

**SEAMLESS TRANSITION: MEETING THE NEEDS OF
SERVICEMEMBERS AND VETERANS**

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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MAY 25, 2011
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SEAMLESS TRANSITION: MEETING THE NEEDS OF SERVICEMEMBERS AND VETERANS

WEDNESDAY, MAY 25, 2011

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

The Committee met, pursuant to notice, at 10:02 a.m., in room 418, Russell Senate Office Building, Hon. Patty Murray, Chairman of the Committee, presiding.

Present: Senators Murray, Begich, Sanders, Burr, Isakson, Wicker, Brown of Massachusetts, and Boozman.

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

Chairman MURRAY. Good morning and welcome to today's hearing. We are going to be examining the ongoing efforts of the Department of Defense and the Department of Veterans Affairs to provide a truly seamless transition for our servicemembers and veterans. Last week Deputy Secretary Lynn and Deputy Secretary Gould highlighted the challenges and successes DOD and VA have encountered on the path toward a truly seamless transition.

Today we are going to be hearing directly from some of our Nation's wounded warriors, who will share their views and firsthand experiences on how DOD and VA can further improve the transition for servicemembers and veterans. Thank you all for being here today. I look forward to hearing from you about what went well, but also about how you may have been negatively impacted by the lack of collaboration between DOD and VA, and what you believe can be done to improve the transition for the thousands upon thousands of servicemembers still to come home.

I also look forward to talking with our departments' witnesses who are working to improve this critical transition period to ensure veterans are not falling through the cracks. I know that VA and DOD have big challenges facing them. Servicemembers and veterans continue to take their own lives at an alarming rate. Wait times for benefits continue to drag on for an average of a year or far more, and the quality of prosthetic care continues to be inconsistent between the departments.

Now, in some instances, DOD and VA have come to the table to make headway on these issues, and they should be commended for that. But we still have work to do. In fact, sometimes it is the simplest fixes that for some reason the two departments cannot come together on.

A good example of this is the Traumatic Extremity Injuries and Amputation Center of Excellence that was mandated to move forward on October 14, 2008. This new center was supposed to be a place where best practices could be shared and a registry of these injuries could begin. But here we are, 2½ years later, and we have not seen any substantial movements toward the creation of this center. When I asked Secretary Lynn last week what progress had been made, he could not provide an answer. That is unacceptable.

But as our witnesses' testimony today will show, this is, unfortunately, not the only area where we need better medical collaboration. We have a lot of work to do to make sure that each department knows what the other is doing to provide our servicemembers and veterans.

It was evident from last week's hearing that the sheer number of programs that are in place have resulted in several parallel but not collaborative processes. Last week we also discussed the need for the best amputee care that can be provided, as well as the divide between the level of technology at the DOD and the VA.

Beyond the Center of Excellence that I mentioned earlier, I look forward to hearing about the improvements that are being made in this area. Veterans cannot come home to VA facilities that cannot care for the devices that our servicemembers are getting at cutting-edge DOD prosthetic facilities. We need to do everything we can to bring all services up to the standard our seriously injured veterans deserve.

I am optimistic that we can do this because I know there are facilities like the new Polytrauma and Amputee Care Transition units that are being piloted at the VA medical center in Richmond, Virginia. Not only is this an innovative and critical component of care, but it is also an example of where DOD and VA came together, jointly assessed the problems in the system of care, and responded appropriately. I would like to see this approach brought to bear on all aspects of transition.

Today we will also further discuss the efforts to expand and improve mental health care. We do not need the courts to tell us that much more can and should be done to relieve the invisible wounds of war. Although some steps have been taken, the stigma against mental health issues continue within the military, and VA care is still often too difficult to access.

This has had a tragic impact. Last month, VA's suicide hotline had the most calls ever recorded in a single month, more than 14,000. That means that every day last month, more than 400 calls were received.

While it is heartening to know that these calls for help are now being answered, it is a sad sign of the desperation and difficulties that our veterans face, that there are so many in need of that lifeline. I look forward to speaking with all of our witnesses about this most pressing issue.

But health care is not the only area that needs better collaboration. Last week we discussed the delays and dissatisfaction that characterized the Joint Disability Process, the program that was supposed to streamline the way our veterans get their benefits.

