all returning servicemembers to inform them of the benefits and services for which they may be eligible. VA provides pre- and post-mobilization briefings as well as 3-day TAP workshops and disabled transition assistance program (DTAP) workshops which advise injured/ill servicemembers about benefits available through VBA's Vocational Rehabilitation and Employment Program. To assist recently separated veterans, the Veterans assistance at discharge system (VADS) process generates a "Welcome Home Package" that includes a letter from the Secretary, VA Pamphlet 21–00–1, A Summary of VA Benefits, and VA Form 21–0501, Veterans Benefits Timetable. Servicemembers receive one-on-one transition assistance through the BDD program which allows servicemembers to begin the VA disability examination process up to 180 days prior to discharge.

Veterans service center case managers are assigned for each compensation claim received from a seriously disabled OEF/OIF servicemember. The case manager be-

comes the primary VBA point of contact for claims processing; however, the VBA counselors at the MTF may continue to be involved if the servicemember is still a patient at the MTF.

VA continues to explore additional ways to meet the needs of both the active duty and Reserve and Guard members supporting OEF/OIF. The Secretary of Veterans Affairs just announced that VA is beginning a new initiative to provide priority processing of all disability compensation claims from OEF/OIF veterans. A second component of this initiative is focused on identifying additional enhancements that can be made to our outreach program for Reserve and Guard members. The Secretary is also creating a special Advisory Committee on OEF/OIF veterans and families, which will advise on the full spectrum of issues affecting these veterans and their families.

Question 4. Aggregate Health Data. The Pentagon provides limited data to the VA about servicemembers when they are separating, but does not provide comprehensive systematic data on the numbers of wounded that could help VA in long-term planning. A recent Harvard report put the number of American servicemembers wounded in Iraq and Afghanistan at more than 50,500. Some of these soldiers are sent to military hospitals in the U.S., but many are healed and returned to service. VA polytrauma facilities often care for injured Active Duty troops. What kind of lead time does the Pentagon give the VA before transferring these patients to VA care? What does that do to your budget planning?

Response: The time between notification of the Polytrauma Rehabilitation Centers' (PRC) intent to transfer a seriously injured servicemember or veteran to a VA health care facility and actual patient transfer is variable. That time can be hours, days or weeks before transfer. The process involves exchange of clinical information regarding patients to be transferred from the MTF. The VA Polytrauma system of care uses this information to monitor capacity and to plan clinical care.

As to budget planning, the budget estimates are updated each year with the most current information available. This helps to ensure that the budget estimates are consistent with changes in the numbers of patients treated.

Question 5. Total Costs of Caring for OEF/OIF Veterans. A recent report by the Kennedy School of Government at Harvard put the lifetime costs of caring for Iraq/Afghanistan veterans at $350 to $700 billion. Do you agree with this estimate, and if not, what estimate can you offer in its place?

Response: The Administration reviews and funds the needs of veterans 1 year at a time. In Fiscal Year 2008, VA estimates that it will treat over 263,000 OIF/OEF veterans at a cost of approximately $752 million. This estimate is based on the actual enrollment rates, age, gender, morbidity, and reliance on VA health care services of the enrolled OIF/OEF population. OIF/OEF veterans have significantly different VA health care utilization patterns than non-OIF/OEF enrollees, and this is reflected in the estimates above. For example, when modeling expected demand for PTSD residential rehab services for the OIF/OEF cohort, the model reflects the fact that they are expected to need three times the number of these services than non-OIF/OEF enrollees. The model also reflects their increased need for other health care services, including physical medicine, prosthetics, and outpatient psychiatric and substance abuse treatment. On the other hand, experience indicates that OIF/OEF enrollees seek about half as much inpatient acute medicine and surgery care from the VA as non-OIF/OEF enrollees.

At this point in time, the full impact of the conflict remains uncertain. Many unknowns will influence the number and types of services that VA will need to provide OIF/OEF veterans, including the duration of the conflict, when OIF/OEF veterans are demobilized, and the impact of our enhanced outreach efforts. VA has estimated the health care needs of OIF/OEF veterans based on what we currently know about the impact of the conflict. To ensure that we are able to care for all returning OIF/OEF veterans, we have made additional investments in our medical care budget.

Chairman AKAKA. Thank you. Thank you very much.

May I now ask, Secretary Chu, for your statement.

STATEMENT OF HON. DAVID S.C. CHU, UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

Dr. CHU. Good morning, Mr. Chairman, Members of the Committee. I have a statement for the record which I hope will be in-

cluded in the proceedings of this hearing. It is a distinct privilege to appear with Gordon Mansfield——

Chairman AKAKA. It will be included in its entirety.

Dr. CHU. Thank you, sir. It is a distinct privilege to appear here this morning with Gordon Mansfield, the Department of Defense Council and Secretary Mansfield, as our partner in addressing the issues that Members of the Committee have outlined this morning. I want to thank him and his predecessor, Leo McKay, for the partnership they have created over these last 6 years. It is a different relationship than it was 6 years ago, and I think the reason for that difference is commitment—commitment by the Administration, commitment by the two Cabinet Secretaries, commitment by the individuals up and down the line in the two agencies that are responsible for our military personnel and the veterans of the United States.

The mechanism we use to move forward improvements to service in the two Cabinet Departments is, as Secretary Mansfield alluded, the so-called Joint Executive Council. This was formed during this Administration, sanctioned by the earlier President's Task Force to Improve Health Care for our Nation's Veterans, and enshrined in statute by the Congress. It oversees the work of the two separate councils—one on health, one of benefits—both devoted to strengthening the services and improving the delivery of services to our Nation's veterans. The guidance document that we use is an annual Joint Strategic Plan that outlines goals in the six key areas touching on the very issues that Members of the Committee have addressed this morning.

I believe that if you look at the record over the last half a dozen years, you will see progress in every area that your letter of invitation outlined, Mr. Chairman. I would like to call attention to just two issues of particular concern that are highlighted this morning, those being health and the transition to civil life.

In the health arena, the Department now assesses the health status of each departing, deploying servicemember before he or she goes overseas. When the servicemember returns, there is a parallel assessment. That is the source of data on issues like mental symptoms, et cetera. And realizing especially that post-traumatic stress disorder will not necessarily evince itself at the point of return, we reach out to all returning servicemembers, including those who have left active duty, 3 to 6 months after that service. So there is now a record of their status at these three key points in time.

We recognize that the two Departments have a special responsibility to those who have severe injuries. Each military service has its own program for caring for these individuals and assuring that their needs are met, but to be doubly sure that there is no issue that falls through the cracks, we constituted several years ago a Military Severely Injured Center. Its responsibility is to pick up on any issue that an individual might have. Those range from how the Transportation Security Agency treats veterans who may have prosthetic devices—for example, implants of various kinds—when they transition airport security, through the issue of what will their future look like. And, indeed, the model to which we are moving is one in which we proffer opportunities to them rather than waiting for them to seek out the opportunities that may be there.

And certainly, the Department of Defense and I think the Veterans Affairs Department has a similar view. We view these as potentially attractive individuals who might well qualify for civil employment in our agencies, bring to those agencies the knowledge, the ethos, really, of military service that is so important to our future success.

Transitioning to civil life is a challenge for all military personnel in every area. That is why the three Cabinet Departments have for some time now constituted the Transition Assistance Program. This is a multi-day program, a portion of which is mandatory for all separating personnel, that outlines the benefits to which they are entitled, outlines how they might approach those benefits. The Department of Labor in particular offers them assistance in locating positions, understanding what job banks are out there, and how to approach them, how to use the Department of Labor's decentralized job referral system, and how to build their resume.

Secretary Mansfield has highlighted what I think is an example of the continued success of the two agencies, and that is the commitment to a common electronic inpatient record. We have now in DOD a worldwide record for outpatient care, but we need to create a parallel record for inpatient care. We intend to do that in partnership with the VA so we have a single record.

Do we need to do more? Of course. Will we do more? Yes, we will. And, in fact, tomorrow is the next quarterly meeting of the very Joint Executive Council that Secretary Mansfield celebrated in his comments.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Chu follows:]

PREPARED STATEMENT OF HON. DAVID S.C. CHU, UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

Chairman and distinguished Members of the Committee, thank you for the opportunity to discuss a key element in the President's Management Agenda—Department of Defense (DOD) and Department of Veterans Affairs (VA) collaboration. DOD sets a high priority on expanding existing efforts and identifying new opportunities for collaborative and cooperative activities with the VA. I am pleased to be here today to provide an overview and status update of many of these innovative programs and initiatives.

While the two Departments have been working together in earnest for over two decades, the many professionals within both Departments are bringing DOD and VA closer together at a pace greater than at anytime before, under the guidance of the VA/DOD Joint Executive Council (JEC). The JEC provides guidance and establishes policy for the full spectrum of collaborative activities and initiatives between the two Departments. The JEC oversees and guides the activities of the VA/DOD Benefits Executive and Health Executive Councils (BEC and HEC, respectively), as well as their many working groups. The HEC is responsible for implementing a coordinated health care resource sharing program. The BEC is responsible for examining ways to expand and improve benefit information sharing, refining the process for records retrieval, and identifying procedures to improve the benefits claims process.

Program managers and directors from both departments have been working closely with one another to improve access, quality and efficiency. DOD believes that none of our efforts are more important than creating an uninterrupted continuum of care for severely injured and ill servicemembers and their families, whatever their individual needs may be, as they transition from military service to veteran status.

Tomorrow, VA Deputy Secretary Mansfield and I are scheduled to sign our Annual Report on Resource Sharing. The report will present in considerable detail what I believe are our accomplishments of the past fiscal year, and will offer a look into the future for our collaborative efforts as we endeavor to make transition between the two departments as seamless as possible.

An important appendix to the report contains the third update to the VA/DOD Joint Strategic Plan for Fiscal Years (FY) 2001–2009. This plan guides our joint activities and serves as the primary instrument by which we measure progress and success throughout each year. As a testament to the firm foundation that has been established, the guiding principles have remained unchanged since their inaugural release in 2004. However, the current plan reveals lessons learned in the areas of identifying opportunities for improvement, developing goals and strategies to achieve these improvements, and developing performance measures.

Accordingly, my statement today will address the many activities under way that reflect the shared commitment to delivering care and benefits across our departments.

RESOURCE SHARING OVERVIEW

Health care resource sharing is a broad term used to describe a wide spectrum of collaboration between DOD and VA. Within this spectrum lie many areas of sharing, including general and specialized patient care, education and training, research and development, and health care administrative support. The departments provide these services to one another under mostly local agreements that involve reimbursement or exchange of services. At the end of Fiscal Year 2006, DOD military treatment facilities (MTFs) and Reserve units were involved in sharing agreements with 157 VA Medical Centers.

In addition to these local sharing agreements, which are the cornerstone of our collaborative relationship, there are a variety of systemic initiatives. Section 721 of the Fiscal Year 2003 National Defense Authorization Act (NDAA) required VA and DOD to establish an account in the Treasury, referred to as the Joint Incentive Fund (JIF), and fund the account on an annual basis. The JIF is intended to eliminate budgetary constraints that deter sharing initiatives by providing funding to cover the startup costs associated with innovative and unique sharing agreements. JIF projects are selected using criteria that include improvements in access, return on investment, and overall contributions to the goals and objectives of the Joint Strategic Plan. Fiscal Year 2006 projects embraced a broad spectrum of health care programs: mental health counseling, Web-based training for pharmacy technicians, cardio-thoracic surgery, neurosurgery, and increased physical therapy services for both DOD and VA beneficiaries. At the end of Fiscal Year 2006, 47 JIF projects accounting for $88.8 million of the $90 million in the fund had been approved by the HEC from a total of over 200 proposals.

Section 722 of the Fiscal Year 2003 NDAA mandated the DOD and VA to execute no less than three health care coordination demonstration projects over a 5-year period. There are seven sites currently testing initiatives such as the Bi-Directional Health Information Exchange, on which I will elaborate later, as well as a Laboratory Data Sharing Initiative and Joint Market Workload Data Analysis.

The DOD and VA also collaborate extensively in the area of education and training. There are 159 VA/DOD agreements involving education and training, including training for physicians and nurses. In Fiscal Year 2006, the HEC continued to monitor a pilot program for military physician residents placed at academically affiliated VA medical centers. The military residents rotate through VA facilities and provide care to VA patients under the supervision of university faculty.

COLLABORATION RESULTS

While resource sharing is a fundamental part of our relationship with the VA, I am proud that this partnership has expanded further and now entails a significant number of programs within both the DOD personnel and health affairs communities. A particular focus is facilitating a coordinated transition, enabling servicemembers, veterans, and their families to navigate a complex benefits systems with relative ease—a seamless transition. I will describe several of our ongoing efforts.

• One program under the purview of the BEC facilitated 130 Memoranda of Understanding between local DOD and VA facilities for a cooperative separation physical examination process. This program, called Benefits Delivery at Discharge (BDD), brings claims specialists from the Veterans Benefits Administration (VBA) to assist separating servicemembers in filing disability claims as soon as 6 months before they leave uniform. According to VA, BDD has reduced the average time for an adjudication decision to approximately 60 days.

• The Army Liaison/VA Polytrauma Rehabilitation Center Collaboration program, a "Boots on the Ground" program, stood up in March 2005. The intent of this collaborative effort is to ensure that severely injured servicemembers who are transferred directly from an MTF to one of the four VA Polytrauma Centers in Richmond,

Tampa, Minneapolis, and Palo Alto, are met by a familiar face in a uniform. DOD has a long-standing relationship with the VA, in which VA provides rehabilitative services for patients with traumatic brain injuries, amputations, and other serious injuries as soon after the incident as clinically possible. A staff officer or non-commissioned officer assigned to the Army Office of the Surgeon General is detailed to each of the four locations. The role of the Army liaison is primarily to provide support to the family through assistance and coordination with a broad array of issues, such as travel, housing, and military pay. The liaisons have also played a critical role in the rehabilitation process by promoting resiliency in servicemembers. The presence of a uniformed liaison reassures these servicemembers and their families that we appreciate their service and are committed to ensuring their needs are met by our sister agency.

• The Joint Seamless Transition Program, established by VA, in coordination with the Military Services, facilitates a more timely receipt of benefits for severely injured servicemembers while they are still on active duty. There are 12 VA social workers and counselors assigned at 10 MTFs, including Walter Reed Army Medical Center and the National Naval Medical Center in Bethesda. They ensure the seamless transition of health care includes a comprehensive plan for treatment. VBA counselors visit all severely injured patients and inform them of the full range of VA services, including readjustment programs, and educational and housing benefits. As of December 15, 2006, VA social worker liaisons had processed 6,714 new patient transfers to Veterans Health Administration (VHA) at the participating military hospitals.

VA social workers work on-site at the MTFs to respond to referrals to coordinate inpatient care and outpatient appointments at a VA medical center near the patient's intended residence. They coordinate transfer of care and maintain follow-up with patients to verify success of the discharge plan, and to ensure continuity of therapy and medications. Case managers also refer patients to Veterans benefits counselors and vocational rehabilitation counselors.

• The Department is committed to providing the assistance and support required to meet the challenges that confront our severely injured and wounded servicemembers and their families during the difficult time of transition. Each military Service has programs to serve their severely wounded from the war: the Army Wounded Warrior Program (AW2), the Navy SAFE HARBOR program, the Air Force Helping Airmen Recover Together (Palace HART) program, and Marine4Life Injured Support Program. DOD's Military OneSource Center is part of this effort to augment the support provided by the Services. It reaches beyond the DOD to other agencies, the nonprofit world and corporate America. What makes the Center unique is that it serves as a fusion point of four Federal agencies—DOD, the VA, the Department of Homeland Security's Transportation Security Administration, and the Department of Labor.

