S. HRG. 110–132

HEARING ON THE NOMINATION OF MICHAEL J. KUSSMAN, M.D., TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

MAY 16, 2007

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.access.gpo.gov/congress/senate

U.S. GOVERNMENT PRINTING OFFICE

37-239 PDF WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

DANIEL K. AKAKA, Hawaii, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia	LARRY E. CRAIG, Idaho, *Ranking Member*
PATTY MURRAY, Washington	ARLEN SPECTER, Pennsylvania
BARACK OBAMA, Illinois	RICHARD M. BURR, North Carolina
BERNARD SANDERS, (I) Vermont	JOHNNY ISAKSON, Georgia
SHERROD BROWN, Ohio	LINDSEY O. GRAHAM, South Carolina
JIM WEBB, Virginia	KAY BAILEY HUTCHISON, Texas
JON TESTER, Montana	JOHN ENSIGN, Nevada

WILLIAM E. BREW, *Staff Director*
LUPE WISSEL, *Republican Staff Director*

C O N T E N T S

MAY 16, 2007

SENATORS

WITNESSES

APPENDIX

HEARING ON THE NOMINATION OF MICHAEL J. KUSSMAN, M.D., TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS' AFFAIRS

WEDNESDAY, MAY 16, 2007

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

The Committee met, pursuant to notice, at 10 a.m., in Room 562, Dirksen Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Tester, Webb, Craig, and Burr.

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

Chairman AKAKA. The hearing of the U.S. Senate Veterans' Affairs Committee will come to order.

I note that we have a series of votes scheduled for 10:30. My hope is that we can withhold all opening statements, and move directly to the testimony of the first panel as we consider the nomination of Dr. Michael Kussman to serve as Under Secretary for Health of the Department of Veterans Affairs. When we return from votes, we can proceed with opening statements and hear from our nominee, Dr. Kussman. But in the meantime, we will proceed with the panel.

But before we do that, I want to make a special introduction and that is of Dr. Kussman's wife, Ginny. Ginny, it is good to have you here, also Josh, who is here, as well as Josh and Deana's significant others, as well, here with us today for this very, very special hearing.

I welcome our first panel of witnesses. We have invited each of you to hear your perspective on Dr. Kussman's qualifications to be Under Secretary for Health for the Department of Veterans Affairs.

First, I welcome Dr. Darrell Kirch, President of the Association of American Medical Colleges since July of 2006. Dr. Kirch, thank you so much for being here today. I look forward to hearing your views on Dr. Kussman from the perspective of VA's medical school affiliations.

Dr. Fred Frese is a respected clinician and is here on behalf of the National Alliance on Mental Illness.

I also welcome Douglas Mitchell of the Association of VA Social Workers. It is important to have VA employees represented at this

hearing, and I am glad that you could make it here to provide us with your perspective.

Finally, I have asked Robert Wallace of the Veterans of Foreign Wars to speak for his organization regarding Dr. Kussman. Mr. Wallace, as a representative of those who rely on VA health care and the health care system, your opinion is particularly important.

Again, I want to thank all of you for being here today.

Your full statements will appear in the record of the Committee.

[The prepared statement of Hon. Daniel K. Akaka follows:]

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

This hearing is to consider the nomination of Michael J. Kussman, M.D., to be VA's Under Secretary for Health.

Dr. Kussman, your nomination comes before the Senate at a difficult and challenging time for VA. The terrible conditions at Walter Reed put a spotlight on VA health care. With each passing day, more and more servicemembers are returning with serious traumas and injuries, which for some will mean a lifetime of care from VA. As servicemembers reach out to VA, inevitably we hear tragic stories of those who did not get the care they needed.

There is no doubt that mental health issues will also be a challenge for VA. A truth of the war is that the toll will be felt by servicemembers and their families for years to come. I am talking about invisible wounds—wounds which cannot be seen but are every bit as devastating as physical wounds.

VA's Under Secretary for Health is one of the most important public servants. The next Under Secretary will guide the VA medical system at a time when so many new veterans will be turning to VA. From my vantage point, VA was not prepared to deal with the types of injuries stemming from this war. Capacity must be rebuilt. And the next Under Secretary will have this challenge.

I urge you, Dr. Kussman: if you are confirmed, to first and foremost serve as an advocate for veterans. I am quite cognizant of the constraints placed upon you by the White House and OMB. I promise you my full cooperation and assistance, but I tell you now, that I will not be satisfied unless you work to uphold the promises made to all our troops.

May I call first on Dr. Kirch.

STATEMENT OF DARRELL G. KIRCH, M.D., PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. KIRCH. Mr. Chairman, Members of the Committee, I very much appreciate the opportunity to testify in support of Dr. Kussman today. As you said, I am Darrell Kirch and I serve as the President of the Association of American Medical Colleges. We represent the 125 medical schools in the United States and 107 of those schools are closely affiliated with the VA. We also represent over 400 major teaching hospitals, and that includes 68 VA medical centers.

It has been more than six decades that America's medical schools and the VA have had this remarkable partnership around research, education, and patient care. I have to say that relationship means a great deal to me personally. The majority of my clinical experiences as a medical student, as a resident in training, happened in VA medical centers. The physicians, the staff of the VA, but most of all, the patients of the VA were among the finest teachers I had in my career. Additionally, my first exposure to the excitement of medical research and the beginning of my career as a medical scientist came seeing studies conducted at the VA to improve patient care.

It is really clear to me from the work of the Joint VA–AAMC Deans Liaison Committee we have that Dr. Kussman takes a great deal of pride in this special relationship and partnership, and it is also clear to me from his distinguished career that his first priority is ensuring first-class health care for the Nation's veterans.

Before I speak specifically to why I think he is so well-suited to carry forward our joint mission, I do want to mention two items that are in my written testimony that I think are critically important to our Nation going forward. The VA plan to increase support for graduate medical education by adding 2,000 residency positions over the next 5 years is absolutely vital at this time to our Nation. It is increasingly clear with the growth and aging of our population we face a severe physician shortage and this will help us dramatically with that.

The second point I wanted to underscore is the urgent need to increase funding for the VA Medical and Prosthetic Research Program. This attracts high-caliber clinicians, scientists, to deliver care, conduct research at the VA facilities, and it is my hope that Dr. Kussman, the Administration, and this Congress can work to provide more funding for that program.

But turning my attention to Dr. Kussman and the VA Deans Liaison Committee, I can highlight four things that I have seen under his stewardship where we are making great progress.

First, we have worked with Dr. Kussman and the VA staff to ensure that the Blue Ribbon Panel on Medical School Affiliations will have measurable outcomes. We want this panel to help us establish specific criteria so that we can look at each affiliation and evaluate its health as a partnership.

Second, to prevent conflicts of interest, the VA has very appropriately determined that we have to have limits on remuneration from affiliated institutions for VA employees who serve at the level of chief of staff or above. We have been pleased, though, to work with Dr. Kussman and the VA to ensure that while these arrangements scrupulously avoid conflicts of interest, they also address concerns that prohibiting certain kinds of academic compensation could hinder the VA's ability to recruit the best staff from its affiliates.

The third thing we have worked on under Dr. Kussman's leadership has been a pilot of the new hours bank concept for the way part-time physicians can work at the VA.

Medical work is very complex and the hours bank will allow medical faculty who also have appointments at the VA to work more efficiently to negotiate pay schedules and get the job done for patients.

And then last, we have worked with Dr. Kussman to ensure that the changes required by the Veterans' Health Care Eligibility Reform Act of 1996 would not adversely affect the affiliations, and we are very pleased that recognizing the benefit of the affiliated training programs, the VA has concluded that contract awards that overlap with medical education have to be weighed by additional factors beyond just the pure contract cost.

I thank you for the opportunity to testify today. I congratulate Dr. Kussman on his nomination and I personally very much look forward to working with him and continuing what is a truly re-

markable partnership for America. I will be happy to answer any questions you have at any point.

[The prepared statement of Dr. Kirch follows:]

PREPARED STATEMENT OF DARRELL G. KIRCH, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Good morning. Mr. Chairman, Members of the Committee, I would like to thank you for the opportunity to testify in support of Dr. Michael J. Kussman's nomination as Under Secretary for Health at the Veterans Health Administration (VHA) of the U.S. Department of Veterans Affairs (VA).

My name is Dr. Darrell G. Kirch and I am President and Chief Executive Officer of the Association of American Medical Colleges (AAMC). The AAMC is a nonprofit association representing all 125 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and 94 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians.

For more than 60 years, academic medicine and the VA have enjoyed a remarkable partnership in our joint missions of medical education, research, and patient care. This relationship is especially meaningful to me because the majority of my own clinical experience as a medical student and resident occurred in VA medical centers. The physicians and staff, and especially the patients, of the VA were among my finest teachers. Additionally, my first exposure to the excitement of biomedical research, leading to my own career in science, came through studies being conducted at the VA to improve patient care.

Dr. Kussman understands that the first priority is the patient. And throughout his distinguished military career, he has dedicated himself to ensuring world-class health care for our Nation's military servicemen and women. Dr. Kussman also understands that veteran care can be improved by the partnerships the VA has built with medical schools and teaching hospitals.

In my comments today, I would like to tell you more about the relationship between the VA and academic medicine—and why I believe Dr. Kussman's leadership will be pivotal in carrying forward our joint missions of education, research, and patient care, with the goal of ensuring the best care for our Nation's veterans.

HISTORY OF VA—ACADEMIC AFFILIATIONS

Our longstanding association with the VA began shortly after World War II when the VA faced the challenge of an unprecedented number of veterans who would need medical care and a shortage of qualified VA physicians to provide these services. At the same time, medical schools had been looking for ways to expand graduate medical education opportunities to accommodate all physicians who had entered the armed services without completing specialty training.

Responding to these pressing needs, President Truman signed Public Law 79–293, providing the legal basis for the VA to affiliate with schools of medicine and establishing the VA Department of Medicine and Surgery, the predecessor of the VHA. Less than a month after this law went into effect, the VA published Policy Memorandum No. 2, the "Policy on Association of Veterans' Hospitals with Medical Schools." This memorandum officially launched our partnership with the VA, enabling medical schools to staff VA hospitals with top-notch medical school faculty physicians, residents, and interns. The affiliated VA facilities, in turn, would provide medical schools with new venues in which to conduct research and educate young physicians.

VA GRADUATE MEDICAL EDUCATION

Today, the VA manages the largest graduate medical education training program in the United States, with 107 of the Nation's 125 accredited allopathic medical schools now affiliated with VA medical centers. The VA system accounts for approximately 10 percent of all graduate medical education in the country, supporting more than 9,000 full-time medical residency training positions. More than half the Nation's physicians receive some part of their medical training in VA hospitals, as over 31,000 medical residents and 16,000 medical students rotate through the VA health system each year.

As our Nation once again faces a critical shortage of physicians, the VA has been the first to respond. Under Dr. Kussman's leadership, the VA plans to increase its support for graduate medical education, adding an additional 2,000 positions for residency training over the next 5 years. The expansion will begin in July 2007

when the VA adds 341 new positions. These training positions will address the VA's critical needs and provide skilled health care professionals for the entire Nation. The additional residency positions also will encourage innovation in education that will improve patient care, enable physicians in different disciplines to work together, and incorporate state-of-the-art models of clinical care—including VA's renowned quality and patient safety programs and electronic medical record system.

VA MEDICAL AND PROSTHETIC RESEARCH

The VA research program is another important element of the affiliations that Dr. Kussman is charged to oversee. The VA Medical and Prosthetic Research program is one of the Nation's premier research endeavors and attracts high-caliber clinicians to deliver care and conduct research in VA medical facilities. The program is supported by a dedicated source of funding available only to physicians with full- or part-time VA appointments. As a result, our Nation's medical schools use VA research as a recruiting tool to attract top-quality physicians. The VA currently supports over 3,800 researchers, of whom nearly 83 percent are practicing clinicians who provide direct patient care to veteran patients. As a result, the VHA has a unique ability to translate progress in medical science directly to improvements in clinical care.

As we move forward, it is imperative that the Administration work with this Congress to reverse the recent flat-funding for VA Medical and Prosthetic Research. The VA needs significant growth in its annual research and development appropriation to develop solutions for new conditions prevalent among our most recent veterans, as well as continuing the groundbreaking research that has benefited veterans of previous wars—and certainly our Nation as a whole.

Of course, state-of-the-art research requires state-of-the-art technology, equipment, and facilities. In coordination with increases in the research budget, the Administration must also ensure a steady stream of resources dedicated to renovating existing research facilities. An environment that promotes excellence in teaching and patient care as well as research will help VA recruit and retain the best and brightest clinician scientists.

VA—AAMC DEANS LIAISON COMMITTEE

Finally, I would like to talk briefly about the VA—AAMC Deans Liaison Committee—a standing committee of medical school deans and VA officials, including the Chief Academic Affiliations Officer, the VA Chief Research and Development Officer, and three Veterans Integrated Service Network (VISN) directors. Dr. Kussman and I meet regularly with this committee to maintain an open dialogue between the VA and academic medical centers and provide advice on how to better manage their joint affiliations. The agendas usually cover a variety of issues raised by both parties and range from ensuring information technology security to the integrity of sole-source contracting directives.

At its most recent meeting last February, the VA-Deans Liaison Committee reviewed the remarkable progress being made on several VA initiatives under the stewardship of Dr. Kussman in his capacity as VA Acting Under Secretary for Health. These include:

• Establishment of the Blue-Ribbon Panel on Veterans Affairs Medical School Affiliations—This panel will provide advice and consultation on matters related to the VA's strategic planning initiative to assure equitable, harmonious, and synergistic academic affiliations. During the panel's deliberations, those affiliations will be broadly assessed in light of changes in medical education, research priorities, and the health care needs of veterans. The AAMC has worked with Dr. Kussman and VA staff to ensure that this will be an operational commission with measurable outcomes. Similarly, we have discussed the aspiration that the panel would facilitate putting in place criteria for evaluating the "health" of individual affiliation relationships.

• Development of VA Handbook on VHA Chief of Staff Academic Appointments—To prevent conflicts of interest or the appearance thereof, the VA has determined that limits on receiving remuneration from affiliated institutions are necessary for VHA employees at levels higher than chief of staff. While it is important to ensure that remuneration agreements do not create bias in the actions of VHA staff, prohibition of certain compensation from previous academic appointments (e.g., honoraria, tuition waivers, and contributions to retirement funds) could significantly hinder the VA's ability to recruit staff from their academic affiliates. The AAMC has worked with Dr. Kussman and VA staff to develop a mutually amicable agreement that considers this balance.

• Piloting the VA physician time and attendance/hours bank—Monitoring physician time and attendance for the many medical faculty holding joint appointments with VA medical centers has been complicated and inefficient. The VHA has accepted the "hours bank" concept to improve the tracking of part-time physician attendance. Under the hours bank, participating physicians will be paid a level amount over a time period agreed to in a signed Memorandum of Service Level Expectations (MSLE). This agreement will allow the supervisor and participating physician to negotiate and develop a schedule for the upcoming pay period. A subsidiary record will track the number of hours actually worked, and a reconciliation will be performed at the end of the MLSE period to adjust for any discrepancies. A pilot for this program has been successfully completed under Dr. Kussman's leadership.

• Implementing health care resource contracting for veterans' care—VA Directive 1663 implements provisions of the "Veterans Health Care Eligibility Reform Act of 1996" (Public Law 104–262), which expands VA's health care resources sharing authority. Dr. Kussman and VA staff have worked with the AAMC to ensure that these changes would not adversely affect the VA's academic affiliations. As a result, the VA determined that sole-source contract awards with affiliates must be considered the preferred option whenever education and supervision of graduate medical trainees is required. Similarly, the decision to compete contracts for services overlapping programs in which the facility has graduate medical education training in place must be weighted by additional factors beyond the contract costs. The decision must consider all implications to the business, including the impact to the facility's training program, which is a direct contributor to the facility's productivity and may provide beneficial offsets.

Mr. Chairman and Members of the Committee, I hope my testimony today has provided a better understanding of the extraordinary partnership between academic medicine and the VA, and in particular, the strong leadership Dr. Kussman has provided in many of our joint endeavors. I am confident that as Under Secretary for Health, Dr. Kussman's outstanding track record in public service as well as in putting patients first will combine to strengthen what has become the Nation's largest integrated health system.

Once again, I would like to thank the Committee for this opportunity to appear here today and to congratulate Dr. Kussman on his nomination. Over the last 60 years, we have made great strides toward preserving the success of our affiliations. I look forward to working with Dr. Kussman in the future to strengthen these model partnerships between the Federal Government and nonfederal institutions. I am happy to answer any questions the Committee may have now or at a later date. Thank you.

Chairman AKAKA. Thank you very much.

Dr. Frese?

STATEMENT OF FREDERICK J. FRESE III, PH.D., MEMBER, NATIONAL BOARD OF DIRECTORS, NATIONAL ALLIANCE ON MENTAL ILLNESS

Mr. FRESE. Chairman Akaka, Ranking Member Craig, Senator Murray, Senator Tester, and the other Members of the Veterans' Affairs Committee, thank you very much for inviting me. I am Fred Frese. I am here to give voice for the National Alliance on Mental Illness, NAMI, on the nomination of Michael Kussman, M.D., to be Under Secretary for Health of the Department of Veterans Affairs.

My formal statement was submitted earlier and I ask that that be included in the record. The statement provides the Committee background on myself and background on NAMI, on whose national Board of Directors I have been serving for most of the last 12 years. With over 200,000 members and 1,200 chapters in every State, NAMI is the Nation's largest membership organization that advocates for the mentally ill.

At the outset, lest there be any doubt, the Committee and Dr. Kussman should know that NAMI supports his nomination to be Under Secretary for Health, albeit with some reservations, which I would like to discuss.

Mr. Chairman, I have a personal connection with these issues. In addition to being a psychologist and medical school faculty member, I am also a service-connected disabled veteran. In 1966, while serving in the Marine Corps, I was diagnosed with schizophrenia. I have been treated for this condition mostly by the Veterans' Administration, both in hospitals, and I have been in ten times, and as an outpatient. I believe I am an example of someone with a serious mental illness who can still contribute positively to American society. I am providing this Committee with my history to validate that mentally ill veterans such as myself can, in fact, serve in useful capacities and need not be shunted away or locked away in institutions. This, indeed, is the heart of NAMI's message, as well.

We at NAMI are deeply involved in the care of veterans and the veterans' mental health programs nationwide because many of our family members and many of us are veterans. On the ground every day, we see the effects of national veterans service organizations that have been reported in the Independent Budget for years, every year for 21 years now, regarding the chronic underfunding of veterans' health care. Funding shortages have caused deterioration in many VA programs, including those about which we are most concerned.

As veteran consumers and monitors, we know the VA programs that treat mentally ill veterans certainly need more funding for staff, administrative help, program development, technology, equipment, furnishings, et cetera. Our veterans, whether new ones from the current wars or previous military service, depend on the good will of key officials, such as Dr. Kussman, to meet the needs of those of us with these disabilities.

In that regard, we are particularly pleased that the VA's National Mental Health Strategic Plan has been put together to reform its mental health program, taking from the President's New Freedom Commission's recommendations on mental health. It has been designed and is beginning to be implemented very well and we are very pleased about that.

However, the Government Accountability Office documented recently the VA's failure to spend millions of available dollars for important initiatives that would continue these VA reforms. We ask the Committee to closely monitor the VA's investments and programs in mental health to guarantee funding that will remain available and will be used for the purposes which you would want them used.

NAMI desires a closer relationship with Dr. Kussman and those who work on mental health policy. A number of obstacles have emerged recently that become somewhat problematic.

NAMI is represented on the Consumer Affairs Council of the VA's Committee on Care of the Seriously and Chronically Mentally Ill Veterans, also known as the SMI Committee, authorized under Section 7321, Title 38 of the U.S. Code.

Historically, the SMI Committee was an independent voice evaluating the VA. Recently, however, the activities of this Committee have been cut back and those of us both with the VSOs and consumer organizations have not had the input into this Committee that we have had in the past.

Mr. Chairman, thousands of our troops have been exposed to massive explosions in Iraq and Afghanistan and come away apparently unharmed. We believe that these explosions have been called the signature injury of this war. Both Congress and NAMI will need to depend on Dr. Kussman's judgment to ensure needs of these veterans, as well as veterans from other wars, need to be addressed.

Mr. Chairman, NAMI appreciates your invitation to testify and I will be pleased to answer any questions you may have for me on any of these issues. Thank you very much.

[The prepared statement of Mr. Frese follows:]

PREPARED STATEMENT OF FREDERICK J. FRESE III, PH.D., MEMBER, NATIONAL BOARD OF DIRECTORS, NATIONAL ALLIANCE ON MENTAL ILLNESS

Chairman Akaka, Ranking Member Craig, and Members of the Senate Committee on Veterans' Affairs:

The National Alliance on Mental Illness (NAMI) appreciates your invitation to provide testimony regarding the President's nomination of Michael J. Kussman, M.D., to be Under Secretary for Health of the Department of Veterans Affairs (VA). My statement today constitutes a joint effort by our NAMI Veterans Council, ably chaired by Mrs. Mary Gibson of Waco, Texas, as well as our full national NAMI Board of Directors, on which I serve as a member and also as Chairman of its Veterans Subcommittee.

At the outset, lest there be any doubt, I want the Committee and Dr. Kussman to know that NAMI supports his nomination to be Under Secretary for Health, albeit with some reservations that I will discuss in more detail in this statement.

With 210,000 members, NAMI is the Nation's largest organization representing and advocating on behalf of persons with serious brain disorders that manifest in chronic mental health challenges. Through our 1,200 chapters and affiliates in all 50 states, NAMI supports education, outreach, advocacy and biomedical research on behalf of persons with serious brain disorders such as schizophrenia, manic depressive illness, bipolar disorder, major depression, severe anxiety disorders and other major mental illnesses affecting children and adults.

In addition to serving on the NAMI Board, I have a very personal connection to these issues. I am a veteran. In 1966 while serving in the U.S. Marine Corps, I was selected for promotion to the rank of Captain. During that period I was first diagnosed as having the brain disorder schizophrenia—perhaps the most severe and disabling mental illness diagnosis. Over the years since my original diagnosis, I have been treated within the VA health care system, both as an inpatient at the VA hospital in Chillicothe, Ohio, and as an outpatient. I believe I am an example of someone with a serious mental illness who can still contribute positively to American society. During the past three decades I have functioned as a clinical psychologist and an administrator, served as Director of Psychology at Western Reserve Psychiatric Hospital for a 15-year period, and coordinated the Summit County Recovery Project to assist persons in recovery from mental illness to integrate into the vocational and social framework of greater Akron.

I hold degrees from Tulane University, the American Graduate School of International Management, and masters and doctoral degrees in psychology from Ohio University. I am currently an Assistant Professor of Psychology in Clinical Psychiatry in the psychiatry departments at both Case Western Reserve University and the Northeastern Ohio Universities College of Medicine. At the latter facility, I lecture psychology interns and third year medical students, as well as third and fourth year psychiatry residents. Additionally during the past several years I have been invited to deliver annual lectures at the Uniformed Services University of the Health Sciences and the George Mason University Law School. I am providing the Committee this personal history not to boast, but to validate that mentally ill citizens like me can still serve in useful capacities and need not be shunted aside or locked in institutions.

Mr. Chairman, our veteran members established the NAMI Veterans Council and Veterans Subcommittee to assure that closer attention is paid to mental health issues in the Department of Veterans Affairs (VA), not only at the national level, but also within each Veterans Integrated Service Network (VISN). The NAMI Veterans Council includes members from each of VA's 21 VISNs, and in that capacity we advocate for an improved VA continuum of care for veterans with severe and

persistent mental illnesses. The council is composed of persons with mental illnesses, relatives of persons with mental illnesses, or friends with mental illnesses who have an involvement and interest in issues affecting veterans who suffer from severe and persistent mental illness. Some of the roles that Veterans Council members play include serving in liaison to VISNs; providing outreach to national veterans service organizations; educating Congress on the special circumstances and challenges of severe mental illness in the veteran population; and, working closely with NAMI state and affiliate offices on issues affecting veterans. Also our Veterans Council Executive Committee holds regular monthly conference calls where featured speakers present new information on developments in treatment, research, service delivery and service initiatives for veterans and active military servicemembers or dependents with severe and persistent mental illness. We also use these opportunities to stay informed of national developments in Congress and the executive branch that affect veterans struggling to recover from mental illnesses.

Much has been reported in the news in the past few months about conditions at the Walter Reed Army Medical Center. Our organization—dedicated to advancing health care, research and improving social understanding on matters that deal with dysfunction of the human mind—was deeply disturbed as were you at hearing how combat veterans recovering from serious disabilities, including mental and emotional problems, were being maltreated and mistreated by the system then in place at Walter Reed. Adjusting to and recovering from, disability, whether it is physical or mental, is a challenge in itself that can rival the crossing of a mighty river against the current. But when that challenge is made more difficult by a layering of mindless but "official" bureaucracy, delay, confusion, lost records, intimidation, threats, hazing and other inexcusable behaviors displayed in multiple reports of the media, this is doubly disturbing to us. These veterans should be treated more decently, with compassion and with care, assured that their needs are going to be met by a grateful government, not one that is bent on minimizing the cost of war by reducing or hiding the liability for their injuries and illnesses. One of the bittersweet lessons that may be learned from this war is that the ultimate cost to the human beings who had to actually fight it cannot be hidden from public view. We hope that this shameful episode in the facility's history has been laid to rest with renewed intentions and actions to improve our care of American military heroes. No veteran should be treated this way.

NAMI members are deeply involved in the care of veterans in VA's mental health programs nationwide because many are family members of those veterans. Some of us are those veterans. On the ground every day we see the effects of what the national veterans service organizations have reported through the Independent Budget for years: chronic underfunding of veterans' health care. Funding shortages and emergency supplemental appropriations, combined with the regular employment of Continuing Resolutions as stopgap measures to provide financial resources for VA health care, have caused deterioration in many VA programs, including those about which we are concerned.

We are particularly concerned that VA's "National Mental Health Strategic Plan" to reform its mental health programs, has been stalled by VA's over-arching financial problems. The General Accountability Office (GAO) issued a startling report last year to your House counterpart Committee documenting VA's failure to spend several millions of available dollars in pursuit of important initiatives that would continue moving VA in the right direction to reform its mental health programs. The Veterans Council Executive Committee met a few months ago with Dr. Ira Katz, Deputy Chief Patient Care Services Officer for Mental Health, to discuss his plans to improve the allocation of funds dedicated to the initiatives under the new strategic plan. We hope Congress will closely monitor VA's implementation of the new strategic plan to ensure it meets that promise.

Mr. Chairman, we ask today: Is Michael Kussman qualified to be Under Secretary for Health? Speaking for NAMI, I must say that, while we have observed his presence in VA health care for several years, and are generally aware of his distinguished military career, it is fair to say that we at NAMI really do not know Dr. Kussman as well as we desire to know him. While serving as Chief Patient Care Services Officer, Dr. Kussman supervised the mental health programs of the Department. In that capacity and also during his term as Deputy Under Secretary, Dr. Kussman contributed positively to VA's corporate decision to engage and adopt concepts from the President's New Freedom Commission on Mental Health. He is to be commended for this stance. More recently as Acting Under Secretary, Dr. Kussman distinguished himself by making a number of comments in the media concerning the state of mental health of our fighting force in Iraq and Afghanistan. This statement is illustrative:

"Readjustment and reintegration issues are very common among servicemen returning from any combat. A large portion of people have this temporary reaction. These are normal reactions to abnormal situations and are not considered mental illnesses." (*Washington Post*, March 1, 2006)

NAMI commends Dr. Kussman's view that we should not stigmatize veterans who need care for adjustment disorders that may be temporary in nature following a period of combat exposure. We strongly believe no one with a mental illness should be stigmatized, whatever the cause. However, some veterans of war come home with serious problems, including deep-seated mental health problems. We trust Dr. Kussman believes these veterans' needs must be addressed by a caring VA.

As an organization concerned about the mental health of hundreds of thousands of Dr. Kussman's patients, NAMI desires to have a closer relationship with Dr. Kussman and those who work with him in mental health policy in Washington. A number of issues have emerged to make those relationships problematic, but should you confirm him we hope to work with Dr. Kussman to relieve them. Let me give you some pertinent examples.