Instead, however, what we learned is that veterans are still waiting for up to 400 days for word on their benefits, and that all too

often, veterans are committing suicide or turning to drugs and alcohol in that time in their lives that they are put on hold during this process. Today I want to hear how we are going to do much better.

We must not forget that the commitment we make to our service-members and to their families when they join the military does not end when they return home. Whatever condition they arrive in, this Nation will provide them with the care and services they need and deserve.

Just a couple days ago, a Marine whose home base is here in the Nation's capital and with whom a member of my staff served, was wounded by an IED in southern Afghanistan. He has lost much of his leg and doctors are struggling to save one of his arms. During one surgery, one of his lungs collapsed. This is in addition to serious shrapnel wounds that he received.

I want that Marine and all Marines, soldiers, sailors, airmen, and Coast Guardsmen to have every benefit and every service we have available. I want him to receive care that is not just excellent, but truly the best in the world. I do not want him, or any service-member or veteran who has sustained such injuries, to have to wait months or even years to have a claim adjudicated because we cannot make the bureaucracy efficient.

I do not want him to receive anything less than the best prosthetic limb we can design and ensure that it has been perfectly adapted to him. I want him to receive treatment and support as he copes with this new reality. Just as important, I want his loved ones to get the support they need, because if we cannot be there for them, they will not be able to be there for him.

I know all of us here share those desires and the dedication to achieving those goals. We are almost 10 years into these conflicts. It is past time to get it right. The system is doing many things well, but there is always more than can be done, and I believe that all the Members here, and all of our VA and DOD employees, share the commitment to excellence our veterans deserve.

So again, I want to thank all of our panelists who are here today. I particularly appreciate your sharing with us your experiences and look forward to hearing from all of you. With that, I will turn it over to the Ranking Member, Senator Burr, for his opening statement.

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

Senator BURR. Thank you, Madam Chairman, and I welcome all of our witnesses today. And, Madam Chairman, as I got the notice on this hearing, I had to chuckle when I read seamless transition after the last hearing that we got through. It is a great goal, and I think we both agree we are a long way from it.

Before I continue, I would sort of like to raise for the Committee's thoughts, how much is enough time to prepare testimony before this Committee. I asked DOD how much time they need to be able to submit testimony. The Committee sent an invitation to testify on May 11. With less than 24 hours notice before this hearing, we had still not received their testimony.

Madam Chairman, I do not know where the hangup is. If I am on ground that I should not be, I apologize to you. But I think we

have to publicly hold responsible, especially the Federal agencies that we invite to testify, to the rules of the Committee, and that is that testimony has to be timely. If they cannot do that on time, then I have little faith that we can ever achieve a seamless transition for some very, very tough issues that we have got before us.

Chairman MURRAY. Senator Burr, if I can just comment? I was as disappointed as you that the Department of Defense was extremely late in getting their testimony to us and appreciate your comments and want to work with you on what we can do about that. But I am going to allow it for today, for the DOD's testimony to be read because I think this hearing is very important, and I think we need to move forward. I appreciate your comments.

Senator BURR. Well, I thank the Chair for that and remind all Members that it seems like occasionally people do not believe that it is important in this Committee, and I have seen the Chair before refuse to accept testimony and would encourage the Chair to consider that as appropriate in the future.

I appreciate the opportunity to discuss the collaborative issues with VA and DOD and hear firsthand from veterans about their personal experiences moving from active duty to veteran status. Stories from the field like those we will hear about on our first panel are invaluable in getting a true assessment of what works well and what does not work well.

Each veteran testifying today has had a different experience, and unfortunately, they are all not positive experiences, which echoes concerns brought up in last week's hearing. For instance, we will hear about the bureaucratic hassles, delays, and confusions Specialist Bohn faced after he was severely injured in Afghanistan when a suicide bomber detonated an explosive at the post near the Pakistan border. His story is a real example of the lack of communication between two departments.

We will also hear from Lance Corporal Horton, who suffered from TBI, has nerve damage in his hands, had his left leg partially amputated after his Humvee hit an IED in Iraq. He will share his experiences in obtaining his benefits from the VA.