The BEC also monitors the implementation of Traumatic Injury Protection under Servicemembers' Group Life Insurance (TSGLI) program authorized by Public Law 109–80. The first payments under this authority were released on December 22, 2005, and as of the end of Fiscal Year 2006, 2,607 claimants were paid a total of $170 million with the average payment at just over $65,000.

HIGH QUALITY HEALTH CARE

Having the right programs in place is not enough. There must be an unyielding commitment to quality when it comes to providing world-class health care to our Nation's servicemembers and veterans. Thus, in addition to the four VA Polytrauma Centers and VA social workers in place at select MTF's, VA and DOD have also begun or expanded collaborative programs in the areas of deployment health, evidenced-based clinical practice guidelines, and patient safety.

DEPLOYMENT HEALTH

DOD has been performing health assessments on servicemembers prior to and just after deployment for several years now. These assessments serve as a screen to identify any potential health concerns that might warrant further medical evaluation. This includes screening the mental well-being of all Soldiers, Sailors, Airmen and Marines in both the Active and Reserve Components.

Every year, members are screened for mental health problems when they complete a preventative health assessment. Now, they are again screened before they deploy. In addition, before returning home from deployment, members complete a post deployment health assessment, which contains questions aimed at identifying physical or mental health concerns; environmental exposure concerns; psychosocial

concerns, such as acute post traumatic stress disorder, depression, anger, or interpersonal conflict; and potentially unexplained symptoms.

The Services are now implementing an additional health reassessment that is conducted 3–6 months after returning home—the Post Deployment Health Re-Assessment. Our experience has taught us that problems are not always apparent at the time servicemembers are immediately returning home, but they may surface a few weeks or months later. We want to assist in early identification of these concerns and facilitate ready access to care at the level most appropriate to the individual servicemember.

CLINICAL GUIDELINES

DOD and VA have worked hard to develop joint evidenced-based clinical practice guidelines. The medical literature supports the premise that guidelines reduce variations in care, optimize patient outcomes, and improve the overall health of beneficiaries. There is a working group that works specifically on developing, updating, and promulgating these guidelines to clinicians in both health care systems.

Because of challenges faced by our forces, some servicemembers may develop chronic mental health symptoms. Mental health experts from the DOD and VA developed joint clinical practice guidelines for acute and post traumatic stress disorder, major depressive disorder, substance use disorders, medically unexplained symptoms, pain, and general post deployment health concerns. DOD uses all available resources, including local military or TRICARE providers (a benefit extended for up to 180 days post deactivation for Reservists), to provide treatment for affected servicemembers. VA is a partner in this process by providing health care and counseling services to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans who are no longer on active duty.

PATIENT SAFETY

In addition to deployment health, the HEC is committed to ensuring that care is delivered with the absolute least risk to the patient. DOD and VA have highly respected patient safety programs and work with other government agencies, such as the Centers for Disease Control and Prevention and the Food and Drug Administration, to prevent harm to patients while they are receiving care. As a prime example of working together to minimize risk of adverse events and to support the commitment to provide the best health care treatment outcomes, in Fiscal Year 2006 DOD implemented a system for developing patient safety alerts that was modeled on the VA's system.

EFFICIENCY OF OPERATIONS

The JEC is committed to efficiency. Through the VA/DOD Acquisitions and Pharmacy Working Groups, the two departments have achieved substantial savings to the taxpayer, obtaining economies of scale through joint purchasing of capital equipment and pharmaceuticals.

These working groups recently reported there are currently 46 shared contracts for medical and surgical equipment contracts: the Defense Supply Center Philadelphia reported sales in Fiscal Year 2006 from these contracts in excess of $170 million and VA reported another $201.5 million. The Pharmacy Working Group reported 77 Joint National Contracts that resulted in a combined cost avoidance of $423 million for pharmaceutical purchases in the first three quarters of Fiscal Year 2006.

INFORMATION SHARING

The programs and benefits earned by servicemembers could not be delivered without complete cooperation between the DOD and the VA in the area of information sharing. Indeed, information sharing is critical to an effective and transparent transition process, and that is why so much attention is paid to information management and information technology in the Joint Strategic Plan.

Important to health care related information sharing is the requirement to comply with the Health Insurance Portability and Accountability Act (HIPAA). DOD and VA signed a Memorandum of Agreement governing the sharing of Protected Health Information (PHI) and other individually identifiable information in June 2005.

The Federal Health Information Exchange (FHIE) supports the monthly electronic transfer of health information from DOD to VA at the time of the servicemember's separation. The data contained in this transfer include: pharmacy and allergy data; laboratory and radiology results; consult reports; discharge summaries; admission, disposition and transfer information; and patient demographic information. Health

care providers within VHA, and benefits counselors within VBA, access this information via the Computerized Patient Record System and Compensation and Pension Records Interchange, respectively. As of the end of Fiscal Year 2006, DOD had transmitted health data on over 3.6 million patients. DOD uses FHIE to transmit data to the VA regarding VA patients receiving care within an MTF, and has sent over 1.8 million individual transmissions.

FHIE is also being used as a platform from which DOD transmits pre- and post-deployment assessment information for separated servicemembers and demobilized Reservists and Guardsmen. Over 1.5 million assessments on more than 623,000 individuals have been electronically transmitted to VA.

Building from the FHIE, which is a one-way flow of information, DOD and VA have developed and begun deployment of the Bidirectional Health Information Exchange (BHIE). This exchange enables near real time sharing of allergy, outpatient prescription, inpatient and outpatient laboratory and radiology results, and demographic data between DOD and VA for patients treated by both departments. BHIE is operational at all VA medical centers and at 14 DOD medical centers, 19 hospitals, and over 170 outlying clinics.

With an eye toward the future, the VA/DOD Health Information Technology Sharing Working Group began in Fiscal Year 2006 to establish an interface between BHIE and the DOD Clinical Health Data Repository in order to accelerate progress in sharing appropriate health information. This interface will ensure that all VA sites and all DOD sites worldwide will have the ability to view data from the other department for shared patients. We are also focusing on increasing the amount of inpatient data exchanged. Most recently, BHIE began to exchange inpatient and emergency department discharge summaries. Other inpatient documentation, such as operative reports and inpatient consultations, are planned for the future.

DOD is aware of the concerns regarding the time it has taken to establish the desired level of interoperability. With the full deployment of DOD's electronic health record (EHR)—AHLTA—across the Military Health System accomplished, we are poised to continue building on our significant achievements in sharing critical health information across department lines. The ultimate desired end-state will be a completely electronic health care record that is accessible and useable to the provider regardless of which health care system they are operating within.

In pursuit of that goal, DOD and VA are developing an assessment of the clinical workflow and health information for the care of inpatients. Management of inpatient care is a future capability planned for AHLTA. VistA, the VA EHR, supports ambulatory care plus a segmentable but integrated inpatient care capability. VA is planning to modernize VistA, including its inpatient module. We believe that this is an opportunity to explore a "born seamless" approach for a joint inpatient EHR.

I want to discuss two additional information sharing programs that provide VA with essential data in order to expedite the benefits delivery process. First, DOD is providing contact information for servicemembers when they separate. DOD began routinely providing VA rosters on recently separated OEF and OIF veterans—Active Duty and Reserve Components—in September 2003. VA uses these lists to send letters to veterans containing information on VA benefits related to service in a combat theater. Over 580,000 letters have been mailed.

Second, DOD is transmitting to VA's Office of Seamless Transition a monthly list of key demographic and contact information about servicemembers for whom a Medical Evaluation Board has referred them to a Physical Evaluation Board. This list enables VA case managers to make contact with servicemembers at the earliest time possible, while they are still in uniform. By the end of Fiscal Year 2006, DOD had provided VA with contact information for 13,622 individuals.

To support streamlined benefits processing and reduce operating costs, VA and DOD continue to develop and implement military personnel data sharing initiatives under the auspices of the BEC. Movement toward a single bidirectional data feed between VA and DOD is achieved by incorporating necessary data sets into a data sharing schema and then eliminating legacy feeds. Specific data sets incorporated into the VA/DOD data sharing schema in Fiscal Year 2006 include Reserve and Guard activation and mobilization data, deployment data and combat pay indicators on all servicemembers and veterans, education eligibility data enhancements which support the Montgomery GI Bill and Montgomery GI Bill Selected Reserve programs, and medical eligibility for combat injuries. Additionally, DOD also made the Defense Personnel Records Information Retrieval System available to VA online to enhance VA employees' access to the Official Military Personnel File. In Fiscal Year 2006, the number of separate data exchanges flowing from DOD to VA were reduced from 31 to 20. From VA to DOD, the number of separate data exchanges dropped from 11 to 8.

OUTREACH

Arguably the most important link in the value chain is the level of awareness and understanding among our beneficiaries and employees regarding the myriad benefits, their disparate eligibility criteria, and the processes for obtaining those benefits. Education and outreach must occur at multiple intervals throughout a servicemember's career, beginning at accession into the military. The BEC has overseen the establishment and expansion of such programs. In November 2004, VA began distributing a pamphlet entitled *A Summary of VA Benefits* to all Service inductees at the Military Entrance Processing Stations. This year, distribution of this pamphlet was expanded to the Military Service Academies for graduates about to receive their commissions.

There has also been an increased emphasis on training our employees and familiarizing them with their VA counterparts. While we often talk about coordinated transition in terms of programs and initiatives, a smooth transition requires personnel to understand the other department. It also means developing working relationships at the point of care or service. DOD has dedicated a series of presentations to this important topic within the annual Military Health System Conference, which is attended by leadership and professional staff from DOD sites across the globe. We also presented VA/DOD Collaboration and Coordinated Transition as a plenary session at the annual TRICARE Beneficiary Counselors and Debt Collection Assistants Conference, attended by approximately 500 front-line staff who daily assist servicemembers, retirees and veterans in understanding their benefits.

DOD TRANSITION ASSISTANCE PROGRAM

Returning to private life after serving in the military can be a very complex undertaking. The DOD, VA, and the Department of Labor (DOL) are working together to provide servicemembers with the tools and information they need to fashion individual solutions to the challenges they face.

The Montgomery GI Bill (MGIB) is vital to recruiting efforts—money for college ranks among the major reasons young men and women enlist. However, education is also an important transition tool, attractive to both servicemembers and their families. GI Bill enrollments increased from only 50 percent in its first year (in 1985) to nearly 97 percent starting in the early 1990s and continuing at that level to this day. A total of 2.8 million men and women, from an eligible pool of 3.8 million, have taken advantage of the MGIB. Eligibility requires the Active, Guard, or Reserve member to serve at least two consecutive years on active duty. While a servicemember who has met the requirement may use the GI Bill while still serving on active duty, it is primarily a veteran's benefit, thus, the program is administered by the Department of Veterans Affairs.

The Transitional Assistance Management Program (TAMP) offers transitional TRICARE coverage to certain separating active duty members and their eligible family members. Under the Fiscal Year 2005 NDAA, TRICARE eligibility under the TAMP was permanently extended from 60 or 120 days to 180 days. After the TAMP eligibility expires, members and eligible family members may choose to enroll in the Continued Health Care Benefit Program (CHCBP). CHCBP provides a conversion health plan similar to TRICARE Standard for a specific time (18 months) to all former servicemembers and their families who pay quarterly premiums.

DOD has improved access to the Verification of Military Experience and Training (VMET) document (DD Form 2586) by making it available to eligible members through a VMET Internet site. This document provides descriptive summaries of the servicemembers' military work experience, training history, and language proficiencies. The VMET document also includes recommended college credits to be awarded based on an individual's military experience and training, as determined by the American Council on Education, and related civilian equivalent job titles, when such information is available. The VMET Web site, *https://www.dmdc.osd.mil/vmet*, is available 365 days a year, and provides VMET documents on-demand. Since January 2003, over 1 million documents have been provided to current and former servicemembers.

Since 1999, a DOL platform has been providing employment-related information for servicemembers and veterans. DOL established the DOD Job Search Web site (*www.dod.jobsearch.org*). This Web site provides employers with a link to transitioning servicemembers' resumes and provides transitioning servicemembers with access to job opportunity listings with military-friendly employers.

During the preseparation counseling phase of the Transition Assistance Program (TAP), servicemembers learn where and how to access information relating to licensure, certification and apprenticeship. The Army created "Credentialing Opportunities On-Line" or Army COOL. This robust Web site helps soldiers find civilian

credentialing programs related to their military occupational specialty. It also helps them understand what it takes to obtain a credential and it identifies resources available to pay credentialing fees. In 2006, the Navy followed with Navy COOL.

The preseparation counseling phase also includes a discussion of DOL's Web site, "America's Career Info Net." One of the tools on this Web site is the Credentials Center, which a servicemember can use to locate the examinations that test or enhance knowledge, experience or skills in an occupation or profession. Finally, DOD and DOL have established a "Credentialing Working Group" to develop appropriate goals, objectives, and outcomes that will help remove credentialing barriers that some veterans and transitioning servicemembers face.

I want to point out that DOL established the Recovery and Employment Assistance Lifelines (REALifelines) as a joint initiative among the DOL, the Bethesda Naval Medical Center, and the Walter Reed Army Medical Center. REALifelines is designed to create a seamless, personalized assistance network to ensure that seriously wounded and injured servicemembers who cannot return to active duty are trained for rewarding new careers in the private sector. REALifelines staff provide employment assistance to severely injured and wounded servicemembers as they transition back into the civilian community to fulfill their employment potential and dreams. Today, REALifelines has expanded from its initial two locations to five additional military medical treatment facilities (Fort Carson, Brook Army Medical Center, Balboa, Madigan, and Tripler).

Approximately 300,000 servicemembers have returned to the private sector every year since 2001. Of this number, 90,000 per year are from the Guard and Reserve. When TAP was initially developed in 1990, it was not designed with the needs of the National Guard and Reserve Components in mind. Their mission has changed dramatically since September 11, 2001, and therefore some TAP requirements warrant a fresh look.

To better meet the needs of the Guard and Reserve, DOD, with the assistance of DOL and VA, is designing a new, dynamic, interactive, automated, Web-based system for delivery of transition assistance and related information. This portal architecture will become the backbone of the updated TAP processes. Usability, flexibility, adaptability, and individual customization are key to successful implementation of this new technology-enabled process. The portal will emphasize and augment the personal service provided by our transition counselors, while providing servicemembers access to crucial transition-related information anytime, anywhere. The goal for this new system is to increase servicemember accessibility, participation and satisfaction.

All three partners are excited about the possibilities for this new portal. Its intent is to automate TAP services; standardize TAP information; create an external communication link between TAP customers and providers, whether DOD, VA, or DOL; and enhance the military-to-civilian experience.

We are also updating our current pre-separation guide for active duty personnel, and creating a new transition assistance guide specifically for the Guard and Reserve. This effort should be completed by the end of February. Both guides will include traditional TAP subject matter, as well as links to a wide variety of other transition-related Web sites. As with the new portal, the Department is heavily engaged with all stakeholders, especially our partners at VA and DOL, to ensure the information in these guides is up-to-date.

NEXT STEPS

The JEC will step up its efforts in monitoring the coordinated transition process and joint health care facility operations in the short term. The newly established Coordinated Transition Work Group will concentrate efforts to improve the transition process. This group is responsible for ensuring continuity of the service and benefits delivery value chain, which, as I've previously mentioned, must be characterized by an improved understanding of and access to the full continuum of health care and benefits available to servicemembers, veterans, and their families.

The JEC will also be more involved in assisting local initiatives that feature joint operations. The newly created Joint Health Care Facility Operations Steering Group is a lesson learned from our experience with the collaboration between the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes. The steering group is responsible for providing support to local leadership, identifying impediments to collaboration, resolving legal issues, and clarifying statutory interpretation.