NAMI is represented on the consumer affairs council associated with VA's Committee on Care of Severely and Chronically Mentally Ill Veterans, also known as the "SMI Committee," authorized in Section 7321, Title 38, United States Code. This independent committee has played an active and vital role in determining policy and shaping programs in VA mental health care. I am privileged to have been a regular participant on this consumer affairs council. The SMI Committee was a driving force in VA's shift toward the "New Freedom" philosophy. To paraphrase the law, the Committee has a clear mandate to assess, and carry out a continuing assessment of, the capability of the VA to meet effectively the treatment and rehabilitation needs of mentally ill veterans whose mental illness is severe and chronic. The law requires the Committee to identify system-wide problems in caring for such veterans; identify specific facilities at which program enrichment is needed to improve treatment and rehabilitation; and identify model programs that should be implemented more widely in or through facilities of the VA. The Committee is required to advise the Under Secretary regarding the development of policies for the care and rehabilitation of severely chronically mentally ill veterans, and to make recommendations to the Under Secretary for improving programs of care of such veterans; for establishing special programs of education and training relevant to their care; regarding research needs and priorities relevant to the care of such veterans; and regarding the appropriate allocation of resources for all such activities. The Secretary is required by law to submit a variety of reports to Congress on the work of the SMI Committee and VA's responses to the Committee's recommendations.

Historically the SMI Committee met four times each year to carry out its responsibilities, held regular conference call meetings, reported at regular intervals, and provided VA and Congress an important and independent voice in evaluating VA's mental health programs, especially those that deal with veterans with psychoses and other very serious problems. Several years ago, VA Central Office (VACO) determined the SMI Committee would be afforded only two meetings annually. VA rechartered the Committee in 2006 and populated it with new membership, some of whom were unfamiliar with the Committee's history or role. The Consumer Affairs Council's participation since that time has been severely restricted. The SMI Committee now seems moribund. To NAMI and other participating organizations, this is a very large matter in terms of muffling a source that has provided VA and Congress an independent means of evaluating a very important VA program. We hope your Committee will determine whether VA's justification for restricting and suspending the activities of this key committee was warranted, and to examine Dr. Kussman's role and reasons for those decisions.

Another issue of concern to NAMI bears discussion today. In the past several fiscal years, VA's expenditures in mental health have unquestionably risen, and we deeply appreciate this Committee's insistence that VA mental health spending be maintained. Nevertheless, in the final compromise on Public Law 110–5, the "Revised Continuing Appropriations Resolution, 2007," Congress removed a recurring requirement that VA spend at least $2.2 billion in programs of mental health care this year. The following text carried out that decision:

"Sec. 20810. Notwithstanding any other provision of this division, the following provisions included in the Military Quality of Life, Military Construction, and Veterans Affairs Appropriations Act, 2006 (Public Law 109–114) shall not apply to funds appropriated by this division: the first, second, and last provisos, **and the set-aside of $2,200,000,000, under the heading 'Veterans Health Administration, Medical Services'**; the set-aside of $15,000,000 under the heading 'Veterans Health Administration, Medical and Prosthetic Research'; the set-aside of $532,010,000 under the heading 'Departmental Administration, Construction, Major

Projects'; and the set-aside of $155,000,000 under the heading 'Departmental Administration, Construction, Minor Projects'." (emphasis added)

While we appreciate the need to give the VA flexibility in its spending decisions under the Medical Services account, NAMI comes from a perspective of observing, and hopefully protecting, a number of programs important to our members and to the veterans under VA care about whom we are most concerned. The set-asides in prior appropriations acts gave us assurance of dependability of funding sources for VA programs that provide our loved ones the care they need. Without that protection, some in VA may believe they are free to shift resources from these programs to the detriment of veterans with serious mental illnesses. We ask that your Committee closely examine Dr. Kussman's commitment to spend appropriate sums on mental health programs to ensure this commitment is kept.

Mr. Chairman, the current overseas wars in Iraq and Afghanistan are producing a very heavy burden in follow-on mental health treatment and counseling requirements. While we very much want to agree with the sentiments of Dr. Kussman, that the vast majority of our soldiers, sailors, marines, airmen and Coast Guardsmen are repatriating whole and healthy, with temporary adjustment problems, some reports are not encouraging. About two of every ten serving members are experiencing problems of a magnitude about which we all should be concerned. About 70,000 individuals have so far touched VA with some kind of mental or emotional challenge in post-service life. The military departments are rotating active, reserve and Guard forces through these wars in multiple deployments of individuals and units. The press has reported a number of cases of individuals having been deployed who may not be in ready condition to serve, some with worrisome mental states. Given the drag of this war, it is not surprising that military recruiters are beginning to fail to meet their quotas or are meeting them by enlisting marginal candidates whose mental status might be of serious concern to domestic employers. Another outcome of these wars is the unknown degree to which "mild" and "moderate" traumatic brain injury (TBI) is going to manifest into behavioral, medical and psychosocial problems later. Thousands of our troops have been exposed to massive explosions in Iraq and Afghanistan but have come away apparently "unharmed" according to our current technology to measure harm. We believe the complete story of those exposures is yet to be told.

Dr. Charles Hoge of the Walter Reed Army Institute of Research reported the following findings last year in a study he published in the *New England Journal of Medicine*:

"This study has shown that overall 15–17 percent of Soldiers from combat units screen positive for PTSD when surveyed 3–12 months after returning from deployment to Iraq. When we added one additional question related to functional impairment at the end of the 17 question PTSD scale, we found that 10 percent of Soldiers surveyed 12 months after deployment reported that PTSD symptoms have made it very difficult to do their work, take care of things at home, or get along with other people. The inclusion of screens for major depression and generalized anxiety raise the rates of screening positive to approximately 20 percent; 16 percent of Soldiers surveyed 12 months after returning from Iraq screened positive for PTSD, depression, or anxiety and reported that there was functional impairment at the 'very difficult' level."

Mr. Chairman, while many say that TBI is the "signature injury" of these wars, we believe the picture is more mixed, with a large burden of the war legacy expressing itself in mental and emotional damage from both TBI, post-traumatic stress disorder (PTSD), depression, substance abuse and other problems. We hope the Committee as well as the VA will remain vigilant and sensitive to the needs of this new generation as time goes by, because their needs are going to exist long after cessation of deployment of our forces into Southwest Asia. In this instance both Congress and NAMI need to depend on Dr. Kussman's judgment to ensure these needs are addressed with sensitivity and care.

The Secretary of Veterans Affairs James Nicholson has testified on VA's intentions with respect to funding mental health services in Fiscal Year 2008. On February 8, 2007, and again on February 13, 2007, he stated *"The President's request includes nearly $3 billion to continue our effort to improve access to mental health services across the country. These funds will help ensure VA provides standardized and equitable access throughout the Nation to a full continuum of care for veterans with mental health disorders. The resources will support both inpatient and outpatient psychiatric treatment programs as well as psychiatric residential rehabilitation treatment services. We estimate that about 80 percent of the funding for mental health will be for the treatment of seriously mentally ill veterans, including those suffering from post-traumatic stress disorder (PTSD). An example of our firm commit-*

ment to provide the best treatment available to help veterans recover from these mental health conditions is our ongoing outreach to veterans of Operation Iraqi Freedom and Operation Enduring Freedom, as well as increased readjustment and PTSD services." (emphasis added)

Without guidance from your Committee, Mr. Chairman, and strong oversight by other committees of jurisdiction, it is challenging at best for NAMI to measure whether, indeed, Secretary Nicholson's commitment, and presumably one to which Dr. Kussman agrees, will be fulfilled next year. As consumers and monitors, we know the VA programs that treat mentally ill veterans certainly need more funding—for professional and support staff, administrative help, program development, technology, equipment, furnishings, infrastructure, family caregiver respite and other supports. Our veterans in need of care for serious mental health conditions, whether new veterans from current wars or veterans from previous military service periods, depend on the good will of such promises. We ask your Committee to monitor VA's investments and programs in mental health care to guarantee funding will remain available and will be used for the purpose for which it is intended.

In summary, holding in abeyance our stated reservations and looking optimistically to the future, NAMI believes Dr. Kussman is fully qualified to serve as VA Under Secretary for Health. We recommend you report this nomination and that the Senate confirm him to serve as Under Secretary for Health. Should the Senate in its wisdom confirm him for this position, we hope to gain a better working relationship with Under Secretary Kussman as time goes along. NAMI wants to be a partner with VA as the New Freedom reforms are put into place, and as more veterans of the current wars come to VA for aid. We want to work with Dr. Kussman, Dr. Katz and other key VA officials in Washington and across the VA system to ensure VA meets its responsibilities for the care of veterans with serious and chronic mental illnesses, whether from this war or previous military engagements.

Chairman Akaka, Ranking Member Craig and other distinguished Members of the Committee, NAMI appreciates your invitation to testify, and we thank you for giving consideration to our views.

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

Mr. Mitchell?

STATEMENT OF DOUGLAS H. MITCHELL, JR., ACSW/LCSW, PRESIDENT, ASSOCIATION OF VA SOCIAL WORKERS

Mr. MITCHELL. Mr. Chairman and Members of the Committee, good morning. I am here today representing the Association of VA Social Workers, all of whom are employed obviously by the Veterans Health Administration. I myself am a veteran of the United States Army. I served from February 1966 to September 1973. I also received health care in the private sector and I currently have elected to receive my own health care within the Department of Veterans Affairs. I can tell you, it is my firm belief that the health care available in the Department of Veterans Affairs is second to none.

During the 22 years I have been employed by the Department of Veterans Affairs, I have been through several reorganizations and several changes in functioning. Most recently, I would like to talk about the changes that have been enacted by Dr. Kussman. Specifically, I believe that he is committed for each of our veterans to make the transition from active duty to veteran status as seamless as possible. Dr. Kussman was responsible for placing a liaison social worker at Walter Reed Army Medical Center to help ease this transition. Within a few months, a second social worker was added, and now we have 14 social workers at military treatment facilities, all designed to assist with easing the transition from veteran status into VA care.

Dr. Kussman is, of course, seriously interested in those most severely injured, the polytrauma veterans. The second phase of seamless transition included a case management program to ensure that

no veteran falls through the cracks. Each VA medical center has a nurse or a social worker, a case manager who follows their patients wherever they go, either inpatient, outpatient, or back to the community.

Although the VA has had a system of four Traumatic Brain Injury Centers for years, Dr. Kussman, through his concern for OIF/OEF veterans, required more comprehensive care. He converted those TBI centers to polytrauma centers to ensure that veterans received concurrent care for all of their injuries, including TBI, amputation, spinal cord injury, visual impairment, hearing loss, combat stress, and PTSD, in one location. More recently he expanded this with the polytrauma system of care, which includes the four polytrauma TBI centers and 17 additional network polytrauma sites.

When the Secretary announced that he wanted to hire 100 new patient advocates, Dr. Kussman had a vision for how these new employees could help the most severely injured OIF veterans with their transition. The new transition patient advocates are being assigned to active duty patients while they are still on active duty. They go to the military treatment facility, establish contact, establish a relationship, and act as an ombudsman for those severely injured veterans as they return both to the VA and to their community.

Dr. Kussman understands that our patients and families are people who are experiencing multiple life crises and he fully supports the team effort to help patients and families cope with all of these challenges they are facing, which includes medical, social, psychological, and spiritual. He recognizes that we are as we go reinventing the health care system to serve a new generation of veterans and he supports this effort.

At Dr. Kussman's direction, a committed team of VA staff developed a template that automatically screens for medical conditions endemic to the Gulf area as well as TBI. This template, again, automatically triggers specialty consults for further evaluation. This multi-disciplinary team consists of physicians, nurse practitioners, physician assistants, information management, social work, nursing, speech pathology, and mental health practitioners. It is truly an effort to treat the whole veteran.

Equally extraordinary, if I may, is the relationship that has developed in Phoenix between the Veterans Health Administration and the VBA regional office. Lower-level workers, myself included, established relationships with their lower level workers and together we developed a working relationship that resulted in a memo of understanding with the U.S. Army Reserves and the Army National Guard that we would attend every demobilization, every sort of activity we could in order to make these new veterans aware, or these potential veterans aware of benefits that were available to them.

Finally, and personally, very personally, most important to me, is that I believe that Dr. Kussman has empowered each of us at the facility level to do the right thing for the veteran. Thank you.

[The prepared statement of Mr. Mitchell follows:]

PREPARED STATEMENT OF DOUGLAS H. MITCHELL, JR., MSW, LCSW, ACSW,
PRESIDENT, ASSOCIATION OF VA SOCIAL WORKERS

Mr. Chairman and Members of the Committee, good morning. I am here today representing the membership of the Association of VA Social Workers employed by the Veterans Health Administration.

First of all, I am a veteran of the United States Army. I proudly served my country from February 22, 1966 to September 4, 1973.

I also receive my medical care through the Department of Veterans Affairs. I am equally proud to do so. Having received care both outside VA and inside, I feel qualified to state unequivocally that there is no comparison; the VA is second to none.

I have been employed by VA for 22 years. For the past 13 years, I have been assigned to the Carl T. Hayden VA Medical Center in Phoenix, AZ as the Assistant Chief of Social Work and for the last 10 years as the Chair of the Social Work Department.

During my tenure in Phoenix, I have observed the VA health care system evolve from a rigid, facility centered hospital system with virtually little regard for resource availability to a vibrant, patient-centered system determined to deliver the best quality care in the most efficient manner closer to home. I would like to highlight some specifics concerning experience in the field based upon decisions Dr. Kussman has made.

I believe Dr. Kussman is committed to making the transition from active duty military to veteran status and community life as seamless as possible. In August 2003, Dr. Kussman started the seamless transition program. He placed a VA social worker at the Walter Reed Army Medical Center to help transfer active duty patients to VA medical centers. Within a few months, a second social worker was added. Today, we have 14 social worker liaisons at 10 military hospitals. Dr. Kussman supports the liaisons and knows them by name. In Phoenix, our case managers interact often with these individuals.

- Dr. Kussman is committed to the best quality care possible for all veterans. But he is particularly concerned with the severely injured OEF/OIF veterans. The second phase of seamless transition included a case management program to ensure that no veteran falls through the cracks. Every VA medical center has nurse or social worker case managers who follow their patients wherever they go—inpatient to outpatient to the community.
- Although VA has had a system of 4 Traumatic Brain Injury (TBI) Centers since the early 1990s, Dr. Kussman believed that the severity of the injuries of OEF/OIF veterans required that we provide more comprehensive care. He converted the TBI centers to Polytrauma Centers to ensure that veterans could receive concurrent treatment for all of their injuries including TBI, amputation, spinal cord injuries, visual impairment, hearing loss, combat stress and PTSD in one location. Further, he developed the Polytrauma System of Care, which includes the 4 Polytrauma/TBI Centers and 17 Network sites.
- When the Secretary announced that he wanted to hire 100 patient advocates, Dr. Kussman had a vision for how these new employees could help the most severely injured OEF/OIF veterans with their transitions. The new transition patient advocates (TPAs) are being assigned to active duty patients while they are still at the military hospital to meet the patient and family and serve as an ombudsman to help them with any problems or concerns and assist them in navigating in both the DOD and VA systems.
- Under Dr. Kussman's guidance, VA developed a computerized veterans tracking system to (a) notify the gaining facility of the patient's pending discharge, (b) document the patient's status and, c) notify staff as to both the clinical and logistical status.
- Dr. Kussman is a physician who understands and promotes interdisciplinary care. Under his leadership, all clinical team members work together with patients and families on treatment plans and treatment decisions.
- Dr. Kussman also understands the importance of families and supportive services for them. He has been a staunch supporter of the VA Fisher House Program and has ensured that VA medical centers, particularly the Polytrauma/TBI Centers, address family needs. He understand that our patients and families are people experiencing multiple life crises and he fully supports a team effort to help patients and families cope with all of the challenges they are facing which include medical, social, psychological and spiritual.

In summation, I strongly believe that:

Dr. Kussman is a hands-on leader in terms of supporting the staff and the patients.

He recognizes that we are re-inventing a health care system to serve a new generation of veterans and his enthusiastic support for innovative ideas has resulted in unprecedented levels of case management and high quality care for a veteran population transitioning from active duty to civilian life.

An immediate local example in Phoenix is that, for more than two years, we have known of the need to evaluate all veterans who have been exposed to blasts, incidents or accidents that could conceivably result in neuropsychological impairment. At Dr. Kussman's direction, a committed team of VA clinical staff developed a CPRS template that screens for medical conditions endemic to the Gulf area as well as TBI. This template automatically triggers specialty consults for further evaluation. This multidisciplinary team consists of Physicians, Nurse Practitioners, Physician Assistants, Information Management, Social Work, Nursing, Speech Pathology, and Mental Health practitioners. It is truly an effort to treat the whole veteran.

Perhaps even more extraordinary is the relationship that has developed between the VBA Regional Office and the VA Medical Center due to Dr. Kussman's leadership. The Phoenix VARO sends personnel to evening groups at our medical center to explain veteran's benefits, initiate claims for service connected disability compensation and to provide access to the complete array of services available through VBA. In previous years, "One VA" was a slogan. In Phoenix, it has become the practice.

Finally, and most important to me, Dr. Kussman empowers each of us in VA to do the right thing for our patients.

Chairman AKAKA. Thank you very much, Mr. Mitchell.

Mr. Wallace?

STATEMENT OF ROBERT E. WALLACE, EXECUTIVE DIRECTOR, WASHINGTON OFFICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. WALLACE. Thank you, Mr. Chairman, Senator Craig, and Members of the Committee. I am pleased to appear before you today representing the 2.4 million men and women of the Veterans of Foreign Wars of the United States and our Auxiliaries. I am here to discuss the nomination of Brigadier General Michael J. Kussman, M.D., United States Army, Retired, to be the Under Secretary for Health for the Veterans Health Administration of the United States Department of Veterans Affairs.

It is my privilege to offer the strong support of the Veterans of Foreign Wars of the United States for Dr. Kussman, a man we believe is clearly qualified for this vital position and whom we feel sincerely and honestly cares about veterans and the issues they confront. He will be an excellent Under Secretary for Health.

I am also pleased to note for the record that my colleagues from the AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Vietnam Veterans of America join with the VFW in supporting Dr. Kussman's nomination.

I come before you today not just as a veteran's advocate, but as a VA shareholder. I earned my stock when I wore the uniform of this great Nation, like millions of other veterans have. As a shareholder of a corporation, I want the best leadership for the company that I have invested in. Veterans demand effective and efficient leadership in a Department in which they have also so much invested.

We have all witnessed over the years problems that VHA has encountered. So many times, the issues could have been prevented if there were true leadership, management, and accountability at all levels of the system. Dr. Kussman's experience demonstrates that he possesses these and many other qualities that make him the right person for the position.

His years of service in the United States Army, rising to the rank of Brigadier General of the Medical Corps, shows he is a leader, knows how to work with others, knows how to manage people, hold them accountable, and at the same time knows how to motivate people. Dr. Kussman was selected as the top candidate for this position by an independent search Committee, a requirement of Congress. You made this a requirement, I believe, to ensure that the highest quality and most professional candidate would be recommended for this position and that no undue influence would play into the process.

The American Legion, due to their constitution, is unable to publicly support or oppose any nominees. However, based on the need for a permanent Under Secretary for Health of VHA and the fact that Dr. Kussman was recommended by the search committee, they also agree that his nomination should move forward.

I did not serve on the search committee. However, I have served on other search committees in the past and can attest to the fact that they are fiercely independent. The VFW's support of Dr. Kussman is not just based on the search committee's recommendation. Our beliefs are based on our personal experience interacting with him on health care issues faced by our Nation's veterans.

Dr. Kussman cares deeply about veterans and the issues confronting their health care and well-being. He is highly responsive to their needs. In conversations, you can tell his sincerity. When we differ on policy issues or have policy-related questions, he does not hesitate to give us a fair hearing and is open to ideas, whether he ultimately agrees with us or not. That is all that we as VA shareholders can ask for from the head of the Veterans Health Administration.

But that truly is his strength. He cares passionately about VA's mission to help veterans and their dependents and he takes criticism of the system personally, leading him to strive for excellence and in doing so to motivate others. He is not a person who is full of excuses when mistakes are made and we have found that he takes a personal approach to solving problems, ensuring that the best care is provided to our Nation's veterans by the VA.

Dr. Kussman can rightly pride himself on the high quality of veterans' health care. Since 2000, he has been a part of VHA, a period in which VHA has rightfully been lauded for the high quality of its health care. Many articles in major publications have said VHA delivers the best care anywhere. His personal philosophy is to continue to improve on these facts and the quality of care delivered and to never allow the care given to our Nation's veterans to diminish, just improve.

Certainly, the system is not perfect. Access, especially for specialty care, continues to be a challenge, although we would argue that this is a function of a lack of dedicated and on-time resources, not one of administration. Once in the system, veterans are very pleased and typically receive the best care. There have been some high-profile examples yesterday where this has not been the case, and I do not want to make light of them, but I am confident and the VFW is confident that Dr. Kussman's leadership and his strong desire and dedication to improving VA health care will do much to fix these situations.

Dr. Kussman has demonstrated a deep concern about the health issues facing all veterans, especially those with specialized needs and those serving today. He wants to have VA learn more about traumatic brain injuries as well as improve on the delivery of mental health care.

One of the major challenges he will face is finding qualified clinicians who fully understand the new challenges brought on by the war and to help the thousands of returning servicemembers who need first-rate mental health care and specialized services. We are confident that he is up to the challenge.

We feel that his years of experience managing health care facilities and systems give him the knowledge and experience to understand the business side of VHA and how to best use taxpayers' money in an efficient way while still delivering high-quality health care. Those years of experience demonstrate that he is more than qualified to lead the thousands of hardworking and dedicated employees within VHA.

We believe he is a man who will not be afraid to butt heads with the Office of Management and Budget, you the Congress, or the Department of Defense. Many of the issues and challenges VHA faces today will be helped by Dr. Kussman's military experience. All of us in Washington have been talking about a true system where DOD and VA create a seamless transition for military personnel to veteran status. We believe that if anyone can make it happen, it is Dr. Kussman because he understands both systems.

The VFW sincerely believes Dr. Michael Kussman is the right person to lead the Veterans Health Administration and we cast our unanimous votes, our shares, for his immediate confirmation. We urge the Committee to favorably report his nomination to the full Senate and we ask your colleagues to confirm him as the Under Secretary for Health without delay.

I thank you for the opportunity to testify today. I would be more than happy to answer any questions you may have.

[The prepared statement of Mr. Wallace follows:]

PREPARED STATEMENT OF ROBERT E. WALLACE, EXECUTIVE DIRECTOR, WASHINGTON OFFICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of the Committee:

I am pleased to appear before you today representing the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries. I am here to discuss the nomination of Brigadier General Michael J. Kussman, M.D. (United States Army Ret.) to be the Under Secretary for Health for the Veterans Health Administration (VHA), United States Department of Veterans Affairs (VA).

It is my privilege to offer the strong support of the Veterans of Foreign Wars of the United States for Dr. Kussman, a man we believe is clearly qualified for this vital position, and whom we feel sincerely and honestly cares about veterans and the issues that confront them. He will be an excellent Under Secretary for Health.

I am also pleased to note for the record that my colleagues of the AMVETS, Disabled American Veterans, Paralyzed Veterans of America and the Vietnam Veterans of America join with the VFW in supporting Dr. Kussman's nomination.

I come before you today, not just as a veterans advocate, but as a VA shareholder. I earned my stock when I wore the uniform of this great Nation, like millions of other veterans have. Just as a shareholder of a corporation wants the best leadership for the company they have invested in, veterans demand strong, effective and efficient leadership of the Department in which we all have so much invested.

We have all witnessed over the years problems that VHA has encountered. So many times the issues could have been prevented if there were true leadership, management and accountability at all levels of the system. Dr. Kussman's experience demonstrates that he possesses these and many other qualities that make him

the right person for the position. His years of service in the United States Army rising to the rank of Brigadier General of the Medical Corps shows he is a leader, knows how to work with others, and knows how to manage people, holding them accountable and motivating them.

Dr. Kussman was selected as the top candidate for this position by an independent search committee, a requirement of Congress. You made this a requirement, I believe, to ensure the highest quality and most professional candidates would be recommended for this position, and that no undue influence would play into the process.

I did not serve on this search committee; however, I have served on search committees in the past, and can attest to the fierce independence of the process. Dr. Kussman's selection as the top candidate of the three recommended to the Secretary is a strong indication that his credentials and interview impressed the committee—many of whom are not involved in the day-to-day operation of VHA. It further demonstrates that they too felt he would be a capable, independent and effective leader.

The VFW's support for Dr. Kussman is not just based on the search committee's recommendation. That just reaffirmed our beliefs that he is the right person for the position. Our beliefs are based on our personal experiences interacting with him on health care issues faced by our Nation's veterans.

Dr. Kussman cares deeply about veterans and the issues confronting their health care and well-being. He is highly responsive to their needs. In conversations, you can tell his sincerity. When we differ on policy issues or have policy-related questions, he does not hesitate to give us a fair hearing, and is open to ideas whether he ultimately agrees with us or not.

That is all we—VA's shareholders—can ask for from the head of the Veterans Health Administration.

That truly is his strength. He cares passionately about VA's mission to help veterans and their dependents. And he takes criticism of the system personally, leading him to strive for excellence, and in doing so to motivate others. He is not full of excuses when mistakes are made, and we have found that he takes a personal approach to solving problems, ensuring that the best care is provided to veterans in VA.

Dr. Kussman can rightfully pride himself on the high quality of veterans' health care. Since 2000, he has been part of VHA, a period in which VHA has rightfully been lauded for the high quality of its health care. Many articles in major publications have said VHA delivers the best care anywhere.

- A 2004 RAND study found that VA hospitals outperformed private facilities in over 294 categories of care.
- The 2006 American Customer Satisfaction Index found that veterans had a 10 percent higher satisfaction rate with VA health care than the general public has with private hospitals.
- VA is at the forefront of advances in medical records technology, and their electronic medical records system is the envy of the medical care field.
- VA health care is significantly cheaper per patient than private health care and efficiency of service has kept the increase in per patient costs far below the overall costs of medical inflation.

His personal philosophy is to continue to improve on these facts and the quality of care delivered, and to never allow the care given to our Nation's veterans to diminish, just improve.

Certainly the system is not perfect. Access, especially for specialty care, continues to be a challenge; although we would argue that this is a function of a lack of dedicated and on-time resources, not one of administration. Once in the system, veterans are very pleased and typically receive the best of care. There have been some high profile examples recently where this has not been the case, and I do not want to make light of them, but we are confident that Dr. Kussman's leadership, and his strong desire and dedication to improving VA health care will do much to fix these situations. Dr. Kussman has demonstrated a deep concern about the health issues facing all veterans, especially those with specialized needs, and those serving today. He wants to have VA learn more about traumatic brain injuries as well as improve on the delivery of mental health care.

One of the challenges he will face is finding qualified clinicians who fully understand the new challenges brought on by the war, and to help the thousands of returning servicemembers who need first-rate mental health care and specialized services. We are confident that he is up to the challenge.

We feel that his years of experience managing health care facilities and systems give him the knowledge and experience to understand the business side of VHA and how to best use taxpayer's money in an efficient way while still delivering high-

quality health care. Those years of experience demonstrate that he is more than qualified to lead the thousands of hardworking and dedicated employees within VHA.

Further, we believe he is a man who will not be afraid to butt heads with the Office of Management and Budget for proper funding, the Congress or the Department of Defense (DOD).

Many of the issues and challenges VHA faces today will be helped by Dr. Kussman's military experience. All of us in Washington have been talking about a true system where DOD and VA create a seamless transition for military personnel to veterans' status. We believe that if anyone can make that happen, it is Dr. Kussman, because he understands both systems and knows the necessity of creating such a system for the care and treatment of our wounded warriors, ensuring that they receive the benefits they have rightly earned by their honorable service to our Nation.

The VFW sincerely believes Dr. Michael Kussman is the right person to lead the Veterans Health Administration and we cast our unanimous votes—our shares—for his immediate confirmation.

Mr. Chairman, as I mentioned earlier, the VFW is joined by the AMVETS, Disabled American Veterans, the Paralyzed Veterans of America, and the Vietnam Veterans of America in strongly supporting the nomination of Dr. Michael Kussman for the position of Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs.

We urge this Committee to favorably report his nomination to the full Senate, and we would ask your colleagues to confirm him as the Under Secretary of Health without delay.

I thank you for the opportunity to testify today, and I would be happy to answer any questions you may have.

Chairman AKAKA. Thank you very much, Mr. Wallace.

I want to thank all of you for your thoughtful and comprehensive testimony. I believe you have given the Committee a good understanding of where your organizations stand on Dr. Kussman's nomination, and I want you to know that I appreciate your taking the time to appear here today.

As I said at the outset, because of time, we would go directly to this first panel and therefore did not offer an opening statement. At this time, I would like to include my full statement in the record and ask other Members for any statement or questions they may have for this panel.