Another veteran witness, Lieutenant Colonel Lorraine, is not only a veteran himself, but a military spouse and the founding Director of Special Operations Command and Care Coalition. So his personal experience touches the issues of collaboration between VA and DOD from all sides. A veteran transitioning to VA, a military spouse helping his wife transition, and the director of a DOD wounded warrior program.

While it is critical to hear these personal stories from our Nation's veterans, it is just as important to continue our dialog with the agencies tasked with ensuring a seamless transition for servicemembers from active duty to veteran status.

One area that VA and DOD have worked on together is improving the mental health care for servicemembers, veterans, and their families. In October 2010, recognizing that two agencies serve the same individuals at different stages of their lives, VA and DOD adopted a cohesive mental health plan. Although it is hard to say after only 7 months whether this will improve services, I look forward to hearing about how this coordinated effort to improve qual-

ity, access, and effectiveness helps improve the lives of our Nation's warriors and their families.

Another area that I noted in my opening statement last week that needs attention is the Federal Recovery Coordination Program. This program was envisioned to help veterans and their families access all Federal benefits available to them, not simply those benefits available through the VA. I still believe this is an example of an idea that looks great on paper, but has to live up to its potential, and I look forward to exploring ideas to help this program live up to everybody's expectations.

On the benefits side, the worldwide rollout of the Integrated Disability Evaluation System has clearly gotten off to a rocky start. As Deputy Secretary Lynn testified last week, the goal is for veterans to complete the IDES process within 295 days. But nationwide, it is taking over 394 days, and in some cases, such as at Camp Lejeune, much longer than that.

Also, it will take 1 to 2 years before the agencies will actually be able to meet the goal, particularly considering the number of suicides, court martials, and other unfortunate outcomes among IDES participants. We need to take a serious look at what personal toll the delays and uncertainties of the IDES process is taking on our wounded servicemembers.

Madam Chairman, it has been 4 years since the scandal surrounding Walter Reed brought this lack of cooperation to light, and gauging by the stories of our first panel and what was learned in last week's testimony, the bureaucracy we tried to cut through may have become worse.

I look forward to working with you, Madam Chairman, on a truly seamless transition for our Nation's wounded warriors. To our veterans testifying today and to the witnesses from the agency, we are grateful to you not only for your efforts, but for your service. Thank you.

Chairman MURRAY. Thank you very much, Senator Burr.
Senator Isakson.

**STATEMENT OF HON. JOHNNY ISAKSON,
U.S. SENATOR FROM GEORGIA**

Senator ISAKSON. Thank you, Madam Chairman. I want to thank our veterans, Steve Bohn and Tim Horton, for their sacrifice, their service, and their willingness to testify today, and I particularly want to welcome Lieutenant Colonel Jim Lorraine. I think it is very appropriate that the Committee asked Colonel Lorraine to testify today. He is the Executive Director of the Wounded Warrior Project in the Central Savannah River Area of Georgia where Fort Gordon, the Eisenhower Medical Center, and the Charlie Norwood VA are, where General Schoomaker was originally stationed, and where they began the pilot for seamless transition between Eisenhower Medical Center at Fort Gordon and the Augusta—what was then the Uptown Augusta VA.

He had some very great stories to tell about keeping people from falling between the cracks, identifying TBI and PTSD, bringing veterans back. In fact, I love to tell the story about my visit there 3½–4 years ago with Lori Ott.

We were going through the VA Hospital and a staff sergeant, female staff sergeant, turned the corner and the Director at that time stopped her and said, "Please meet Senator Isakson." I shook her hand and I said, "Thank you for your service." She said, "I am going back to Iraq tomorrow." And she had come back, was diagnosed with Traumatic Brain Injury, had been going through a recovery program and a treatment program, and returned to active duty in the military. So that shows you—

Chairman MURRAY. And she was a woman.

Senator ISAKSON. And she was a woman. Well, they are always stronger than the guys anyway. My wife taught me that a long time ago.

But I want to just thank Lieutenant Colonel Lorraine for being here. I think if the Committee will pay close attention to his recommendations on the Federal recovery coordinators. It will make a marvelous difference in that program, and I thank all of you for your service to the country.

Chairman MURRAY. Thank you very much.