The TAP Steering Committee, with representatives from DOD, the Military Services, VA, DOL, and the Department of Homeland Security (Coast Guard) meets quarterly to discuss and address issues and challenges that fall under the transition

umbrella. The Committee works to find solutions to problems, conduct pilots, and look for new initiatives that will enhance and improve our current transition program and the overall quality of life of all members of the Armed Forces.

DOD and VA will continue to build on past successes as we move forward in Fiscal Year 2007, and beyond. I am proud of the hard work and dedication to duty that the professionals within both departments display daily as they intensify efforts to increase beneficiary and employee awareness, improve existing data exchanges, promote world-class health care and benefits delivery, and increase the value of the Transition Assistance Program to all stakeholders.

Mr. Chairman, this concludes my statement. I look forward to working with the Committee in this new Congress to uphold our traditional outstanding support of American heroes—our Nation's servicemen and women, veterans, and their families.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA

Question 1. To what extent have efforts been made to coordinate with the Department of Labor to assist returning servicemembers in finding meaningful employment in a timely fashion? What efforts has DOD made on its own accord?

Response. The Transition Assistance Program (TAP) Steering Committee is the mechanism to coordinate with the DOL to assist returning servicemembers in finding meaningful employment in a timely fashion. This Committee is comprised of representatives from the DOD, the Military Services, Department of Veterans Affairs, DOL, and the Department of Homeland Security.

The Deputy Under Secretary of Defense for Military Community and Family Policy, who has oversight for TAP at DOD, collaborated with the Assistant Secretary of Labor for Veterans Employment and Training Service regarding some new initiatives for this year. Those initiatives are outlined below.

DOL INITIATIVES

DOL has taken the lead in developing 15 employment assistance modules specifically for the Guard and Reserve to receive the equivalent of the 2½-day TAP Employment Workshop that is provided at major active duty installations for active component transitioning servicemembers.

In addition, DOL is working to implement a methodology of seamlessly "handing off" servicemembers directly to a counselor at a DOL Career One-Stop Center close to the final destination of the servicemember and his or her family.

DOD INITIATIVES

DOD staff is preparing a policy change that will strengthen the Department's commitment to those servicemembers who want to attend an employment workshop. The updated policy will inform Commanders that they shall release servicemembers (who request attendance at a DOL, or Service equivalent, Employment Workshop) during duty hours to attend this important workshop.

In addition, the Department has contracted with RAND to examine recent trends in veteran unemployment rates for 20 to 24-year-old veterans in relation to non-veteran counterparts, using administrative data on the receipt of unemployment compensation for ex-servicemembers. This effort will assist the Department in evaluating its current programs and policies with respect to unemployment benefits and the effectiveness of current programs aimed at assisting active duty and Reserve personnel transitioning from full-time military to full-time civilian employment. The study is to be completed in 2007.

The Department is updating the current active duty Pre-separation Guide and creating a new Transition Assistance Guide for the Guard and Reserve. We also developed a new Pre-separation Counseling Checklist for demobilizing Guard and Reserve personnel.

The Department developed a Pre-separation Counselor Training Course, through the National Learning Center, University of Colorado at Denver, to increase the professional proficiency of Pre-separation Counselors, by reinforcing the understanding of the requirements and how important their role is in the beginning of successful transition.

The Department established the Interagency Demobilization Working Group to specifically address the needs of the Guard and Reserve. As a result, DOD is developing a new dynamic Web portal to provide access to transition assistance and other related information anytime, anywhere. "TurboTAP," the Department's nickname for the portal, will enhance the existing transition program.

Question 2. Given the increased obligations of the Guard and Reserves, there is a feeling among servicemembers and veterans that their education benefits do not match their service commitments. What, if anything, is being done within the Department of Defense to address these concerns?

Response. Education benefits under the Montgomery GI Bill for the Selected Reserve have long been an effective tool to meet strength and force management objectives. Recognizing the increased obligation of the Guard and Reserve in an operational Reserve construct, the President proposed a new program that provides an enhanced educational assistance benefit for Ready Reserve members who have served in support of a contingency operation—the Reserve Educational Assistance Program (REAP). Congress included this provision in the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, which was enacted on October 28, 2004. REAP recognizes the additional service performed by Guard and Reserve members and provides additional financial assistance to accommodate lost educational opportunities while activated and a readjustment benefit following activation.

A key component in both of these programs is that eligibility for benefits requires continued participation in the Guard or Reserve. In particular, REAP serves as an incentive to remain in the Guard or Reserve following the rigors and stresses associated with mobilization and time away from families and employers—a time when pressure to separate may be significant. It is worth noting that a Reserve component member who meets the same service requirements as an active duty member is eligible for the same active duty benefit. But not all reservists serve on active duty for extended periods, so the REAP benefit was designed to provide an enhanced benefit for Ready Reserve members who serve on active duty for shorter periods.

Although there have been some recruiting challenges, the Department's success in meeting its recruiting and retention objectives suggests that the current educational incentives are having the desired effect, coupled with the other recent changes to recruiting and retention incentives.

However, there has been interest in revamping educational benefits provided to all military members. One such proposal calls for consolidating the three separate programs into a single "Total Force" benefit. In light of the way we are using the force—active, Guard and Reserve—I think it is worth considering some consolidation or streamlining of the three educational assistance programs we have today. But, we must guard against undermining the original purpose of the various programs and their effectiveness in achieving their respective program objectives.

To assess the impact of consolidating the various education programs, a joint DOD/Department of Veterans Affairs (DVA) working group was formed to examine the possibility of a "Total Force GI Bill." This group has been meeting over the past several months.

The DOD and the DVA, through the Joint Executive Council (co-chaired by me and Deputy Secretary Mansfield), will review the findings and recommendations of the working group, and any legislative changes to the various educational assistance programs supported by the Administration will be forwarded to Congress.

Question 3. Please explain the role of the Employer Support of the Guard and Reserves in helping servicemembers resume employment post-demobilization.

Response. ESGR provides information, education, and informal mediation to servicemembers and employers through an ombudsman customer service center and grassroots relationships through a network of over 4,000 volunteers.

Specifically, ESGR works collaboratively with each of the Services to establish a military unit employer support representative throughout the Reserve component. This specifically identified servicemember acts as the liaison between his or her unit's members and the local ESGR military unit liaison volunteer.

ESGR also helps provide briefings during the demobilization process to explain the servicemembers' rights and responsibilities under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

ESGR's aggressive efforts have resulted in a decline of requests for assistance with informal mediation to the ESGR ombudsman services for the past 3 years, from 486 per month average in Fiscal Year (FY) 2004 to a 390 per month average for Fiscal Year 2005 to an average of 262 per month for Fiscal Year 2006. Additionally, although ESGR does not have statutory authority to enforce USERRA, it does coordinate activities with the three Federal Government organizations with responsibility over USERRA—the Veterans' Employment and Training Service from the Department of Labor, the Department of Justice, and the Office of Special Counsel—in order to better serve servicemembers and employers.

Question 4. How many servicemembers, by year, have been medically retired or given a disability discharge as a result of injuries or wounds sustained in OEF/OIF?

Response. The following represents the number of servicemembers who have been separated or retired (in the year indicated) under Service Secretary authority (Chapter 61, title 10, United States Code) for wounds or injuries incurred in the line of duty, associated with OEF/OIF:

- 2003: 332
- 2004: 804
- 2005: 1,646
- 2006: 1,887

Caveats: Accounting represents those who were awarded a disability disposition as a result of:

- Armed conflict or,
- Instrumentality of war.

Source: Military Department Physical Disability Agencies.

Question 5. How many OEF/OIF veterans were separated from active status (by component—active, Guard and Reserves) between January 2002 and January 2005?

Response. The number of OEF/OIF veterans separated from active status between January 2002 and January 2005 are as follows:

Component	Separated/Retired
Army Active Duty	47,452
Navy Active Duty	37,197
Air Force Active Duty	20,631
Marine Corps Active Duty	22,804
Army National Guard	21,818
Army Reserve	12,049
Navy Reserve	4,021
Air National Guard	5,761
Air Force Reserve	2,943
Marine Corps Reserve	4,759
Total	179,435

Source: Defense Manpower Data Center.

Question 6. The 2003 Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) recommended that the Administration direct Health and Human Services (HHS) to declare the two Departments to be a single health care system for purposes of implementing Health Insurance Portability and Accountability Act (HIPAA) regulations. How did DOD and VA respond to the recommendation. How have the HIPAA requirements impacted your health information exchange efforts?

Response. Under the HHS HIPAA Privacy Final Rule, two or more covered entities who participate in certain joint activities may qualify as an Organized Health Care Arrangement (OCHA), which allows them to share protected health information about their patients in order to manage and benefit their joint operations. The VA and DOD do not qualify as an OCHA under the requirements currently promulgated by HHS in the HHS HIPAA Privacy Final Rule. To change those requirements, HHS would need to engage in the time consuming process of administrative rulemaking. Absent such administrative rulemaking, it is our belief that HHS lacks the authority to make such a declaration.

DOD and VA responded to the recommendation by making maximum use of the authority already provided in the HHS HIPAA Privacy Final Rule to share protected health information for purposes of treatment at time of separation and between covered entities that are government entities providing public benefits. Given the existing authority which is currently available, which arguably provides for broader protected health information sharing than that available to an OCHA, DOD sees no benefit in petitioning HHS to engage in administrative rulemaking to change the OCHA qualification requirements.

Question 7. The Departments have indicated that their joint effort to develop the interface between VA's and DOD's health data repositories is expected to result in the secured sharing of health data between the new systems that each Department is currently developing and beginning to implement. What measures does DOD have in place to protect personally identifiable information that is being maintained in

its health data repository? How is DOD securing the transfer of personally identifiable information from DOD to VA?

Response. DOD has implemented the following security controls to tighten restrictions on access to our network and databases: isolating sensitive data from public data, expanding content of audit controls, enhancing training, implementing encryption of data at rest and updating network devices capability. We are also working with Defense Information Systems Agency to incorporate additional monitoring tools and intrusion detection devices to identify and address malicious activity immediately.

The exchange of information between DOD and VA utilizes the DOD Business to Business Gateway to encrypt the transmission of patient identifiable data and incorporates authentication and auditing controls into the data exchange.

The DOD's AHLTA Clinical Data Repository complies with the following security requirements:

- DOD Instruction 5200.40, DOD Information Technology Security Certification and Accreditation Process (DITSCAP), dated 30 December 1997.
- DOD Directive 8500.1, "Information Assurance," October 24, 2002.
- DOD Directive 8500.2, "Information Assurance (IA) Implementation," February 6, 2003.
- Public Law 104–191, "Health Insurance Portability and Accountability Act (HIPAA) of 1996," August 21, 1996.
- FIPS 140–2, "Security Requirements for Cryptographic Modules," May 25, 2001.
- CJCSI 6510.01D, "Information Assurance (IA) and Computer Network Defense (CND)," June 15, 2004.
- DOD Directive 4630.5, "Interoperability and Supportability of Information Technology (IT) and National Security Systems (NSS)," May 5, 2004.
- Military Health System (MHS) IA Policy Guidance Manual, March 5, 2004.
- DOD Regulation 6025.18–R, "DOD Health Information Privacy Regulation," January 24, 2003.

Question 8. How will the Future Military Healthcare Task Force look at VA's role when making recommendations about the future of DOD health care?

Response. The Task Force has a representative from the VA (Mr. Bob Henke). It is anticipated that where DOD and VA can work together, that perspective would be part of findings and recommendations. Although not a specific task assigned to the Task Force, partnership with the VA remains part of the larger Department agenda under the VA/DOD Joint Executive and the Health Executive Councils. Recent agreement between the Secretaries of the Departments of VA and DOD have a focus on four major areas common to each Department: healthcare planning in joint markets; working toward a common Electronic Health Record, starting with a partnership on a joint inpatient record; focus on work with severely injured traumatic brain injury patients; and, joint work on mental health and associated diagnoses including Post Traumatic Stress Disorder.

Question 9. In 2003, the PTF recommended that there should be a mandatory physical exam for all separating servicemembers. I understand that currently a separation physical is only mandatory for those who are retiring. Do you believe that a separation physical should be mandatory for all? If not, why not?

Response. I believe there should be a health screening at separation tailored to the military occupation. For example, a tank mechanic or jet engine mechanic should receive an occupation specific termination health screening at the end of their enlistment or, if they move out of that specialty. Currently "termination" exams are being accomplished across the Services for those individuals in certain occupational positions. We should consider the specific military occupational position and conduct a tailored screening. Mandatory comprehensive physical exams have not been shown to be cost effective for health screening.

Question 10. For VA and DOD, the Joint Executive Council Strategic Plan is the primary way by which you advance and measure performance and progress. What specific measures are in place to evaluate the effectiveness of your efforts?

Response. The VA/DOD Joint Strategic Plan guides our joint activities and serves as the primary instrument by which we measure progress and success throughout each year. As a testament to the firm foundation that has been established, the guiding principles have remained unchanged since their inaugural release in 2004. However, the current plan reveals lessons learned in the areas of identifying opportunities for improvement, developing goals and strategies to achieve these improvements, and developing performance measures.

The Strategic Plan is at Appendix A of the VA/DOD Annual Report to Congress, which will be delivered to the Senate Veterans Committee Chairman and Ranking Member by the end of February 2007.

Question 11. GAO has recommended that attendance at Transition Assistance Programs be mandatory for all separating servicemembers, or that, at minimum, servicemembers should have the opportunity to participate with the support of their supervisors. Do you believe that attendance should be mandatory? If the programs were mandatory, does DOD have the resources to support it?

Response. Pre-separation Counseling is mandatory for all Military Services and for eligible demobilizing Reserve component servicemembers.

The Department is updating existing policy to allow all servicemembers who wish to attend a Department of Labor or Service equivalent employment workshop to do so during duty hours.

DOD supports attendance at Veterans Affairs (VA) Benefits Briefings for all eligible servicemembers. The Department has a responsibility to ensure all servicemembers are made aware of their VA benefits before separation or retirement. The Department is undertaking an effort to make transition resources available online. This will allow servicemembers who prefer a more hands on, automated approach to get the information on VA and other transition related information. The online service also will allow servicemembers to access this information as the need arises in the future (just-in-time access).

The Department supports mandatory attendance at the Disabled Transition Assistance Program for all servicemembers referred to a Physical Evaluation Board and those put in a "medical hold" status by their Service. We also support a policy that allows members who may be separated or discharged with a Service connected disability to be released to attend. Commanders should release these individuals during duty hours to attend.

Cost analyses will be conducted by each Department before addressing whether sufficient resources are available.

Question 12. In my view, all transitioning servicemembers should receive the same level of service and information, whether they separate in the United States or overseas. I am concerned that this is not happening. For example, I understand that VA's Overseas Military Services Coordinators are only available in Europe for 9 months a year and that they are stretched too thin, with only 2 persons covering all of Europe at any given time. I understand that in 2006, DOD notified VA it could no longer fund this program. What was the basis for that decision?

Response. The Department is committed to servicemembers overseas receiving the same level of service as those in the United States. Since the implementation of the Overseas Military Services Program in 1994, coordinators have been available for less than 12 months each year. It is our understanding that, effective in Fiscal Year 2008, VA will provide coverage 12 months a year.

Agencies are responsible for providing necessary resources and delivering their component of the Transition Assistance Program. DOD is responsible for Pre-separation Counseling; Department of Labor is responsible for Department of Labor Employment Workshops; and VA is responsible for VA Benefits Briefings and Disabled Transition Assistance Program.

Question 13. In September 2005, DOD issued a policy memo to the Services Secretaries directing them to provide VA with the names of servicemembers entering DOD's Physical Evaluation Board process. I understand that in May 2006 this initiative was put on hold because of DOD concerns about data security compliance. Why was the initiative put on hold and what is its current status?