Chairman AKAKA. May I call first on Senator Craig?

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

Senator CRAIG. Mr. Chairman, thank you for holding this hearing and doing a confirmation hearing in a way that, I think, adds the dimension and the reality of the personality as much as the experience and the qualifications of the personality that comes before us. So I thank you for that.

I do have a full statement I will enter into the record. But I do want to say in entering that statement into the record that in my conversations with Dr. Kussman, recognizing almost 40 years now of the kind of experience that he brings to this position, recognizing that we have been without a person in this capacity for an extended period of time, the thing that I was most impressed about, because the credentials are evident, as you know—there is the resume, look at it, a phenomenal list of experiences—but my conversations with Mike Kussman left me appreciating something that sometimes you don't hear from nominees and that was an open and obvious passion for the job and a sincerity and concern about veterans that really stood out.

We recognize the new challenges, and I think Mr. Mitchell put it well. You keep reinventing this health care system to fit the new veteran, and we have got to do that. It has got to be a dynamic system, and sometimes we are not as quick to catch up, but we do catch up. When you have somebody in the capacity that the President has asked Dr. Kussman to serve in, you need that kind of talent, and I think it is obvious within the man. It is obviously clearly to me within the passion of the person that we have got before us, and so I am pleased. I hope we can move him and move him expeditiously.

And let me thank this panel for their openness and their directness about this particular gentleman. It is a phenomenally important position for veterans because it will sustain and, I hope, enhance one of the best health care delivery systems in the country today, if not the best, and that is what we are all about here.

Thank you, Mr. Chairman.

[The prepared statement of Senator Craig follows:]

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

Good morning, Mr. Chairman. I want to thank you very much for calling this hearing to review the qualifications of Dr. Michael Kussman to head the VA health care system. I also want to thank all of the witnesses on the first panel for coming here this morning to voice their views on this man.

Mr. Chairman, I'd like to say at the outset of this hearing that based on a review of his record and having spent some time with him personally, I believe Dr. Kussman is *very qualified* for this job. And I strongly support his nomination.

Mike Kussman, a physician for almost *40 years*, is a veteran of the United States Army, who retired as a Brigadier General after serving this Nation on active duty for over 20 years. . . . He has published numerous papers; served on countless boards and Committees inside and outside of government; and managed some of the military's largest medical installations.

In short, he is a highly educated and dedicated, Army veteran, with management experience who understands both the military and VA health care systems inside and out.

But Mr. Chairman, I'd also like to suggest to the Committee that perhaps Dr. Kussman is more than simply qualified for the job. After all qualifications are largely just objective facts about a person. They are a person's education and experience. While I hope I'm not offending him by saying this. Candidly, I'm sure there are a few other people along with Dr. Kussman who are *technically* qualified to lead VA's health care system.

But, when you add Mike's qualifications together with the enormous passion for the job he displayed during my interview with him. And then you wrap that passion around the integrity and character of this gentleman, I find someone with more than just qualifications. I find the right man for the job.

Mr. Chairman, I know you and I share this view of Dr. Kussman. So, I hope we are able to work with our colleagues to move quickly on his confirmation. The VA health care system needs strong, confirmed leadership at the helm to care for our veterans. We have spent nearly 9 months seeking out the person to fill the position left vacant by Dr. Perlin's departure last year.

I believe we have found that person. He enjoys the strong support of our veterans' service organizations, the professional medical community, many of his former colleagues in the military, and even his current employees. I think that speaks volumes about this nominee. I hope our colleagues will join us in supporting Dr. Kussman.

Thank you, again, Mr. Chairman, for holding this hearing. I look forward to hearing from all of our witnesses.

Chairman AKAKA. Thank you very much, Senator Craig.

I would like to call on Senator Tester and Senator Murray for any comments, statements, or questions they may have. Senator Tester?

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman, Ranking Member Craig. I want to thank the panel also for being here and taking time out and giving us your perspective on Dr. Kussman. I appreciate that.

I had an opportunity to visit with Dr. Kussman last week. I appreciate your frankness and that discussion. I think the biggest issue that I have is not the quality of care, once again, as we talked about, but it is access to that care and how we are going to cut down on those access times to make sure that those folks who made the commitment to this country and the military get the kind of care they deserve and don't have to wait an extended period of time for that care.

It is important to reiterate, though, that the VA is going to have increased challenges like they have never seen before with what has transpired in Iraq and Afghanistan and it is very, very important that as we go through with this, and I will hold my questions until the end, Mr. Chairman, that as we go through with this process of confirmation, that you understand that you have got a hard job ahead of you once confirmed because our military is coming back with some injuries that in previous wars probably wouldn't have survived.

So I look forward to the questions and answers and I look forward to working with you once you are confirmed because I think you will be. Thank you.

Chairman AKAKA. Senator Murray?

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

Senator MURRAY. Mr. Chairman, thank you so much for holding this hearing, and I want to thank all of our panelists for their testimony.

Certainly, we do a lot of nominations here and to me this is an extremely important one for a number of reasons.

Dr. Kussman obviously has an excellent resume and I had a chance to meet with him and appreciate his honesty and his trying to confront the many challenges that the VA has.

But we all know there are 1.5 million men and women who have gone to Iraq and to fight terrorists around the globe who are coming home who need care that we have not thought about before, from traumatic brain injury to post-traumatic stress syndrome to loss of limb, that are fighting to get their benefits, that are fighting to get the right care.

The issue of transition is enormous. We know that there are an increasing number of veterans from previous wars, particularly the Vietnam War, that are now accessing our VA and are finding it very difficult to get in. We have talked about a lot of these issues and we need somebody at the helm at the VA today that can really address those, not just to deal with the crisis of today but to look out further ahead and determine what our VA is going to look like in the future. That is why this position is important.

But even more importantly to me, Mr. Chairman, is the concerns that we have seen consistently come from the VA over the last sev-

eral years. We need a new level of frankness from the Veterans' Administration. We have seen them minimize the costs of this war, both in money and in lives, to the detriment of the men and women who we have asked to serve us. We haven't been able to get straight answers or real numbers, to the detriment of our servicemen and women over the past several years.

Our own experience has been that the VA came to us with information that was inaccurate, underestimating the amount of money that we needed, and we had to come up with additional billions of dollars late in the game to address the needs of the VA in the past few years. The GAO has found in report after report that the VA has misled the Congress, concealed their funding problems, and based its projections on inaccurate models. And very troubling to me, Mr. Chairman, is a report that we got from *McClatchy News* that the VA has repeatedly exaggerated the past successes of the VA medical systems, exactly at a time when we need honesty from the VA so that we can provide the resources and the policies to make sure that no one falls through the cracks today.

I have been very upset most recently about inaccurate responses to questions that we have asked of VA. I have witnessed the VA transform itself into an agency that guards information like a mother bear hugging her cub. We need that information and that honesty and frankness in order to be able to do the right things on this Committee.

It is troubling to me that we have watched the VA undermine our confidence in its leadership over the last few years, from the troubling issues with the budget, to the records that were lost and not told to us in a timely manner for the VA employees themselves, to backlogs for benefits, and the list goes on. Just yesterday, the Associated Press reported that nearly two dozen officials who received hefty performance bonuses last year at the Veterans Affairs Department also sat on the boards charged with recommending the payments. These are the kinds of things that repeatedly and repeatedly and repeatedly undermine our confidence in what the VA is telling us.

So, Mr. Chairman, this nomination and this appointment to me takes on a very huge significance in the scheme of things. We need a culture of change at the VA. We need someone who will come in front of us and be honest and frank and tell us the truth. We need someone who can provide the leadership to address the real challenges of today and tomorrow. I will be looking forward to hearing Dr. Kussman's response to the many questions that we have here.

I appreciate all of your support of the nomination, but I hope that this Committee bears in mind how important this nomination is, because again, to me, it is about the real need for a culture of change at the VA and a new direction in honesty and frankness so that we, as Members of this Committee and the U.S. Senate, can have the information we need to do the right thing for the men and women who have served us so honorably.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Murray.

Dr. Kussman, your nomination comes before the Senate at a difficult and challenging time for VA. The terrible conditions in Walter Reed put a spotlight on VA health care. With each passing day,

more and more servicemembers are returning with serious traumas and injuries, as was mentioned by Senator Murray, which will cause many veterans to rely on lifetime of care from VA. As servicemembers reach out to VA, inevitably, we hear tragic stories of those who did not get the care they needed.

There is no doubt that mental health issues will also be a challenge for VA. The truth of the war is that the toll will be felt by servicemembers and their families for years to come. I am talking about invisible wounds, wounds which cannot be seen but are every bit as devastating as physical wounds.

VA's Under Secretary for Health is one of the most important public servants. The next Under Secretary will guide the VA medical system at a time when so many new veterans will be turning to VA. From my vantage point, VA was not prepared to deal with the types of injuries stemming from this war. Capacity must be rebuilt and the next Under Secretary will have this huge challenge.

So I urge you, Dr. Kussman, if you are confirmed, to first and foremost serve as an advocate for veterans. I am quite cognizant of the constraints placed upon you by the White House and by OMB, as well, and I promise you my full cooperation and assistance. But I tell you now that I will not be satisfied unless you work to uphold the promises made to all of our troops. I know you have—and this is why I think you are so well suited for this position—that you have been working on seamless transition. This is another huge problem and challenge that we have ahead of us, and thankfully we are not starting from zero with you. Hopefully, we can move to bring a truly seamless transition from active duty to civilian life.

We are expecting, as I told you, a series of votes that was supposed to begin at 10:30, but it is due here any minute. I just received word that we are down to three votes, a series of three votes, and that will happen soon. So I would like to thank our panel for being here, for contributing to the record of Dr. Kussman's hearing. Again, thank you for being here.

With that, I ask the Committee now stand in recess for the series of votes and then we will come back and take Dr. Kussman's statement and also have questions for you, Dr. Kussman. Thank you very much, and we stand in recess.

[Recess.]

Chairman AKAKA. The Committee will again come to order.

I would like to introduce the nominee, Dr. Michael Kussman. I have known Dr. Kussman for many years, since he first served in Hawaii in the early 1980s. His service in Hawaii included several senior positions at Tripler Army Medical Center and later as Division Surgeon for the Hawaii-based 25th Infantry Division. He joined VA in September of 2000 after retiring from a long career of military service at the rank of Brigadier General. He has served as Acting Under Secretary for Health since August of last year, when Dr. Perlin resigned.

If I have the time line correct, by the time the Kussman family left Hawaii, their daughter, Deana, had spent half of her life in the islands. Deana, I hope that by now you and the rest of the family have found it in your hearts to forgive your dad for moving the

family from the beautiful State to continue his service elsewhere. Maybe you can work on him to find his way back to paradise.

Thank you for coming before this Committee today, Dr. Kussman, and to the entire Kussman family, as we say in Hawaii, E Komo mai, or welcome to our hearing.

Dr. Kussman?

STATEMENT OF MICHAEL J. KUSSMAN, M.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Dr. KUSSMAN. I think it is still morning, sir. Good morning, Mr. Chairman. Aloha to you.

Chairman AKAKA. Aloha.

Dr. KUSSMAN. I appreciate your comments. Before I begin my statement, may I mention that my wife, Ginny, whom you acknowledged, my son Josh and his fiance Laura, my daughter Deana and her husband Steve, are all with me today, sitting right behind me next to the Deputy Secretary. Their love and support, especially Ginny's—I love you, dear—have made it possible for me to serve my country faithfully and well through my career. Without their help, I could not possibly have qualified for the office for which I have the honor of being considered.

Mr. Chairman, I began my career with the United States Army back in 1970. Like many at the time, I was drafted and served my 2-year tour honorably before leaving the Service. I finished my medical training, went into private practice for a few years, and then volunteered to return to the Army in 1979. I came back because I realize as a physician and a healer, that being an Army doctor allowed me to practice my profession while being of service to our Nation's greatest heroes, our servicemembers. I am proud of my military service and privileged to have worked my way through the ranks to be selected as a general officer.

When I transitioned from the military, I wanted to continue to serve. The Veterans Health Administration offered me that opportunity in 2000 and I could have not been more grateful. Although I am not still wearing a uniform, I consider myself to be still serving. I appreciate the VHA for giving me that opportunity.

When I joined the VHA, the agency was in the process of successfully redefining itself as the standard of care by which all other health care providers must be measured. Just last month, for example, a new book was published. It is entitled, The Best Care Anywhere: Why VA Health Care is Better Than Yours. I am truly fortunately to have been chosen to carry the standard for this great organization.

From my perspective, VHA not only offers the best health care anywhere, but we have the best people anywhere, as well. With the proper resources and the support we receive from the Senate, the House, the President, and the veterans service organizations, we can continue to set the benchmark for quality care for the Nation and the world.

Mr. Chairman, soon after I came to VA, our Nation went to war. We have been at war for more than 4 years now. Our losses, while they may not be as numerous as those in past wars, have nonethe-

less affected the lives of thousands of America's heroes and their families.

Our Department has no more important mission than to restore those who have been injured or made ill as a result of their service in this war to their highest possible level of functioning. Personally and professionally, I accept the responsibility for VHA's readiness to provide these heroes with the level of care they have earned through their service and the sacrifices they have made in defense of our freedom. That is why I am here and that is my passion.

Our care for OIF/OEF veterans has not been perfect by any means. We continue to learn what world class care means to this new generation of servicemembers, veterans, and their families. Their expectations have raised the bar for our success and we continue to improve in order to meet their expectations. When things have not gone well for individual veterans, I have listened intently and then done whatever I could to ensure that whatever mistakes we made will never happen again.

It is true we made some errors, but we have accepted responsibility for those errors and we will fix them properly, whatever the cost may be. We have learned and we will continue to learn from what we have done wrong. If you confirm me as Under Secretary, that is how we will do business throughout my tenure.

Make no mistake, however. I believe VHA has done an exceptional job of meeting the needs of our newest generation of veterans and we have received remarkable support from the President and Congress. But we still face many challenges. Among them are to improve our level of cooperation and collaboration with our partners at the Department of Defense; to enhance our ability to treat veterans with severe traumatic brain injuries and to detect mild to moderate TBI where brain injuries are not immediately apparent; to continue our search for the most effective therapies for post-traumatic stress disorder and ensure those therapies are quickly distributed throughout our system and elsewhere; to improve access of all enrolled veterans to our world-class care, from our newest veterans to our oldest; and to meet the goal of the President's New Freedom Commission on Mental Health, to emphasize recovery, not stabilization, for every mentally ill veteran.

As Acting Under Secretary, I have established four priorities for improvement in our system to help us meet today's challenges and tomorrow's. First, I have made leadership, responsible, accountable, demonstrated leadership, the key to the VHA's future success. We have many fine leaders in our organization, but the men and women who are willing to accept positions of leadership in our organization must also understand the responsibilities they are asked to accept as leaders. I am committed to getting the right people in the right positions for the good of the entire organization.

Second, I believe that of the VA's four missions—patient care, education, research, and emergency management—patient care is by far the most important. To meet the needs of the veterans it is our privilege to serve, we must bring the quality of our care and our ability to provide that care to a higher level. We are now focusing on some basic questions. Are our waiting times and our wait time measures appropriate? Are our customers satisfied with our service? And are employees satisfied with their work? I believe, and

I know Members of Congress believe, we can do better in those areas.

Third, I do not believe that the quality of our business processes matches the quality of our health care we provide. Among other things, we must be able to properly handle the sensitive personal information our veterans entrust to us. Every VA employee, especially our managers and supervisors, has a duty and responsibility to protect sensitive and confidential information. I have worked with Secretary Nicholson and others to ensure that the VHA is in the first rank of those who are helping to make our Department the gold standard in information security.

And finally, I want to be sure that in measuring performance, we are measuring the right things. Our performance measures system is the best in health care, but we must continue to be vigilant in this area, especially where lives are at stake.

Mr. Chairman, Members of the Committee, let me close by thanking you, Secretary Nicholson, and the President for the privilege that I have been given to continue to serve America's heroes at the Department of Veterans Affairs. I am deeply humbled by the search committee that chose me from among many qualified candidates and by the President's willingness to nominate me to lead the finest health care system in America. If I am confirmed as Under Secretary, I promise to work with you and all Members of the Congress to build a health care system that will meet the needs of all veterans and their families, the men and women it is VHA's privilege and honor to serve.

[The prepared statement of Dr. Kussman follows:]

PREPARED STATEMENT OF MICHAEL J. KUSSMAN, M.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Chairman Akaka, Ranking Member Craig, Members of the Committee and its staff. Good morning.

Before I begin my statement, may I mention that my wife Ginny; my son Josh and his fiance, Laura; and my daughter Deana and her husband Steve are all here with me today. Their love and support—especially Ginny's—have made it possible for me to serve my country faithfully and well throughout my career. Without their help, I could not possibly have qualified for the office for which I have the honor of being considered.

Mr. Chairman, I began my career with the United States Army back in 1970. Like many at that time, I was drafted and served my 2-year tour honorably before leaving the service. I finished my medical training, went into private practice for a few years, and then volunteered to return to the Army in 1979. I came back because I realized, as a physician and a healer, that being an Army doctor allowed me to practice my profession while being of service to our Nation's greatest heroes—our servicemembers.

I am proud of my military service; and privileged to have worked my way through the ranks to be selected as a General Officer. When I transitioned from the military, I wanted to continue to serve. The Veterans Health Administration offered me that opportunity in 2000, and I could not have been more grateful.

When I joined VHA, the agency was in the process of successfully redefining itself as the standard of care by which all other health care providers must be measured. Just last month, for example, a new book was published. It is titled "The Best Care Anywhere: why VA health care is better than yours." I am truly fortunate to have been chosen to carry the standard for this great organization.

From my perspective, VHA not only offers the best health care anywhere, but we have the best people anywhere as well. With the proper resources, and the support we receive from the Senate, the House, the President, and the Veterans Service Organizations, we can continue to set the benchmark for quality care for the Nation and the world.

Mr. Chairman, soon after I came to VA, our Nation went to war. We have been at war for more than 4 years now. Our losses—while they may not be as numerous as those of past wars—have nonetheless affected the lives of thousands of America's heroes and their families.

Our Department has no more important mission than to restore those who have been injured or made ill as a result of their service in this war to their highest possible level of functioning. Personally and professionally, I accept responsibility for VHA's readiness to provide these heroes with the level of care they have earned through their service and the sacrifices they have made in defense of our freedom. That is why I am here.

Our care for OIF/OEF veterans has not been perfect by any means. We continue to learn what world-class care means to this new generation of servicemembers and veterans—and to their families. Their expectations have raised the bar for our success, and we must continue to improve in order to meet those expectations.

When things have not gone well for individual veterans, I have listened intently—and then done whatever I could to insure that whatever mistakes we made will never happen again. It's true we've made some errors, but we have accepted responsibility for those errors, and we will fix them properly, whatever the cost may be. We have learned—and we will continue to learn—from what we have done wrong. If you confirm me as Under Secretary, that is how we will do business throughout my tenure.

Make no mistake, however—I believe VHA has done an exceptional job of meeting the needs of our newest generation of veterans, and we have received remarkable support from the President and from Congress. But we still face many challenges. Among them are:

To improve our level of collaboration with our partners at the Department of Defense;

To enhance our ability to treat veterans with severe traumatic brain injuries, and to detect mild to moderate TBI where brain injuries are not immediately apparent;

To continue our search for the most effective therapies for Post-Traumatic Stress Disorder, and ensure those therapies are quickly distributed throughout our system and elsewhere;

To improve access for all enrolled veterans to our world-class care, from our newest veterans to our oldest; and

To meet the goal of the President's New Freedom Commission on Mental Health to emphasize recovery, not stabilization, for every mentally ill veteran.

As Acting Under Secretary, I have established four priorities for improvement to our system, to help us meet today's challenges—and tomorrow's.

First, I have made leadership—responsible, accountable, demonstrated leadership—the key to VHA's future success. We have many fine leaders in our organization; but the men and women who are willing to accept positions of leadership in our organization must also understand the responsibilities they are asked to accept as leaders. I am committed to getting the right people in the right positions for the good of our entire organization.

Second, I believe that of VA's four missions: patient care, education, research, and emergency management—patient care is by far the most important. To meet the needs of the veterans it is our privilege to serve, we must bring the quality of our care, and our ability to provide that care, to a higher level.

We are now focusing on some basic questions: are our waiting times, and our wait time measures, appropriate; are customers satisfied with their service; and are employees satisfied with their work. I believe, and I know Members of Congress believe, we can do better in these areas.

Third, I do not believe that the quality of our business processes matches the quality of the health care we provide. Among other things, we must be able to properly handle the sensitive personal information our veterans entrust to us.

Every VA employee, especially our managers and supervisors, has a duty and responsibility to protect sensitive and confidential information. I have worked with Secretary Nicholson and others to ensure that VHA is in the first rank of those who are helping to make our Department the gold standard in information security.

And finally, I want to be sure that in measuring performance, we are measuring the right things. Our performance measurement system is the best in health care—but we must continue to be vigilant in this area, especially where lives are at stake.

Mr. Chairman, Members of the Committee, let me close by thanking you, Secretary Nicholson, and the President, for the privilege I have been given to continue to serve America's heroes at the Department of Veterans Affairs. I am deeply humbled that the search committee chose me from among many qualified candidates,

and by the President's willingness to nominate me to lead the finest health care system in America.

If I am confirmed as Under Secretary, I promise to work with you and all Members of Congress to build a health care system that will meet the needs of all veterans and their families—the men and women it is VHA's privilege, and our honor, to serve.

RESPONSE TO PRE-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO MICHAEL J. KUSSMAN, M.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Question 1: The VHA leads the private health sector in many areas, such as electronic medical records, overall patient satisfaction, and negotiations with pharmaceutical companies. In what areas do you believe VA still lags behind? In what fields could VHA learn from the private sector or benefit from the implementation of methods used in the private sector, and what are your plans to make the necessary improvements?

Response: I agree that the Veterans Health Administration (VHA) leads the private health care sector in the areas of electronic medical records, overall patient satisfaction, and effective negotiations with pharmaceutical companies. However, the Department of Veterans Affairs (VA) has room to improve regarding best practices from the private sector. VA is learning to leverage private sector business practices to increase our productivity.

VA has implemented a private sector-based business model pilot known as the Consolidated Patient Account Center (CPAC) tailored for our revenue operations. This private sector-based business model will enable VA to increase collections and improve our operational performance. CPAC is addressing all operational areas contributing to the establishment and management of patient accounts and related billing and collections processes. CPAC currently serves revenue operations for medical centers and clinics in one of our Veterans Integrated Service Networks (VISN) but this program will be expanded to serve other networks.

Question 2: I consider VHA's university affiliations, and related programs such as internships, medical residencies, and joint research, as among VHA's greatest strengths. Aside from existing initiatives, what original plans or ideas would you propose in order to maintain the long-term strength of these programs?

Response: Our university affiliations are a cornerstone of our delivery of care and the quality of our delivery system. This symbiotic relationship has been going on for over 60 years and remains strong today. As part of this relationship, VA works with affiliates to address concerns. For example, we are examining how VA can use its clinical learning environment to maximize the training of physicians for the realities of practice in the modern health care environment. VA has one of the best, if not the best, patient safety program in the Nation. The question then becomes, how can we best use this resource in our health professional training programs? We have had continuous and ongoing dialogue with the Association of American Medical Colleges to assess these and other issues. The outgrowth of dialogue such as this was the establishment of a Blue Ribbon Task Force to look at where we are and where we need to go.

Acting on Task Force recommendations to improve and strengthen VHA's university affiliations, I have directed VHA's Office of Academic Affiliations to work with our medical school and academic medical center partners to explore new and potentially transformative approaches to medical education. The centerpiece of this approach is the emerging realization by medical educators that educational reform without concurrent redesign of the care delivery environment is unlikely to be successful and that clinical redesign has profound implications on the process and content of education as well. For example, one has only to consider the importance of continuity of care in forming the attitudes of young physicians and provider continuity in managing patients with chronic disease to appreciate the essential unity of education and care delivery. Indeed, learning and care are inseparable.

But physicians alone will be insufficient in the team-based care delivery system of the future, and VA must increase its attention to other health professions. At my direction, the Office of Academic Affiliations is expanding inter-professional training opportunities and, in partnership with VHA's Office of Nursing Services, has just launched a major initiative in nursing education, the VA Nursing Academy.

The central intent of the Nursing Academy is to work hand in hand with the Nation's nursing schools in addressing the major problem underlying the present nursing shortage—insufficient numbers of teaching faculty. A 5-year pilot project is already underway to identify VA facility-nursing school partnerships willing and able

to invest in nursing faculty while at the same time admitting additional numbers of qualified students.

VA nurses will be given faculty appointments and VA will provide additional funding for nursing school faculty. Innovative ways of enhancing the learning environment and nursing curriculum will be explored and the scholarly and research development of nursing faculty will be enhanced.

As is evident from the initiatives summarized above, new, more collaborative management models are appropriate for the current relationship between VA and its affiliates. One potential model that I would like to see explored in more depth is "educational consortia"—in which VA works much more closely with its academic affiliates to jointly manage educational programs while still retaining sole control of its health care delivery operations.

In summary, I believe VA's academic affiliations provide significant opportunities for improving health care for veterans while strengthening academic institutions throughout the country. We should, and we will, work hard to keep these relationships vibrant by continuously exploring new approaches to collaboration and securing the resources necessary to ensure excellence in our statutory educational mission.

Question 3: What is your overall direction for the VA research program?

Response: The VA research program is a jewel in the crown of the Nation's research capability. Over the years it has done magnificent research, and VA researchers have received two Nobel Prizes and six Lasker Awards. Our goal is that the research we conduct needs to have direct transferability to veteran care. Over the last 3 years we have shifted the direction of our research program to increase emphasis on research related to Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans, including traumatic brain injury (TBI) and other neurotrauma, combat-related mental health, prosthetics and amputation health care, polytrauma, and other related issues.

VA's research is performed in house with funding coming from direct appropriation, other government entities and the private industry. We have increased our percentage of research dollars directly related to OEF/OIF issues to 58 percent. We are also continuing to focus on chronic disease research and our research in this area is expanding to incorporate genomics research. In addition, we are increasing our focus on research related to reducing health disparities, including minority and rural health disparities, and are beginning interventional studies in this important area.

Question 4: Anecdotal evidence suggests that waiting times for medical appointments—including non-specialist appointments—often reach several months, and occasionally exceed six months. In addition, it is my understanding that VA is not tracking the time it takes specialty medical procedures and surgeries to be scheduled once they are recommended. Finally, the IG has reported manipulation of the electronic waiting list and other procedures used to track waiting times. If confirmed, what would you do to ensure that waiting times are accurate and, more importantly, that veterans are not waiting excessive times for care, including medical procedures and surgeries?

Response: The most important issue is making sure veterans see a provider as quickly as possible. Delaying the provision of care beyond reasonable periods of time is not acceptable.

At present, 95 percent of all appointments are made within 30 days of the desired date and 98 percent within 60 days of the desired date. We have been tracking the number of new veterans to the system that have had to wait more than 30 days from the desired date to get an appointment. This number has declined from 22,000 in May 2006 to 1,300 in March 2007.

To ensure the accuracy of waiting times, VA has undertaken various measures to improve the performance of schedulers who initiate appointments. For example, we have made a concerted effort to identify schedulers that are making mistakes. To improve performance, VA developed and implemented a comprehensive policy on the proper way to schedule and record appointments.

As part of the implementation process, training is mandated for all employees working on scheduling appointments. VHA has conducted training for schedulers to help them determine and document these desired appointment dates. Our efforts have been successful at reducing the wait times for veterans across the country.

With respect to waiting for medical procedures and surgeries, this is not yet being tracked. One of my top priorities is to develop tertiary care performance standards to do just this.

Question 5: VISNs were implemented a dozen years ago. Since that time the total number of personnel assigned to each VISN has grown from the originally envi-

sioned 8–10 employees to, in some cases, hundreds. Please share your views about what are the advantages and disadvantages of the current structure.

Response: VHA is among the largest health care systems in the country. The VISN structure supports the integration of service delivery within a network. VISNs can provide their population of veterans with the full range of health care services from primary care, available at locations throughout the network, to highly specialized treatment, which may be available at only one location. Since the VISN system was established, the role of VISNs has grown significantly as they take advantage of myriad efficiencies. They have taken on a significant work load that could no longer be done in Central Office.