With that, I want to turn to our panel this morning, and I really do appreciate both your service and your willingness to testify here today on a very important topic. We are going to begin with Afghanistan veteran, Steve Bohn, who is representing the Wounded Warrior Project; followed by Tim Horton, an Iraq veteran; and our third witness, as you heard, is Jim Lorraine, Executive Director of the Central Savannah River Area Wounded Warrior Care Project.

So, Mr. Bohn, we will begin with you.

STATEMENT OF STEVE BOHN, OEF VETERAN, WOUNDED WARRIOR CARE PROJECT

Mr. BOHN. Good morning. Chairman Murray, Ranking Member, and Members of the Committee, I am honored to testify today and to share my experience as a wounded warrior in transitioning from military service to civilian life. I sincerely hope my experience can help this Committee identify and fix the problems that many others face every day.

A little about myself. I was born and raised in Salem, Massachusetts. I grew up poor and I worked for everything I have. I dropped out of high school with three and a half credits left to graduate so I could get a full-time job and help support my family.

I joined the Army in 2007 after learning that a friend had been killed in Iraq. After infantry training, I was assigned to the 101st Airborne Division, 1/506th Infantry Regiment. I deployed to Afghanistan in March 2008 to a remote base near the Pakistan border. Conditions were pretty primitive. I enjoyed the challenge, but also had to dig deep to deal with losing my best friend as well as our first lieutenant who were killed in August 2008 by an IED.

I was badly injured in November 2008 when a suicide bomber detonated a dump truck packed with 2,000 pounds of explosives next to our outpost. The building I was in collapsed on me, and I suffered severe internal injuries and spinal injuries. I was hospitalized for a total of 6 months and underwent two major surgeries that included resection of the small intestine, bladder reconstructive surgery, and spinal surgery.

I experienced some rough transitions long before my medical retirement. After initial hospitalization at Bagram Air Base, Afghanistan and then to Landstuhl, Germany, I was flown to Fort Campbell, Kentucky, rather than to Walter Reed where I was supposed to be sent for surgery. At Fort Campbell, I was assigned to a WTU. Doctors finally realized the mistake and got me transferred to Walter Reed.

After undergoing spinal surgery there, I was transferred to a spinal cord injury unit at a VA medical facility in Boston, but whatever coordination should have taken place apparently did not because Fort Campbell threatened to put me on AWOL if I did not return. As a result, I was flown back to Fort Campbell. Later, I was returned to Walter Reed to undergo bladder surgery.

After post-surgical convalescence at Walter Reed, I was assigned to a Warrior Transition Unit at Fort Meade, Maryland. That WTU experience involved little more than spending time in the barracks. Thanks to Senator Kerry's intervention, I was transferred to a community-based Warrior Transition Unit at Hanscom Air Force Base in Concord, Massachusetts which enabled me to live at home, work on the base, and finish up my medical care.

Over a 12-month period there, I went through a medical evaluation board which eventually gave me a 40 percent permanent disability rating, 30 percent for my spinal injuries and 10 percent for my neck injuries. That rating does not take account of my internal injuries. I was finally medically retired from the Army on October 27, 2010.

My transition to the VA began with the WTU in Concord, Mass. sending my paperwork to VA 180 days before my estimated separation date so that a claims adjudication could be as timely as possible. VA contacted me soon after leaving the military to schedule compensation and pension examinations, but those examiners were backlogged, and I have had long waits to schedule the many required exams.

I still have a neurosurgery exam, which was delayed to get another MRI. As I understand it, VA cannot adjudicate my case until it has the results of all those exams.

While I could see some evidence of DOD/VA coordination regarding the compensation process, something fell through the cracks in terms of getting VA medical care. It was not until early this month, more than 6 months after I became a veteran, that anyone at VA approached me to discuss my treatment. At that time, I was contacted by a social worker who arranged for me to get physical therapy. Unfortunately, no one seemed aware of my spinal cord injuries. Because of those injuries, physical therapy really is not appropriate.

I still have herniated disks, which are pinching nerves in my neck and causing great pain, but I am uncertain what additional treatment might still be possible. At this point, I still have not been assigned a VA primary care doctor. People ask, How are you doing since getting out of the service? I am not a complainer, but I have to say I am struggling.