Response. Information containing the names, Social Security Numbers, and diagnoses of servicemembers referred by Medical Evaluation Board (MEB) to Physical Evaluation Board is Protected Health Information. Consistent with the provisions of the Health Insurance Portability and Accountability Act, transfer of PHI from DOD to VA requires that reasonable steps be taken to protect the confidentiality of such information.

In October 2005, the Services' medical departments began to forward MEB information to the Office of the Assistant Secretary of Defense for Health Affairs, which assumed responsibility for transfer of the information to the VA. Such transfer took place via encrypted email until mid-2006, when the VA concluded that more stringent measures were appropriate to protect the information. The e-mail transfers were suspended and the Departments began to weigh several alternative means to affect transfers electronically on a permanent basis. In the interim, 4 months of data were transferred in the autumn of 2006 via a password-protected compact disk, hand carried to the VA. The Departments expect to decide upon and implement an improved, secure transfer procedure this month.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV

Question 1. Overall Funding Issues. Whenever I can, I try to host a roundtable in West Virginia to talk to newly returned soldiers, including National Guard and Reservists. I learn a great deal from these heroes. I fully support the goals of DOD and VA in improving the transition, and many of the policies sound good. But when I talk to West Virginia veterans, I do not hear about these policies, I hear about problems getting care and delays in service. What is the level of new funding committed to these important policies? What are top officials in DOD and VA doing to train staff and deliver on the good intentions and commitments? Will DOD and VA be seeking additional funding to meet the health care needs of our returning veterans?

Response. The Transitional Assistance Management Program (TAMP) offers transitional TRICARE coverage to certain separating active duty members and their eligible family members. Under the National Defense Authorization Act for Fiscal Year (FY) 2005, effective October 28, 2004, TRICARE eligibility under TAMP was permanently extended from 60 or 120 days to 180 days. Estimated TAMP requirements developed for Program Objectives Memo (POM) 08–13 are: Fiscal Year 2007—$167M, Fiscal Year 2008—$184M, Fiscal Year 2009—$202M, Fiscal Year 2010—$223M, Fiscal Year 2011—$245M, Fiscal Year 2012—$270M, and Fiscal Year 2013—$296M.

TRICARE Reserve Select (TRS) is a premium-based TRICARE health plan available for purchase by qualified members of the Selected Reserve. Estimated TRS requirements developed for POM 08–13 are: Fiscal Year 2007—$127M, Fiscal Year 2008—$381M, Fiscal Year 2009—$563M, Fiscal Year 2010—$714M, Fiscal Year 2011—$763M, Fiscal Year 2012—$816M, and Fiscal Year 2013—$874M.

One initiative aimed at increasing the level of familiarization among DOD staff with regard to VA is the Family Transition Initiative. This group is identifying variations and impediments to maximizing patient/family communication, specifically verbal guidance and written material provided by DOD and VA staff in anticipation of care transition. The group will also provide recommendations to the Health Executive Council for improvements in communicating with families. There will be an emphasis on sensitivity for the families' prognosis, social and economic realities, and flexibility to incorporate individual timetable needs.

Question 2. Timely Access to Care for National Guard and Reservists. I have heard from West Virginia National Guard personnel of several instances in which the standards you established in your October 2003 policy regarding timely access to care have not been met for Guard soldiers returning to the civilian world from deployment in Iraq and Afghanistan. It appears that the major injuries are usually taken care of prior to discharge from active duty, but then after they return home, the soldiers slip through the cracks for care recommended by their doctors for less critical combat injuries. What are you doing to ensure that these combat veterans receive all of the care that they need and that their doctors have recommended, and that they receive it on a timely basis? Have you established an effective quality control system? Is there an appeal or grievance process through the Veterans Affairs system. What can be done to meet the health insurance needs of our medically retired National Guard members and their families?

Response. The Community Based Health Care Organization (CBHCO) program was created to assist Guard and Reserve servicemembers injured in the line of duty to return to their homes where they will continue to receive care locally while they are evaluated for return to duty, medical release, or medical board. To be eligible, the servicemember must have a referral into the program from their respective branch of Service. While CBHCO is not available in all States, West Virginia is served by the CBHCO located in Richmond, Virginia.

The Department of Defense (DOD) and VA have separate disability determination processes which provide differing economic and medical benefits with some overlap between the two. As a result, members often pursue both. All veterans with a VA disability rating can enroll with the VA for health services. The DOD disability system is, in essence, a form of compensation and benefit system for work-related injuries. When the member is eligible for services from both agencies, the member may choose.

For 2 years after leaving the military, all combat theater veterans are eligible for VA hospital care, medical services, and nursing home care for any illness possibly related to wartime deployment, without having to prove that their health problems are related to their combat service. VA refers to the Certificate of Release or Discharge from Active Duty (DD Form 214) as proof of service in a designated combat theater of operations to determine this eligibility.

After 2 years, these veterans may still be eligible for VA care as determined by the VA regulations. These regulations generally place a member in various priority categories considering type of disability, amount of disability, service connection, and the member's economic abilities. For Service-connected injuries for which a disability rating is received, the VA beneficiary may receive care without cost. He or she may be eligible to receive care for non-Service connected disability needs at a cost share. The DOD respectfully defers to the VA for the details of its programs.

Question 3. Flow of Information. What can be done to facilitate a more efficient flow of communication between military medical facilities, to include Community Based Health Care Organization (CBHCO) and Military Treatment Facilities (MTF), and the individual state Adjutant General when an injured soldier transitions from one duty status to another? (From the National Guard's point of view, there should be a point of contact clearly identified or established at every military medical facility, including CBHCOs and MTFs, who would be responsible for notifying the soldier's Adjutant General when the soldier is admitted, discharged or transported to another facility. The Adjutant General would then assure the delivery of transitional benefits access and counseling to include Veterans Affairs healthcare options, TRICARE programs that may be available, VA benefits counseling such as home loan guarantee, education benefits, and or vocational rehabilitation services.)

Response. I appreciate the opportunity to address this important topic. Two options come to mind, each of which requires more information from the Army. The first is to assign National Guard liaisons to each CBHCO and to each MTF. The second option is to add each State Adjutant General to distribution for admission and disposition notifications. I defer to the Army for further analysis of the efficacy of these options, as well as other possibilities.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BARACK OBAMA

Question 1. Aggregate Health Data. I am concerned that the military is not giving VA enough concrete data to help them conduct long-term planning. Let's take mental health as an example. The Army's Mental Health Advisory Team found that soldiers who deployed to Iraq for a second time were more likely to suffer mental health problems. Dr. Chu, does the Pentagon systematically share information with VA on the total number of soldiers who have deployed to Iraq and the number of times each has deployed?

Response. The Defense Manpower Data Center (DMDC) provides a monthly list of separated Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans to the VA using Service deployment data submissions and the DMDC's most current Active and Reserve component files. The latest list is a cumulative roster of separated veterans who deployed in support of OIF/OEF anytime from September 2001 to November 2006. Data provided include both the start and end date of each deployment that the VA can use to identify the number of times each individual has deployed.

Question 2. Falling Through the Cracks. In an average year, 10,000 to 20,000 servicemembers are separated from the military through the Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) process. These are soldiers who, because of physical or mental health problems, are unfit to be deployed. How many servicemembers were separated from the military last year through the MEB/PEB process? How many of these troops had benefits claims filed before they discharged? How many had their first Veterans Affairs (VA) medical appointment scheduled before they discharged? What kind of comprehensive case management is being offered to these troops? What about the 631,000 total Iraq/Afghanistan vets wounded or otherwise? What kind of one-on-one transition assistance did these veterans receive?

Response. The MEB/PEB process is designed and operated by the individual Services. The Services monitor the separations within their respective personnel communities.

The VA reported in the VA/Department of Defense (DOD) Joint Executive Council Annual Report to Congress on Resource Sharing that, as of December 15, 2006, Social Workers Liaisons assigned to Military Treatment Facilities (MTFs) had processed 6,714 patient transfers to Veterans Health Administration health care facilities. VA Social Workers work onsite at the MTF to respond to referrals to coordinate inpatient and outpatient appointments at a VA Medical Center near the patient's intended residence. They coordinate transfer of care and maintain follow-up with patients to verify success of the discharge plan, and to ensure continuity of therapy and medications. Case managers also refer patients to counselors from the VA who can speak about benefits in general, including vocational rehabilitation.

The DOD has several different programs designed to provide assistance to servicemembers as they transition from active duty to veteran status. The Army Liaison/VA PolyTrauma Rehabilitation Center Collaboration program stood up in March 2005. The intent of this program is to ensure that severely injured servicemembers who are transferred directly from an MTF to one of the four VA PolyTrauma Centers, in Richmond, Virginia; Tampa, Florida; Minneapolis, Minnesota; and Palo Alto, California are met by a familiar face and a uniform. DOD has a long standing relationship with the VA in which they provide rehabilitative services for patients with traumatic brain injuries, amputations, and other serious injuries as soon after the incident as clinically possible. The role of this Army liaison is primarily to provide support to the family through assistance and coordination with a broad array of issues, such as travel, housing, and military pay.

The Joint Seamless Transition Program was established by VA in coordination with the Military Services, to facilitate and coordinate a more timely receipt of benefits for severely injured servicemembers while they are still on active duty. There are 12 VA social workers and counselors assigned at ten MTFs, including Walter Reed Army Medical Center and the National Naval Medical Center in Bethesda. They ensure the seamless transition of health care which includes a comprehensive plan for treatment.

The Military Severely Injured Center (MSIC) operates a hotline center which functions 24 hours a day, 7 days a week. servicemembers or family members can call a toll free number and speak to a care manager, who may become their primary point of contact over time. The Center's mission is to augment the Service-specific programs—the Army Wounded Warrior Program, the Navy Safe Harbor Program, the Air Force Helping Airmen Recover Together Program, and Marine4Life—and work closely with each of these programs to ensure seamless care and benefits as long as it takes—even after members have left the Service.

The Center features creative partnerships with the Department of Labor and Transportation Security Administration, in addition to the VA, and is augmented by field support in the form of a network of credentialed Counselor-Advocates who provide face-to-face assistance in nineteen locations across the country. Collectively, the personnel staffing the MSIC expedite processes help families and alleviate complex road blocks for the severely injured. The MSIC also works closely with non-government agencies to coordinate local assistance programs, such as Heroes to Hometown, in partnership with the American Legion and job fairs.

Question 3. Aggregate Health Data. The Pentagon provides limited data to the VA about servicemembers when they are separating, but does not provide comprehensive systematic data on the numbers of wounded that could help VA in long-term planning. A recent Harvard report put the number of American servicemembers wounded in Iraq and Afghanistan at more than 50,500. Some of these soldiers are sent to military hospitals in the U.S., but many are healed and returned to service. Does DOD provide comprehensive real-time casualty figures to VA, by that I mean the number injured, medically evacuated, and returned to duty every week or every month?

Response. On a monthly basis, the DOD updates casualty figures on the publicly accessible Web site maintained by the Defense Manpower Data Center. The Web site includes month-by-month counts of the wounded in action (WIA) for each operation. The information is available at the following hyperlinks to the site: *http://siadapp.dior.whs.mil/personnel/CASUALTY/OIF-Total-by-month.pdf* and *http://siadapp.dior.whs.mil/personnel/CASUALTY/oefmonth.pdf*.

Other monthly reports on the Web site detail the number of servicemembers whose injuries or illnesses have required their medical transport out of the theater of operation. These data are derived from the information system that is used to manage the air transport of injured and sick servicemembers. Common diseases that require transport include such things as lower back pain, chest pain, vertebral disc disease, inguinal hernia, mood disorders, and urinary stones. Common non-combat injuries include dislocation of knee, fractures of the leg, arm, ankle, and foot and shoulder dislocation. The information is available at the following hyperlinks to the site: *http://siadapp.dior.whs.mil/personnel/CASUALTY/OIF-Total.pdf* and *http://siadapp.dior.whs.mil/personnel/CASUALTY/WOTSUM.pdf*.

As of January 22, 2007, these casualty data showed the following:

Category	OIF	OEF	Totals
Injuries Necessitating Medical Air Transport	13,702	2,009	15,711
Wounded In Action	6,911	648	7,559
Non-hostile injuries	6,791	1,361	8,152
Diseases Necessitating Medical Air Transport	18,547	3,671	22,218
Total Number Air Transported	32,249	5,680	37,929

The Web site also includes reports of the total Wounded in Action. As of January 22, 2007, the total was 24,476. Of those, 7,559 required medical air transport for their wounds. The recent Harvard report used erroneous data from a VA Web site to estimate the number of wounded. The VA subsequently corrected the data on its Web site.

All of the information above is readily accessible to the VA as well as to the general public; therefore, it is not necessary for the DOD to send such data in a special report to the VA. In addition, the vast majority of injuries resolve after appropriate treatment and convalescence, so reporting to the VA is unnecessary as they do not represent a future resource drain for the VA. The more applicable reporting would be of "severe injuries" that we know will require long-term rehabilitation, especially those where the VA will be the likely service provider, e.g., spinal cord injuries and amputations, but we are still working on how to prospectively identify this group of individuals.

In addition, DOD provides data to the VA on servicemembers who have been referred to Physical Evaluation Boards (PEBs). These individuals are most likely to have Service-connected disabilities associated with their illnesses and injuries and are likely to transition soon to VA care after completion of their PEBs. Such data encompass all servicemembers, including those who have medical problems associated with service in OIF and OEF.

Question 4. Total Costs of Caring for OEF/OIF Veterans. A recent report by the Kennedy School of Government at Harvard put the lifetime costs of caring for Iraq/Afghanistan veterans at $350 to $700 billion. Do you agree with this estimate, and if not, what estimate can you offer in its place?

Response. This question addresses lifetime costs of caring for Iraq/Afghanistan veterans, the biggest piece of which will be Department of Veterans Affairs (VA) costs. The referenced report speaks to VA medical and disability costs for Operation Enduring Freedom/Operation Iraqi Freedom veterans. The quoted $350–$700 billion amount must, therefore, be assessed in the context of VA costs. Since we do not possess VA cost data, we respectfully defer to the VA and suggest that this question be redirected to them.

Response to Written Questions Submitted by Hon. Larry E. Craig

Question 1. Two years ago, this Committee held a hearing on the quality of casualty assistance services provided to the spouses of those killed on active duty. We learned about problems in continuity of the personnel assigned for casualty services, confusion among survivors regarding the array Federal benefits available to them, and inconsistencies among the military branches. DOD was directed to develop a uniform policy on casualty assistance. Please provide an update of DOD's efforts to comply with the law. Are survivors provided with electronic access to updated, integrated information regarding their benefits?

Response. The Department takes very seriously its responsibility to provide assistance to families of fallen servicemembers and continues to explore new methods, procedures, and policies to enhance the current level of support or assistance. A guiding principle is this must be a zero-defect program and opportunities for improvement must always be pursued.

Subsequent to the hearings of 2005, several policy improvements and initiatives were implemented to provide standardized assistance to families and eliminate inconsistencies among the Services wherever possible. In response to your specific question, "Are survivors provided with electronic access to updated, integrated information regarding their benefits," it would be helpful if I explain the current process and then our plan on the way ahead to address this issue.

The provision of information on all known Federal benefits and the availability of financial counseling are currently being provided to all applicable survivors and next of kin during the casualty assistance process. Information is provided in

hardcopy, referral to applicable Web sites, and in-person with subject matter experts from the appropriate Agency.

In March 2006, the Department published "A Survivor's Guide to Benefits, Taking Care of Our Own." The guide was subsequently updated in June and November of 2006 and can be found on the Military HomeFront Web site at *http://www.militaryhomefront.dod.mil*. The guide, developed in collaboration with the Military Services, including the Coast Guard, the Department of Veterans Affairs (DVA) and the Social Security Administration (SSA), details the Federal benefits available to families of servicemembers who die on active duty from the DOD, DVA, and SSA.