VHA recently held a Summit Meeting in Baltimore to assess where we have come in the past 10 years from enrollment reform and the establishment of the VISNs and where we would like to go. One of the issues is the role of the VISNs vis-a-vis Central Office. Most agree that health care is local, so the development of regions has its advantages, but there still needs to be consistency and standardization of delivery of care. Although the balance between centralization and decentralization will always be debated, there is no absolute. It is my opinion the pendulum probably has swung a little too far in the direction of decentralization and needs to come back toward the center in order to ensure appropriate consistency and standardization.

Question 6: Are you comfortable with the amount of oversight that VA Headquarters program managers are able to conduct? In your view, is budgetary authority a requisite for such oversight?

Response: I am comfortable with the amount of oversight VHA program managers have and I do not believe any additional budgetary oversight is required. Central Office program managers are responsible for establishing policies and procedures and setting standards. They work closely with the Chief Financial Officer to ensure program funds are appropriately planned, allocated, and used. They are not operators. Program managers advise VA leadership on what should be done. If they believe existing policies and procedures are not being followed, they have opportunities to raise their concerns before the National Leadership Board and, using the chain of command, to bring these issues to my attention. Our managers are evaluated based upon objective performance measurement criteria, so they have a direct interest in maintaining oversight and accountability. I do not believe budgetary authority is a requisite for oversight and direction.

Question 7: What would you do as Under Secretary for Health—beyond increasing funding for the existing EDRP and scholarship programs—to enable VA managers to recruit and retain health professionals, especially in the area of nursing?

Response: VA places a high priority on hiring and retaining nurses. We are fortunate our retention rate seems to be higher than civilian markets. Our nurses believe in our mission and enjoy the work environment we create as well as our mission. We are in the process of establishing a VA Nurse Academy we hope will lead to better visibility of the VA in Nursing Schools and increased hiring.

I would like to highlight the programs for recruitment and retention of health care professionals noted in your question. The Education Debt Reduction Program (EDRP) receives $15 million each year. This program has authorized over 5,200 awards since its inception in 2002 for health care employees with outstanding student educational loans. There is a current total obligation through Fiscal Year (FY) 2012 of $89 million. The impact on retention is significant. A study in 2005 revealed the resignation rate for EDRP nurses, physicians, and pharmacists was less than half that of non-EDRP staff (for nurses, 13.7 percent versus 28 percent; physicians 15.9 percent versus 34.8 percent; pharmacists 13.4 percent versus 27.6 percent).

In addition to continuing and enhancing the Education Debt Reduction Program, VHA manages one of the largest employee scholarship programs in the Federal Government, the Employee Incentive Scholarship Program. Over 6,300 academic scholarships have been awarded to VHA employees seeking degrees in health care occupations or advancing their education in the nursing professions.

Question 8: In your view, what can be done to enhance compensation for senior non-medical personnel? How do you perceive the discrepancy between compensation in VA and in the field of private hospital management, given the similar nature of the work?

Response: Proper and equitable compensation for our most experienced executive personnel is a challenge. The government pay system prevents us from paying non-medical personnel comparable competitive salaries.

Growing pay disparities both within and outside VHA make it increasingly likely that many executives will be lured away by more lucrative private sector opportunities or will choose retirement, leaving a void in the ranks of senior leadership positions needed to ensure VHA's continued pre-eminent position in health care. In a

study published in 2000, the Hay Group affirmed the scope of responsibilities of VHA health care executives was, overall, comparable to that of private sector executives.

Recent trends in VHA senior executive positions provide evidence of a growing problem, since turnover in medical center director positions increased from 6.8 percent in 2005 to 21.7 percent in 2006. VHA is engaged in rigorous succession planning, using such models as the High Performance Development Plan and the Leadership Development Plan, to identify, train, and retain promising managers. VA, like other Federal agencies, is taking advantage of Office of Personnel Management (OPM) programs designed to develop the next generation of leaders.

Question 9: Are you confident that current VHA authorities and procedures allow for sufficiently expeditious hiring of medical personnel? Please describe any recommendations that you may have for changes to the current hiring system.

Response: No, I am not confident that our Human Resources policies and procedures allow for expeditious hiring in all areas. In fact, I believe that there have been instances where we lost the opportunity to hire good people because our process took too long for our clinical professionals. We have appointing authority under title 38 for physicians, dentists, and registered nurses, and similar authority under our hybrid title 38 appointment for pharmacists, physical therapists, social workers, psychologists, medical instrument technicians, and others, which allows for quicker hiring for these positions, However, other allied health areas do not fall under this same authority and are subject to prolonged hiring processes. Like most of the rest of the Federal Government, we do not have this authority for other professionals and technical staff, but we are working internally to identify obstacles and develop solutions to speed up the process.

Question 10: In my view, Physician Assistants play a vital and growing role in the delivery of health care. You have already indicated your dedication to expanding the role of the PA Advisor. What new efforts would you undertake as Under Secretary for Health to ensure full participation of the PA Advisor in health care planning and to provide adequate resources for the position?

Response: I agree that physician assistants (PA) are valuable and essential to the delivery of care in the VA. VHA increasingly relies on PAs for critical contributions to providing quality and timely health care to our Nation's veterans. The PA Advisor is now required to travel to Central Office on a regular basis to enhance his full participation in the position's expanded responsibilities. I have made the decision that, with the next iteration of consultant for PAs, the position will be full time and will be located in Central Office. I am requesting the PA Advisor provide periodic briefings identifying barriers and recommended changes to expand the scope of responsibilities in order to fully use PAs in VA.

Question 11: The Veterans Benefits, Health Care, and Information Technology Act of 2006 enacted by Congress last year added Marriage and Family Therapists and Licensed Professional Mental Health Counselors to the list of health professionals that VA may employ. Please outline your plan for how this law will be implemented, specifically with regard to how these professionals will be fully integrated into VA mental health care.

Response: To assist with implementation of Public Law (P.L.) 109–461, VHA is currently evaluating the graduate training requirements for Marriage and Family Therapists and Licensed Professional Mental Health Counselors. Specifically, we are looking at the post-graduate clinical experience and supervision required for licensure, the scopes of practice developed within the states, and the evidence-base for the effectiveness of care provided. It is necessary to take these steps to define the combinations of credentials and experience, as well as the scope of practice, required to ensure the professionals will enhance VHA's ability to deliver high quality mental health care services to veterans in need.

Question 12: Marriage and Family Therapists and Licensed Professional Mental Health Counselors have similar or comparable qualifications with social workers, who have been eligible to work with VA for years. If confirmed, how will you utilize these health professionals?

Response: The education of professionals in each discipline is defined by conceptual models specific to each discipline and an understanding of the clinical needs of the population served. Under my direction, the Offices of Mental Health Services and Management Support are reviewing the knowledge-base, supervision, and experience that define training, as well as the scope of practice in other settings to develop plans using these professions to an optimal degree. These evaluations will inform the strategies for utilization.

Question 13: Last month, you issued a policy that introduced anesthesiologist assistant (AAs) to the VA health system. Please explain the basis for this new policy, including how you expect it to enhance the quality of VA health care.

Response: In some markets, VA has difficulty recruiting nurse anesthetists. Allowing facilities to use anesthesiologist assistants (AAs) to provide care offers us another option in providing veterans timely and quality access to needed health care. The use of AAs in VA has been an issue even before the December 22, 2006 Human Resources Management Letter (HRML) No. 05–06–12 allowing human resources offices to establish these positions. Anesthesiologist assistants practiced in VA before this decision as contractors, and some physician assistants performed this role as well.

This is a relatively new field that could potentially expand the ability of the VA to provide anesthesiology services to veterans. These professionals must work under the supervision of an anesthesiologist and more than 10 States currently offer licenses to practice. There has been some concern from the Certified Registered Nurse Anesthetist (CRNA) community about this approach. It is our opinion that in the right setting and with appropriate oversight, the use of anesthesiology assistants will expand our capability and in no way diminish quality. It is my understanding that the VA CRNA organization is not opposed to the use of AAs in VA, but they have some concerns about the specifics outlined in the recently published directive. VA leadership agrees with the VA CRNA organization that further discussion will take place to ensure their concerns are addressed. If needed, we would issue a new directive.

Question 14: What is the standard by which you would approve or reject enhanced use lease applications for use of VA facilities?

Response: The Enhanced-Use Lease (EUL) legislation (i.e., 38 U.S.C. § 8161–8169) allows VA to enter into an enhanced-use lease if: (1) at least part of the property under the lease will provide appropriate space for an activity related to VA's mission; the lease will not be inconsistent with nor adversely affect VA's mission; and the lease will either enhance the use of the property; or (2) the lease would provide consideration to be used to improve the health care for veterans in the affected community.

Essentially, there are three levels of strategic review—one at the initial stage when the EUL requests (concept papers) are submitted through VISNs to VHA's Capital Assessment and Management and Planning Services (CAMPS) office; another when VHA submits the concept papers to VA's Office of Management (OM); and then finally when OM submits the request to the Secretary. At any of these levels, if it is identified that the legislative criteria is not met, the concept paper is disapproved and returned to the VISNs and medical centers.

Question 15: Much has been promised about ensuring that there is a smooth transition between DOD and VA for separating servicemembers. I understand you have been directly involved in many of VAs initiatives to improve this process. What is the state of progress in this area, and what more needs to be done?

Response: Seamless Transition has been a goal of VA and the Department of Defense (DOD) for many years, but our success has been measured and has, in some instances, fallen short of what our veterans deserve. In August 2003, I was asked by Secretary Principi to co-chair a Task Force to look at specific issues related to the new group of severely injured OEF/OIF servicemembers. I served in this capacity until January 2005, when VA established a permanent Office of Seamless Transition, composed of representatives from VHA and the Veterans Benefits Administration (VBA), as well as an active duty Marine Corps Officer and an Army Officer. Unprecedented efforts were taken by both DOD and VA to put VA personnel full time in 10 DOD military treatment facilities (MTF) and to place full time military personnel in VA facilities. Our four traumatic brain injury (TBI) centers were converted to polytrauma rehabilitation centers to deal with the complex injuries of some of our recently injured servicemembers. VA began employing a system of clinical case management to assist in the movement of servicemembers from DOD to VA. We recognized the challenges faced by previous generations, and we wanted to simplify the process for servicemembers and their families, especially those dealing with medical issues. If servicemembers are not going to a Polytrauma Center, our case managers coordinated with the nearest VA facility as selected by the veteran. Veterans are scheduled to be enrolled in VA prior to leaving the MTF and social workers are tasked with coordinating appointments with VA, while case managers will handle clinical issues and Transition Patient Advocates (TPAs) address logistical issues for our most seriously wounded veterans and servicemembers.

In March 2007, Secretary Nicholson announced VA would be hiring 100 patient advocates to serve as ombudsmen for severely injured OEF/OIF veterans. These new

TPAs will assist seriously injured veterans and their families with issues and concerns and help them navigate the VA system. In March 2007, VHA published a policy document outlining the responsibilities of the TPAs, which include traveling to military hospitals to meet severely injured patients and their families and following those patients into the VA health care system. Also in March 2007, VHA began recruiting to fill the positions. As of this date, VA medical centers have hired 46 TPAs and are interviewing to select the remaining 54. Each medical center with vacant TPA positions has detailed employees to perform the functions while recruitment is underway. I believe that the TPAs will help us assure that no severely injured OEF/OIF veteran falls through the cracks.

We are improving our coordination in joint-case management situations with more communication. Veteran Tracking Application, VA's adaptation of the Joint Patient Tracking Application system will help track and provide clinically important information. VA has also started using ombudsmen for each severely injured veteran or servicemember to ensure one person will follow him or her across the continuum of care; we are filling these positions now. We need to do better with less severely injured servicemembers who do not enter the Polytrauma System of Care. Our improved case management system will help them as well.

Seamless transition for all separating servicemembers is also very important and, to a large degree, is handled through the Benefits Delivery at Discharge process. We must continue to improve our Compensation & Pension process to ensure effective, standardized and timely examinations so veterans receive the care and benefits they earned.

With those limits and needs acknowledged, VA has done a great deal for our servicemembers. VHA staff has coordinated over 7,000 transfers of OEF/OIF servicemembers and veterans from an MTF to a VA medical facility. Active duty Army Liaison Officers are assigned to each of the four VA polytrauma rehabilitation centers and assist servicemembers and their families from all branches of Service on a wide variety of issues. VA established an OEF/OIF Polytrauma call center to assist our most seriously injured veterans and their families with clinical, administrative, and benefit inquiries. VA has implemented an automated tracking system to track servicemembers and veterans transitioning from MTFs to VA facilities. During the period October 2006 through March 31, 2007, over 150 severely ill/injured patients were transferred from MTFs to VA medical centers (VAMC). VA is participating in DOD's Post Deployment Health Reassessment (PDHRA) program for returning deployed servicemembers, and between 5 November 2005 and 30 April 2007, over 85,000 Reserve and Guard members were screened, generating more than 20,000 referrals to VAMCs and over 10,500 referrals to Vet Centers.

In addition, VA signed a memorandum of agreement (MOA) with the National Guard in May 2005 to form state coalitions in 54 States and territories. A similar MOA is being developed with the U.S. Army Reserve Command and the U.S. Marine Corps at the national level. VA and the National Guard Bureau teamed up to train 54 National Guard transition assistance advisors who assist VA in advising Guard members and their families about VA benefits and services. We are currently reviewing the recommendations of the President's Task Force on Returning Global War on Terror Heroes. Some of these recommendations are already being developed and implemented, such as the call to develop a system of co-management and case management between DOD and VA and providing full support to DOD for PDHRA for Guard and Reserve members, as an extension of the outreach described above.

Question 16: In an attempt to respond to the demand for care from servicemembers from the operations in Iraq and Afghanistan, the Administration has chosen to prioritize the care of veterans who served in these operations. Do you believe it is appropriate for older veterans to wait behind new veterans for care? Would you advocate for increase funding to obviate the need for this type of prioritization?

Response: We certainly do not want to create a situation that pits one group of veterans against another. Specific clinical needs should be the final arbiter of priority access. If there is no clinical difference, it is administrative policy to expedite appointments for new veterans, including OEF/OIF veterans. Our goal is to have all veterans seen within 30 days of their requested appointment date, or within 30 days of their request in the case of new enrollees. If we achieve that, there is no need to prioritize one group of veterans over another. Almost all facilities currently comply with this 30-day standard 90 percent or more of the time. We believe our current level of funding will allow us to meet that goal. The expansion of non-institutional services targeted for Fiscal Year 2008 is the most rapid expansion that can realistically be achieved in a single year in services for our veterans.

Question 17: Criticism of VA's prosthetics, TBI, and mental health programs has raised the issue of VA contracting with private and/or community entities to make up for either perceived or real shortcomings in these programs. What are your thoughts about this? Is it not possible for VA to reach the pinnacle of care in these areas? Would you consider the need for contracting out for care in these areas? Can a viable VA health care system exist if its role is relegated to solely that of a payer versus a provider in these clinical areas?

Response: Let me first say that our Nation's veterans deserve the best care possible and we continually work to improve our care and services that we provide. VA achieves a gold standard according to external and internal measures of quality for our prosthetic, TBI, and mental health care. VA performs over 5,000 amputations each year and provides state-of-the-art care to all. Our research, academic affiliations, and clinical programs uniquely place VA as a national leader in the treatment of TBI, a position we have held since 1992 when we developed our four Lead TBI centers. Mental health care is one of our most important areas of concern, and we have led the country in the treatment of severe mental illness and substance abuse. In fact, our National Center for Post Traumatic Stress Disorder (PTSD) is a recognized international leader in the field.

While no program is perfect, I do not feel the criticism about our prosthetic program raised by some is accurate. I will concede that early on in the war, VA was not adequately prepared for this new group of veterans. We dealt primarily with geriatric amputees, many with diabetes, making them less than ideal candidates for new technologies like myoelectric upper extremity prosthetics and computer-driven lower extremities. But, we have redirected our attention and our prosthetists and physical therapists have learned from the great work being done at Walter Reed Army Medical Center (Walter Reed) and other DOD sites.

As far as TBI, I believe we have world class care. Again, we must provide the best care possible. To reassure our patients and their families, I have instructed our facilities to seek a second opinion from reputable civilian experts when servicemembers or families are concerned about our level of care or our diagnosis. When we have done this, these experts have usually concurred with our work and the services provided. The Commission on Accreditation Rehabilitation Facilities certifies each Polytrauma Rehabilitation Center, home to our TBI Lead centers. We are in the process of requesting a civilian review of our care.

As far as mental health services, I am very proud of what we provide. We spend approximately 10 percent of our budget directly on mental health services and are the largest provider of mental health services in the country. Obviously there are geographic challenges, and VA appreciates the need to overcome these obstacles, which is why we initiated a very aggressive hiring campaign for mental health workers. If there are insufficient services available in an area for us to provide needed care, we will to consider fee-basing the care; however, in many under-served areas, there are few providers, if any, who would meet our quality standards for care.

VA, as a provider of specialty care, is able to exercise direct supervision and oversight on the care and health care policies associated with our veterans. Contracting out this functionality entirely will lead to fragmentation of care and an adverse effect on the continuity of care needed to ensure quality of care, patient safety, and efficiency.

We take our commitment to providing care to our Nation's heroes and will continually strive to achieve the highest quality of care and services which they deserve.

Question 18: When asked by AP about a VA report stating that 30,000 or 16 percent of the 184,000 OEF/OIF veterans who had sought VA care as of late 2006 had symptoms of PTSD, you called this a "gross overestimation" of actual mental health disorders. However, I note that the 16 percent figure is consistent with Colonel Charles Hoge's testimony at the September 28, 2006, hearing of the House Committee on Veterans' Affairs. According to Colonel Hoge' s research, "16 percent of soldiers surveyed 12 months after returning from Iraq screened positive for PTSD, depression, or anxiety and reported that there was functional impairment at the 'very difficult' level." Do you still believe the reports of PTSD are grossly overestimated?

Response: Let me clarify what we know about mental health disorders. As of the end of Fiscal Year 2006, over 205,000 OEF/OIF servicemembers have come to VA; 72,000 had symptoms of some kind of mental health disorder. That does not mean that they came for a mental health problem or that they actually had a mental health disorder. Our screening process identifies many symptoms that would not have been elicited without asking. Of the 72,000, 34,000 have symptoms consistent with PTSD. It is not clear exactly how many of these are finally diagnosed with PTSD, but several small studies show that 75 percent to 90 percent of those with

symptoms will have some degree of PTSD. In Colonel Hoge's first report, he states 16 percent of servicemembers were diagnosed with PTSD, depression, or anxiety, but 9 percent of all servicemembers had that diagnosis prior to their deployment, meaning only 7 percent of servicemembers diagnosed with PTSD as the result of combat experience.

With regard to your question, it is possible that many of our returning servicemembers have readjustment issues that are not due to mental illness but are normal reactions to abnormal situations. If so, it would be unfair and inaccurate to label them as having mental illness. I can tell you that VA is very concerned about cases of PTSD and we are doing everything we can to identify and provide treatment to those in need. The actual prevalence of PTSD among recent combat troops can only be determined by well-designed, large-scale epidemiological studies that rely on clinically confirmed diagnoses of PTSD. Multiple deployments to hazardous theaters of military operations can increase the risk of developing PTSD and other mental health problems and PTSD often develops over many years. The level of PTSD among OEF/OIF troops will not be completely known until well after the end of current hostilities and deployments to Southwest Asia.

To better understand the long-term health concerns of OEF/OIF veterans, I'm pleased to report I approved funding for VA's Office of Public Health and Environmental Hazards to conduct a longitudinal health surveillance of OEF/OIF veterans to track the illnesses and diagnoses they have after their deployment.

Question 19: As I have shared on many occasions, I am concerned about VHA's ability to manage the mental health needs of servicemembers if deployments continue indefinitely. With current levels of staffing and resources, how will VHA continue to meet the mental health needs of both long-time and new veterans three or four years from now?

Response: Most of our increase in PTSD patients has not been because of veterans returning from Iraq or Afghanistan, but from veterans of previous wars experiencing a resurgence of their symptoms. On the basis of projected need for all veterans, VHA is increasing the estimated budget for mental health services in both our medical facilities and our Vet Centers. We have placed a clear emphasis on mental health and combat related experiences, with almost $3 billion allocated to mental health following an increase of $545 million from 2006 to 2008. We believe this should be adequate to meet our needs. VHA anticipates continued growth in funding for mental health programs, both through Veterans Equitable Resource Allocation and the Mental Health Initiative, beyond 2008.

We are aggressively expanding our staffing wherever possible, but I do not think we are yet where we need to be. The Office of Mental Health Services is working with Management Support to augment our current strategies for recruiting mental health professionals into our system. We are actively involved in research on mental health and clinical neuroscience where findings can be translated into improved care within a few years, and other, more basic studies, that may translate into more dramatic advances over longer time frames. Similarly, VA is educating and training our existing staff to ensure they have the knowledge and skills needed to provide the most up-to-date forms of evidence-based care in a safe, effective, efficient, and compassionate manner. If we cannot meet the clinical needs of these veterans with the appropriate type of care, then we need to leverage the civilian community. We will monitor this very closely and adjust resources as needed.

Question 20: Early diagnosis and referral can limit the development and effects of mental health problems, particularly PTSD. As such, VA and DOD must cooperate closely on an effective screening and referral system. What specific steps will you take to improve this cooperative system, and to make it comprehensive, reliable and ultimately, successful?

Response: I agree that early diagnosis is very important. When this occurs, we have the opportunity to prevent or ameliorate the long term consequences of PTSD. It is clear that the immediate post-deployment screen is only of marginal value. Recognizing this, VA and DOD generated the PDHRA process. This occurs at 90 and 180 days after deployment. Research shows this is an optimal time to screen for PTSD. We screen all OEF/OIF servicemembers that come to us for care, regardless of the initial diagnosis. Many people will not come and express a need for psychiatric assistance. Our goal is to ensure all servicemembers and their families are aware of the available help and to make it as easy as possible for them to access care.

For veterans and servicemembers with severe injuries who have required medical evacuation from combat areas, VA and DOD conduct a comprehensive and formal system of seamless transition including monitoring any signs or symptoms of mental health conditions.

For those with planned returns from deployment, veterans and servicemembers requiring help can be identified through PDHRA and collaborative PDHRAs 3 to 6 months after their return.

There are currently 83 Returning Veterans Outreach, Education and Care (RVOEC) teams in VAMCs across the Nation. By the end of Fiscal Year 2007 there will be 90 such teams in operation. The goal of these teams is to provide early assessment and care to returning OEF/OIF veterans designed to address psychosocial problems before they deteriorate into actual mental disorders. If existing mental disorders such as PTSD are identified clinical services are provided by the team or by referral to other mental health programs including PTSD clinical teams. Outreach activities are carried out in coordination with Vet Centers. Education on clinical conditions and coping skills training are basic approaches to controlling emotional/behavioral problems in a manner that promotes coping skills yet can avoid the potential stigma of the term "treatment." RVOEC teams also serve veterans in primary care settings, as do other mental health providers using evidence based collaborative and coordinated care approaches. A survey of the 38 teams established in Fiscal Year 2005 indicated that over 7,700 OEF/OIF veterans were seen for problems including PTSD, depression, substance use disorders and employment problems. VA is already working closely with community health providers to educate them on the signs and symptoms of PTSD. At the urging of the President's Task Force on Returning Global War on Terror Heroes, VA is reinforcing and expanding this outreach.

Question 21: In this era of extensive Reserve component call-ups, do you foresee a need for additional Vet Centers beyond the current modest expansion?

Response: The Vet Centers are extremely effective in providing a venue for help with readjustment issues. Through 2008 we will have increased our number of locations by 23 for a total of 232 while also augmenting the staff at 61 existing Vet Centers with 150 additional positions. In addition to the 100 OEF/OIF outreach workers hired in 2004 and 2005, VA has added 269 positions since before 2004.

VA's internal budget for the Vet Center program in Fiscal Year 2008 will be $125 million dollars, which is a 25 percent increase over the program's Fiscal Year 2006 $100 million budget. Although we anticipate that these additional resources will be of great value to VA's efforts to intervene early and serve the OEF/OIF troops returning from combat, we are aware of the increasing number of returning combat veterans and will evaluate the need for additional resources on an ongoing basis.

Question 22: What is your view on maintaining the continued independence of Readjustment Counseling Service and its Vet Centers from the medical operations under VHA?

Response: The Vet Centers have my full and total support in their mission of providing early intervention and quality readjustment services to our Nation's war veterans and their families. These community-based centers provide a unique combination of outreach and effective readjustment counseling services aimed to assist veterans and family members in making a successful transition from military deployment to civilian life. Vet Center services have enabled VA to better serve the newer generation of veterans returning from OEF/OIF. It is my view that the optimal way to ensure their continued success is to maintain their current status within the health care structure.

Question 23: VA currently has the authority to involve families only in a limited course of treatment. It is now apparent that increased attention to family members, outside of specific courses of treatment, would directly benefit veterans at risk of mental health problems. What changes, legislative or otherwise, would you pursue to increase attention to veterans' families and to encourage their participation in the veteran's recovery process?

Response: Family involvement is essential to the care of the veteran. In fact, we have adapted our policies to encourage the maximum level of family support, consistent with the clinical or rehabilitative needs of the veteran, particularly in TBI cases.

In VA medical centers and clinics, families are involved in treatment when this is covered in a treatment plan developed to benefit the veteran. This has allowed the dissemination and implementation of family psycho-education, an evidence-based intervention with a focus on families of veterans with serious mental illness, and outcomes that include decreased rates of hospitalization for the veteran. We have heard of a number of cases in which families are aware of mental health symptoms, but where veterans are reluctant to come for care. In these cases, there can be a real need for families to know that they can come to the VA to talk with mental health professionals about their loved one and to learn how to manage symptoms

and potentially dangerous behaviors. This type of care is already available through Vet Centers, but we lack the authority to allow it in medical centers and clinics.

As you are aware, Vet Centers have been authorized to provide bereavement counseling for family members of deceased servicemembers. Counseling after return from deployment often focuses on the veteran's readjustment to the family as well as to the job, school, and community.

Question 24: Women make up a growing portion of the military and veteran population and are serving in theaters of combat in increasing numbers. This growing group of veterans will continue to require new services from VA. What steps would you take to keep pace with the demands of women veterans? What is your view on what VHA could be doing to improve services for women veterans?

Response: Providing gender-specific, age-appropriate health care is our most important responsibility to women veterans. Since Fiscal Year 2002, 37.2 percent of separated women OEF/OIF veterans have sought VA health care services. This means we will be dealing with women veterans of child-bearing age. To properly address this situation, we created the Women Veterans Health Strategic Healthcare Group (SHG). I have given my full support to this SHG in planning and implementing the highest quality care to women veterans.

VA has designed services and programs to be responsive to the gender-specific needs of women veterans. VA offers comprehensive health care services for women including: all aspects of primary care, gender-related health care, counseling for sexual trauma, pregnancy and infertility care. In addition, VA has Women Veterans Program Managers at every VA medical center. VA sets the benchmark for care in the United States in such areas as breast and cervical cancer screening.

More and more research is being done to assess the special needs of women in the military, including Military Sexual Trauma (MST), and the differences in how women respond to stress, especially PTSD. We have a special inpatient women's PTSD center in Cincinnati named Chrysalis and we will consider opening more of the same as the need is identified. Similarly, the Women's Mental Health Center in Palo Alto was opened in October 2002 to provide treatment and support for sexual trauma. VHA's Office of Mental Health Services recently established a MST support team to monitor MST screening and treatment, coordinate MST-related education and training, and to promote best practices in the field. New cognitive-processing therapy and behavioral therapy have proven highly effective, and these lessons are being disseminated to other locations.

VA is pursuing improved care on multiple levels. We are:

- Providing enhanced training for primary care providers in the complexity of women's health medicine;
- Adding a nationally renowned female surgeon to work in our Office of the Medical Inspector;
- Establishing a "provider registry" so VHA providers can access "real-time"interaction on gender-related medical issues; and
- Improving the physical environment of care, with particular attention given to the need for private, welcoming space for women veterans.

With regard to what else can be done, I think it would be appropriate to have additional research in the areas of general women's health, such as cardiac disease, breast cancer, and cervical cancer rates for veterans and in issues related to military service, such as MST. We are particularly interested in collaborating with DOD in efforts to understand how to best respond early after sexual trauma exposure and to assist veterans to achieve recovery from traumatic events.

Question 25: You have testified that currently when wounded service personnel enter the VA health system that there is a detailed procedure to minimize the infection and spread of the acinetobacter infection. What type of testing is currently being used to screen patients?

Response: When patients are admitted to VA facilities, the standard of care is to assess all wounds or open sores. This assessment would include a review of all available previous culture and susceptibility data from any other facility. Additional culture and susceptibility testing would be dictated by the clinical presentation and assessment. Acinetobacter baumanii is an organism that grows on usual media in VA microbiology laboratories and where routine susceptibility testing is available to allow appropriate antibiotic decisionmaking.

