STATEMENT OF THE HONORABLE GORDON H. MANSFIELD DEPUTY SECRETARY DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF
THE HONORABLE GORDON H. MANSFIELD
DEPUTY SECRETARY
DEPARTMENT OF VETERANS AFFAIRS

before the
SENATE COMMITTEE ON VETERANS' AFFAIRS

VA/DoD COOPERATION and COLLABORATION
JANUARY 23, 2007

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

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

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

VA/DoD Joint Executive Council and Strategic Plan

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

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

The current Plan institutionalizes our collaborative efforts across a diverse range of health care and benefits. These broad-based areas include:
(1) Clinical practice guidelines in managing care for overweight and obese patients;
(2) Mental health;
(3) Patient safety practices;
(4) Deployment health and research, to include surveillance and planning activities related to depleted uranium exposure and pandemic flu;
(5) Contingency planning, as outlined in a VA-DoD Memorandum of Understanding for health care delivery during war or national emergency;
(6) Financial management that addresses VA-DoD billing and reimbursement issues;
(7) Joint facility utilization;
(8) Information management and information technology;
(9) Pharmacy;
(10) Medical materiel acquisition and procurement in new VA-DoD shared high-technology medical contracts;
(11) Shared continuing education and training opportunities;
(12) Benefits delivery.

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

Seamless Transition of Care and Benefits

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

The staff of the Veterans Health Administration (VHA) has coordinated the transfer of over 6,700 injured or ill active duty service members and veterans from DoD to VA. We hold as our highest priority those returning from the Global War on Terror and transitioning directly from DoD Military Treatment Facilities (MTFs) to VA Medical Centers (VAMCs).

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

VA social workers, benefits counselors, and outreach coordinators advise and explain the full array of VA services and benefits. These employees assist active duty service members as they transfer to VA medical facilities from MTFs. In addition, our social workers help newly

wounded soldiers, sailors, airmen and Marines and their families plan a future course of treatment for their injuries after they return home. Currently, VA Social Work and Benefit liaisons are located at 10 MTFs, including Walter Reed Army Medical Center (WRAMC), the National Naval Medical Center Bethesda (NNMC), the Naval Medical Center San Diego, and Womack Army Medical Center at Ft. Bragg.
A VA Certified Rehabilitation Registered Nurse (CCRN) is now assigned to WRAMC to assess and provide regular updates to our Polytrauma Rehabilitation Centers (PRC) regarding the medical condition of incoming patients. The CCRN advises and assists families and prepares active duty service members for transition to VA and the rehabilitation phase of their recovery.

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

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

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

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

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

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

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

For a period of two years following separation from active duty, all veterans who served in combat locations are eligible for free health care services for conditions potentially related to combat service. These veterans can access VA health care, even those who have no service-connected disability. Veterans who enroll continue to be eligible for medical care after this two year window. This enrollment ?window? applies to regular active-duty personnel who served in Iraq or Afghanistan, as well as Reserve or National Guard members who served in combat theaters.
Each VAMC and VARO has a designated point of contact (POC) to coordinate activities locally and to ensure the health care and benefits needs of returning service members and veterans are fully met. VA has distributed specific guidance to field staff to ensure that the roles and functions of the POCs and case managers are fully understood, and that proper coordination of benefits and services occurs at the local level.
In March 2005, the Army assigned full time active duty liaison officers to VA's four Polytrauma Rehabilitation Centers, located at Tampa, FL; Richmond, VA; Minneapolis, MN; and Palo Alto, CA. The Army Liaison Officers support military personnel and their families from all Service branches by addressing a broad array of issues, such as travel, housing, military pay, and movement of household goods.

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

VA understands the critical importance of supporting families during the tumultuous time of transition. We established a Polytrauma Call Center to assist the families of our most seriously injured combat veterans and service members. Initiated in February 2006, the Call Center operates 24 hours-a-day, 7 days-a-week to answer clinical, administrative, and benefit inquiries from polytrauma patients and family members. The Center's value is threefold. It furnishes patients and their families with a one-stop source of information; it enhances overall coordination of care; and, very importantly, it immediately elevates any system problems to VA for resolution.
VA's mission is to deliver 21st century care to 21st century combat veterans. We are meeting our mandate through the life-saving and life-shaping medicine in our health care arsenal.

VA Outreach
Office of Seamless Transition
The Office of Seamless Transition is the lynchpin in VA's outreach efforts. Two Outreach Coordinators?one a peer-support volunteer and veteran of the Vietnam War?regularly visit

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

The National Guard and Reserve

VA has developed a vigorous outreach, education, and awareness program for the National Guard and Reserve. To ensure coordinated transition services and benefits, a Memorandum of Agreement (MOA) was signed with the National Guard in May 2005. Combined with VA/ National Guard State Coalitions in 54 states and territories, VA has significantly improved its opportunities to access returning troops and their families. We are continuing to partner with community organizations and other local resources to enhance the delivery of VA services. At the national level, MOAs are under development with both the United States Army Reserve and the United States Marine Corps. These new partnerships will increase awareness of, and access to, VA services and benefits during the de-mobilization process and as service personnel return to their local communities.

Post Deployment Health Reassessment

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

VA actively participates in the administration of PDHRA at Reserve and Guard locations in a number of ways. We provide information about VA care and benefits; enroll interested Reservists and Guardsmen in the VA health care system; and arrange appointments for referred service members. As of December 2006, an estimated 52,000 service members were screened, resulting in over 13,900 referrals to VA. Of those referrals, 32.5% were for mental health and readjustment issues; the remaining 67.5% for physical health issues.