The Department created, "The Days Ahead, Essential Papers for Families of Fallen Service Members," a three-inch binder designed to assist families in organizing the avalanche of paperwork that is necessary as the family applies for and receives Federal benefits as a result of an active duty death. Spouses who receive "The Days Ahead" notebook will also receive a printed copy of the most recent version of "A Survivor's Guide to Benefits," and another excellent resource, "Military Widow—A Survival Guide," which is the first book specifically focused on the unique challenges women face when they become military widows. This resource is available through Military OneSource.

For the past few years, Service Relief Societies working with the Military Services have contracted with a local firm, the Armed Forces Services Corporation (AFSC), to purchase a lifetime membership, upon request, for eligible family members for AFSC's services. The services provided by AFSC include the capability to consolidate all known Federal benefits into a single document that also forecasts benefits changes over time based on various data changes, e.g., children become the age of majority, spouse remarries, etc. Although the DOD does not currently have a system such as AFSC's, the critical need for information is being addressed in this way.

The Department is considering alternative options, including possibly contracting for this service on a Department-wide basis. The Army has developed a Web-based benefits information system called "myArmy Benefits," which is currently being field tested and considered for possible DOD-wide application. In the interim, family members will continue to receive high-quality benefits counseling from appropriate agency benefits experts at no cost, or, if they accept, through services provided by AFSC, which is paid for by the Service Aid Societies.

The Department's policy on casualty assistance, DOD Instruction 1300.18, "DOD Personnel Casualty Matters, Policies, and Procedures," will provide for standardized processes and procedures throughout the Department, with the exception of those unique customs and traditions of a Military Department. This Instruction is in its final stages of formal coordination.

Question 2. I have learned a lot about the transition experience of Idaho's 116th Armor Cavalry Brigade, since their return from Iraq. In general, their experiences seem to have been positive. But, I do have concern over waiting sometimes as long as 6 months for their post-deployment health reassessments, understaffed call centers, long waiting times for 6-month check-ups, etc. What is DOD doing to improve timeliness on follow-up services and care once our Guardsmen and Reservists are back in-country and transitioning to civilian life?

Response. The PDHRA was designed to be completed after the member returned home and had time to settle into their civilian life. It is conducted three to 6 months after return. In fact, our epidemiological research indicates that concerns continue to emerge over the first year. It would be ill-advised to complete this assessment earlier than 3 months after redeploying. This contrasts with the Post-Deployment Health Assessment (PDHA), which is completed within 30 days of return from theater. The benefit of having an extra post-deployment assessment, the PDHRA, is that it allows time for additional concerns to emerge, especially those related to reintegration with one's family, friends, and community.

The original contract to conduct the PDHRA for the National Guard and Reserves encountered unexpected surges rather than an even demand. For example, virtually all National Guard units drill on the first or second weekend of each month. Once this issue came to light, we implemented changes to increase staffing for those weekends. Initially, the Reserves indicated they would prefer to use a call center to accomplish PDHRAs throughout the week, but then realized that it would be easier for commanders to emphasize the importance of these assessments if they were completed at the unit during a drill weekend, which was also the first weekend of the month. Again, modifications to the supporting business processes remedied the workflow problem.

The PDHRA is a new clinical process, so we were not surprised that we would need to make changes as the process matured. As we identify challenges and recognize more responsive ways to complete the PDHRA, we make rapid adjustments to meet the needs.

The DOD requires returning servicemembers to undergo PDHAs to document current health status, experiences, environmental exposures, and health concerns. The assessments enable health care providers to promptly refer those needing medical evaluation and care.

Completion of the PDHA takes place within 30 days of the expected date of redeployment from the theater to the servicemember's home station. Use of the PDHA was mandated in an October 6, 1998 Health Affairs policy memo. A healthcare provider reviews the form, interviews the servicemember and recommends additional clinical evaluation or treatment as needed. Copies of the PDHA become part of the servicemembers' medical records and are also stored in the central electronic database of the Defense Medical Surveillance System. Registered health care providers can access electronic copies of the PDHA forms via TRICARE Online. Additional post-deployment testing, such as serum samples, tuberculosis skin testing, etc., occur at specified intervals following redeployment. Post-deployment blood specimens are collected within 30 days of redeployment and are processed to produce serum that is frozen and archived in the DOD Serum Repository. A PDHRA occurs within 90–180 days following redeployment.

Between January 1, 2003 and December 18, 2006, more than one million redeploying servicemembers have completed the PDHA process. Approximately 92 percent of returnees have described their general health as "good," "very good," or "excellent."

Copies of the PDHA forms are part of the servicemembers' permanent medical records, which are provided to the VA through the Seamless Transition Program whenever an individual elects for VA care at the time of separation or retirement. DOD has successfully developed the capacity to add electronic pre- and post-deployment health assessment information on separated servicemembers to the monthly patient information being sent to the VA. DOD completed a historical data pull in July 2005 that resulted in approximately 400,000 pre- and post-deployment health assessments being transmitted to the data repository at the VA Austin Automation Center. Monthly transmission of electronic pre- and post-deployment health assessment data to the Federal Health Information Electronic data repository began in September 2005. DOD added the new PDHRA information to the monthly date feed in November 2006. As of December 2006, VA has access to over 1.5 million PDHA and PDHRA forms on more than 623,000 separated servicemembers and demobilized Reserve and National Guard members.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. ARLEN SPECTER

Question 1. Does the Department of Defense consider Post Exchange and Commissary services part of the compensation and benefits package offered to individuals serving in/retired from the military?

Response. DOD policy recognizes the commissary and exchange services as part of the compensation and benefits package offered to active duty members of the Military Services. Because the commissary and exchange benefits provide an income effect through savings on purchases, the compensation status of the military member is the primary determinant when authorizing these privileges. Commissary and exchange shopping privileges are extended to Reserve and Guard members, retired servicemembers, veterans with 100 percent service-connected disability, Medal of Honor recipients, and the dependents of the authorized groups.

Question 2. When do DECA and AAFES plan to release the plan for implementing the BRAC 2005 law, related to Post Exchanges and Commissaries across the country?

Response. Commissary and exchange activities are addressed within each of the individual installation closure plans. There are no DOD-wide commissary or exchange plans to implement the Base Realignment and Closure 2005 recommendations except that, under DOD policy, commissaries and exchanges normally close when the base closes.

Question 3. Has DECA and AAFES conducted the required study of the catchment area and usage levels in the tri-state area (western Pennsylvania/eastern Ohio/northern West Virgina) of the Post Exchange and Commissary at the Kelly Support Center, Oakdale, Pennsylvania? If not, what is the time frame for the study to be concluded?

Response. No, the Base Realignment and Closure (BRAC) process does not require a study of the catchment area and usage levels of the exchange and commissary in the tri-state area surrounding the C.E. Kelly Support Center. The commissary and exchange at C.E. Kelly are scheduled to close when the installation closes by October 2008. However, two smaller AAFES facilities in the Pittsburgh area (Pittsburgh

Air National Guard, 171st Air Refueling Wing and Airport Air Force Reserve, 911th Airlift Wing) are unaffected by BRAC and will remain open. In addition, if a Military Department were to request establishment of new facilities in the Pittsburgh area, that request will be evaluated under Department established criteria.

Question 4. How will this information be used in determining the ongoing operation of the Oakdale facility?

Response. The Base Realignment and Closure process does not require a study of the catchment area and usage levels in the tri-state area. At this time, there are no plans for ongoing operations at Oakdale, the location of C.E. Kelly Support Center. The commissary and exchange at the C.E. Kelly Support Center are scheduled to close by October 2008, when the installation closes.

Question 5. As the Army's Kelly Support Center in Oakdale, Pennsylvania is the host of the Post Exchange and Commissary, and under Base Realignment and Closure (BRAC) 2005 law, the facilities will be closing, has any consideration been given to moving the Post Exchange and Commissary to an alternate location in western PA?

Response. There are no plans to open new commissary and exchange facilities in western Pennsylvania. As long as sales warrant, the Army and Air Force Exchange Service plans to keep two stores at Pittsburgh Air National Guard, 171st Air Refueling Wing and Airport Air Force Reserve, 911th Airlift Wing. These locations are unaffected by BRAC.

Question 6. What role can the community serve as the Defense Commissary Agency and the Army and Air Forces Exchange Service evaluates the future of the Post Exchange and Commissary at the Oakdale, Pennsylvania facility?

Response. The community should contact the Redevelopment Authority of Allegheny County, which is recognized as the Local Redevelopment Authority (LRA) for planning and directing the reuse of C.E. Kelly Support Center, Oakdale, Pennsylvania. The LRA has not proposed continuation of the commissary and exchange in the local reuse plan. A decision to continue operating a commissary or exchange at a closed base is based on established criteria, including the number of active duty servicemembers remaining in or around the closed installation.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LINDSEY O. GRAHAM

Question 1. Interagency Coordination. We all support our troops, especially those who are disabled as a result of their service to our Nation. However, members and their families continue to report that they face an overlapping and confusing set of benefits that require our injured servicemembers or their family members to navigate, in many cases, several large bureaucracies (Department of Defense, Veterans Benefits Administration, Veterans Health Care Administration, Social Security Administration and Medicare). Because so many agencies are involved in the care of our veterans, how do you keep those other agencies informed of your efforts, and what is the process to resolve problems that exist between agencies?

Response. While it is true that many agencies are involved, there are mechanisms in place to keep all agencies informed of the others' efforts and to resolve problems that exist between agencies.

For systemic issues associated with benefits, transition, or support of the severely injured and their families in general, a number of councils and programs are in place to facilitate communication and cooperation between Departments, as well as serve as the mechanism to resolve issues and find solutions to systemic problems.

- The Joint Executive Council (JEC) provides guidance and establishes policy for the full spectrum of collaborative activities and initiatives between the DOD and Veterans Affairs (VA). The JEC oversees and guides the activities of the VA/DOD Benefits Executive and Health Executive Councils (BEC and HEC, respectively), as well as their many working groups.
- The HEC is responsible for implementing a coordinated health care resource sharing program.
- The BEC is responsible for examining ways to expand and improve benefit information sharing, refining the process for records retrieval, and identifying procedures to improve the benefits claims process.
- The Transition Assistance Program (TAP) Steering Committee, with representatives from DOD, the Military Services, VA, Department of Labor (DOL), and the Department of Homeland Security (DHS) meets quarterly to discuss and address issues and challenges. They work to find solutions, conduct pilots, and look for new initiatives that will enhance and improve the current transition program and the overall quality of life for all members of our Armed Forces.

• DOD's Military Severely Injured Center (MSIC) augments the support provided by the Services programs (the Army Wounded Warrior Program, the Navy SAFE HARBOR Program, the Air Force Helping Airmen Recover Together Program, and the Marine4Life Injured Support Program. The MSIC reaches beyond the DOD to other agencies, to the nonprofit world, and to corporate America. It serves as a fusion point for four Federal agencies—DOD, VA, DHS Transportation Security Administration, and DOL.

Additionally, to better meet the needs of the Guard and Reserve, DOD, with the assistance of DOL and VA, is designing a new, dynamic, interactive, automated Web-based system for delivery of transition assistance and related information. The Department completed phase one of the new site and released a "soft-launch" in February 2007. The site is called TurboTAP and can be accessed at *http://www.TurboTAP.org*.

On February 23, 2007, Secretary Gates established an independent review group, co-chaired by two former Secretaries of the Army, Togo West and Jack Marsh, to review the care and support for the wounded at Walter Reed Army Medical Center and National Naval Medical Center (Bethesda). On March 6, 2007, President Bush established a committee, co-chaired by former Senator Robert Dole and former Secretary of Health and Human Services, Donna Shalala to look more broadly at this issue. Both committees will offer opportunities to strengthen support and encourage interaction among agencies.

Question 2. Interagency Coordination. To what extent have your agencies interfaced with State government agencies which may also be of assistance to severely injured and disabled veterans?

Response. Through the Department's Heroes to Hometowns program, we have partnered with the National Guard Bureau, the American Legion, and most recently with the National Association of State Directors of Veteran's Affairs (NASDVA) to tap into their national, State, and local support systems to provide essential links to government, corporate, and nonprofit resources at all levels and to garner community support. Support has included help with paying bills, adapting homes, finding jobs, education and job training, arranging welcome home celebrations, help working through the bureaucracy, holiday dinners, sports and recreation opportunities, mentoring, and, importantly, hometown support.

Charter members of State Heroes to Hometowns Committees include the American Legion's State Adjutant, the National Guard's State Family Program Directors, and NASDVA's State Directors of VA. The intent is for severely injured servicemembers and their families to dialogue with the State Committee members well in advance of their return home. The committee members can then work with their networks in the State and local community to coordinate government and nongovernment resources and establish support networks for servicemembers and their families so they can live productive lives.

The American public's strong support for our troops is especially evident in their willingness to help severely injured servicemembers and their ever-supportive families, as they transition from the hospital environment and return to civilian life.

Question 3. Electronic Medical Records. According to the Department of Defense, much more work is needed on development of a comprehensive inpatient health care record. What funds have been allocated by the DOD and the VA in 2008 to support the development of an inpatient electronic record that is compatible and interoperable between the two agencies?

Response. A comprehensive electronic health record (EHR), to include inpatient care, is DOD's goal; however, the first priority for AHLTA, the DOD EHR, was to address ambulatory care. The AHLTA inpatient electronic record development/acquisition is currently targeted to begin in Fiscal Year 2010. VA is embarking on a modernization of its EHR to include the inpatient component.

Since both Departments were planning new inpatient electronic record acquisition or modernization, DOD and VA are initiating a project to work together on a 6-month study to assess the benefits and impacts of various alternatives before making a final decision on a joint acquisition strategy for an inpatient electronic health record system. We anticipate a contract award to a study support contractor within the next 30–60 days. The completed study will make a recommendation on an acquisition/development strategy for an inpatient EHR. The study will provide data needed to determine the acquisition/development strategy, timelines, impacts on current systems, and projected costs. The Departments will then be able to evaluate alternatives for funding the chosen technical solution.

Question 4. Expanded Partnership between the DOD and VA in Health Care Services. S. 1042, the National Defense Authorization bill for Fiscal Year 2006, as passed by the Senate on November 11, 2005, contained requirement for the GAO

to study an expanded partnership between the DOD and VA in the provision of health care services, including an assessment of the advantages and disadvantages for military retirees over age 65 and their dependents to participate in the VA's health care system. Please share with the Committee your thoughts on the potential value of such an expanded partnership, especially for military retirees over the age of 65.

Response. The proposal to shift all retiree health care to the VA appears to prohibit their use of DOD Military Treatment Facilities (MTFs), and would then be viewed by retirees as a breach of faith.

TRICARE provides a comprehensive, integrated health care program of DOD MTFs and civilian providers for retirees and their families. Forcing all retirees to use the VA would be a radical change. All VA medical centers can already participate in the TRICARE program as network providers, where retirees and their families have the freedom to use them voluntarily.

It is not clear what would be gained by converting a system of broad choice of health care providers into a system that makes using VA medical centers compulsory. For Medicare eligible retirees over the age of 65, under current law, the VA is not able to receive payment from Medicare and TRICARE is now the second payer for their care. Thus, if this group were required to use VA facilities there would be a large cost shift for the care of these individuals which would need to be addressed.

Chairman AKAKA. Thank you very much, Dr. Chu.

Before I begin my questions, I would like to call on Senator Webb for any statement that you may have.

STATEMENT OF HON. JIM WEBB, U.S. SENATOR FROM VIRGINIA

Senator WEBB. Thank you, Mr. Chairman. I am sorry I am late. We have got three Committee hearings backed up today on my schedule, and I very much appreciate your calling this hearing.