VA has provided a great deal of information to our veterans and staff on this bacterium and we have coordinated with DOD to be sure our providers are aware of the potential of this bacterium. Acinetobacter baumanii was reported to be the most common gram-negative bacillus recovered from traumatic injuries to extremities during the Vietnam War. It also occurs in other non-veterans who suffer traumatic injuries suggesting environmental contamination of wounds as a potential source.

A staff physician in Infectious Diseases at the National Naval Medical Center Bethesda (Bethesda Naval) first informed VA about multi-drug resistant gram-negative rods on the USNS Comfort and at Walter Reed. This occurred in a memorandum to the National Director for Infectious Diseases on April 22, 2004. Because some of these patients potentially could have been transferred to a VA Medical Center, VA prepared and released a Colleague's Letter the next day alerting VA staff to this possibility. This letter also noted the general susceptibility pattern, made general therapeutic recommendations, and covered overall infection protocol from Bethesda Naval. Additional information was sent to the field on November 19, 2004 that provided more information on isolates, susceptibility testing, and military protocols for isolation precautions.

Question 26: Witnesses from the Committee's recent hearing on seamless transition health issues testified that there needs to be improved screening and testing of wounded service personnel for conditions such as TBI (traumatic brain injury) and infection (such as acinetobacter) as they are transferred to the VA system. Do you intend to have VA work with DOD to gain information about an existing testing mechanism for such infections currently being used at Fort Sam Houston?

Response: We have been working closely with DOD and have developed a screening mechanism for TBI that was implemented VA wide as of 1 April 2007. VA is now screening all returning servicemembers for mild to moderate TBI. VA, in coordination with DOD developed a tool for effective early screening of TBI. This tool stands ready for use, as directed by the President's Task Force on Returning Global War on Terror Heroes. While screening for mild to moderate TBI is a challenge, we have set up a registry to ensure follow-up for people who come up positive on the screen.

VA is also working with DOD through the VA–DOD Deployment Health Workgroup to obtain more information about acinetobacter among recent combat veterans. At Fort Sam Houston, wounded patients are screened for this and other infectious diseases. Information about this screening and any follow-up health care is provided to VA in the patient record when these patients transition to VA for health care.

Question 27: Do you anticipate a continued need for annual increases, significantly above the rate of inflation, to VHA's budget for the foreseeable future? In rough numbers, what is VHA's budget projection through the next five fiscal years, and how does it relate to projected patient load?

Response: The Administration determines the details of its appropriations request one year at a time. That said, our budget increases have historically been over inflation. An increase in the size of the budget equal to the rate of inflation would be practical only if no new veterans came into the system, veterans' health remained unchanged, and there were no increased changes in the delivery of care from year to year. We have a very rigorous and accurate actuarial model we are continuously improving each year that projects our need through a budget year. In addition, VA and OMB together monitor performance and resources monthly to ensure no issues arise. We do not have a budget projection for the next 5 years.

Question 28: As stated in the proposed Fiscal Year 2008 budget, the Administration intends to continue its ban on so-called "middle-income" or Priority 8 veterans. What are your views on explicitly excluding certain veterans from the VA health care system?

Response: The Enrollment Act of 1996 required VA to establish priority levels of veteran care to ensure that those with the greatest needs receive timely and high quality care. The law requires the Secretary on a yearly basis to determine what priorities he believes VA can support. In January, 2003, then-Secretary Principi made a decision precluding new priority 8s from enrolling. This was predicated on an unprecedented influx of enrollees and growing wait times. Over 80 percent of this group had other forms of health insurance and care available, so this group was not put in a situation where they had no access to any kind of care. Secretary Nicholson has continued that policy. VA estimates that if Priority 8 veterans were again allowed to enroll, 1.6 million veterans would do so in the first year at a cost of $1.7 billion. Our 5-year estimate places the cost at $4.8 billion, and our 10-year projection estimates a cost of $33 billion.

Any change in this determination would require several years of preparation. We would require new, larger facilities and additional staff to handle the added workload. Simply opening the door for Priority 8 veterans now, without taking these steps, would prove disastrous for the quality and timeliness of care VA provides.

I will note, however, that VA has the authority to enroll combat-theater veterans returning from OEF/OIF in VA's health care system, regardless of income level, making them eligible to receive any needed medical care or services.

Question 29: In your view, what are the merits of a predictable and viable funding mechanism for VA, such as mandatory or guaranteed funding?

Response: While I am not familiar with the details of how mandatory or guaranteed funding would work, we believe it could have serious, unintended effects. VA has greatly benefited from a receptive Congress and Administration and has actually done better in our budget than would have been the case with mandatory funding. A strict financial formula would not be able to capture the complexity and dynamism required by a health care system for a population as diverse as our veterans. Potentially, rapid advances in medical science, prescription drugs, and treatment modalities would be stymied.

A mandatory funding system also does not appear to allow Congress to exercise the oversight it now does in the budgetary process. This could result in inadequate funding by the Congress and the President for America's veterans.

Question 30: What are the practical effects of running a health care system under the constraints of a Continuing Resolution? Are those constraints any different than those included in a budget request which essentially flat-lines medical care funding?

Response: The process of a Continuing Resolution places a great strain on VA. We cannot move forward on new initiatives and leadership is unable to make new plans or significant changes in our delivery process. It is in effect a flat line budget which if continued could significantly impact our ability to provide needed care for our veterans.

Question 31: The theft or loss of computer equipment containing sensitive personal information on private citizens or agency employees is becoming a routine feature of our government. However, I am concerned that hastily issued security directives could lead to unforeseen difficulties and negatively impact agency operations. What will you do to ensure that VHA mitigates the loss of any more laptops or memory devices, while not harming essential functions?

Response: Protecting Personally Identifiable Information (PII) is critically important to this agency. We owe that to our veterans. VHA is reducing the risk of future breaches through better physical security and better business practices. We are working closely with Office of Information & Technology (OI&T) to deploy data protection solutions, including encrypted laptops and encrypted removable storage media. We are also working with OI&T's Information Protection Office to develop business requirements, validation processes, and classification requirements.

As we have developed initiatives to protect data, we have always operated under the admonishment to do no harm. We are constantly dialoging with VA Ol&T about issues concerning patient care and the delivery of care. When we have had concerns, I personally have brought those up to VA leadership; they have, and are, being addressed.

Question 32: VA and DOD have allegedly been working for over a decade to develop an interoperable and bidirectional electronic health record that would facilitate the smooth transfer of medical information between DOD and VA. Please give your assessment of the state of development of the electronic health record, and what steps are needed to reach the goal.

Response: There have been real and significant advances in the transfer of medical information from DOD to the VA. VA and DOD have achieved a significant level of success and are currently using standards-based interoperable electronic health records to share clinical data bidirectionally.

DOD provides as much electronic data as possible using their current system. At present, DOD does not have a mature in-patient electronic health record that could be transmitted to VA. VA and DOD have agreed to work expeditiously toward the development of a compatible inpatient electronic health record that would leverage the strengths of the Armed Forces Health Longitudinal Technology Application (AHLTA) as well as our CPRS/VISTA.

On January 24, 2007, the Secretaries of VA and DOD agreed to study the feasibility of a new common inpatient electronic health record system. During the initial phase of this work, expected to last between 6 and 12 months, VA and DOD are working to identify the requirements that will define the common VA/DOD inpatient electronic health record. The Departments are working to conduct the joint study and report findings as expeditiously as possible. At the conclusion of the study, we will begin developing a common solution.

For now, VA receives available electronic data through secure and successful one-way and bidirectional data exchange systems. These interfaces, known as the Federal Health Information Exchange or "FHIE" and the Bidirectional Health Information Exchange or "BHIE", ensure that DOD provides VA as much of the health record as possible electronically. FHIE supports the care of separated and retired Service members and supports the transfer of pre- and post-deployment health as-

sessment and reassessment data on separated Service members and demobilized National Guard and Reserve patients. Through FHIE, DOD has transferred electronic health data on almost 3.8 million unique separated servicemembers. VA has provided care or benefits to more than 2.2 million of these veterans.

BHIE supports the care of and active duty patients and dependants using both systems pursuant to sharing agreements or other arrangements. BHIE is now available at all VA sites of care and is currently installed at 25 DOD host locations. These 25 locations consist of 15 DOD medical centers, 18 DOD hospitals and over 190 DOD outpatient clinics. By June 2007, VA will be able to access data from all DOD sites.

VA and DOD are implementing several pilot projects to expand our cooperation and the transfer of records that will potentially be expanded enterprise wide. In El Paso, Texas, VA and DOD are using BHIE to share radiology images, while in the Puget Sound area (and at several other locations, including Hawaii, San Antonio, and San Diego), VA and DOD can share inpatient discharge summaries and other narrative documents.

VA and DOD also developed transferable, computable allergy and pharmacy data between next-generation systems and data repositories. This interface, known as CHDR, permits VA and DOD systems to conduct automatic drug-drug and drug-allergy interaction checks using data from both Departments to improve patient safety of those active dual consumers of VA and DOD, just as CPRS already does within the VA system.

VA is now able to access DOD medical digital images and electronically scanned inpatient health records. We successfully piloted this program, at least in one direction (from DOD to VA), between Walter Reed and three of the four VA Polytrauma Rehabilitation Centers, located in Tampa, Richmond, and Palo Alto. VA clinicians can immediately access critical components of the veteran or servicemember's inpatient record from DOD military treatment facilities. Bethesda Naval is also sending digital images to Tampa and Minneapolis. Expansion of this capability to Brooke Army Medical Center is planned for this summer.

Question 33: Prior to the Secretary's directive to centralize all Information Technology (IT) operations under VA's Chief Information Officer, VHA was responsible for its own IT functions. What has been the impact of this reorganization on VHA? What problems, if any, have resulted from the reorganization?

Response: The VA Chief Officer (CIO) assumed authority over the Information Technology (IT) staff and their responsibilities on April 1, 2007, approximately 6 weeks ago. VA is still in the early phases of constructing an IT governance framework, a critically important task. When the governance structure is established, VHA's will shift toward being a "customer" requiring products and services from its new IT provider, the VA CIO. Anytime you make as dramatic a shift as we have, there will be challenges. Thousands of personnel have been moved from the administration to VA OI&T. I believe that this has gone amazingly well given the magnitude of the project. I believe we have worked together in a cooperative spirit to continue providing IT services for clinical activities and to ensure quality care for our veterans. The VA CIO, the Secretary, and I share the view that VHA will set the business requirements to ensure our internationally recognized electronic health record system continues to provide the highest quality of health care to veterans.

Some of the challenges we have encountered involve ensuring everyone understands the new procedures and maintaining communication at all levels.

Question: 34: Do you believe that the Inspector General can continue the oversight of VA operations, if budget cuts are once again required of the OIG?

Response: While I cannot speak directly to the adequacy of the Office of Inspector General's (OIG) budget, I can say that I will provide any and all assistance or consultation the OIG requires to make the most effective use of its resources in providing oversight of VHA programs. Such consultation will assist OIG in prioritizing areas for review and in addressing critical concerns of the Department while maximizing available resources.

Question 35: Given the surge and complexity of claims that VA is receiving as a result of ongoing operations abroad, does VHA have the capacity to provide timely and accurate medical examinations on behalf of VBA? What would you do, as Under Secretary for Health, to ensure that these exams are expedited?

Response: VHA has been working closely with VBA to ensure that OEF/OIF veterans get the evaluations that they require and deserve in a timely fashion. VHA compensation and pension (C&P) initial exams have a timeliness of 34 days, which is within the standard established in the VHA/VBA memorandum of understanding. We will put in the necessary resources to meet whatever goal is established.

VA's Compensation and Pension Examination Program Office (CPEP) recently compared workload for the first 6 months of Fiscal Year 2007 with the first 6 months of Fiscal Year 2006. While there was an 11 percent increase in completed requests and an almost 20 percent increase in completed exams, we also saw a 5 point jump (to 86 percent) for "A" quality C&P exams, those that meet more than 90 percent of our quality indicators. Essentially, our quality and our timeliness have improved in spite of the increased workload.

VA anticipates an increase in C&P claims from approximately 800,000 in Fiscal Year 2007 to approximately 815,000 in Fiscal Year 2008. As the Under Secretary for Health, I will ensure that VHA continues to identify and commit the resources needed to manage the anticipated C&P examination workload increase.

Question 36: Do VHA and VBA facility directors work together to reduce the percentage of incomplete examinations in order to improve the timeliness and accuracy of medical examinations? Please cite examples.

Response: Yes, VHA and VBA facility directors and staff at all levels are expected to work together to improve C&P exam processes.

Veterans Service Center officials at each regional office (RO) are required, at a minimum, to meet with their VHA medical center counterparts at least once per year to address C&P exam related issues. However, in a recent survey of communication practices between VBA ROs and VHA examining sites, CPEP found the majority of respondents met more frequently than once a year to address C&P issues, and approximately 30 percent conducted monthly meetings. In addition to VHA facility directors, these meetings are attended by RO service center managers, VAMC chiefs of staff, associate directors, and other staffers. These meetings often cover exam requests and report on quality, timeliness, cancellations, workload projections, staffing, and other issues.

But even more can be done to enhance effective communication. VBA and VHA jointly conducted a national conference on improving communication between ROs and VAMCs concerning C&P exams in April 2007. VBA and VHA were both well represented (about 150 attendees each). VBA/VHA teams jointly developed concrete action plans for improving communications at this meeting. Appropriate experts are currently reviewing these action plans in an ongoing progress for improved service and support.

Florida (VISN 8) and Southern California (VISN 22) provide two examples of our best practices for VBA/VHA coordination. In Florida, the VISN 8 Network Director and Health Systems Specialist have worked with the St. Petersburg RO Director and Service Center Manager to establish working collaborations resulting in VISN 8 being one of the Nation's leading performers in C&P exam quality. In VISN 22, VISN Network Director and Network Strategic Management Officer have worked with the VBA Western Area Director and San Diego RO Assistant Director to identify problems, establish working groups to apply systems improvement principles, and develop service agreements to serve as a tool for change. VISN 6 is another example where leadership has established ongoing processes for collaborative ownership of C&P exam processing issues. The Director of the Salisbury VA Medical Center has taken the lead for the VISN 6 Network Director and worked with RO Directors in Huntington, WV, Roanoke, VA, and Winston-Salem, NC. VISN 6 is a high performer in both quality and timeliness of exams.

Question 37: Do medical facilities reschedule examinations, when a first examination has been missed, without a Regional Office having to resubmit an examination request? Please provide any direction that has been given to the field regarding this matter.

Response: The Chief Business Office (CBO) VHA Procedure Guide 1601E, C&P Examinations, states that a veteran's C&P exam will be rescheduled by the medical facility on a one-time basis if the veteran requested the exam be postponed for a valid reason. If the veteran failed to report for the exam and provides no justifiable reason for missing the exam, the exam request is returned to the regional office.

Web links to the CBO procedure guide are embedded in the electronic posting of VHA Handbook 1601E.01, Compensation and Pension Examinations, which is available on the VHA Intranet. The Handbook was distributed to VHA by email on 4/5/2006. In addition, CBO provided training via conference calls and "live meetings" to VHA facilities on these procedure guidelines and the Web based educational materials.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL AKAKA TO MICHAEL J. KUSSMAN, M.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Question 1: Recent news stories have noted that American Samoan servicemembers have extremely high per capita casualty rates in our current conflicts in Iraq and Afghanistan—more than 13 times higher than the national average. While American Samoans are overrepresented in uniform, those who return home after their service have difficulty receiving health care. Currently, there are no VA hospitals in American Samoa. In fact, there is only one hospital in all of American Samoa, which does not provide certain types of care. Frequently, American Samoan veterans must fly to Hawaii to receive care, which can be a difficult process.

I was pleased to learn that a new VA clinic is scheduled to be dedicated in American Samoa this July. Please provide me an update on the clinic, including progress on staff recruitment and linking to computer systems in Hawaii. Also, please describe VA's plans over the next 5 years to better meet the needs of American Samoan veterans.

Response: The Department of Veterans Affairs (VA) Pacific Islands Health Care System (VAPIHCS) will open its community-based outpatient clinic (CBOC) in American Samoa on June 25, 2007, and dedicate the CBOC on Saturday July 21, 2007. The CBOC will be staffed with six employees—internal medicine physician, psychiatrist, social worker, nurse, medical assistant and clerk. All employees have been selected and accepted VA offers (three currently reside in American Samoa). However, the primary care provider will join the staff several weeks after the clinic opens. The CBOC will provide care to approximately 1,000 eligible veterans and support up to another 600 Army Reserve and TRICARE beneficiaries.

The CBOC will use the VA computerized patient record system (CPRS). Initially, to link to electronic systems in Hawaii, CPRS will run on a "site to site virtual provider network" connection to an internal VA gateway. VAPIHCS and VA Office of Information and Technology (OI&T) are currently negotiating with several vendors for a permanent solution that will offer additional speed and bandwidth. VAPIHCS and OI&T are optimistic they will be able to successfully establish a "T1 line" via satellite. This additional speed and bandwidth will be necessary to support planned telehealth activities. Currently, there is no high-speed information technology cable to American Samoa and this is not expected to be rectified soon.

Over the next 5 years, VA plans to establish an active telehealth program. Telehealth capabilities in cardiology, endocrinology, ophthalmology, orthopedics and rheumatology are currently being evaluated. The establishment and maturation of the American Samoa CBOC will be the linchpin to meeting the health care needs of veterans on American Samoa. Veterans will continue to use LBJ Tropical Medical Center for specialty care i.e., non-primary care and non-mental health services. Also, veterans will obtain needed care from VA providers traveling to American Samoa (e.g., currently a VA orthopedist travels to American Samoa quarterly) and referrals to VA facilities in Hawaii or U.S. mainland.

Question 2: On February 23, 2003, the VHA and the Indian Health Service signed a Memorandum of Understanding to encourage cooperation and resource sharing between the two parties, for the benefit of American Indian and Alaska Native veterans. The MOU included agreement on five mutual goals and on nine different items regarding health care for American Indian and Alaska Native veterans.

Please provide a status report on VHA and IHS's progress regarding each of the goals and agreed-to items. Also, please provide all reports published by the interagency work group proposed in the MOU.

Response: The Department of Veterans Affairs (VA) and the Department of Health and Human Services (HHS), Indian Health Service (IHS) have partnered on a number of national projects to implement the goals and agreed-to items in the February 23, 2003, Memorandum of Understanding (MOU). In addition, local VHA facilities and Tribes have established programs and agreements to implement the goals and objectives at the local level.

To accomplish the goals of improving beneficiary's access to quality health care and services and to improve health promotion and disease prevention services to AI/AN, VA and IHS identified five objectives: facilitating collaboration on effective health care delivery, promoting activities to improve health and quality of life for AI/AN veterans, identifying needs and gaps to ensure optimal health care for the AI/AN population, creating an interagency workgroup to oversee national initiatives, and developing a common methodology to track VA and IHS activities. VA and IHS created a Shared Health Care Workgroup, which drafted an Inter-Departmental Coordinated Care Policy to optimize the quality, appropriateness, and efficacy of health

care services and to improve patient satisfaction. Fifteen VISNs are engaged in various access-related outreach activities, four VISNs have incorporated disease-specific or prevention services, and seven Networks are planning and negotiating new access initiatives. The Office of Rural Health will play an important role in coordinating with IHS to meet the needs of AI/AN veterans in rural areas. VA and IHS conduct monthly meetings to oversee proposed national initiatives and both agencies have an agreed upon framework for documenting and tracking these discussions.

VA and IHS identified two other goals: IHS facilitating improved communication between VA and AI/AN veterans and tribal governments, and encouraging partnerships and sharing agreements. Four objectives support these goals: collaborating in the exchange of program communications and other information; cosponsoring and providing reciprocal support for Continuing Medical Education, training, and certification of IHS and VA health care staff; developing and implementing strategies for information sharing and data exchange; and developing national agreements on sharing related to electronic medical records systems, telemedicine, prescriptions, bar code medication, national credentialing programs, and other technologies. VA is providing training programs to IHS staff and the Tribal community through its Employee Education Service and supporting internships and residencies in three VHA intensive care units (Phoenix, Minneapolis, and Houston). VA and IHS are currently test piloting the use of VetPro, VHA's electronic credentialing system, in the Phoenix area, and the Tribal Veterans Representative (TVR) Resource Guide and the TVR Facilitator Guide were completed and distributed in November 2006. VA and IHS are collaborating on several IT projects, including medical record and data-sharing, pharmacy benefits, potential integration into IHS Integrated Behavioral Health package, and other forms of connectivity. Telemedicine has proven to be extremely effective in treating PTSD in AN communities.

The final goal is to ensure appropriate resources are available to support programs for AI/AN veterans. An Interagency Working Group of senior leaders from VA and IHS conducts a monthly conference call to discuss programs and associated resource needs. VHA has also initiated a performance measurement to track progress. A progress report is issued quarterly detailing the group's work and to ensure programs are implemented as planned. Two published documents are available—the first, a cumulative report from Fiscal Year 2005, and the second, a White Paper prepared and submitted to the White House in October 2006. These documents and the MOU are attached.

[FY 2005 issue update, VHA and IHS collaboration report, and VA and HHS Memorandum of Understanding follow:]

ISSUE UPDATE FOR FISCAL YEAR 2005
VHA AND IHS SUPPORT FOR AMERICAN INDIAN ALASKA NATIVE VETERANS

ISSUE

Over the last two years, Indian Health Service (IHS) and Veterans Health Administration (VHA) have implemented a memorandum of understanding (MOU) to promote greater cooperation and sharing between the two health services to enhance the health of American Indian and Alaska Native veterans. This brief summarizes the progress made under the MOU to date and highlights a few of the more than 150 activities and programs undertaken in FY2005.

BACKGROUND

American Indians and Alaska Natives (AI/AN) have a distinguished history of exemplary military service to the United States. They have served in high numbers and were often assigned to forward combat areas. As a result, they have a wide range of combat related health care needs. AI/AN veterans may be eligible for health care from VHA or from IHS or both. Despite this dual eligibility, Indian veterans report the highest rate of unmet health care needs among veterans and exhibit high rates of disease risk factors.

PROGRAM SUMMARY

The MOU between the Departments of Health and Human Services and Veterans Affairs, specifies five objectives to enhance the health of AI/AN veterans: (1) improving communication, (2) encouraging partnership and sharing, (3) expanding access to health services for Indian veterans, (4) ensuring organizational support, and (5) improving health promotion and disease prevention services.

National Activities

The Office of the Deputy Under Secretary for Health for Health Policy Coordination (DUSH/HPC), 1OH, is the principal office responsible for coordinating implementation of the MOU within VHA. The office works with the leadership and staff of VHA and IHS to identify priority actions and ensure they are carried out. The office fosters progress on national initiatives and supports local implementation activities through the annual VHA strategic planning process and quarterly VISN monitoring system.

Communication: The Headquarters Advisory group meets monthly, the Steering Committee meets three times each year and the Area and Network Directors have twice been convened to discuss priorities and coordinate activities. A FAQ sheet about the collaborations has been developed, an annual report was produced in August 2004, and an implementation guide highlighting best practices was completed in January 2005. A Web site is under development. VHA has initiated connections to tribal and national AI/AN organizations such as the National Indian Health Board and National American Indian Veterans, Inc. Briefings and presentations about the partnerships have been made at more than a dozen events around the country.

Sharing and Collaboration: VHA Employee Education Service (EES) and the Nashville Area of IHS signed an operational agreement in April 2005 to implement a sharing demonstration of VHA educational resources with IHS and tribes in the region. A password protected Web site has been established to provide IHS staff with electronic educational materials and to provide and track continuing education credits. Twenty programs were made available to IHS staff in 2005.

VHA and IHS have a long partnership of sharing in software development, and new activities are underway to enhance this partnership. The VHA/IHS Information Technology Collaboration has developed a five-point work plan and has established a shared Web site to facilitate joint project management. An Interconnection Security Agreement that paves the way for direct network-to-network electronic communication has been signed. A project agreement for IHS use of VISTA imaging has been drafted and is under review. IHS and VHA staff are regularly attending the planning, development and training meetings of the other agency.

Expanding Access: Access is focused at the local level. However, the national telehealth collaboration supports the use of telehealth to provide remote access to health services for AI/AN veterans. In April 2005, eighteen IHS staff attended the annual VHA telehealth coordination meeting for the first time. During the meeting, VHA agreed that IHS and tribal representatives will join each VHA VISN-level telehealth coordination workgroup and two test sites for joint network development were identified: the Billings Area IHS and the Utah telehealth network (which includes tribes).

Organizational Support: VHA has developed an implementation guide that shares best practices with the field. Both VHA and IHS require progress reports from the field on collaboration and the expansion of services to AI/AN veterans. VHA sharing is an element of the IHS Area Directors performance contract with the Director of IHS. Starting in 2005, VHA requires that each facility provide access to American Indian spiritual practices equivalent to that provided for other religious affiliations. EES is developing a national Tribal Veteran Representative training curriculum.

Health Promotion/Disease Prevention: IHS/VHA workgroups in Diabetes Prevention and Behavioral Health were established. On the recommendation of the Diabetes Prevention workgroup, three diabetes prevention partnerships were funded in Albuquerque, Los Angeles and San Diego. The programs incorporate primary prevention measures, including diet modification and physical activity, into activities targeted to AI/AN veterans.

The Behavioral Health workgroup developed a framework for AI/AN communities to assist the 3,668 returning Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) AI/AN servicemembers and veterans reintegrate with their families and communities and readjust to civilian life. The objective is to promote a community health model that gives tools to Tribal communities and families to help returning veterans address emerging adjustment reactions, traumatic stress, and Post Traumatic Stress Disorder (PTSD), emphasizing recovery as the goal. Outreach and informational materials have been developed and, to date, have been shared directly with four Tribes for local customization and adaptation. The program also includes education for local VHA, IHS and Tribal clinical staff on special health care concerns that arise following combat exposure; and training for VHA staff on cultural and spiritual needs of AI/AN veteran patients.

Three projects have been funded to pilot-test evidence-based mental health treatment resource kits for use with veteran and AI/AN veteran populations.

IHS Area and VHA Network Activities (Examples, Attachment 1)

Communication: In FY2005, VISNs reported more than 120 contacts with IHS, Tribal leaders or AI/AN veteran groups. Nearly two-thirds of these discussions occurred directly with Tribes.

Sharing and Collaboration: The Networks reported more than 25 agreements to promote sharing and collaboration in FY2005. Projects included the sharing of space, information technology expertise, educational programming, joint purchasing, and contracting for laboratory or diagnostic services.

Access: By the end of FY2005, VISNs reported more than 20 programs that expand access to services for AI/AN veterans. For example, Network 19 reported nearly 300 telepsychiatry patient contacts, 84 veteran participants in traditional ceremonies or native healer consults, and the completion of a residential substance abuse treatment program by 10 patients. Other programs around the country include a dedicated AI coordinator to assist with nursing home placements, Tribal/reservation based CBOCs, telehealth home health care, telecardiology services, emergency room care agreements and reservation based housing for homeless AI/AN veterans. Network 18 reported an overall 17 percent increase in the number of AI/AN patients served in FY2005.

Organizational Support: At the local level, organizational support frequently manifests as VHA sponsored health fairs, pow wow or homeless stand downs for AI/AN veterans, often held on or near a reservation. VISNs reported holding or participating in more than 70 such events in FY2005.

Health Promotion/Disease Prevention: Three Networks reported prevention oriented programs: OIF/OEF readjustment outreach in VISN 18 and 20 and health promotion programs in VISN 18 and 22.

Two Year Review

The Steering Committee (SC) met in April 2005 to review progress under the MOU, hear from veterans and Tribal leaders, and determine if changes were needed to the agreement. The SC recommended that the MOU and the programs under it continue unchanged. However, the SC expects to see a greater emphasis on communication, outreach and the sharing of program and benefit information with veterans and Tribes including information on housing programs and support for homeless AI/AN veterans. In addition, the leadership of each organization has been asked to develop a joint policy for the coordination of health care for dual use veterans. Finally, the development of a new home health care demonstration for long term care elderly patients is expected.