Outreach Readjustment Counseling

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

The program helped form the basis for the President's New Freedom Commission on Mental Health. It is recognized as a National model for outreach and readjustment services, and

emulated by other countries in their efforts to ease the readjustment of combat veterans to civilian life.

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

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

Polytrauma/Traumatic Brain Injury
VA Clinical Reminders for Mild Traumatic Brain Injury (TBI)

Veterans and active duty service members with TBI recognized at the time of injury receive state-of-the-art, highly specialized care at both DoD and VA TBI Centers. However, less severe injuries may not become evident until military personnel return home to the care of their community physicians, DoD, or VA medical centers. Prompt diagnosis is often complicated by the fact that many who sustain mild brain injury do not recall the trauma that caused it. As a result, some patients with symptoms seemingly unrelated to mild TBI, such as headaches, sleep disturbances and depression, may go undiagnosed.
To assist clinicians in the diagnosis of mild TBI, the VA Chief of Patient Care Services stood up the Traumatic Brain Injury Clinical Reminder Work Group to develop clinical reminders to identify possible TBI in OEF/OIF veterans.

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

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

VA/DOD Memorandum of Agreement
VA and DoD have in operation a longstanding MOA regarding referral of active duty military personnel who sustain spinal cord injury, TBI, or blindness to VA medical facilities for health care and rehabilitation. The MOA facilitates transfer of personnel to VA facilities that specialize in care and rehabilitation of these conditions. Effective January 1, 2007 the Assistant Secretary

for Health Affairs, Department of Defense and the Acting Under Secretary for Health, Department of Veterans Affairs, renewed this MOA in support of VA/DOD resource sharing.

Mental Health Issues

In Fiscal Years (FY) 05 and 06, VA increased funding of new and enhanced mental health programs for OEF/OIF veterans and others with Post Traumatic Stress Disorder (PTSD). VA will do so again in FY 2007 to better meet the clinical needs of all veterans.

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

In FY 07, VA will fund enhanced integration of Mental Health and Primary Care services to increase our ability to provide veterans with comprehensive health care. Given the possible reluctance of some veterans to disclose emotional problems, increased mental health capacity in primary care will allow veterans to receive mental health services without actually going to an identified mental health clinic.

In FY 2006, under the auspices of specialized and general mental health programs, VA treated 345,713 veterans with a clinical diagnosis of PTSD. This represents an increase of 27,099 individuals over FY 2005. Of those treated in FY 06, 241,884 (70%) had a primary diagnosis of PTSD.

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

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

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

VA/DoD Information Sharing

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

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

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

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

FHIE also supports the one-way transmission of pre- and post-deployment health assessment data from DoD to VA. The Departments have recently begun the transmission and viewing of post-deployment health reassessments (PDHRA) to (1) monitor the overall health condition of troops; (2) inform them of potential health risks; and (3) work to benefit the overall health of service members and veterans.
In 2004, VA and DoD leveraged FHIE technologies to develop the capability to support the real-time bidirectional exchange of electronic medical records. By using the Bidirectional Health Information Exchange, VA and DoD clinicians share text-based clinical data between medical facilities where patients (who receive care from both systems) are seen. BHIE also supports the real-time bidirectional exchange of outpatient pharmacy data, anatomic pathology/surgical reports, cytology results, microbiology results, chemistry and hematology laboratory results, laboratory order information, radiology text reports, and food and drug allergy information.

BHIE data from every VA site are available at select DoD sites where BHIE is installed. DoD is continuing to install BHIE, and system implementation has been completed at 21 major sites. These include facilities where large numbers of OEF/OIF service members are seen, such as Walter Reed Army Medical Center and the National Naval Medical Center Bethesda, the Landstuhl Regional Medical Center in Germany, and the Naval Medical Center San Diego.

As mentioned, JEHRI is a comprehensive strategy for sharing data. Where BHIE supports the bidirectional sharing of health data between legacy systems, JEHRI takes into account that both DoD and VA are modernizing their health information systems. The next phase of JEHRI, the Clinical Health Data Repository (CHDR), provides a means for VA and DoD to develop an interface between the DoD Clinical Data Repository (CDR) of DoD's AHLTA system and the VA Health Data Repository (HDR) of the next-generation VistA system, known as HealtheVet. Through CHDR, DoD and VA have the groundbreaking ability to share computable data between next-generation systems featuring automatic decision support for clinicians, e.g., drug-drug and drug-allergy interaction checks. DoD and VA currently use this interface between the William Beaumont Army Medical Center and the El Paso VA Healthcare System to support care of shared patients as well as at Augusta, Georgia, and Pensacola, Florida locations. VA and DoD are working to expand the types of clinical data available through CHDR, specifically laboratory data.

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

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

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

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

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

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

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

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

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

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

When the Center is dedicated on January 29, 2007, seven VHA and two VBA staff members will be working side-by-side with Army colleagues to provide the best possible rehabilitative services to severely injured service members and veterans. VHA will provide physical therapy, occupational therapy, prosthetics services, social work case management, and seamless transition liaison services. VBA will offer information and education about benefits and vocational rehabilitation services, and provide assistance with benefits claims.

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

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

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

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

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

Closing

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

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

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

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

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

Mr. Chairman, this concludes my statement. I thank you and members of this committee for your outstanding and continued support of our service members, veterans, and their families.