I am sorry I missed the other opening statements, but I have a long regard for the capabilities of our two panelists today. I have known Dr. Chu for many years. We worked together in the Pentagon, and I have known Secretary Mansfield personally and by reputation, and I know these are people who are personally committed to the same things that those of us on the Committee are.

I would like to say one precatory comment, however. I spent 4 years of my life working every day on veterans issues as a Committee counsel on the House side, and the one really shocking piece of reality to me returning to this area was the bureaucratic stagnation in the VA that I see, and particularly in terms of claims. I want to make that one of my priorities to find a way that we can streamline this claims process and get more energy into it and get the answers out to the people who are trying to have their situations resolved. And I will be looking forward, Secretary Mansfield, to working with you on that.

I have one other very brief comment. I was present at the creation of some of these DOD/VA cooperative efforts. And when you were talking about the Chicago situation, we worked on that. When I was Assistant Secretary of Defense for Reserve Affairs, that was one of our pilot programs. We were looking at that in terms of expanding usage of the VA in case we had to mobilize. That was one of the things that was on the table. But that has been a little more than 20 years since we did that, and this is an area where I hope we can, again, really put some energy into it.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Webb.

I have a question for both Secretary Mansfield and Dr. Chu. I understand that it may be 2012 before DOD and VA have an elec-

tronic medical record that can be shared and accessed by providers in both Departments. In the year 2003, the President's task force believed that this could be in place by 2005. My question to both of you is: Why is this taking so long? Secretary Mansfield, you can respond first.

Mr. MANSFIELD. Mr. Chairman, I would agree that this is one of the things I have mentioned we have had ups and downs, and it has been a combination of problems within the VA, I think, and within DOD. The VA system is an old system on an old platform that we need to take into the 21st century and upgrade. In the process of doing that, it would be good if we could work with DOD, and I think the announcement that we will hear later on today is that there will be a commitment to doing that so that we can agree that the VA has a record system that should be usable by both entities, and we can move forward to do that.

As far as the timing, I think part of it has been, as I mentioned, we had this universal depository of information where the three medical services in DOD could put information in, and then we could get the feeds out of that. That was the agreement that we were working on for the last 2 or 3 years. We can take this quantum leap forward if we agree that we use one system, and it is time to do that, and we are going to do that.

Chairman AKAKA. All right. Do you have an idea of when that may be?

Mr. MANSFIELD. Sir, as always, it is a combination of not only the feasibility but also the ability to have the resources to make it work, and we are in the process of attempting to be able to justify what we need to the Congress of the United States, the Appropriations Subcommittees, in an effort to do that. I do not have an exact time frame right now.

Chairman AKAKA. Dr. Chu?

Dr. CHU. I think, Mr. Chairman, that we need to offer a little more detail on what has been accomplished.

First of all, the Department of Defense has transmitted just under 4 million electronic records for veterans to VA, so there is a major repository of record data there.

Second, as Secretary Mansfield said, we have initiated as pilots what are called bidirectional data exchanges, meaning that a provider in either facility, in real time or near real time, can look up the ongoing record of the individual. That is not a trivial information technology problem given that the two Cabinet Departments have very different information technology architectures, but it has been demonstrated at a handful of sites.

Third, I do think we would all benefit from some precision about what we mean by "the medical record." Do we mean a summary of the patient's diagnoses? That is fairly straightforward. Do we mean the clinical notes that the clinician may have recorded? Which, of course, historically were written down. It would have to be transcribed. Do we mean actual X-ray images? That is a much more significant data requirement and much more difficult to assemble and maintain. Do we mean the pharmacological record for the patient? That is another set of data.

So when we say "the medical record," I think what I would emphasize is straightforward medical records in large volume have

been and are continuously being transmitted to VA. The real issue going ahead is what Secretary Mansfield indicated. Can we create a record that is bidirectional, that is real time in nature, and that eventually does append these data storage device intensive records like X-ray images? That is a significant challenge. We think it can be done. We are committed to that goal. It will take time. I do not want to be naive about what is required. And I should emphasize, it would be the largest—we are already the largest such exchange in the country in terms of information. This would take all of that endeavor to an even more ambitious level.

Chairman AKAKA. Thank you very much, Dr. Chu.

I have other questions, but since my time will soon be expired, let me ask Senator Craig for the questions he has, and we will have a second round.

Senator CRAIG. Thank you very much, Mr. Chairman.

Gentlemen, thank you for your testimony. And, Dr. Chu, thank you for broadening the overall understanding of what we are attempting to get done here. We look at VA today and see its interoperability from center to center with total record movement, including X-rays. We assume you can put two wires together or wirelessly transmit, and that will happen with DOD. Unless you are all on the same electronic system, unless you are doing the input, then the transitional time is going to be considerable. But what I think is significant—and I am hearing it, I am beginning to hear it from both of you—is that work is underway. That is what this Committee and this Congress has insisted upon, and we are going to stay with it until there is total interoperability with these two systems. Then we will have accomplished a great deal in time and transition that is critically important, and in that process I would trust that the active becoming veterans would not fall through the cracks in a way that is being expressed today with great frustration on the part of many of my colleagues and myself.

To both of you, many severely injured servicemembers are now being disability-retired from active duty, making them eligible for TRICARE. Clearly, as service-connected disabled veterans, they are also eligible for VA Care. All of us want to do whatever is necessary to assist service-connected veterans, but I would like to hear from both of you your thoughts as to whether your agencies, which are both trying to be all things to all severely disabled veterans, are creating some confusion and frustration on the part of beneficiaries as well as real problems for health care coordination by having dual eligibility. Gordon?

Mr. MANSFIELD. Yes, Mr. Chairman, a good question. I think part of what we are looking at here has to be in the context of what the VA has set up and excels in. For example, the Spinal Cord Injury Network is one that is nationwide, provides individuals the only ability across the country to have the same type of care, the same degree of quality of care, and allows a spinal cord injured individual to be rehabilitated and to be taken care of and to have a long-term care plan for them within that system.

If you look at the Inspector General's recent report—last year, I believe, or late the year before—on traumatic brain injury, there was a finding in that assessment of the VA Care that we were doing as well as and probably better than the civilian sector in tak-

ing care of traumatic brain injury, with the caveat that there was a problem, again, with the long-term care. But the IG suggested that we should look at the spinal cord injury system again as something to follow in the TBI area.

I think it may well depend on the nature of the injury and who has the best ability to make this person as whole as possible or to give them the best care or to be able to rehabilitate them the best. And I think we have to look and make the decision based on that, what is best for the individual. And, something that we are learning, dealing with, and practicing, is, now we are not just dealing with the individual soldier or the veteran; we are also dealing with the family. Both the Spinal Cord Injury Network and the TBI Network are ones that have included the family in the process of designing a care program, moving through it, and having the family members understand what is happening and what the probable outcomes are. So, I think, those are the issues that you have to look at in making decisions about what really is best for that individual.

And then the last issue that you have to deal with that we have seen some problems or some issues with is a geographic one, because we are not everywhere. We are not everywhere, and we cannot deliver care everywhere. So then it becomes a question of what the veteran or the veteran's family wants as far as where do they want to be and what care can we provide in that location.

Senator CRAIG. David?

Dr. CHU. Senator, if I may add to Mr. Mansfield's response, first, we recognize that providing people with more choices can create some degree of confusion. It is one of the reasons that the VA has moved to put counselors into the major hospitals to which the significantly wounded return, so that there are people on-site who can help people make these choices intelligently and with knowledge of what the pros and cons of the selection might be.

Second, we established the Military Severely Injured Center to ensure that there was a backstop for all of this, a place 24 hours a day the families can call and get answers to their questions. It is a warm handoff to a human being, to a person who is going to deal with the issue at hand, whatever it might be.

Third, as Secretary Mansfield outlined, we recognize that the country is better off if the two institutions specialize, and so as he suggested, for traumatic brain injury we turn to VA. We recognize they are going to be the premier source of care for those with significant degrees—there is mild concussion and so on. There is a whole gradation, as you recognize. I think the clinical staffs of the two Cabinet Departments, which do work very closely together on these issues, are charting a course of who is going to do what as we move ahead. So that while the veteran may select, based on geography or personal preference or provider relationship, a particular facility—and that is the veteran's right—we try to direct people to the areas where they are going to get the best result.

Senator CRAIG. Thank you.

Mr. Chairman, thank you.

Chairman AKAKA. Thank you very much, Senator Craig.

I would like to ask Senator Obama, before I ask Senator Rockefeller for his questions, to make any opening statement he may have.

STATEMENT OF HON. BARACK OBAMA, U.S. SENATOR FROM ILLINOIS

Senator OBAMA. Thank you, Mr. Chairman. I just want to commend the Chairman and Ranking Member for organizing this hearing. I think that we have all been concerned about the steps that we need to take to ensure that when our veterans come home, that they have got the best possible services available. I think that is going to be a heightened concern in the years to come, as we have Iraqi and Afghani eterans coming home. And so, rather than make a lengthy statement, I will submit my statement for the record, if there are no objections, and let Senator Rockefeller proceed with his questions.

Chairman AKAKA. Thank you very much, Senator Obama. Your statement will be placed in the record.

[The prepared statement of Senator Obama follows:]

PREPARED STATEMENT OF HON. BARACK OBAMA, U.S. SENATOR FROM ILLINOIS

Thank you, Chairman Akaka and Senator Craig,for holding this hearing.

I'm pleased that the Pentagon and the Department of Veterans Affairs have taken some steps to smooth the transition from active duty to civilian life. For example, significant efforts have been made on behalf of the most severely injured servicemembers. But, when I look at the programs and systems put into place to help our veterans and compare them to the sheer numbers of servicemembers entering civilian life, I'm worried that many veterans—especially, the less severely injured and those with mental health problems—will fall through the cracks.

The numbers are overwhelming. More than 630,000 servicemembers who were deployed in the War on Terror are now veterans. More than 50,500 soldiers have been injured in Iraq and Afghanistan. Yet the VA has only provided intensive casework assistance to 6,700 severely injured veterans. That means that a vast majority of troops leaving the military, including many injured men and women, do not have caseworkers dedicated to guiding them through the bureaucracy, scheduling their first medical appointments, and ensuring their benefits are coming through in a timely fashion. This lack of coordination may be the reason why fewer than one-third of Iraq and Afghanistan veterans have actually sought care at the VA.

I'm pleased that the Committee will be holding hearings on transition, and I hope that the Committee will focus on several aspects of this issue.

First, proper budget planning is critical. A recent Harvard report estimated that the total lifetime costs of providing disability benefits and healthcare to Iraq and Afghanistan veterans will range from $350 billion to $700 billion. The reality, however, is that the VA has little idea what those numbers actually will be. Over the last 2 years, the VA has experienced $3 billion in budget shortfalls, largely because it failed to account for the demands of new Iraq/Afghanistan veterans. DOD has taken some steps to provide the VA with data on separating servicemembers, but has not turned over the information that the VA needs to conduct accurate long-term budgetary planning. The VA is essentially operating in the dark, and we need to start keeping better track of soldiers and potential future demands on the veterans' system.

Second, we need to focus on electronic medical records. I know we cannot wave a magic wand and get interoperable health records, or real-time, two-way information sharing. But the Pentagon has dragged its heels in modernizing and sharing data, and veterans are suffering as a result. The GAO found that even in cases when DOD facilities set up information-sharing agreements with VA hospitals, the system is plagued with technical glitches. I've proposed that all servicemembers should receive secure electronic copies of their health and service record to simplify the process for applying for benefits and health care. I hope the Committee will act on my proposal.

Finally, I'm concerned about the VA's ability to deal with post-traumatic stress disorder and traumatic brain injury. Thirty-six percent of Iraq and Afghanistan vet-

erans treated so far have been diagnosed with some kind of mental health condition. Traumatic brain injury, the signature injury of the Iraq war, is one we still know little about. We need to make sure the VA has the expertise and manpower to care for veterans with TBI and PTSD.

Thank you again Chairman Akaka, Senator Craig. I look forward to this hearing.

Chairman AKAKA. I want to tell our witnesses that your full statements will be placed in the record as well.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I want to say to our witnesses that I take it as a given what most medical journals now say, and that is that the VA system as a system is better than our private health care system. One of the two of you indicated such in one field, but I think it is generally true.

But there is one major difference. The private health care system has a fairly predictable stream of people coming in and coming out. The veterans care system is based on, as we say these days, surges and they are very dramatic surges, and they take catastrophic, you know, substantive forms.

I think about 25 percent of soldiers who have served in Iraq display symptoms of very serious mental health problems. On the other hand, almost 80 percent of soldiers serving in Iraq and Afghanistan who have exhibited those same traits are refused mental health services. If you can refute that, I will be happy. Of those who needed services, only 40 percent expressed an interest in receiving help. Now, that is an important thing because that is human nature, particularly human nature among men. They do not like to admit that. It comes out in horrible forms later on, but that accounts for half of the 80 percent. And, actually, only about 26 percent are receiving the mental health care that they need, and that is not getting up to the suicide area. That is just regular mental health care.

Now, I would like you to explain that to me. I make it a practice that virtually every weekend I go home, I have a no-pencil, no-press, no-staff, me—alone, my tie on—I will not take it off because I am not changing anything I am. So they do an "Arnold Schwarzenegger glasses" check on me. I pick none of them out, and 12 or 13 of them decide that maybe I am OK to talk to. And then the most unbelievable surge of PTSD and mental health stress, suicidal tendencies come pouring forward. I clear my afternoon so these sessions can go 3 to 4 hours. And it is unbelievable, to waking up in the middle of the night and being convinced that the person lying next to you, who is otherwise known as your wife, is, in fact, an Iraqi—an Iraqi who has a knife who is about to slice your throat, and you run out of the house; to, you know, any clicking door anytime during the night, you are on full alert; people moving as far away from other people as they possibly can; and just endless examples of that sort. Painful, painful. One starts going, the others start going. And it incredibly painful, and it grounds me in the area of veterans.

Which takes me back to what Senator Murray said, and that is that the President did not mention veterans. And I think veterans are sort of—this may be a little bit unkind, but it is my impression because I have no other way of expressing it—that it is a little bit like education or, you know, other things that we need to do in this country but after the war is over we will get to that. Veterans are

a part and parcel—I do not have to tell you—of war. And as Jim, I think, said, until you do veterans, the war is not complete. Perhaps you said that. You do not complete the war.

So I am just interested in this: number one, what do you do about the 40 percent who do not talk about it? You say you have specialists over there, and you have specialists at home, and they are available. That is what Vet Centers are for, so you do not have to go to veterans' hospitals. They are more convenient. They are localized. People tend to take their families so it becomes cheaper. But they do not express that view.

I can remember in Charleston walking into a Vet Center once when there were five gray-suited people that looked like I did, and I thought they were all, you know, auditors from the VA. Well, they were all there for PTSD appointments. And so everybody has their disguises; everybody has their ways of not discussing things.

And so, number one, what do you do about that 40 percent? You know what the statistics are. You know what the probabilities are. And, therefore, how can you reach out to them earlier and later? Because you know they are going to explode at some point.

And then, second—I guess my time is up. I will continue on the next round.

Mr. MANSFIELD. Well, let me take it from there. Number one is that there can be some difference in what the numbers are, whether it is 40 percent or 25 percent. The bottom line is there is a problem, and we recognized that. And I think you can say that DOD has recognized that, and the VA definitely has recognized that.

We recently went through the issue to put in place a new mental health plan in an effort to make sure that we had mental health practitioners across our system in all our——

Senator ROCKEFELLER. But is it enough? That is always the question. Of course, you have those programs. Of course, you attend to those matters. But are there enough of them out there to find out the people who have these problems?

Mr. MANSFIELD. Well, no, there are not enough. I can tell you for people in——

Senator ROCKEFELLER. Why? Because you don't have the budget.