ATTACHMENT 1

Examples of IHS/VHA Sharing and Collaboration Activities
FY2005

Access:		
1. Telecardiology Services	SC, IHS at Rockhill	12 clients served to date.
2. Patient diet counseling	NM, IHS Gallup	IHS provided counseling for VA.
3. Home based care	AZ, LA	Telehealth enabled.
4. Tribal staffed CBOC	OK, Choctaw Nation	1,000 vets; save 130 mile drive.
5. ER diagnostic/treatment	OK, Choctaw Nation	Saves 2 hour emergency trip.
6. Health fair prevent screen	LA, Jena Band Choctaw	Enrolled vets w/ presumptive Dx.
7. Mental Health Therapy	AZ, reservation based WY	2 group; 63 indiv consults Q2.
8. Telepsychiatry	WY	@ 100 patient contacts, Q2.
9. Residential SA treatment	UT	Eight patients completed.
10. Co-management w/ CPRS	SD/ND; Pine Ridge, Ft. Yates, Eagle Butte.	IHS staff can view VA records for all shared patients.
11. Homeless Housing	SD, Pine Ridge	Building dedicated Nov 2005.
12. Vet Centers	AZ, SD, OK, AK	Hopi, Navajo, Pine Ridge, Rosebud, Tahlequah, AK Native Villages.
13. Shared FTE veteran coord	NC, Cherokee Hospital	108 clients served FY2005.
Sharing & Collaboration:		
1. Radiology and Pathology	KS, Haskell Nation	100–200 reads/month.
2. Space Lease	WI, Ho-Chunk Nation	5,661 sq ft space leased.

Examples of IHS/VHA Sharing and Collaboration Activities—Continued
FY2005

3. Tribal College affiliation	OK, Cherokee Nation	Training for student RN, opt, rad.
4. Laboratory contract	TX	$3,361 revenue generated Q2.
5. PTSD education training	AK	Prepare IHS for OIF/OEF vets.
Organizational Support:		
1. Veteran Tours of VAMC	NC, Cherokee Hospital	Tours introduce AI vets to VA.
2. Credentialing Tribal staff	NC, Cherokee Hospital	Smooth referral, access CPRS.
3. Share patient edu material	VISN 12, Bemidji IHS	
4. Tribal veteran rep training	VISN 23, 19, 18, 12	
5. Weekly talking circle	AZ	PTSD patients enrolled.
6. Full Time AI Coordinator	AZ	Assist nursing home placement.

VETERANS HEALTH ADMINISTRATION AND INDIAN HEALTH SERVICE COLLABORATION FOR AMERICAN INDIAN/ALASKA NATIVES (AI/AN)

On February 25, 2003, the Department of Health and Human Services (HHS) and the Department of Veterans Affairs (VA) entered into a Memorandum of Understanding (MOU) to encourage cooperation and resource sharing between the Indian Health Service (IHS) and the Veterans Health Administration (VHA). The goal of the MOU is to use the strengths and expertise of both organizations to deliver quality health care services and enhance the health status of American Indian and Alaska Native veterans. Through the Headquarters Advisory Group, numerous national programs have been initiated to serve AI/AN veterans. In addition, local activities take place between the Veterans Integrated Service Networks (VISN), VA medical facilities, and the tribes themselves.

Outreach. At the national level, outreach activities have consisted of increased communications between VHA and IHS through the Headquarters Advisory Group and the Steering Committee, briefings such as the VA briefing on VA Seamless Transition Activities to IHS leadership, IHS participation in the VHA Symposium on "Caring for Veterans Returning from Recent Conflicts," and the pending revision of the joint IHS/VA Web site. The Tribal Veterans Representative (TVR) Resource Guide and the TVR Facilitator Guide have been completed and will be distributed in November 2006. A video broadcast of the materials is also scheduled for release in November. At the local level, thirteen networks are engaged in a variety of outreach activities, including meetings and conferences with IHS program and tribal representatives, VA membership in the Native American Healthcare Network, VA participation in traditional Native American ceremonies, transportation support to AI/AN, etc.

Education. VHA Employee Education Service (EES) is providing training programs to IHS staff and the tribal community. A password protected Web site has been established to provide IHS staff with electronic educational materials and to provide and track continuing education credits. In 2006, VHA delivered 145 training programs, of which 90 were made available using satellite technology and 55 using web based technology. These educational programs will be continued in 2007, and VHA will also provide selected IHS staff an opportunity to attend regional EES workshops on buprenorphine.

Behavioral Health. The Behavioral Health workgroup developed a framework for AI/AN communities to assist returning Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) AI/AN servicemembers and veterans reintegrate with their families and communities and readjust to civilian life. The objective is to promote a community health model that gives tools to Tribal communities and families to help returning veterans address emerging adjustment reactions, traumatic stress, and Post Traumatic Stress Disorder (PTSD), emphasizing recovery as the goal. The joint committee has developed a slide presentation to be used by outreach teams when addressing various Tribal veterans. There have been briefings using the slide presentation in Montana, with approximately 30 veterans now receiving services from VA.

Expanded Health Care Services. At the local level, ten VHA networks are engaged in targeted initiatives aimed at providing a full continuum of healthcare services, such as health fairs, VA/IHS Advisories, Use of Health Buddy, and education and/or shared services in substance abuse, domestic violence programs, cardiac rehabilitation, dietetics, behavioral medicine, etc.

Information Technology. VHA and IHS are collaborating on numerous information technology projects, including Medical record and data-sharing policy, a Bar Code Medication Administration (BCMA) project, Centralized Mail Out Pharmacy (CMOP) support, potential integration into IHS Integrated Behavioral Health package, potential use of VA information technology systems for some IHS sites, data networking and communication—exploring VA network operations for alternate connectivity for non-clinical applications (i.e. electronic lab services) and collaboration on hardware whereby approximately 100 CPUs will be sent to the Aberdeen Area.

Patient Safety Program. The VHA National Center for Patient Safety (NCPS) has trained the newly appointed IHS patient safety manager in Root Cause Analyses and Healthcare Failure Mode and Effects Analysis and has provided a small library of core patient safety literature and various NCPS tools.

Care Coordination. The VHA–IHS Shared Health Care Workgroup has drafted an Inter-Departmental Coordinated Care Policy, the goal of which is to optimize the quality, appropriateness and efficacy of the health care services provided to eligible American Indian and Alaska Native (AI/AN) veterans receiving care from both VHA and IHS or Tribes; and to improve the patient's satisfaction with the coordination of care between the two Departments.

Diabetes Prevention Programs. Three Diabetes Prevention programs have been initiated in San Diego, Greater Los Angeles, and Albuquergue. The goal of the program is to assist AI/AN veterans integrate healthy lifestyles, and therefore to prevent healthcare problems related to diabetes. Various components of the program include training Diabetes Prevention Program (DPP) lifestyle coaches, producing deliverable DVDs of the training sessions and distributing them to each AI site; providing sites with related equipment, including TVs, TV carts and DVD/VCR players and other related educational materials.

Telemedicine. Another VA program that is very effective and popular with Indian and Alaskan Native Veterans is Telemedicine. It is proving to be extremely effective in the treatment of PTSD in Alaskan Native villages. VA and IHS are working to spread the use of telemedicine services by AI/AN veterans, which will allow VA to bring physical and mental health care to the tribes, especially those in remote areas of the country.

Credentialing Program. VA and IHS are currently in a pilot test of the use of VetPro, VHA's electronic credentialing system by the Phoenix Area Indian Health Service. The intent of this pilot is to demonstrate the value of sharing Federal information technology used for the credentialing of health care providers. The pilot began in May 2006. To date, 61 Licensed Independent Practitioners have been enrolled by the two IHS facilities and IHS appears enthusiastic about the VetPro process.

Research. The Los Angeles VA Geriatric Research Education and Clinical Center has been funded for a research study entitled "VHA and IHS: Access for American Indian Veterans." The study will describe dual utilization of VA and IHS services, including fragmentation or potential overlap of services, identify organizational and individual factors that impede or facilitate access to care, and generate recommendations on how VA and IHS can work together to improve access to health care.

Traditional Healing. Some VHA facilities and Vet Centers have incorporated Traditional Healing Ceremonies along with modern methods of treatment and counseling. As a national initiative, VA has sent over 500 letters to tribal leaders to ask them to provide information on appropriate providers of Traditional Practices so that they may be called upon for religious/spiritual care of AI/AN veterans.

DEPARTMENT OF VETERANS AFFAIRS,
VETERANS HEALTH ADMINISTRATION,
Washington, DC, June 24, 2003.

DEAR COLLEAGUES IN VETERANS AND INDIAN HEALTH: On February 25, 2003, the Department of Health and Human Services (HHS) and the Department of Veterans Affairs (VA) entered into a Memorandum of Understanding (MOU) to provide optimal health care for the more than 165,000 American Indian and Alaska Native veterans in the Nation. This MOU, signed by the Deputy Secretaries of VA and HHS on behalf of Secretary Anthony J. Principi and Secretary Tommy G. Thompson, offers many opportunities to enhance access to health services and improve the quality of health care for Indian veterans. The purpose of our letter is to provide guidance on the intent and potential applications of the MOU. We have enclosed a copy of the MOU for your reference.

The MOU is designed to improve communication between the agencies and Tribal governments and to create opportunities to develop strategies for sharing informa-

tion, services, and information technology. The technology sharing includes the VA's electronic medical record system, bar code medication administration, and telemedicine. Also, VA and the Indian Health Service (IHS) will co-sponsor continuing medical training for their health care staffs. Significantly, the MOU encourages VA, Tribal, Urban, and IHS programs to collaborate in numerous ways at the local level. We expect that the most progress will be made where effective local partnerships are formed among the IHS, VA, and Tribal governments to identify local needs and develop local solutions. You are encouraged to establish a means for routine and periodic communication between local elements of VA and the IHS. At a minimum, such communication would serve to clarify and share information on which services are provided by each organization and to whom at each location. At its most effective, the communication would include a broader discussion of joint program initiatives in clinical service delivery, community-based care, health promotion, and disease prevention. The management and prevention of chronic disease is a challenge that confronts both Departments; creative solutions in case management, home and community-based care, and primary prevention activities will improve the health of those we serve.

Collaborations already exist in many locations but the intent of the MOU is to expand these activities where they are and extend them to more communities and facilities. Examples of shared service arrangements already in place include the following: In some locations, specialists from VA provide cost-effective consultation to Indian health facilities; at others; telemedicine capabilities are shared to enhance access to otherwise unattainable services; and continuing education through access to veterans' programs is another shared capability that has been developed in some areas. Other collaborative efforts remain to be developed and might include primary care for non-Indian veterans in exchange for hospital care for non-veteran Indians. The creation of joint community-based care and prevention is another area of collaboration where few models currently exist.

Another principle embodied in the MOU is that collaboration and more creative and effective use of resources will meet the President's management objectives. President Bush has clearly stated his management agenda to improve the efficacy and efficiency of Federal Government activities. Where there are opportunities to fill gaps or eliminate the duplication of effort, collaboration can help with the planning and deployment of resources in the most cost-effective and highest-quality manner. The MOU encourages the development of resource-sharing, within our current legal authority, to enhance the services provided to meet the missions of both Departments. It does not mean that each Department will begin to bill the other for services provided to the other's beneficiaries, except where it is agreed to by both entities. It may mean, however, the development of responsible sharing of services to meet the needs of patients and communities.

At the national level, the two Departments will continue their very productive collaboration in developing more effective information technologies. Collaboration has led to many advancements in electronic health record systems and quality improvement tools. The MOU should facilitate the engagement of local entities in both Departments that are able to influence national program development in these areas.

In summary, the MOU expresses the commitment of both Departments to expand our common efforts to improve the quality and efficiency of our programs. It provides policy support to local planning and collaboration, and it charges local leadership to be more innovative and engaged in discharging our responsibilities. It is clear that the goal of the MOU is to improve both the quality and quantity of services provided to the populations we serve. Ultimately, it is a tool to elevate the health of our patients, communities, and the Nation.

Sincerely yours,

ROBERT H. ROSWELL, M.D.,
Under Secretary for Health.

CHARLES W. GRIM, D.D.S., M.H.S.A.,
Assistant Surgeon General,
Interim Director, Indian Health Service.

MEMORANDUM OF UNDERSTANDING BETWEEN THE VA/VETERANS HEALTH ADMINISTRATION AND HHS/INDIAN HEALTH SERVICE

I. PURPOSE

The purpose of this Memorandum of Understanding (MOU) is to encourage cooperation and resource sharing between the Veterans Health Administration (VHA) and Indian Health Service (IHS). The goal of the MOU is to use the strengths and

expertise of our organizations to deliver quality health care services and enhance the health of American Indian and Alaska Native veterans. This MOU establishes joint goals and objectives for ongoing collaboration between VHA and IHS in support of their respective missions.

II. BACKGROUND

The mission of the Indian Health Service is to raise the physical, mental and spiritual health of American Indians and Alaska Natives to the highest level. The IHS goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

The mission of the Department of Veterans Affairs is to "care for him who shall have borne the battle and his widow and orphan." Those words were spoken by Abraham Lincoln during his second inaugural address and reflect the philosophy and principles that guide VA in everything it does. The Veterans Health Administration six strategic goals are: put quality first until we are first in quality; provide easy access to medical knowledge, expertise and care; enhance, preserve, and restore patient function; exceed patient's expectations; maximize resource use to benefit veterans; and build healthy communities.

The IHS and the VA enter into this MOU to further their respective missions. It is our belief, that through appropriate cooperation and resource sharing both organizations can achieve greater success in reaching our organizational goals.

III. ACTIONS

A. This MOU sets forth 5 mutual goals:

1. Improve beneficiary's access to quality healthcare and services.
2. Improve communication among the VA, American Indian and Alaska Native veterans and Tribal governments with assistance from the IHS.
3. Encourage partnerships and sharing agreements among VHA headquarters and facilities, IHS headquarters and facilities, and Tribal governments in support of American Indian and Alaska Native veterans.
4. Ensure that appropriate resources are available to support programs for American Indian and Alaska Native veterans.
5. Improve health-promotion and disease-prevention services to American Indians and Alaska Natives.

B. To further the goals of this MOU, VA and IHS agree to:

1. Facilitate collaboration on effective healthcare delivery for American Indian and Alaska Native veterans and shared responsibility for implementation of appropriate health promotion and disease prevention efforts. Ensure that IHS and VA facilities develop and provide effective linkages between facilities to support health promotion for American Indian and Alaska Native veterans that benefit their communities.
2. Identify needs and gaps between the VA and the IHS to develop and implement strategies to ensure optimal health for the American Indian and Alaska Native veteran population.
3. Promote activities and programs designed to improve the health and quality of life for American Indian and Alaska Native veterans.
4. Develop and implement strategies for information sharing and data exchange.
5. Collaborate in the exchange of relevant programmatic communications and other information related to American Indian and Alaska Native veterans.
6. Cosponsor and provide reciprocal support for Continuing Medical Education, training and certification for IHS and VA healthcare staff.
7. Develop national sharing agreements, as appropriate, in healthcare information technology to include electronic medical records systems, provider order entry of prescriptions, bar code medication, telemedicine, and other medical technologies, and national credentialing programs.
8. Create an interagency work group to oversee proposed national initiatives.
9. Develop a common methodology to track VA and IHS interagency activities and report progress.

IV. OTHER CONSIDERATIONS

A. All VA Medical facilities and the IHS will comply with all applicable Federal laws and regulations regarding the confidentiality of health information. Medical records of IHS and VA patients are Federal records and are subject to some or all of the following laws: the Privacy Act, 5 U.S.C. 552a; the Freedom of Information Act, 5 U.S.C. 552; the Drug Abuse Prevention, Treatment, and Rehabilitation Act, 21 U.S.C. 1101, the Comprehensive Alcohol Abuse and Alcoholism Prevention,

Treatment and Rehabilitation Act, 42 U.S.C. 4541, the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1301, VA's Confidentiality of Certain Medical Records, 38 U.S.C. 7332; Confidential Nature of Claims, 38 U.S.C. 5701; Medical Quality Assurance Records Confidentiality, 38 U.S.C. 5705, and Federal Regulations promulgated to implement those Acts.

B. Care rendered under this MOU will not be part of a study, research grant, or other test without the written consent of both the IHS and the VA facility and will be subject to all appropriate HHS and VA research protocols.

C. The VA and the IHS will abide by Federal Regulations concerning the release of infonnation to the public—and will obtain advance approval from either VA or IHS before publication of technical papers in professional and scientific journals—for articles derived from information covered by this MOU. The VA and the IHS agree to cooperate fully with each other in any investigations, negotiations, settlements or defense in the event of a notice of claim, complaint, or suit relating to care rendered under this VA/IHS MOU.

D. No services under this MOU will result in any reduction in the range of services, quality of care or established priorities for care provided to the veteran population or the IHS service population.

E. The VA may provide IHS employees with access to VA automated patient records maintained on VA computer systems to the extent permitted by applicable Federal confidentiality and security law. Additionally, the IHS will likewise provide VA employees access to Veteran IHS records to the same extent permitted by applicable Federal confidentiality and security law.

F. Both parties to this MOU are Federal agencies and their employees are covered by the Federal Tort Claims Act, 28 U.S.C 1346(b), 2671–2680, in the event of an allegation of negligence. It is agreed that any and all claims of negligence attributable to actions taken pursuant to this MOU will be submitted to legal counsel for both parties for investigation and resolution.

V. TERMINATION

This MOU can be terminated by either party upon issuance of written notice to the other party not less than 30 days before the proposed termination date. The 30 days notice may be waived by mutual written consent of both parties involved in the MOU.

VI. EFFECTIVE PERIOD

The VA and the IHS will review the MOU annually to determine whether tenns and provisions are appropriate and current.

LEO S. MACKAY, JR.,
Deputy Secretary of Veterans Affairs,
Department of Veterans Affairs.

CLAUDE A. ALLEN,
Deputy Secretary of Health and Human Services,
Department of Health and Human Services.

Date: February 25, 2003.

Question 3: I understand from representatives of the Disabled American Veterans, based on a recent briefing at the Walter Reed Army Medical Center (WRAMC), that the average number of prosthetic limbs issued to amputees treated at WRAMC is six. These sophisticated artificial limbs enable severely wounded service personnel to run, climb, swim, lump and do other physical exercises and sports that were impossible for earlier generations of amputees. I understand that VA's average prosthetics issue is three prostheses for a veteran amputee under your care.

Question 3(a): Does VA have plans to modernize its prosthetic and orthotic programs in a similar way to that of WRAMC, and if so, what are those plans?

Response: Yes, VA has begun a modernization process to upgrade existing computer aided design-computer aided manufacture (CAD–CAM) equipment in the 58 prosthetics labs. In the personnel area, VA has mandated and has achieved full accreditation for all 58 of its Prosthetic and Orthotic Labs. Each lab has been mandated to have at least one Certified Prosthetist, Orthotist or an individual certified in both specialties. VA has also established training programs with private industry to learn more about the latest technology and fitting techniques.

VA has established two national contracts to provide state-of-the-art upper extremity prostheses. To ensure convenience to the veteran amputee and access to the

state-of-the-art prosthetic appliances, VA contracts out to private industry 95 to 98 percent of the total limbs fabricated for all veterans. In addition, VA has established a rotation system with Walter Reed Army Medical Center and Brooke Army Medical Center to send VA Prosthetists, Physical and Occupational Therapists to their amputee centers to ensure continuity of care between VA and Department of Defense (DOD).

Question 3(b): If a veteran comes to VA today for newly invented prosthetic appliances or limbs, such as the "C-Leg," or a prosthetic arm that would allow him to play golf or tennis, what is VA's policy for providing those limbs and the necessary training to use them?

Response: When a veteran comes to VA for a prosthetic appliance, VA provides the newest versions available and trains the veteran in its proper use. Prosthetists, physical or occupational therapists, and other rehabilitation specialists provide training relevant to the veteran's specific needs as part of the rehabilitation process. If the patient has a lower extremity amputation and requires a C-leg, for example, VA offers training on how to walk on various surfaces, how to negotiate stairs, how to get back up after falling, how to care for the appliance, and how to don the device. For veterans with an upper extremity amputation requiring a myoelectric arm, for example, VA trains the veteran in how to don and care for the appliance, how to manipulate the hand, wrist, and elbow, and how to employ independent living techniques to care for themselves. This training is available whenever VA provides a prosthetic, whether the veteran is a new patient or not.

Question 3(C): How will VA respond when veterans who have been issued these high level appliances come to the Department's Prosthetics and Sensory Aids Program for repairs and replacements?

Response: When a veteran comes to VA for a repair or replacement of an appliance they received from DOD, they are provided repairs for that appliance or a replacement of equal or greater technology and provided the necessary training for use and maintenance.

Question 4: I am concerned that there are a great number of enrolled veterans who are at risk of Obstructive Sleep Apnea (OSA) who today are not being tested and diagnosed. I understand that the current backlog of sleep studies is quite high. While I understand that VA considers adding a large number of sleep study beds and contracting with community facilities as options to meet the current demand, what other innovative approaches for diagnosing OSA is the Department evaluating?

Response. A number of VA sleep centers including, Houston and Los Angeles, are working to integrate a combination of in-laboratory and at-home testing into a comprehensive program. These programs are designed so we can continue to meet the national standards of practice for OSA diagnosis set forth by the American Academy of Sleep Medicine. VA will continue to evaluate the need for additional sleep centers and will expand to other facilities as the need arises. A description of the program, its operating procedures, guidelines, and implementation are currently being produced in the new volume of sleep clinics.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO MICHAEL J. KUSSMAN, M.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Question 1: Over 1 million active duty soldiers and over 400,000 Guard and Reservists have served in Iraq and Afghanistan, including 8,000 West Virginia service personnel and over 4,000 Guard and Reservists. Policymakers believe at least one-third or more soldiers will need mental health care at some point, and having met with many West Virginia soldiers, you believe this number could be even higher. The Vet Centers, created after the Vietnam War, are independent centers and provide quality counseling and care with the least bureaucracy in the VA system. Rumors suggest that VA is considering changing Vet Center so that each would report to a VA Medical Center, but this is a terrible idea, in my judgment. Dr. Kussman, I meet with returning West Virginia veterans privately, and they are strong advocates for the Vet Centers, and the independence of such centers.

Question 1(a): What is your view of the Centers, and what will VA do to support the Centers and increase the staff and support necessary to fully care for the more than 1.4 million veterans who may need mental health care?

Response: I believe Vet Centers play a unique role in VA's services to returning combat veterans and I fully support maintaining them as a separate section within VHA. VA continues to expand into more communities with our Vet Centers, thus

bringing our services closer to the veterans who need them and to help combat veterans successfully readjust to life at home.

Since the beginning of Fiscal Year (FY) 2005, VA has created 26 new Vet Centers and added 72 staff, not including the 100 Global War on Terrorism (GWOT) outreach specialists authorized and now in place since Fiscal Year 2004 and Fiscal Year 2005. This represents a 26 percent increase in Vet Center staffing and a 13 percent increase in the number of Vet Centers.

Question 1(b): What special arrangements are underway to prepare to serve the unique needs of female veterans, especially on the sensitive issue of military sexual trauma?

Response: VA offers special training on women's health care issues to the 100,000 medical trainees who rotate through VA every year. We also provide 13 fellowships in health issues of women veterans, and a number of our clinical scholars pursue research projects on women veterans. VA recently created the Women Veterans Strategic Health Care Group (WVSHG). The WVSHG is closely examining the access to, and environment of care in, inpatient areas to recommend enhancements necessary to ensure adequate security and privacy on inpatient areas and comfort in outpatient waiting rooms and counseling centers. This will be accomplished in part through the annual plan of care/clinical inventory Web based survey sponsored by the WVSHG. In the past 3 years, this survey has shown significant improvements in the environment of care, specifically in the area of privacy.

VA has made great strides in caring for women veterans over the past several years. We offer a number of programs specifically for women through the Center for Women Veterans. VA offers special counseling options for women recovering from trauma through the National Women's Trauma Recovery Program. It should be noted that women receive better care on average in the VA system than from Medicare or from the best non-governmental provider. In fact, VA scores nearly 10 points better in breast cancer and cervical cancer screening than Medicare or the private sector according to the American Journal of Managed Care, thanks to our award-winning electronic health record system.

VA screens all veterans for military sexual trauma (MST). If a veteran reports military sexual assault or harassment, he or she is eligible for copay exempt health and mental health services for treatment of problems related to those experiences. Unless specifically established for women, programs serve both genders. There are, in absolute numbers, as many men as women who have experienced MST.

Every VA facility has designated a MST coordinator, and Vet Centers also have specially trained sexual trauma counselors. Thirteen programs offer sexual-trauma specific treatment in a residential or inpatient setting, and at least two more are under development. In Fiscal Year 2007, VA established a Military Sexual Trauma Support Team to ensure VA is in compliance with mandated MST screening and treatment. This team also helps coordinate and expand education and training efforts related to MST and to promote best practices in the field.

Question 1(c): Do you think that VA should consider mandatory screening for mental health care as recommended by the Iraq and Afghanistan Veterans of America (IAVA)?

Response: The post-deployment health assessment is conducted by DOD and includes some screening for mental health concerns, but we defer to DOD on those issues. VA participates in the post-deployment health reassessment (PDHRA) and conducts mental health evaluations. Returning Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) veterans are screened for post traumatic stress disorder (PTSD) when they are first seen in VHA, at least annually thereafter for 5 years, and at least every 5 years after that. Like all veterans seen in VA medical centers and clinics, returning veterans are also screened for depression and substance abuse on at least an annual basis. VHA policy requires physicians to conduct follow-up care for all positive screens, and provides treatment for all veterans found positive for indicators of PTSD, depression, substance use disorders, or other mental health conditions. These measures are taken to provide preventative care for patients and identify those in need of treatment.

Question 2: Under current law, Guard and Reservists who serve in combat have access to VA health care for 2 years after deployment and lifetime care if they can prove it is service-connected which is easier for physical injuries than mental health care. Combat veterans who apply for enrollment in VA health care before their two-year post discharge period ends, remain enrolled and are eligible for hospital care, medical services and nursing home care. However, their priority group assignment and copay responsibilities will be based on the eligibility factors applicable at that period of time.

Question 2(a): Dr. Kussman, what is VA doing to improve the transition and outreach for Guard and Reservists, particularly on the mental health care issues?

Response: National Guard members and reservists who served in combat, who meet the minimum active duty length of service requirement, and who are discharged or released under conditions other than dishonorable are treated the same as other combat-theater veterans. They are enrolled in Category 6 for 2 years and then placed in whichever enrollment category is appropriate, based on their particular situation. Like other combat-theater veterans, they may be subject to copayment requirements if placed in Category 7 or 8. But, importantly they still remain eligible for VA care and the medical care package. They are enrolled as Category 6 veterans when they present to VA during the 2-year period after their discharge or separation and are not dis-enrolled.

To ensure Guard members and Reservists are aware of these opportunities, VA uses its Vet Centers to facilitate transition and outreach for veterans, particularly for mental health issues. Vet Centers have provided outreach to 173,277 OEF/OIF veterans since October 2001 through the end of the second quarter Fiscal Year 2007. VA has hired 100 OEF/OIF combat veterans to provide outreach services to their fellow returning OEF/OIF veterans. Our Vet Centers have provided readjustment counseling to 54,451 OEF/OIF veterans in Vet Centers and have engaged in outreach to active duty, National Guard, and Reserve units demobilizing upon their return from combat. Vet Centers have participated in all 595 PDHRA screening events, including the pilot project and Vet Center staff members have facilitated 10,578 referrals for readjustment counseling through the end of the second quarter Fiscal Year 2007.

Question 2(b): I strongly support legislation by Chairman Akaka to expand access for Guard and Reservists from 2 years to 5 years which will give them more time to seek care for mental health; will you work with us to implement such a policy?

Response: VA would support an extension of the enrollment period from 2 to 5 years. When OEF/OIF veterans seek care from VA they are placed in priority Category 6 and make no copayments for covered conditions. When the special treatment authority for combat-theater veterans was originally enacted, it was generally assumed that 2 years was sufficient. However, experience has shown that is not always the case. In caring for OEF/OIF veterans we have discovered the onset of symptoms and adverse health effects related to PTSD, and even traumatic brain injury (TBI), are often delayed, or do not manifest clinically, for more than 2 years after a veteran has left active service. As a result, many OEF/OIF veterans do not seek VA health care benefits until after their 2-year window of eligibility has closed. Without eligibility for enrollment in priority Category 6, many, i.e., those with higher incomes and non-service connected conditions, would not be eligible to enroll because they would be in priority Category 8.

In addition, many OEF/OIF veterans are non-career military members who are unfamiliar with veterans' benefits and the procedures for obtaining them. For that reason many fail to enroll in a timely fashion. Providing combat-theater veterans with an additional 3 years within which they can access VA's health care system would help ensure none of them are penalized because of reasons beyond their control or because they have been unable to navigate VA's claims system in time.

Question 3: Traumatic Brain Injury (TBI) seems to be a growing concern for many of our soldiers returning from combating. At previous hearings, witnesses have testified about the challenges in getting an accurate diagnosis, due to problems with hearing and vision issues.

Question 3(a): What screening is being done now, and what plans are underway to expand such screening?

Response: VA has implemented mandatory TBI screening of all OEF/OlF veterans receiving medical care within VA. Those who screen positive for TBI are offered further evaluation and treatment by clinicians with expertise in TBI.

Patients with Polytrauma and TBI receive vision evaluations as part of their comprehensive rehabilitation management evaluation. Blind rehabilitation outpatient specialists serve as members of interdisciplinary polytrauma teams and provide thorough functional assessment of polytrauma veteran's vision to ensure that functional vision problems are diagnosed and treated.

Veterans receive basic eye examinations by ophthalmologists and/or optometrists in VA medical center eye clinics. Veterans documented with vision loss are referred to VA medical center low vision clinics or blind rehabilitation centers, where they receive clinical visual rehabilitation examinations by optometrists or ophthalmologists.

VA does not routinely screen returning veterans for hearing loss; however active duty servicemembers receive a post-deployment health survey that addresses hear-

ing-related concerns. Audiology services are routinely provided for veterans injured on active duty and undergoing physical evaluation boards within military treatment facilities. Injured veterans transferred to the VA system of care are typically screened for hearing loss by an audiologist and more comprehensive evaluation and treatment is completed by an audiologist as warranted.

Question 3(b): What research is in development to care for TBI among our returning soldiers?

Response: To advance the treatment and rehabilitation of soldiers returning with traumatic brain injury (TBI) and related neurotrauma, VA has issued a request for research proposals that focus on TBI; cervical spinal cord injury; co-morbid conditions such as PTSD and trauma to extremities; screening and diagnostic tools related to mild TBI, especially field-based; and continuity of care between DOD and VA. Applicants are asked to pay special attention to cooperative projects with DOD.

Some exciting research projects currently underway include: (1) studying neural repair after brain injury to build a theoretical understanding of cognitive rehabilitation and creating targets for practical treatments to enhance quality of life; (2) exploring community re-integration for servicemembers with TBI (to promote seamless transition between servicemembers currently being treated, or who will one day be treated, in both DOD and VA medical facilities); and, (3) assessing whether there are differences in the cost patterns for rehabilitation among soldiers returning from OEF/OIF with combat-related TBI compared to those with non-combat-related TBI. Investigators are also examining how PTSD impacts future outcomes and costs associated with combat-related TBI.

In addition, VA has established a Polytrauma and Blast-Related Injury Quality Enhancement Research Initiative (PT/BRI QUERI) coordinating center to promote the successful rehabilitation, psychological adjustment, and community reintegration of veterans. We have identified two priorities: (1) TBI with polytrauma, and (2) traumatic amputation with polytrauma. The primary target is OEF/OIF patients in VA, many of whom remain on active duty during their initial course of treatment. However, its activities will benefit all VA patients with complex injuries, regardless of service era and mechanism of injury. Finally, VA recently issued a special solicitation for research projects on the long-term care and management of veterans with polytrauma, blast-related injuries, or TBl.

Question 4: Having candid communications is a priority for me, and I have been frustrated during recent hearing with standard testimony noting that VA appointments are quick and almost all veterans are seen in a timely manner. I meet regularly with returning West Virginia veterans, and this is not the story I hear. Dr. Kussman, how can we get direct, candid information about the true funding needs for VA health care?

Response: VA's actuarial model developed approximately 84 percent of the Fiscal Year 2008 VA medical care budget and VA has made every effort to account for the needs of veterans. The Model has had several key methodological improvements including development of separate enrollment, morbidity, and reliance assumptions for OEF/OIF veterans based on their actual enrollment and usage patterns. However, many unknowns can impact the number and types of services that VA will need to provide OEF/OIF veterans, including the duration of the conflict, when OEF/OlF veterans are demobilized, and the impact of our enhanced outreach efforts. VA is well-positioned to provide assistance to veterans returning from Iraq and Afghanistan. As a physician and a veteran myself, if there is ever a situation where patient care is in jeopardy due to inadequate funding, I will be sure to raise those concerns within the Administration.

Question 5: In 2005, when VA acknowledged a shortfall in the health care budget, the Secretary noted that part of the problem was a wrong estimate of the costs of care for the returning soldiers of $273 million. But an even larger amount of the shortfall was the miscalculation of the long-term care costs for our older veterans—VA testified long-term care costs were $446 million short.

Question 5(a): It is easiest to understand how the estimate could be off on the needs of the returning soldiers, but why was VA off by almost half a billion dollars on long-term care?

Response: This was due to unrealistic assumptions in developing the budget estimates for VA long-term care nursing home care. The Fiscal Year 2005 supplemental budget request and the Fiscal Year 2005 budget amendment request corrected these errors. VA's subsequent budget requests demonstrate an improved model of forecasting accuracy.

Question 5(b): How has the budget process been improved and what action is VA taking to ensure quality long term care for our aging veteran population?

Response: The Fiscal Year 2007 and Fiscal Year 2008 budget requests included accurate estimates of VA's long-term care costs and did not repeat the unrealistic assumptions and computational errors. VA continues to provide patient-centered long-term care services in the most independent setting suitable for a veteran's medical condition and personal circumstances, especially in locations close to the veteran's home and community-based settings.

VA facilities may establish an enhanced use lease agreement in which VA leases space for a privately owned assisted living (AL) facility in return for affordable AL for veterans. This public-private partnership provides for supervised housing at an affordable rate structured to address the needs of the community, as well as the specific needs of veterans. VHA helps support veterans in assisted living settings through community residential care, medical foster homes, and home based primary care. Medical foster homes combine the adult foster home concept with VA home based primary care (HBPC), where VA finds people in the community willing to take veterans into their home and provide personal assistance and continuous supervision. Veterans pay for these services using their aid and attendance benefits from the Veterans Benefit Administration (VBA). The home based primary care team continues to provide health care, adaptive equipment, caregiver education, and oversight. We are operating medical foster homes in Little Rock, Tampa, and San Juan, and we are ready to expand to 20 additional sites.

Question 5(c): Will VA make long term care and nursing home care a priority for its construction projects?

Response: VA will continue to make long term and nursing home care a priority for all veterans for whom such care is mandated by statute, and who need such care and seek it from VA. The current budget request will support continued expansion of veterans' access to VA's spectrum of non-institutional home and community based long-term care services while sustaining capacity in VA's own nursing home care units and the community nursing home program and continuing to support modest growth in capacity in the State veterans home program.

VA expects to meet a substantial part of the growing need for long-term care through such innovative services as care coordination/home telehealth. Care coordination in VA involves the use of health informatics; telehealth and disease management technologies to enhance and extend existing care; and case management activities. Home telehealth enables delivery of VA health care to veterans living remotely from VA medical facilities, including those in rural areas.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. PATTY MURRAY TO MICHAEL J. KUSSMAN, M.D., NOMINEE TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Question. Are there any external reviewers involved in the decisionmaking process for VA bonuses?

Response: The Department of Veterans Affairs (VA) has four separate Performance Review Boards (PRBs)—one for VA personnel (employees who report to an Assistant Secretary, General Counsel, and other key staff and offices, usually in Central Office), one for the Veterans Benefits Administration (VBA), one for the Veterans Health Administration, and one for the Office of Inspector General (OIG). The first three are all composed entirely of VA employees, while the fourth is composed of three non-VA members (one from Housing and Urban Development, one from the Department of Labor, and one from NASA). This composition for an OIG PRB is common across government, since Offices of Inspector General are tasked with conducting an independent oversight role of their Department and tying their performance assessments to the Department could present a conflict of interest for personnel.

Each agency is required to publish its PRB membership in the Federal Register. VA reviewed this listing for seven Cabinet-level Departments (Defense, Education, Health and Human Services, Homeland Security, Interior, Justice, and Treasury) and several agencies and administrations (Environmental Protection Agency, Government Services Administration, Small Business Administration, and the Nuclear Regulatory Commission) and found it is very rare for PRBs to include external members. For example, the Office of Personnel Management (OPM), which sets the rules for the bonus process, does not have an external member on its board. The only agencies VA could find that did include an external member for their PRB were relatively small—the Equal Employment Opportunity Commission, the Office of Government Ethics, and the National Transportation Safety Board. It should be noted that each of these agencies provides an oversight role similar to an OIG.

VHA's PRB includes the chair of each of the six national committees for VHA's National Leadership Board, the chairs of the Performance Management Work Group, the Deputy Under Secretary for Health for Operations and Management, the Principal Deputy Under Secretary for Health, and the Chief of Staff. All of the committee members are VHA employees. The PRB determines the ratings of subordinate executives, SES pay adjustments, year-end performance bonuses, and priority rankings for rank awards for subordinate executives. Subsequently, a senior management committee composed of the Deputy Under Secretary for Health for Operations and Management, the Principal Deputy Under Secretary for Health, and the Chief of Staff, makes recommendations on all other executives' ratings, SES pay adjustments, year-end performance bonuses, and the priority rankings for rank awards for subordinate executives, but they do not determine their own. The Under Secretary for Health makes recommendations on the Deputy Under Secretary for Health for Operations and Management, the Principal Deputy Under Secretary for Health, and the Chief of Staff. All recommendations go to the VA PRB for review and recommendation to the Secretary. No member of VA's PRB acts on his or her own rating, bonus, or pay adjustment.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. SHERROD BROWN TO MICHAEL J. KUSSMAN, NOMINEE TO BE UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Question: Our vets returning from the Iraq and Afghanistan theaters of battle have faced enemies who have in many ways, fought in a manner different than any other we have faced in the past. I know that many other nations, particularly the Israelis, have reached out to the VA and that the VA has sent delegations and held meetings with foreign officials in the recent past. I would hope that you would keep those lines of communication open and to the extent that you can, expand on this relationship especially in the fields of brain trauma and stress disorders. Please comment on how you see the relationships developing, and what resources, if any, you might need to take advantage of such an opportunity.

Response: Between January 15 and 19, 2007, a delegation from VA visited the Department of Rehabilitation, Ministry of Defense in Tel Aviv, Israel. The primary purpose of the visit was to examine how Israel deals with PTSD. VA also visited a TBI center and a Veterans' Organization. VA observed that Israeli and U.S. clinicians take similar approaches to PTSD and TBI.

VA welcomes continued discussions with the Israeli Ministry of Defense and is willing to consider funding collaborative, peer-reviewed research projects involving VA and Israeli investigators. We believe this cooperation will yield scientifically rich and highly relevant data to provide even better care to our Nation's veteran population.

[Michael J. Kussman's response to Questionnaire for Presidential Nominees follows:]

QUESTIONAIRE FOR PRESIDENTIAL NOMINEES

PART I: ALL THE INFORMATION IN THIS PART WILL BE MADE PUBLIC

1. Name: Kussman (LAST) Michael (FIRST) James (OTHER)

2. Present Address: 8511 Gavin Manor Court, Chevy Chase, Maryland 20815 (CITY) (STATE) (ZIP CODE)

3. Position to which nominated: U.S. Department of Veterans Affairs Under Secretary for Health

4. Date of nomination: April 4, 2007

5. Date of birth: 22 (DAY) May (MONTH) 1944 (YEAR)

6. Place of birth: Troy, New York

7. Marital Status: Married

8. Full name of spouse: Virginia Dean Kussman

9. Names and ages of children

Joshua Kussman, 35

Deana Kussman, 31

10: Education:

Institution (including city and State)	Dates attended	Degrees received	Dates of degrees
Linton HS, Schenectady, NY	1958 - 1962	HS Diploma	1962
Boston University, Boston MA	1962 - 1968	BS, MD	1968
U.S. Army Command and General Staff College Fort Leavenworth, KS	1984		
U.S. Army War College Carlisle Barracks, PA	1992		
Salve Regina University	1994	MS Management	1994

11. Honors and awards: List below all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and any other special recognitions for outstanding service or achievement.

Diplomate of the National Board of Medical Examiners - 1969

Diplomate of the American Board of Internal Medicine – 1974

Advanced Achievement in Internal Medicine – 1987 (Recertification

Fellow of the American College of Physicians - 1987

Laureate Award Recipient – ACP/ASIM - 2000

Master of the American College of Physicians – 2002

John D. Chase Award for Physician Executive Excellence – 2004

Outstanding Federal Healthcare Award (AMSUS) - 2006

12. Memberships List below all memberships and offices held in professional, fraternal, business, scholarly, civic, charitable, and other organizations for the last 5 years and any other prior memberships or offices you consider relevant

Organization	Office held (if any)	Dates
American College of Physicians, Credentials Committee		1989 – 1991
American College of Physicians, Clinical Efficacy Assessment Committee		1992
American Diabetes Assoc.		
Association of Military Surgeons of the United States Member, Board of Managers	Chairman	2004 – Present
Association of the United States Army		1995-Present
38th Parallel Medical Society		1970-Present
The Society of Medical Consultants to the Armed Forces		1995-Present
National Infrantryman's Association		2004-Present
American Medical Association		1988-Present

13. Employment record: List below all employment (except military service) since your twenty-first birthday, including the title or description of job, name of employer, location of work, and inclusive dates of employment.

1968-69	Straight Internship in Medicine New England Deaconess Hospital Boston, Massachusetts
1969-70	First Year Residency in Internal Medicine New England Deaconess Hospital Boston, Massachusetts
1972-73	Second Year Residency in Internal Medicine New England Deaconess Hospital Boston, Massachusetts
1973-74	Chief Fellow in Diabetes Joslin Clinic Boston, Massachusetts
1974-79	Practice of Diabetes, Endocrinology and Internal Medicine Pittsfield, Massachusetts
2000-2001	Deputy Medical Inspector for Investigations Veterans Health Administration Washington, D.C.
2001-2003	Chief Consultant, Acute Care Strategic Health Group Veterans Health Administration Washington, DC
2003- 2004	Deputy Chief Officer Patient Care Services Chief Consultant, Medical/Surgical Services Alternate Delegate to AMA House of Delegates
2004-2005	Acting Chief Officer Patient Care Services Acting Deputy Under Secretary for Health
2005	Principal Deputy Under Secretary for Health
2006	Acting Under Secretary for Health

14. Military service: List below all military service (including reserve components and National Guard or Air National Guard), with inclusive dates of service, rank, permanent duty stations and units of assignment, titles, descriptions of assignments, and type of discharge.

1970-71	Battalion Surgeon, 7th Infantry Division (CPT) U.S. Army Hospital, Seoul Republic of South Korea
1971-72	Chief, Hospital Clinics (Major) Cutler Army Hospital Fort Devens, Massachusetts
1979-82	Assistant Chief, Endocrine Service (Major/LTC) Tripler Army Medical Center Honolulu, Hawaii

1980-82	Chief, General Medicine Service (LTC) Tripler Army Medical Center Honolulu, Hawaii
1980-81	Training Officer, Department of Medicine (LTC) Tripler Army Medical Center Honolulu, Hawaii
1981-82	Chief, Medical Specialty Clinic (LTC) Tripler Army Medical Center Honolulu, Hawaii
1981-82	Chief, Internal Medicine Clinic (LTC) Tripler Army Medical Center Honolulu, Hawaii
1982-83	Division Surgeon (LTC) 25th Infantry Division Schofield Barracks, Hawaii
1983-84	Student, Resident Course (Honor Graduate) (LTC) U.S. Army Command and General Staff College Fort Leavenworth, Kansas
1984-86	Assistant Chief, Department of Medicine (LTC) Brooke Army Medical Center Fort Sam Houston, Texas
1986-87	Chief, Department of Medicine (Col) Brooke Army Medical Center Fort Sam Houston, Texas
1986-88	Program Director in Internal Medicine (Col) Brooke Army Medical Center Fort Sam Houston, Texas
1986-88	Internal Medicine Consultant (Col) Health Services Command Fort Sam Houston, Texas
1987-88	Deputy Commander for Clinical Services (Col) Brooke Army Medical Center Fort Sam Houston, Texas
1987-88	Director, Medical Education (Col) Brooke Army Medical Center Fort Sam Houston, Texas
1987-88	Director, Health Services (Col) Fort Sam Houston, Texas
1987-88	Quality Assurance Coordinator (Col) Brooke Army Medical Center Fort Sam Houston, Texas
1987-88	Associate Director of Medical Education (Col)

Joint Military Medical Command
San Antonio, Texas

1988-91 Chief Consultant in Medicine (Col)
Office of the Army Surgeon General
Falls Church, Virginia

1988-91 Governor for the U.S. Army Region (Col)
American College of Physicians
Office of the Surgeon General
Falls Church, Virginia

1991-92 Student, Resident Course (Col)
U.S. Army War College
Carlisle Barracks, Pennsylvania

1992-93 Director, Division of Quality Assurance/Risk Management (Col)
Office, Secretary Of Defense(Health Affairs) PA/QA
The Pentagon
Washington, DC 20301-1200

1993-95 Commander, USA Medical Department Activity (Col)
Fort Benning, Georgia

1993-95 Director, Health Services (Col)
Fort Benning, Georgia

1994-95 PROFIS Commander, 2d MASH (Col)
Fort Benning, Georgia

1995-96 Assistant Deputy Commander for Health Care Operations (Col)
US Army Medical Command
Fort Sam Houston, Texas

1995-96 Director of Clinical Operations (Col)
US Army Medical Command
Fort Sam Houston, Texas

1995-96 Deputy Medical Corps Chief (Col)
US Army Medical Command
Fort Sam Houston, Texas

1996-98 Commander, Walter Reed Hospital (Col/BG)
Commander, Walter Reed Health Care System
Washington, D.C.

1996-98 Board of Directors – National Capitol GME Consortium (Col/BG)
Board of Regents – Uniformed Services University of Health Sciences
Board of Trustees – U.S. Soldiers and Airmen's Home
Member – National Capitol Area Federal Health Council
Washington, DC

1998-00 Commander, Europe Regional Medical Command (Col/BG)
US Army Europe/ 7th Army Command Surgeon
Lead Agent TRICARE Europe
Heidelberg. Germany

15. Government record: List any advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments other than those listed above.

None

16. Published writings: List the titles, publishers, and dates of books, articles, reports, or other published materials you have written.

Kussman, M.J. and Marble, A.,Management of the Adult Diabetic, Conn's Current Therapy 1975

Kussman, M.J., Goldstein, H., and Gleason, R.E., Clinical Course of Diabetic Nephropathy, Journal of the American Medical Association, 1976 Oct 18;236(16): 1861-3

Shah, N., Kussman, M.J., and Tulgan, H., Hyperthyroidism and Hypokalemic Periodic Paralysis in a Caucasian Female, New York State Journal of Medicine, 1979 Oct;79(11): 1770-1

Pinholt, EM, Kroenke, K, Hanley, JF, Kussman,MJ, Twyman, PL, and Carpenter, JLFunctional Assessment of the Elderly, A Comparison of Standard Instruments With Clinical Judgement, Archives of Internal Medicine, 1987 Mar;147(3):484-8

Kussman, MJ and Johnson,J, A Prospective Study of Ordering Patterns for Noninvasive Cardiologic Procedures, American Journal of Noninvasive Cardiology, August, 1987

Kussman, M.J., Editor, Pamphlet - Diseases of Clinical Significance for United States Central Command Forces - 1991

Kussman, M.J., Desert Shield/Storm Medical Issues Review and Ad Hoc Working Group, The Journal of the US Army Medical Department, Fall, 1992

Phillips, J.S., Hamm, C.K., Pierce, J.R., and Kussman, M.J., Utilization Management Affects Health Care Practices at Walter Reed Army Medical Center: Analytic Methods Applied to Decrease Length of Stay and Assign Appropriate Level of Care, Military Medicine, 1999 Dec;164(12):867-71

17. Political affiliations and activities: (a) List all memberships and offices held in and financial contributions and services rendered to any political party or election committee during the last 10 years.

None

(b) List all elective public offices for which you have been a candidate and the month and year of each election involved.

None

18. Future employment relationships:

(a) State whether you will sever all connections with your present employer, business firm, association, or organization if you are confirmed by the Senate.

N/A

(b) State whether you have any plans after completing Government service to resume employment, affiliation, or practice with your previous employer, business firm, association, or organization.

N/A

(c) What commitments, if any, have been made to you for employment after you leave Federal service?

None

(d) (If appointed for a term of specified duration) Do you intend to serve the full term for which you have been appointed?

Yes

(e) (If appointed for an indefinite period) Do you intend to serve until the next Presidential election?

Yes

19. Potential conflicts of interest:

(a) Describe any financial arrangements, deferred compensation agreements, or other continuing financial, business, or professional dealings which you have with business associates, clients, or customers who will be affected by policies which you will influence in the position to which you have been nominated.

None

(b) List any investments, obligations, liabilities, or other financial relationships which constitute potential conflicts of interest with the position to which you have been nominated.

Arrangement made to divest Pfizer and General Electric Stock

(c) Describe any business relationship, dealing, or financial transaction which you have had during the last 5 years, whether for yourself, on behalf of a client, or acting as an agent, that constitutes a potential conflict of interest with the position to which you have been nominated.

None

(d) Describe any lobbying activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any Federal legislation or for the purpose of affecting the administration and execution of Federal law or policy.

None

(e) Explain how you will resolve any potential conflict of interest that may be disclosed by your responses to the above items. (Please provide a copy of any trust or other agreements involved.)

See 19.b

20. Testifying before the Congress:

(a) Do you agree to appear and testify before any duly constituted committee of the Congress upon the request of such committee?

Yes

(b) Do you agree to provide such information as is requested by such a committee?

Yes

UNITED STATES OFFICE OF GOVERNMENT ETHICS,
Washington, DC, April 23, 2007.

Hon. DANIEL K. AKAKA,
Chairman, Committee on Veterans' Affairs,
U.S. Senate,
Washington, DC.

DEAR MR. CHAIRMAN: In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Dr. Michael J. Kussman, who has been nominated by President Bush for the position of Under Secretary for Health, Department of Veterans Affairs.

We have reviewed the report and have also obtained advice from the Department of Veterans Affairs concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is a letter dated April 11, 2007, from the agency's ethics official, outlining the steps Dr. Kussman will take to avoid conflicts of interest. In addition to the steps indicated in the enclosed letter, Dr. Kussman informed the ethics official that he will divest General Electric and Pfizer in the immediate future.

Based thereon, we believe that Dr. Kussman is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

ROBERT I. CUSICK,
Director.

Enclosures.

DEPARTMENT OF VETERANS AFFAIRS,
OFFICE OF THE GENERAL COUNSEL,
April 11, 2007, Washington, DC.

Mr. ROBERT I. CUSICK,
Director, Office of Government Ethics,
Washington, DC.

DEAR MR. CUSICK: In accordance with section 2634.605(c) of title 5, Code of Federal Regulations, I am forwarding the enclosed Public Financial Disclosure Report (SF–278) of Dr. Michael Kussman. President Bush has nominated Dr. Kussman to serve in the position of Under Secretary for Health of the Department of Veterans Affairs (VA). It is my opinion that Dr. Kussman's report is complete and discloses no unresolved conflicts of interest under applicable law or regulation.

Dr. Kussman has agreed pursuant to 18 U.S.C. § 208(a) that he will not participate personally and substantially in any particular matter that has a direct and predictable effect on his financial interests or those of any other person whose interests are imputed to him, unless he first obtains a written waiver under section 208(b)(1), or qualifies for a regulatory exemption under section 208(b)(2) and 5 CFR §§ 2640.201–2640.203. Dr. Kussman understands that the interests of the following persons and entities are imputed to him: his wife; minor children; general partner; any organization in which he serves as an officer, director, trustee, general partner or employee; and any person or organization with which he is negotiating, or has an arrangement concerning, prospective employment.

Dr. Kussman currently holds stock in General Electric and Pfizer. Dr. Kussman has agreed that he will divest himself of these stock interests within 90 days of his confirmation. Further, pending his divestiture of these assets, Dr. Kussman has agreed not to participate personally and substantially in any particular matters that will have a direct and predictable effect on the financial interests of either of these companies.

Dr. Kussman also holds stock in Hewlett Packard. We have determined that it is not necessary at this time for him to divest this interest. However, Dr. Kussman has agreed that he will not participate personally and substantially in any particular matter that will have a direct and predictable effect on the financial interests of Hewlett Packard unless he first obtains a written waiver, pursuant to section 208(b)(1), or qualifies for a regulatory exemption, pursuant to section 208(b)(2).

These assurances resolve any concern about real or apparent conflicts of interest that may arise from Dr. Kussman's report. Therefore, I have certified and dated the report.

Sincerely yours,

WALTER A. HALL,
Assistant General Counsel
and Designated Agency Ethics Official.

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

Let me note that the nominee has completed the Committee questionnaire for Presidential nominees and responded to my pre-hearing questions, all of which will appear in the hearing record. Also included will be a letter from the Office of Government Ethics acknowledging that he is in compliance with laws and regulations governing conflicts of interest.

Before we go further here, there is a requirement that I swear in the nominee, and so, Dr. Kussman, I ask that you stand and raise your right hand.

Do you solemnly swear that the testimony you are about to give the Veterans' Committee is the truth, the whole truth, and nothing but the truth, so help you, God?

Dr. KUSSMAN. Yes, sir.

Chairman AKAKA. Thank you very much.

At this time, I would like to ask our Committee Members for any comments or statements they would like to make before we ask questions. We will go to questions, Dr. Kussman.

Let me say that as I spoke of this in my opening statement, about being an advocate for veterans in light of OMB control, I urge you to ensure that the best interests of veterans is behind each and every decision you make. How will you advocate for that approach as VA deals with pressure from OMB to limit spending on health care?

Dr. KUSSMAN. Mr. Chairman, thank you for the question.

As you know, I am a veteran and a retiree and that is what I am here to do. I represent veterans. When Mr. Nicholson asked me to be the Acting Under Secretary and we talked, and I was very flattered that he did so, I told him that—and he knew this already—that I tell the people I work for what I think is correct, not what they want to hear, and he told me very clearly he wouldn't have it any other way.

And so my passion is to fight for veterans, to tell the leadership, including OMB, what I think needs to be done in support of veterans. Those people who know me know that I already have done that in my capacity in the VA and I assure you that is what I will continue to do.

Chairman AKAKA. I want you to address criticisms leveled at you that you have not actively worked to improve things as veterans move from Walter Reed to VA. Please describe your involvement with Walter Reed, including the specific allegation that you knew about the problems at Walter Reed through focus groups carried out in 2004.

Dr. KUSSMAN. Yes, Mr. Chairman. Thank you for the question. I worked at Walter Reed, as you know, from 1996 to 1998. At that time, I was the Commander of the Walter Reed Health Care System, the hospital, not the installation. So even when I was there, I wouldn't have had anything to do with Building 18 or the other residential areas around the post.

I am very proud of my service at Walter Reed in 1996 to 1998. Walter Reed got the highest score it ever got on the Joint Commission survey when I was there and was recognized in DOD as the large military hospital that had the best patient satisfaction during those two years that I was there. Any issues that have occurred

more recently in Walter Reed didn't exist back in 1996 to 1998, the specific issue related to the focus group in 2004.

In 2003, then-Secretary Principi asked me to co-chair with an individual from VBA a Seamless Transition Task Force to look at what the VHA and VBA were doing or not doing in support of servicemembers when they were transitioning. The first thing we did, and I was responsible for that, I think it was noted in the first panel, is call the commanders of the major installations, both Army and Navy, and was successful in getting VBA benefits counselors and social workers full-time in there to assist. That was unprecedented, having full-time VA people working within military facilities.

About 9 months after we had started this, then-Chief of Staff Nora Egan for Mr. Principi asked whether or not we were doing our job, whether the servicemembers at Walter Reed, their families, knew who the VBA/VHA people who were there. A group was put together—I was really not part of that group—to do a sensing session that took place on one day. There were six servicemembers that were there and, I believe, six family members. The issues that they discussed were really related to the VBA and VHA service. There was very little discussion of what was going on nor were we asked about what was going on in relationship to Walter Reed.

I am a big critic of myself, the biggest critic I know, and I have gone back and read this report several times. I have talked to the people who did the report and there really wasn't anything there that could have been presumed to have been related to the issues that came up several years later. In fact, those conditions did not exist at Walter Reed in 2004.

Chairman AKAKA. Thank you very much for that. We will have a second round here.

Let me call on Senator Craig for his questions and comments.

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

Dr. Kussman, you have now spent many years at the highest levels of the VA health care system. Of course, prior to joining VA, you operated in the world of military medicine. VA and DOD, in spite of working under one President, have struggled over the years to work effectively together. From the perspective of the military, why has that relationship been so difficult to foster? That would be my first question.