Mr. MANSFIELD. In Northfield, Massachusetts, right on the Vermont line, the last CBOC that I was up to dedicate, I went through that, and we went through the whole 7,000 square feet. That is where the primary care practitioners are. This is the mental health arena. But we cannot find a mental health practitioner that wants to come to this area to practice here. So that means——

Senator ROCKEFELLER. So that is a special problem for you, isn't it?

Mr. MANSFIELD. It is a problem.

Senator ROCKEFELLER. That has to do with budget.

Mr. MANSFIELD. So that means we have to send the people down the line to Northampton to the hospital and have them treated down there or try and get somebody from the hospital to come out and deal with it.

So one issue is the ability to get enough practitioners and put them in place. That is an ongoing issue, but we have committed additional dollars and additional attention from the highest level to that to make it work. And I know, Senator, a long time ago, you

were one of the ones who were saying the VA needs to have a mental health practitioner in every one of its CBOCs. We are moving toward that, and that is a way of recognizing that we do have a problem, we have to deal with it and solve it.

The other issue is that DOD—and David can answer some of this—have people on the ground in the combat zone that are dealing with this issue, and we have also worked together to come up with this joint assessment record that allows us to attempt to identify those individuals who may need help, and then we can make the offer and start going into the system.

Senator ROCKEFELLER. But why did you spend $100 million less than the $300 million you had on outreach to mental health folks last year?

Mr. MANSFIELD. Well, part of it may be because we couldn't find the practitioner to put in that clinic up there.

Senator ROCKEFELLER. That is not an excuse.

Mr. MANSFIELD. Part of it may be because we are rolling——

Senator ROCKEFELLER. That is an excuse in——

Mr. MANSFIELD. Part of it may be because we are rolling out——

Senator ROCKEFELLER. That is an excuse in the community health care system, but it is not an excuse in the Veterans' Administration system. That is a unique system for unique individuals who render unique services, and that is not an excuse.

Mr. MANSFIELD. And part of it may be that it is a new initiative that we just put the money into. We need to make sure that we keep the effort on from the highest levels to move this thing out through the organization to make sure that it does happen—recognizing from top to bottom that there is this problem, we do have to deal with it, it is an important issue.

Dr. CHU. Senator, if I can come back to two parts of your question.

Senator ROCKEFELLER. Yes. I am way over my time. The Chairman is going to shut me up for the next three meetings.

Dr. CHU. If I might, very briefly, though, respond to two parts of your question. First, the numbers, the 25 percent figure that you cited, I believe that is a figure that does not indicate serious mental health problems. It is the fraction of people on the returning post-deployment health assessments who indicate any issue that might cause us to follow up as to whether there is a mental health issue or not. And that relates to the 80 percent figure that you described. It is not that they are denied care. In many of these cases, it turns out there is not a mental health issue that deserves follow-up. That is where the 80 percent comes from.

Senator ROCKEFELLER. Thank you.

Dr. CHU. To the latter part of your question, which is otherwise to reach out, we recognize that the reluctance of Americans to seek mental health care is an important question. We are not only pursuing, both DOD and VA, the classical remedies that have been employed, which is practitioners who are available to see people, but we are trying new routes.

So, for example, we do have a Web-based self-assessment tool that we are publicizing to our people. It allows you privately, without any recourse to a practitioner, to ask yourself: Do I have an issue? Now, of course, you have got to be able to use that tool. That

would be the next challenge. But it allows privacy, which is what is important to many of these situations.

Likewise, as Secretary Mansfield said, in theater we have put mental health teams in the field to ensure that people who display symptoms or whose commanders are worried about their behavior are seen by appropriate mental health practitioners right then and there, again, to try to reach out in a different way than we have in the past.

Senator ROCKEFELLER. Thank you.

I apologize, Mr. Chairman, very much.

Chairman AKAKA. Thank you.

May I call now on Senator Murray, and she will be followed by Senator Sanders and Senator Obama.

Senator Murray?

Senator MURRAY. Thank you, Mr. Chairman. And thank you to both of you. None of us are questioning that both of you have a strong commitment to whom you serve, and we appreciate that. But you need to understand that the frustration that you are hearing comes from us because we do go home to our States, we do talk to these veterans, and we can no longer face them with the long waiting lines, the lack of care. The veterans, Senator Rockefeller talked about, these are people who are frustrated we see every week when we go home. And it seems to me when we are in a time of war, we should have a heightened sensibility within all of your agencies and an understanding that you all consider this to be a serious problem that needs to be addressed, and take that back to your agencies and the Administration, and we see that reflected in the budget back to us.

It is not acceptable to us that money is not used simply to save money. We have to make sure these veterans are served, and that is the frustration you are hearing from all of us up here.

And, Dr. Chu, I specifically wanted to ask you, because I am concerned about where you are coming from and give you a chance to respond, because I was very disturbed to see an article in the *Wall Street Journal*—it is now a couple years ago—January 25, 2005, which quoted you talking about benefits for veterans. And you said that, "The amounts have gotten to the point where they are hurtful. They are taking away from the Nation's ability to defend itself."

If that is what you said, that is a gross misunderstanding of our obligation to our American veterans, and I could find no record of apology or retraction. So I wanted today to give you a chance. Do you still believe that keeping our promise to American veterans comes at the expense of our military?

Dr. CHU. That is not what I said, Senator. I never used the words "veterans' benefits." Others have mischaracterized my remarks that way and never, frankly—sorry. I should repeat myself.

That is not what I said, Senator. I never used the words "veterans' benefits." Others have mischaracterized my remarks in an effort to distort them and to evade the issue. The issue I addressed was the award, often by the Congress over the objections of both the prior and the present Administration, of additional programs to honor individuals who had served a full career in the military—in other words, this is not the person who serves 2 or 3 years and

goes home—who are well compensated for their military service, including a significant annuity, lifetime subsidized medical care, and so on and so forth.

What I was trying to point out is that the burden of those expenses is starting to eat away at the ability of the American military to prepare for its future. That is a real problem. I think people inside and outside the Department recognize this problem. I regret that my remarks were distorted and mischaracterized in a way that suggests an assault on veterans benefits. That was not the purpose of my remarks. That was not the meaning of my remarks. That is not what I said at the time.

Senator MURRAY. Do you agree that caring for our veterans is a part of the cost of war?

Dr. CHU. We owe our veterans care for their injuries, support for their transition to civil life, support if they have difficulties in that transition, and I support the programs that accomplish those outcomes.

Senator MURRAY. Well, since we have been funding this war through supplementals up to this point, would you agree that the supplementals should include funding to meet the needs of our veterans then?

Dr. CHU. The question of what goes into the supplemental versus the base budget is a decision made by the Office of Management and Budget. I should say that in terms of the immediate funding issues that you outlined, as I think Members of this body are aware, it is now up to Congress to fund the Fiscal Year 2007 budget correctly. There has been talk of funding at the 2006 level because of the appropriation issue out there. The Administration is seeking to get the Veterans Affairs Department funded correctly.

Senator MURRAY. Are you not willing to say that it should be part of the cost of war, part of the supplemental request——

Dr. CHU. The decisions on budget——

Senator MURRAY. [continuing].—or advocate for that?

Dr. CHU [continuing].—structure are made by the Office of Management and Budget. In the end, once Congress appropriates the money, which is what counts for the execution of the programs, it matters little whether it is in the supplemental or in the regular budget.

Senator MURRAY. All right. Let me move on. I wanted to ask a few more questions. I am very concerned that the VA, Secretary Mansfield, is not prepared to care for our Afghan and Iraq veterans when they return. As I said earlier, in Fiscal Year 2006, the VA planned to provide health care for about 110,000 veterans from Iraq and Afghanistan, and, in fact, they served 185,000. The VA was off by 68 percent. For 2007, the VA estimated that 109,000 Iraq and Afghanistan veterans will need service. So we see now that the VA is assuming that they are going to see even fewer veterans this year than they saw last year, and that to me just defies common sense.

Can you tell the Committee why you think the number of veterans served this year is going to be lower than last year?

Mr. MANSFIELD. I am not sure which numbers you are using, I believe those numbers are the additional new veterans coming into

the system, and they are added on to the ones that were in before. So you are really looking at a number that is 260,000 or 280,000.

The other point I would make is that no matter how many of them come into the system—and I believe last year, while we did have more veterans coming in than we projected—the amount of money dedicated to caring for those veterans that was expended was less than we budgeted for. So we actually had more money budgeted for their care, even considering the one-third increase, than we had——

Senator MURRAY. I am having trouble following the logic, but just for this Committee——

Mr. MANSFIELD. It is a report that I can make sure that we get to you and show you, Senator.

Senator MURRAY. What is the total number of veterans that you expect to see this year?

Mr. MANSFIELD. I am sorry. I did not prepare to bring that number with me, but I can ask some personnel.

Do we have that in a budget sense?

It is going to be in the same range that we were talking about before, with some adjustment for what we have seen in the last couple of years.

Senator MURRAY. Well, as I mentioned earlier as well, in Friday's *Houston Chronicle* Secretary Nicholson said that the deployment of 21,000 more troops to Iraq will have a minimal impact on the VA. Most of the veterans that I talked to at home, who are frustrated, disagree with that. And I would like to ask both of you what the impact of this surge will be on transition assistance, on health care waiting lists, and benefits backlog and, subsequently, what you are going to do to minimize the impact of this.

Dr. CHU. If I may, Senator Murray, I think the source—I am merely speculating. I have not talked to Secretary Nicholson. Maybe Mr. Mansfield has more insight here.

I presume the source of his comment is the fact that we enjoy and attribute, really, to young Americans today, we enjoy very high retention rates in both the active and Reserve services of the United States. So a high fraction of those who have served in Iraq and Afghanistan or in other theaters around the world in the Global War on Terror are still in military service. They are not, with some modest exceptions, eligible for the various benefits that you described. So I presume that is the basis of his statement. Most of the people who join the military today stay with the military today.

Mr. MANSFIELD. I think part of it, too, Senator—and this, of course, is a macro view, and you are talking about talking face-to-face with the individual at that level. But we treated approximately 5.3 million individuals during the course of last year, so the effect of 21,500 more and what percentage from there that may come into the system becomes a smaller number.

But the issue you raised is to make sure that we can get those people in the system and access to and in a timely manner is the issue that we really have to pay attention to.

But I would reiterate that last year the amount of money budgeted for care for Iraqi and Afghani returning veterans expended was less than was budgeted for, even though the number was higher. The reports show that.

Senator MURRAY. Well, Mr. Chairman, I hope we can really look at that because that is disconcerting to me, that if we are budgeting money, we already know we have underbudgeted, and then we are not spending that money, we are saying it is less. Why are veterans not getting this care? Is it because of the waiting lines, they do not get in, and so they do not impact the budget? Is it because we are not reaching out and trying to find these veterans, as Senator Rockefeller was talking about, with PTSD? So, you know, obviously, they are not impacting the budget if they are not getting the services they need.

I hope we can really take a look at that. I am very——

Mr. MANSFIELD. The returning veterans, new veterans for their first appointment are getting in generally within the 30-day period that we have set aside. And if it is an emergency care——

Senator MURRAY. We are hearing a 6-month waiting list to get in for primary care.

Mr. MANSFIELD. Well, I would like to follow up with you, Senator, and find out exactly, where and when that is and see what we can do to fix it then.

The information I receive on a monthly basis says that for 98 percent we are getting them in within 30 days. The area where we have a problem, which I would admit, is the specialty care arena, where it is taking longer than we have planned for to get them into the next step.

Senator MURRAY. And could you tell us, if you do not have it today, how many Iraqi veterans are enrolled today in the VA?

Mr. MANSFIELD. I do not have that with me, but I can provide it for the record very soon.

Senator MURRAY. Thank you.

Chairman Akaka Thank you, Senator Murray.

Senator OBAMA. Mr. Chairman, I apologize to Senator Sanders. Unfortunately, I have got a Senate Foreign Relations Committee meeting as well, so what I'd like to do is just submit my questions to the record. I apologize that I am not going to be able to ask questions. But if Dr. Chu and Mr. Mansfield would be willing to have their offices respond, that would be helpful.

Thank you very much.

Chairman AKAKA. Thank you, Senator Obama.

Senator Sanders?

Senator SANDERS. Thank you, Mr. Chairman.

I think the key aspect of this discussion that we have been having this morning is that there are some of us up here who think that, among other things, the VA is significantly underfunded and is not responding in a timely manner or as effectively as it might to the needs of veterans.

I would like to ask Mr. Mansfield, Are you and the Secretary going to recommend to the President a substantial increase in funding for the VA?

Mr. MANSFIELD. Senator, we go through a process in internal budgeting which allows us to figure out how many people we believe we will need to take care of, and then we ask for the money to take care of them.

Senator SANDERS. Right.

Mr. MANSFIELD. So we have asked for and we have been granted, although it has not gone through the total process, significant additional dollars in the last number of years.

Senator SANDERS. Yes, but the needs, as you have heard—we are in the middle of a war, so it is not a surprise that we use additional dollars. My question is: Are you going to ask for substantial increases in funding for the VA to address the needs that you are hearing today for the veterans of this country? Can we expect the President to say we have a serious crisis, we are going to take care of veterans, and to do that, we are going to substantially increase funding? Are you going to make that recommendation, sir?

Mr. MANSFIELD. Sir, I would make the point that we would ask for what we believe we need to get the job done.

Senator SANDERS. Do you believe that we need substantial increases in funding?

Mr. MANSFIELD. I believe that we need some increases in funding and that we have asked for substantially that amount. Again, if——

Senator SANDERS. Well, it sounds to me, sir, like a non-answer, to be honest with you. Let me ask you another question, though.

Last year, in the President's budget, as I recall, he proposed doubling the costs of prescription drugs for our veterans, and he also proposed a substantial increase in the fees for many of the veterans. And, I believe, studies indicated that the increase in fees would drive some 200,000 veterans off of VA health care. Can we expect the President again to ask veterans of this country to pay more for their health care?

Mr. MANSFIELD. That I do not know, sir.

Senator SANDERS. Do you think that that is a good idea?

Mr. MANSFIELD. I think that we presented an argument that showed across the board that there was unequity issue tied in to people that have served 3 or 4 years and are entitled to care and those that have served 20 or 30 years and are in the TRICARE arena and have to pay certain amounts to get the benefits there.

Senator SANDERS. So what we are doing is saying some veterans are in need, more in need, and maybe we should drive some veterans off of VA health care. Do you think that is a good idea?

Mr. MANSFIELD. Well, I would tell you, sir, I do not approach this with the idea that we are driving anybody off of——

Senator SANDERS. Well, the studies seem to indicate that if you propose—I believe it was. I may be wrong on this. Somebody can correct me. Was it a $250 increase in fees? Does that sound right? And I believe that I read that would result in driving hundreds of thousands of veterans off of VA health care? Do we think that is a good idea?

Mr. MANSFIELD. I do not believe that the words "driving people off of VA health care" is, again, the approach that I would have taken to any of these——

Senator SANDERS. But if that is the—well, let me go back again——

Mr. MANSFIELD. People make decisions based on economics about which——

Senator SANDERS. They sure do. And if they do not have much money and they have to pay $250 to get VA health care, you know

what some of them will do? They will say, "I am not going to go into VA health care." Won't they? Do you agree?

Mr. MANSFIELD. Yes.

Senator SANDERS. My question is: Are you going to recommend to the President not to increase fees for VA health care and not to double prescription drug costs? That is my question.

Mr. MANSFIELD. We are in the process, sir, where a budget has been put together and will be presented at an appropriate time here on the Hill in the immediate future.

Senator SANDERS. Well, Mr. Chairman, I think the difficulty is that we have some of us here who think that our veterans are in need of more help than they are getting. We would like to see the VA budget adequately funded, and some of us are a little bit disturbed that the VA is not there demanding that the President provide the kind of resources that, in fact, we need.