And then from your perspective as the potential head of the VA system, how do you think you can continue to improve cooperation of these two systems?

Dr. KUSSMAN. Thank you, sir. The first part of the question was my perception why DOD——

Senator CRAIG. Why has it been difficult to foster a better relationship between the two?

Dr. KUSSMAN. I think that on a personal basis, there are a lot of good relationships with DOD, but I believe that the perceived mission of the two organizations are different. One fights a war, one is a more specific health care system, and there have been challenges in that cooperation.

With this Administration, we have moved far along with the partnering at multiple levels. There is Health Executive Committee chaired by myself and now Dr. Ward Cassells who took over for Dr.

Winkenwerder. There is a Joint Executive Committee co-chaired by Dr. Chu and Deputy Secretary Mansfield. There is a Benefits Executive Committee co-chaired by Mr. Domingous, I believe, and Admiral Cooper, the Under Secretary for Benefits. We are together working common issues. We have developed a DOD–VA strategic plan and we are holding people's feet to the fire to meet those requirements. So I think we are trying to break through the cultures that have existed and are moving along with that.

As far as the second part of the question, what the VA can do, we are committed to doing that and I believe one of the things that I bring to the table is the knowledge of both sides, and when I go talk to people, and sometimes I am in danger of losing my guild card for DOD, but I bleed VA now as much as I bleed any green leftover from the Army, and when people come and ask me about things, I say frequently, stop. Remember who you are talking to. I understand your system. We move on from there.

So I believe that with the Secretary's leadership and the Deputy Secretary, I believe Secretary Gates is committed, Deputy Secretary England, we are going to move very rapidly to continue and improve the relationship between the two entities.

SENATOR CRAIG. Thank you, Dr. Kussman.

Every war produces, from a health care standpoint, a different kind of veteran. Can you talk a little bit about your views on the care and treatment we are providing the severely injured veteran and where you believe changes might need to be made in our approaches and our delivery system, if you are confirmed to lead the VA health care system?

Dr. KUSSMAN. Yes, sir. You are absolutely correct, sir, that every war has its sentinel injuries. I believe there are three signature injuries. I believe that there are three actually in this war. One is PTSD, particularly related to the National Guard and Reserve, not to minimize the active component, but we have in this war, really in an unprecedented manner since World War II, have used and relied upon the National Guard and Reserve. So we have a great obligation to them.

Second is TBI, and we can talk about that in just a second, for major, minor, and moderate TBI.

The third thing that I look at is what we have described and put into the lexicon, polytrauma, or multiple trauma. This war has brought to us unprecedented quality of combat medicine. With the body armor and the far-forward delivery of care, with the forward surgical teams doing unprecedented surgery right on the streets of Baghdad, the survival of severely injured people have come back and they have really challenged the system. These issues are not arithmatic, they are geometric in their complications and we consider people with severe illness to have TBI, spinal cord, mental illness, blindness, and amputations, and sometimes some of these poor kids have had all of them. So how do we approach that multidisciplinary need?

We have had our four TBI centers that were established in 1991 in Palo Alto, Minneapolis, Richmond, and Tampa, in conjunction with the Defense and Veterans Brain Injury Study and Center at Walter Reed. That is partly why they were established, because we were in partnership with DOD, and they have been at the forefront

of the delivery of TBI care in the country. They are staffed by the same people who staff all the civilian agencies, trained in the same places and using the same techniques.

When the war got going, we realized that we needed to put together facilities that had a multi-disciplinary approach so it could take care of the full gamut of the injuries as I described, and what we did is build on our TBI centers. Unfortunately, people forget that they were originally TBI centers. They weren't built as polytrauma centers, but they were expanded. We believe that we can provide the full depth and breadth of services.

As related to TBI, we have known and DOD together do very well with severe traumatic brain injury as far as that evacuation. Those people get into the evacuation chain and come through Landstuhl, come to the Bethesda and Walter Reed and then come to us, and I think we are doing a very good job in treating them.

The bigger challenge right now is mild to moderate TBI that is not diagnosed because the individual doesn't know they had it. The scenario that I describe is that there is an IED that went off. There may be carnage around, people severely injured. A servicemember may have lost consciousness or banged their head or had lost consciousness for a second or two. The sergeant yells, "Is everybody all right?" and the kid says, "Yes, Sarge, I am fine." It may happen more than once. It could happen three or four times. It could happen in multiple deployments. But they never surface in the medical evacuation chain. Nobody knows that they have TBI.

They come back, and the question is the literature doesn't tell us what to do with mild to moderate TBI. The literature that exists in the medical community is very anemic when it comes to this and is generally based on relatively mild head bumps related to football Friday night. I played basketball when I was a kid and I, not so much joking, but I am not too agile and I would get an elbow in the side of the head and see stars for a couple of seconds. The coach would say, "You OK?" I never left the game. I never played too well, either, but I never left the game. That probably is mild TBI.

There is a lot of that that goes on, but it may very well be that the mild to moderate TBI that occurs in the blast injury that is one of the ways that the enemy has fought us causing the TBI may be different. There may be molecular changes that are different from a blast than a more common head bump, if you will. We are initiating research, both in the civilian community and also with DOD, to try to determine that, try to determine if there are tests and things that can be done to identify mild to moderate TBI.

However, we are not waiting for that to happen. As you know, we have put in place a screen for every OIF/OEF person that comes to us, regardless of what the initiating diagnosis is, just like we have done with PTSD, military sexual trauma, substance abuse, and depression. We screen everybody for all those. We have been doing that for a long time. Now we have added a screen for TBI. If those questions are positive, we then refer the patient according to a clinical guidance process to neuro-cognitive testing. Frequently, there is no one test that can be done, but just treat the symptoms.

It appears from the civilian literature that I described as anemic that anywhere from 70 to 90 percent of people will get better within 18 to 24 months, but that may be a different illness compared to the illness that we are talking about with the TBI that we are seeing because of the blast injuries and we are putting together a registry so we can then identify the people and follow them longitudinally to see what happens over 1 year, 5 years, 10 years, and to be sure that we are giving them all the things that we can do. So I believe that we are addressing the multiple levels of the TBI.

From a PTSD perspective, the VA was a prime mover in the diagnosis and the description of PTSD. As you probably know, it wasn't in the medical lexicon until 1980. We have led the country in the treatment of PTSD and have our major center for TBI in White River Junction and is seen as a national, if not international, center of excellence for PTSD.

So we are constantly looking at how we treat people. We are expanding our capability with mental health. We spend almost $3 billion, a lot of it on this. It was mentioned earlier about the money. As you know, there was an issue of $100 million that didn't get spent last year and that was because we have challenges hiring people to do that and getting them to go to areas in the country that we would need the assistance. Having said that, we have hired in the last couple of years over 1,000 new mental health personnel, to include psychiatrists, psychologists, and social workers.

Senator CRAIG. My time is way over, so I will stop.

One—two comments. I just pinned a Purple Heart on a young man the other night out at Walter Reed whose life was saved and may well live a full life because of that street capability in Baghdad today that we are delivering to our men and women in uniform.

Secondarily, I understand that we are, at least in the private sector, working on a device that might go on each individual soldier's uniform to detect and measure impact or concussion, the volume of impact that a person might receive during one of those events. Are you aware of that, and does that have potential to at least begin to measure the amount of impact that might relate to this kind of trauma?

Dr. KUSSMAN. Yes, sir. I have heard about it, but I really don't know enough to comment. But clearly, that is an important thing, because what we really need to do is identify the people who have experienced a blast and then identify them so we can track them when they come and there would be an identifier with that to make sure that they get special attention than just the average person we are screening for.

Senator CRAIG. Thank you, Dr. Kussman. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Craig.

Senator Murray?

Senator MURRAY. Yes. Thank you. Dr. Kussman, I wanted to start by raising an issue that affects every single thing we do in the Senate for veterans. Many Members of Congress, myself included, are extremely wary today of the information that the VA provides to us. As you know, the VA has a track record of being

less than honest with Congress. I know you remember well back in 2005 when the VA told us consistently they had all the money they needed, blocked an amendment three times on the floor that Senator Akaka and I worked on to provide VA with money, and learned later, of course, that the VA was indeed short $3 billion.

Well, as I mentioned a few minutes ago when we were here, I was astonished by an article written by Chris Adams of the *McClatchy* newspaper, and I want to quote it, "the VA has habitually exaggerated the record of its medical system, inflating its achievements in ways that make it appear more successful than it is." In the context of the information we receive from the VA that we are all very wary of, that raises a lot of red flags for me and I wanted to know if you had read that report and if you had a comment on it.

Dr. KUSSMAN. Yes, Senator Murray. As you and I talked about when I had the privilege of talking to you in your office, I agree that we have to work very hard on getting our information clear, concise. One of my goals is to look at our access standards, look at our appointment schedules, and correct anything that is in there that is not accurate.

As far as the *McClatchy* report, I appreciate that report because I take any criticism or corrections very seriously to look at what we are doing. I am very forthright and honest about what I do and so I was actually—there were comments in there by the reporter that were very positive, as well, that the VA has transformed itself, is identified as a leader in health care. I think that there were correct issues that he raised of things that need to be articulated better and we are committed to do that.

Senator MURRAY. I hope that part of your commitment is to give us a picture of reality, not of one that you just want to have us.

Dr. KUSSMAN. I don't believe in fantasies and I guarantee you that I will give you the best information that I know.

Senator MURRAY. OK. I wanted to ask you also about this issue of bonuses. I am sure you are well aware of the issue. When you were acting VHA head, millions of dollars in bonuses were granted to senior managers, particularly those based here in Washington, DC. I know there are good reasons to do bonuses, but I was also perturbed yesterday to read a report by the Associated Press that says that 21 of 32 VA officials who sat on the board responsible for performance reviews and bonuses received more than half-a-million dollars in payments themselves. Would you comment on that?

Dr. KUSSMAN. I don't know specifically what the 21 were or which ones that the reporter is alluding to. I can just tell you, Senator, that to the best of my knowledge, our bonus process that is based on performance is consistent with what OMB's policies are. I believe that the Secretary, because of this latest situation, has asked—I said OMB, I meant OPM—has asked OPM to come and look at our process to assure that we are doing the right things.

Senator MURRAY. Does the VA's Performance Review Board include any outside observers today?

Dr. KUSSMAN. Outside the VA? I would have to go back and look. I don't think so.

Senator MURRAY. OK. Do you think that it should?

Dr. KUSSMAN. I would have to look at that.

Senator MURRAY. If you could get a response back to me, I would appreciate that.

I also wanted to ask you about the VA budget shortfall that occurred back in 2005 because, as you know, the VA relied on 2002 data to forecast medical expenditures and wound up $3 billion short. I was met by opposition from the VA every step of the way as we worked to try and deal with what we knew from the ground out there was a shortfall, and in fact, Secretary Nicholson wrote a letter to Senator Hutchison that denied at the time that VA needed any more money, right before they came back around and said they were indeed $3 billion short.

You were VA's number two medical leader at the time. Can you describe to this Committee any involvement that you had in that budget shortfall?

Dr. KUSSMAN. I wasn't directly involved in the development of the budget. Clearly, there were things that happened that were mistakes. We have tried to learn from that. As you know when we talked, I am now directly involved in the budget. The recommendation for 2008 was the first year that I had spent a lot of time and was directly involved in the development. I believe it is a good budget. It has things that are not in it that potentially were in there before. I believe that we have worked——

Senator MURRAY. Your VA request or what the Senate actually has included, which is about——

Dr. KUSSMAN. No, the VA request for 2008.

Senator MURRAY. Well, I assume that you believe that the budget that the Senate passed with $3.5 billion would better serve the needs of the veterans than the request.

Dr. KUSSMAN. We are very appreciative of dollars and we are a large agency and we will spend it on the best care of veterans.

Senator MURRAY. Well, let me ask you a more specific question. Were you involved in any way with the writing of the letter by Secretary Nicholson that was sent to Senator Hutchison in April of 2005?

Dr. KUSSMAN. Not that I recall.

Senator MURRAY. Let me ask you one other question. The *Washington Post* recently reported about high-level political meetings between White House officials and senior agency officials across the Federal Government, including the VA, and at one of those hearings, the Administrator of GSA asked how she could "help our candidates." Those meetings raised a lot of serious concerns about possible violations of Hatch Act, which prohibit the use, as you know, of Federal funds for partisan political purposes, and they call into question the possibility of undue political influence at the VA, as well. Have you, Dr. Kussman, or anyone you know at the VA ever received a briefing or briefings from the White House that were political in nature?

Dr. KUSSMAN. No, ma'am.

Senator MURRAY. None?

Dr. KUSSMAN. Not—I haven't, or I don't know of anybody who has.

Senator MURRAY. And never heard of them, never been in a meeting—

Dr. KUSSMAN. I am not aware of that happening.

Senator MURRAY. All right. As you heard me talk about in my opening statement, we are all pretty cautious about information we receive from the VA and I am really looking to find somebody in this position that we can trust, that will bring about a culture of change, that won't just paint the happy-dappy picture but will actually tell us the reality, because we have a responsibility to make sure that those men and women who serve us have what they need. And if we are not getting accurate information, if we are being told a happy picture and not getting the reality, then we are not doing our jobs accurately, either, and it reflects on the performance of every one of us. How can you assure us that your going into this position will change that culture and really bring about a better, trustworthy, more honest information to this Committee so we can do the job we need to do?

Dr. KUSSMAN. I am not sure how I can convince you other than to tell you that that is not my character. That is what I do. You and I have talked about this before. I am committed to working with you to correct any deficiencies or inaccuracies that we have. That is what I do. That is my passion.

Senator MURRAY. Thank you, Dr. Kussman.

Chairman AKAKA. Senator Burr?

STATEMENT OF HON. RICHARD BURR,
U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Mr. Chairman. I am at a distinct disadvantage because I don't read newspapers as widely as others. My fear is that if I read the articles about myself, it would probably lead me into the bathroom to slit my wrist if I believed everything that is in it.

Mr. Chairman, I want to thank the Administration because they have, in my estimation, sent us a man that is incredibly qualified, unbelievably experienced, to take on, I think, one of the most difficult tasks that we could ask a nominee to do, not only to go into an agency that has a challenged background and shown tremendous progress, but one that is getting ready to go through a decade of significant challenges that I think most of us can predict exactly what those challenges will be like.

I want to thank you, Dr. Kussman, for your willingness to do this. I want to thank the groups who were willing to publicly come in and support this nomination.

Mr. Chairman, Dr. Kussman have had an opportunity to sit down and we have talked about every issue that I thought was relevant to hear from a nominee. We have explored the outpatient challenges of antiquated facilities with the full understanding that I have and that he has is that we can't go out and build new hospitals everywhere we have got veterans. If we could do that, the delivery of care would be seamless. We wouldn't have the physical challenges of somebody having to go from an outpatient entry point to a third-floor back room where we are now doing endoscopies because that is the only spot we have got. The reality is that we consistently make changes based upon the available funds. I want to thank you for working with the limitations, but also for giving me

hope that we have got a vision of where we need to get from a standpoint of our VA facility.

I have talked to him about the challenges of PTSD and polytrauma and how that is the makeup of the service personnel that we are going to see. It is significantly different from what we have seen.

Mr. Chairman, I believe every nominee deserves to have a champion on the Hill. Maybe by default, I will be Dr. Kussman's, and I want to explain to you why. It is because after I got through meeting with him, I left the room believing he gets it. He understands what this job is all about. For a Member that is involved about 60 percent of my time in health care on the private sector side, and just because of the nature of this Committee pulled into it from a committee jurisdiction, there are a lot of people in health care today that don't get it.

And not only does he get the health care piece, he gets the veterans' piece. He gets the fact that these, in some cases kids, in some cases parents, in some cases friends, made a hell of a commitment for us and that we have an obligation to provide the best level and delivery of care that we can possibly do and that we can't be shaded by the challenges that it presents to us, we can't complain that every one of them is different. We have got to learn how to deal with it and to do it successfully.

So I look at some of the issues that have been raised about this nomination. They have expressed that the VA is a bad system. Well, you know, we have beat that horse, and it is not perfect, but you know, when *Business Week* magazine did an article last summer on it, they said, you know, this is the best performing hospital system in the country. It far exceeds the two that I have got in Winston-Salem or the multiple systems that I have got in North Carolina, and most believe that our State has one of the best delivery systems in the country.

The second belief was that Dr. Kussman's service as co-chair of the DOD Seamless Transition Task Force, that in those focus groups, maybe somehow you should have known that Walter Reed had problems, since they were held at Walter Reed. As a matter of fact, the article was done by *salon.com*. Now, I am not—I don't read *salon.com*, but I don't necessary look to them for the cutting-edge news that happens day to day. And I am sure that it sells magazines to come to conclusions that people want to find something that is in the realm of "gotcha" because this is a town of "gotcha," but the reality is that if you should have known because you did it, Congress should have known.

So if we are blaming you, we should be blaming ourselves and we probably should have blamed ourselves before we blamed anybody else, even the folks that were in charge of Walter Reed because this type of thing shouldn't happen, and ultimately, when we are involved with sign-offs of our leadership, we put a tremendous amount of responsibility on them, but that also requires us to do a degree of oversight. I want you to know, we are going to do our oversight. I think you expect us to do our oversight and we are going to continue to do that.

We discussed the seamless transition from DOD to the veterans. I think that what is important with Dr. Kussman is he has, one, acknowledged the problem. Two, he has a desire to change. Three, he has a plan to transition.

Now, DOD has to play a very, very important role in this and a commitment to technology and a commitment to the sharing of records. I can only speak from my conversation with Dr. Kussman, Mr. Chairman. He is more than willing to pick up the VA's side of that transition. Unfortunately, we don't have the jurisdiction over DOD about their willingness, but I am personally going to stay on the appropriate Committee Members to make sure that DOD, in fact, is a willing partner, but a willing partner at the level of commitment that I think Dr. Kussman and the VA is.

Lastly, I want to end where I started. Dr. Kussman gets it. His focus is on veterans. It is on our children, our parents, our friends, and making sure that the commitment that we all made as a country to our veterans is to provide them with the best possible delivery of care for the rest of their lives. I, for one, believe that this is the man for whatever number of years he might be there can do an exemplary job at representing our best choice as the Medical Director at the VA.

So I have no questions, Mr. Chairman, but I look forward to a speedy conclusion to his nomination. I thank the Chair.

Chairman AKAKA. Thank you very much, Senator Burr, and I thank you so much for your comments about our nominee and look forward with you in trying to move it as quickly as we can.

Dr. Kussman, if you are confirmed, the mental health needs of the returning servicemembers will rightly dominate so much of your agenda. Dr. Frese previously testified that the outside advisory body on mental health, which has been so vibrant, now seems dormant. As we know, the demand for care for invisible wounds continues to grow, and you have mentioned that. I note that if the supplemental is enacted, funding should not be a problem. What do you plan to do to improve mental health care?

Dr. KUSSMAN. Mr. Chairman, if it is dormant, it won't be dormant for long, so we will certainly go back and look at the comments that were made.

Mental health—we are the largest provider of mental health service in the country. As I mentioned, we spend close to $3 billion a year and we will spend more now with your help. That does not include the Vet Centers, the readjustment counseling. That is a separate funding line. We are increasing that. That is critically important to us, led by Al Batres, who is one of my heroes. And we are increasing now—by next year, we will have 232 Vet Centers around the country. We are putting PTSD treatment teams in all our facilities and other groups of people even out into the CBOCs to be sure that mental health is available.

What we need to do is looking—and I will extrapolate a little bit with my comments—besides PTSD is the issue of suicide and other things that are relevant to this age group. We have educated all our people about suicide. We have put suicide counselors in every facility. We are putting together a 24-hour suicide hotline. And working together, we want people who have a mental health issue to be seen right away, not have to wait any period of time, and the

goal is that we will try to get people in within 24 hours to be assessed if they come for a mental health issue.

We have some challenges of getting the resources where they need to be, but those are challenges that actually exist in the civilian community, as well, because there aren't any resources out there. But I am committed to providing the world-class mental health care, PTSD and otherwise, for all our veterans. We will either do it inside or we will buy it.

Chairman AKAKA. Well, I have also heard, Dr. Kussman, concerns but have seen nothing official about changes to the readjustment counseling service. Are there plans to merge readjustment counseling service with VA health care?

Dr. KUSSMAN. No.

Chairman AKAKA. The law is that if a Vet Center is to be moved, the Veterans' Affairs Committees must receive official notification of that fact, and I mention this because I understand that a Vet Center in Chicago may be moved. Please make sure that we have the appropriate notice.

Dr. Kussman, in your response to my pre-hearing questions, you expressed your view that the VA health care system has become too decentralized as a result of its division into regional networks. You also indicated that this decentralization is a detriment to ensuring appropriate consistency and standardization. Will you please explain what your plans are for improving standardization of care through increased centralization?

Dr. KUSSMAN. I believe any organization, particularly one that went through the tectonic shifts of the mid-1990s when we developed the VISN structure, has to continue to assess itself. Just parenthetically, we recently had a summit meeting last month to look at the 10–year evolvement of the VA from the mid-1996 and the millennium changes that took place and one of the things that we were talking about is as the pendulum shifts, there has always been in health care delivery or other agencies this constant balancing of centralization and peripheralization, establishing policies, procedures, and standards and then allowing people to implement those policies and standards. Health care is local.

So I believe that—my personal opinion is that potentially the pendulum has swung a little too far. It needs to be looked at and brought back toward the center, and I think that will help standardization and consistency. That is part of my second issue of leadership, that we need consistence and standard. A veteran should have the same care and the same advantages whether they are in Maine or Manila and that at times, when you go around the system, sometimes you don't find that. So that is one of the things that is a very important issue for me.

Chairman AKAKA. VA TBI care, mental health care, and prosthetics have each been criticized in recent months for not being the best. My goal is to ensure that VA care of all kinds, especially care for war traumas, should be the best. How do you answer those who wish to contract out most VA care?

Dr. KUSSMAN. First of all, Mr. Chairman, let me say that I have the same passion you do. It has got to be the best. Shame on us if we don't do that. I believe that with our TBI care, it is the best. Sometimes it may not appear that way to some patients. What I have initiated is a process where anybody who is unhappy or is concerned about the quality of care, we automatically get a second opinion from a reputable civilian agency to come in and look at it.

I want that done for two reasons. One is if, God forbid, we are not doing the right thing, then we need to know about it and fix it. If we are doing the right thing, at least we owe it to the veteran and their families to tell them. But if they still want to go someplace else because they think that the care would be better, there are options to do that.

I think in mental health, we are doing the same thing, and as I mentioned earlier, our outreach and money put against mental health. I will be the first one to acknowledge, when you mentioned prosthetics, early on in the war, we had some challenges. We do a lot of prosthetic work, as you know, and we probably do more amputations than any other health care system in the country. It is over 5,000 a year. But they tend to be more vascular and geriatrics, not anywhere near what this new generation of veterans needs. They want to go rock climbing and kayaking and play hockey and things. Being asked whether you can get off the floor is seen as an insult. There were instances like that early on.

We have changed. We have sent our prosthetists and our people to Walter Reed and Bethesda and Brooke to train them and get them up to the same level. So we will buy anything for anybody for whatever they need. One of the issues is that sometimes there is experimental stuff with prosthetics going on at Walter Reed and that is the only place you can get it. We would obviously encourage people to go back there.

But as far as outsourcing the care in the generality of things, I would be concerned. I think that we need to partner with the civilian community to get care as appropriate and we are looking at that. But one of the strengths that we have by keeping people in our system is to assure the quality, the integration, and the continuity of care with our electronic health record and things. So I think that we do need to partner with the civilian community, but to make it a common practice that would be of concern to me.

Chairman AKAKA. Well, we also hear that the Brooke Army Medical Center is a premier rehabilitation facility for war injuries, and I am so glad you did mention about prosthetics and how far we have advanced on that and continue to do that. I look forward to see what you can do in keeping this operating.

I really appreciate your responses, Dr. Kussman, and also your patience and your family's, as well, and all those who are here.

So in closing, I again thank all of our witnesses for being here today. We could not have had a truly informed hearing without your insight and your perspectives. I also want to again thank Dr. Kussman's family for their presence here today.

As you all know, every organization needs an unquestioned leader. It is not optimal for the Veterans Health Administration to have an acting leader for an indefinite period of time. With this in mind, I will work, I want to tell you, I will work to move Dr.

Kussman's nomination prior to our adjournment for Memorial Day recess, but we will see.

I want to again say mahalo, thank you, and aloha to all of you. This hearing is adjourned.

Dr. KUSSMAN. Mahalo, Mr. Chairman. Thank you.

[Whereupon, at 12:38 p.m., the Committee was adjourned.]

A P P E N D I X

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

Thank you Mr. Chairman and thank you for holding this important hearing. I want to welcome Dr. Kussman and his family as well as the other witnesses we have with us today. Thank you for being here to share your views.

Mr. Chairman, I don't have to tell you that today's VA faces enormous challenges. We have a backlog of over 400,000 claims waiting to be processed.

We have the VA reportedly paying $3.8 million in bonuses to its employees while veterans are on waiting lists all across this country and Category 8 veterans are not allowed in at all. Some of those receiving bonuses are the very same people that were responsible for the over $3 billion VA budget short fall in 2005 as well as gaming the VA claims system so that it looked like claims were being processed faster than they were.

We have the Institute of Medicine and National Research Council reporting on May 8th of this year that "[a] surge in the number of disability claims for PTSD has revealed inconsistencies in compensation levels awarded across the country, raising questions about the effectiveness of the VA's current ways of assessing and rating this condition, and whether some veterans are getting payments that are too low, too high, or unmerited . . . It urged the VA to base compensation decisions on how greatly PTSD affects all aspects of a veteran's daily life, not just his or her ability to be gainfully employed."

Reuters reports that "the Department of Veterans Affairs estimates 12 percent to 20 percent of those who served in Iraq suffer from PTSD. A 2004 Army study found 16.6 percent of those returning from combat tested positive for the disorder."

We have *USA Today* reporting on May 3 that "from 125,000 to 150,000 U.S. troops may have suffered mild, moderate or severe brain injuries in Iraq and Afghanistan." As many note, that is a number far higher than what the official casualty figures of 26,000 tell us.

The Associated Press reports that the Defense Department's Task Force on Mental Health tells us in its study that it "found 38 percent of Soldiers and 31 percent of Marines report psychological concerns such as traumatic brain injury and posttraumatic stress disorder after returning from deployment . . . Among members of the National Guard, the figure is much higher—49 percent—with numbers expected to grow because of repeated deployments."

Army Times tells us "Suicides are up among combat vets, mental health issues are worse among those who deploy often and for longer periods, . . . "

For example the *Army Times* explained that Marine Commandant General James Conway of the military's Mental Health Advisory Team recently reported:

"Soldiers and Marines who have faced the most combat situations, deployed for longer periods of time, and deployed more than once face more mental health issues, according to a survey of 1,320 soldiers and 447 Marines. Of those on a second, third or fourth deployment, 27 percent screened positive for mental health issues, compared to 17 percent of first-time deployers. And 22 percent of those in-theater for 6 months or more screened positive for mental health issues, compared to 15 percent of those who had been there fewer than 6 months."

The list goes on and on, Mr. Chairman.

My question today is does the VA, does Dr. Kussman recognize the challenges that the VA is up against? Will they stop all the stonewalling and the games with requesting low amounts of funding for the VA and work with the Congress to provide the services and benefits that our veterans need in a timely manner? We need a partner that will work us, not tell us that "we have it all taken care of."

The VA is filled with wonderful and dedicated employees, there is no doubt about that and they give great care to many veterans once they get into the system.

But for too many the VA is a bureaucratic organization where red tape is the norm. As many have said, the VA needs to be an advocate for the veteran not an adversary.

We have a lot of work to do, Mr. Chairman, and I look forward to hearing from our witnesses today about Dr. Kussman's ability to meet these challenges.

Thank you, Mr. Chairman.

U.S. SENATE,
Washington, DC, May 14, 2007.

Hon. Daniel K. Akaka,
Chairman, Committee on Veterans' Affairs,
U.S. Senate Washington, DC.

DEAR MR. CHAIRMAN: It is my understanding the nomination of Dr. Michael Kussman to become the Under Secretary for Health in Department of Veterans Affairs is scheduled for May 16, 2007. Dr. Kussman is also a retired Brigadier General, U.S. Army (Ret.). He has an extremely impressive 10 page Curriculum Vitae which I have attached. In my view, he will make an outstanding Under Secretary for this vital function. I urge your support for his nomination.

Aloha,

DANIEL K. INOUYE,
United States Senator.

○