I would yield back. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Sanders.

As you know, this oversight hearing is on collaboration and cooperation to meet the needs of returning servicemembers, and these concerns will be dealt with in this Committee.

To the second round of questions, this is to Secretary Mansfield and Dr. Chu. Since 2002, OMB has lowered the grade from green to yellow for the President's Management Agenda Initiative on coordination between VA and DOD.

Secretary Mansfield, you first. What explains this drop in grade? And what is VA doing to improve performance?

Mr. MANSFIELD. Sir, I believe part of it is the fact that the VA/DOD cooperation element was included in the President's Management Agenda for the first time only a year ago, and there is a process where they start out at the bottom, so you start out red and then you have to come up from there.

The other point I would make is that Dr. Chu and I agreed when the JEC considered the plan that we offered, which was then looked at by the folks in the President's Management Agenda to make the grades, we would rather reach as high as we could and set the bar as high as we could in an effort to make sure that we could go forward in a way to meet the full needs. So we did not back off of that and put in a lower-level plan. We put the bar as high as we could in an effort to make sure we were trying to drive this effort forward to the fullest degree we could. And that meant that on some of those issues, we did not get the accomplishment that we hoped for.

Chairman AKAKA. Dr. Chu?

Dr. CHU. If I may add to Secretary Mansfield's response, the OMB grades typically reflect progress against a set of milestones. So in Period 1, if you get green, it means you have met the milestones for that period. In Period 2, much as Secretary Mansfield outlined, you have a new set of milestones. And if you do not meet all those milestones, you will not get quite as good a grade.

It is intended to call management's attention to areas that need reinforcement. We have done that. I think you will see the next grades will look better as a result.

Chairman AKAKA. Secretary Mansfield and Dr. Chu, there are many programs in both DOD and VA that work with those who

suffered serious injury in Iraq and Afghanistan. There is DOD's Military Severely Injured Joint Support Operations Center. The Army has its Wounded Warrior Program. The Marines has the Marines4Life Program. The Air Force has its Helping Airmen Recovery Together program. The Navy has SAFE HARBOR. In VA, there is a National Polytrauma Rehabilitation Call Center Helpline.

Dr. Chu, you first. What is being done to ensure that these programs are considered? And how is their effectiveness being measured? How are servicemembers and their families being helped in figuring out where to seek assistance? Dr. Chu?

Dr. CHU. Mr. Chairman, it is a pleasure to address these programs because they are important to the rehabilitation and return to full productive life of our veterans who have suffered significant injuries.

The separate service programs are stronger now than they were before. Therefore, the Severely Injured Center that you described will start stepping back as the services start stepping forward, each in its own lane to care for its own people. That is a model of decentralized effort that I think responds to some of the concerns Members have raised here this morning. Each service is closer to its people. There is a cultural affiliation, a warmth, a caring that is, I think, ennobling in terms of what they do. So we want the individual services to play a strong role.

Now that they are more prepared to do so, we will step back, and, in fact, we will rename the Severely Injured Center as part of the Military OneSource Center, which is our broad outreach program to military families for all issues.

The Veterans Affairs Department has a close liaison with us in these programs. As I indicated, it puts counselors in places like Walter Reed and Bethesda and other significant military hospitals around the country. There is a very strong partnership between the two.

It is important to allow the veterans to choose how they best like to be cared for. Even if clinically we might have one recommendation, ultimately the choice of how they wish to proceed is theirs, and our responsibility is to ensure they know about those choices and can make a considered, thoughtful decision, that the bureaucracy is facilitating rather than standing in the way of their progress. And I think we have got quite a good track record. That is ultimately the measure: Are the families satisfied, are the veterans satisfied with the care that they are receiving? I think you have seen in news media reports the very fine remarks that those with severe injuries have given to the care they are getting at Walter Reed and Bethesda.

Chairman AKAKA. Mr. Mansfield?

Mr. MANSFIELD. Mr. Chairman, I would just make the point that, going back to the initiation of these programs, the VA cooperated with the Secretary of the Army and the Commandant of the Marine Corps originally to put these programs in place. Also, we cooperated with Dr. Chu to put VA people in the OSD office in an effort to make sure these programs went forward.

We recognize that after a severe injury that causes the person to be removed from the battlefield in some cases, or in other cir-

cumstances, to a military treatment facility, then they are faced with the question of what happens next, the fact that they may be leaving the service is another issue that we have to deal with, and it is something that they worry about. And I know this personally from my own background and what happens as you go through this process.

We have the social workers and the benefits counselors from the VA in Walter Reed or Bethesda to help that transfer and to work with that individual, that man or woman who is injured, as well as their family. This is a way to ensure that we have the representatives from the services in the VA facility.

For example, yesterday, in preparation for this meeting, I met with the colonel from the Marine Corps and a representative from the Army who are in VA headquarters prepared to deal with any issues that come up from these seriously injured individuals as they make that transfer to a VA facility, to make sure that they do not get lost in the cracks, any issues they have that come up will be dealt with. So I think it is a very good way to make sure that this seamless transition is covered on both sides—the military treatment facility, DOD; the VA medical center, the VA.

Chairman AKAKA. My time has expired.

Senator Rockefeller?

Senator ROCKEFELLER. I want to reflect a little bit on the Guard and Reserve. The third largest complaint of these listening sessions that I go to, if I may be frank about it, is the disdainful condescension of the regular military toward the Guard and the Reserve, which represents a large part of what West Virginia soldiers are doing in Afghanistan and Iraq.

Now, I do not attribute that to either of you two. Gordon, you have been in my house many times. We are very good friends. You are now representing a different client than you used to be. Dr. Chu, I do not know you. But our General of the Reserve component remembers—feels that the following standards should be: no longer than 1 week for non-urgent routine medical care. Do you think this is possible?

Dr. CHU. Sir, are you speaking to me or to Mr. Mansfield?

Senator ROCKEFELLER. I am sorry?

Dr. CHU. Sir, are you asking me or Mr. Mansfield?

Senator ROCKEFELLER. I am asking you.

Dr. CHU. For VA treatment or for——

Senator ROCKEFELLER. Yes.

Dr. CHU. I really would not be competent to speak to what the VA standard ought to be.

Senator ROCKEFELLER. Secretary Mansfield?

Mr. MANSFIELD. A person needs an appointment and they should get it in 1 week; is that the question?

Senator ROCKEFELLER. Yes.

Mr. MANSFIELD. The Commander of the Reserve believes that?

Senator ROCKEFELLER. For routine medical care.

Mr. MANSFIELD. In the VA.

Senator ROCKEFELLER. In the VA.

Mr. MANSFIELD. These are folks that have now qualified for VA care?

Senator ROCKEFELLER. Correct; otherwise, they would not be there.

Mr. MANSFIELD. So they are out and about. The standard we have, sir, is 30 days for the initial appointment, and if it is emergent care, then it is taken care of immediately. So it is longer than 1 week. It could potentially, depending on——

Senator ROCKEFELLER. OK. The second part of his question is no longer than 1 month for specialty care, which includes, of course, surgeries. Do you know that is possible?

Mr. MANSFIELD. No, sir. Right now, it is not. Specialty care is an area, as I mentioned earlier, I believe, where we have problems meeting our current standards, and we are stretching times on that right now.

However, I would make the point again that my medical advisers continue to tell me emergent care or an obvious need right away would be taken care of right away.

Senator ROCKEFELLER. Do you know what I think this all comes down to, Mr. Mansfield? It comes down to the fact that, other than the Pentagon—and perhaps including the Pentagon—the Veterans' Administration is the largest agency in Government. Now, that may be true of CMS and not the VA, but in any event, it is in the top two or three.

Your answers to questions here today were that you have to do the best you can and you have to work through the "process," a word which you used. The process is as follows: Every word that you spoke to us from your prepared testimony and every word that you spoke to us, Dr. Chu, from your prepared testimony—well, particularly you, Mr. Mansfield; I don't know about Dr. Chu—was vetted by the Office of Management and Budget. That is the way the system works around here. You do not get to give what you think. You get to give what the company line is. I want people to understand that.

So that when we ask you, "Do you think people are getting enough service?" You have to say, "Well, we are doing the best we can," or "Yes," or as they used to say when I went to Iraq, "We have enough troops to accomplish the mission, sir"—which meant that they did not.

Now, in this system where the OMB—and I do not know how many trips they make out to Iraq, and I assume they do make trips out to Iraq and Afghanistan. But they can only give you what they are told to give you, what the budget parameters of that year will allow them to give to you, which, by definition, means that the veteran is put into a second position, the recipient position.

So there is only one way out of that. I tried it once on Vice President Gore, and it worked, because being Vice President is called "up there." And I had an issue on veterans health care, and I proposed to make a stink about it, and I called him up, and I said, "Does the Government have any more money than this in the budget?" Well, the OMB budget had already been drafted. And he was not pleased by my phone call, was not pleased by me, and, nevertheless, at the end he yielded and the budget number went up.

Last year, Danny Akaka and Patty Murray led the fight, not for the $3 billion which should have been the increase in the veterans care budget, for the $1 billion which they thought they could get.

That overruled the OMB in that part of the process because it was, as you said, appropriated, voted, legislative funds, passed both Houses.

So, if Senator Akaka had not done that, if Senator Murray had not done that, you would have a $1 billion shortfall, which then leads to the question: What do you all do about it? You are the ones—and I like you a lot. I respect you a lot. You know that. In spite of the tone of my questioning, you know that. And so the question is then: What do people like you and Dr. Chu do? Or what does somebody like Jim Nicholson do?

There is only one recourse for him, and he can only use it once. And in the case of the veterans, I am not sure that he would have to use it more than once, and that is, he walks in to the President and he says, "If I do not get $3 billion more," or "X" billion dollars more, or whatever it is, for mental health, for suicide prevention, for getting that 80 percent—the 40 percent of which do not declare themselves, but which an experienced eye can tell signs of out there in the field, much less back here. He says, "If I do not get that money, I am going to quit. And I am going to quit and I am going to tell the public why I quit."

That has an amazing effect on a President, I would guess. Veterans, Iraq-Afghan War—or, rather, Afghan-Iraq War is the central subject of our times and that, unfortunately, is the limit of the process. I can make a phone call to Gore, if I happen to know him and if it happens to work. I was Chairman at the time. We can legislate, you know, override OMB and we can legislate.

You do not play a part in either of those, but you are the folks on the line. You are the guy who got the medal. You know what it is. So you are put into a position where you really cannot speak up for the veteran except for the money that is appropriated to you, which is never, under Democrats or Republicans, sufficient. Because always to this point, veterans have been considered by the body politic to be a subsequent matter, a subsequent item.

Now, all of a sudden they are not. Maybe that began with—was it Rebecca Lynch? Hmm? Jessica Lynch—of West Virginia, no less. And she became sort of the voice, the image of the veteran, and then it progressed up from there.

How many was it that were killed yesterday? Was it 79, in the last 2 days, 79? They will not be veterans. But others were wounded; they will be veterans. They now have these Iranian IEDs that put all these long shards of metal into you, and you live, but you probably wish that you did not because the pain is so horrible and so chronic, and it rests with you for the rest of your life because they cannot take those shards out because they are too close to vital veins and organs. So you live in agony for having served your country.

You understand my point. I simply say that there have to be some people who are willing to put themselves on the line. Danny did. He could have lost. Veterans could have said, "Oh, he did not try hard enough." They would not have said that about Danny, the Chairman. But he did it and he won. And Patty Murray, the schoolteacher in tennis shoes, did the same thing, and she won.

Now, if they can win, so can you. Your concern is 24/7 about these folks, all the time. That is all you think about. You bleed

with them. You cry with them. You hug them. And you think about what you have to do to make their lives better. But you cannot, because you are under the thumb of the Office of Management and Budget. You are ruled by them—unless you find a way to supersede them, which is what I ask you and us to do.

I thank the Chairman.

Chairman AKAKA. Thank you very much, Senator Rockefeller.

Let me close with a question to Secretary Mansfield. As you know, Secretary Mansfield—and we are talking about being on the line, and I feel that Vet Centers are on the line for the VA. And I have been working over the years to increase funding for the Vet Centers. I view the services they provide as being very, very critical to the mission of the VA.

My question to you: Are the Vet Centers effectively connecting with returning servicemembers? Does VA have sufficient resources to meet the demand that these returning servicemembers will place on essential programs through the Vet Centers, Secretary Mansfield?

Mr. MANSFIELD. Mr. Chairman, I would make the point that in my travels as I go out to VA facilities, I do try and visit Vet Centers every chance I get. And in the ones that I have visited lately over the course of the last year, in each and every one of them there have been Iraqi veterans present for the effort going forward or ones that have come in and signed up.

We have twice gone out and made an effort to hire Iraqi veterans to bring them in for peer counseling, and each time that I visited a Vet Center, I have heard from those individuals, and they are going out, for example, to the National Guard units that they know about because they are from the town, or maybe they were from that unit, to the Reserve units, as well as active-duty units that may be in the area, and attempting to make sure that the Iraqi and Afghan veterans are aware of the services provided.

I believe—and I have asked the question of my medical advisers—that they are funded sufficiently to get the job done, recognizing that we have given them additional people to get the job done. And I believe that we are adding significant numbers of new Vet Centers over the course of this Fiscal Year, should we get a budget, and also next year, in an effort to make sure we continue to reach out.

The one issue that still comes up and that I am aware of is: Are we doing enough for family counseling? There have been some efforts to require that we get qualified or certified family counselors involved in the process for the effort to deal with the family members present. Right now, I think the approach is, these are Vet Centers and we are there primarily for the veteran. We do recognize that having the family involved helps the veteran, again, to get whole or get better, and we are making an effort to review that issue and come up with some final answers.

I think we are doing a good job in that area. I know that there are a lot of Iraqi veterans that are coming in and are being helped. And in addition to that, we have also, as of 2 years ago, started doing bereavement services. I have been in some Vet Centers where families of veterans who are deceased have been brought in,

and they are having groups of them to help them through the bereavement process.

So they continue to expand the work they do, and the issue of families, I think, is paramount in all that we are doing when we are talking about Iraqi or Afghan veterans.

Chairman AKAKA. Our country is facing huge challenges when it comes to our veterans, and I am so glad you mentioned families. We need to extend it to them because families affect our troops wherever they are.

There is no question that collaboration and cooperation is needed between Congress and the Administration, as well as between VA and DOD. We need bipartisan support in all of these, but the huge challenge is that we need to provide the kinds of services that are being demanded by our veterans, and many problems that arise. One of them is resources, funding, and we have talked about this today, the need to do that. And we need to find ways of doing it because with more resources we may be able to provide better services.

There is also a need to look at and restructure what we have now in the VA services so that we can better serve the veterans. So many of these challenges now face us, and today is the beginning of all of that. And today's hearing has been on collaboration and cooperation, and I mention that to you in the spirit that we want to try to work together to help the veterans of the United States of America. We owe it to them, and they need all the help we can give them.

I want to thank you, Secretary Mansfield and Dr. Chu, for your testimony this morning. I do have a request. At these hearings, we often are unable to ask all the questions we would like, and as a result, we end up sending you post-hearing questions, as was mentioned by Senator Obama. And I do and other Members have post-hearing questions.

The record will be open for 2 weeks for submission of post-hearing questions. In the past, we have experienced difficulty in getting timely responses to post-hearing questions. I would like your assurances that you will do everything within your power to ensure that reasonable response times are met.

Also, if you would each designate one point-of-contact person for any future questions on this subject, we would really appreciate that.

Mr. MANSFIELD. Thank you, Mr. Chairman. You have my assurance.

Dr. CHU. Thank you, Mr. Chairman.

Chairman AKAKA. And so, again, thank you for your responses, and this hearing stands adjourned.

[Whereupon, at 11:24 a.m., the Committee was adjourned.]

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