I still live on my retirement pay of approximately \$699 a month, not even half the pay as an Army specialist. All of it goes to rent for my one-bedroom apartment. I still have other bills, which I can-

not pay. Given the extent of my injuries, I am not physically able to work. My back and neck are in constant pain. I applied for Social Security disability, but was denied.

I expect to get additional compensation from the VA that takes account of all my injuries, but it is difficult to be in this kind of limbo waiting many months for the VA adjudication and to live on so little for so long.

I have always been a hard worker. I am 24 years old. I want to work. I completed my GED degree and have worked as a roofer and a chef, but with my injuries, I cannot go back to either kind of work, and I am not sure what jobs I can do. I did attend a Transitional Assistance Program before leaving the Army, but that did not give the kind of one-on-one help I need and did not really answer my questions about vocational rehabilitation or schooling or prepare me for the rough transition I have faced.

The VA claims adjudication process alone has been complicated, and I have been lucky to have a great advocate from the Wounded Warrior Project to help me with my claim. But I wonder if this process could have gone differently. I know now that with injuries as extensive as mine, VA and DOD policy provides for assigning a senior level nurse and a social worker to help coordinate the complexities involved in the transition process.

No one ever discussed with me or my family the possibility of having a Federal Recovery Coordinator assigned to my case, but I wonder if that kind of help might have made a difference. This has not been an easy journey. I have had a long, difficult recovery. My injuries still cause me a lot of pain, and I will continue to need care and evaluation.

Neurosurgeons warn me that my condition could deteriorate. I can understand and to some extent cope with all that. What is more difficult to understand and causes me concern for other warriors who may get hurt in the days and months ahead is why after so many years, VA and DOD have not solved these transition problems. I hope this hearing will help resolve many of these problems and spare other warriors the difficulty I have encountered.

Thank you for whatever you can do to help future wounded warriors and God bless.

[The prepared statement of Mr. Bohn follows:]

PREPARED STATEMENT OF STEVEN A. BOHN, SPECIALIST 4 (RET.)

Chairman Murray, Ranking Member Burr, Members of the Committee, I am honored to have the opportunity to appear before you today, and as a wounded warrior, to share my experience regarding the transition from military service to civilian life. I believe in my country and I believe in my government. This is why I hope you can help fix the problems that so many of us wounded warriors are dealing with every day after already having gone through so much.

My name is Steven Andrew Bohn. I was born and raised in Salem, Massachusetts. I grew up poor and worked for everything I have. I dropped out of high school with 3½ credits left to graduate, so I could get a full time job and help support my family.

I joined the Army in 2007 after learning that a friend of mine had been killed in Iraq by an IED blast. After infantry training, I was assigned to the historic 101st Airborne Division, 1/506th Infantry Regiment. My unit deployed to Afghanistan in March 2008 to a remote base in Wardak province near the Pakistan border. The base was the size of a soccer field and held 28 of us. Conditions were pretty basic; having no running water, for example, we cleaned ourselves with baby wipes, and got to shower once a month at a forward operating base. I enjoyed the challenge of our rugged conditions. We went on hundreds of missions while holding down our

outpost. But I was devastated when my best friend, Specialist Paul Conlon, from Somerville, MA, and our first lieutenant were killed in August 2008. Still I knew I had to stay strong to survive.

I was badly injured on November 6, 2008, when a suicide bomber driving a dump truck packed with 2000 lbs of explosives drove up to our outpost and detonated it. The building I was in collapsed on me and I suffered severe internal injuries and spinal injuries. I was hospitalized for a total of 6 months, and underwent two major surgeries that included resection of the small intestine, bladder reconstructive surgery and a spinal surgery. I was also diagnosed at Landstuhl, Germany with mild Traumatic Brain Injury.

FROM INJURY TO MEDICAL RETIREMENT

While I know your focus today is on the transition from DOD to VA, I experienced some rough transitions long before my medical retirement from service. After being initially hospitalized at Bagram Air Base in Afghanistan and then at Landstuhl Germany, I was flown to Fort Campbell, KY rather than to Walter Reed where I was supposed to be sent for surgery. At Fort Campbell, I was initially assigned to a Warrior Transition Unit (WTU). When I was finally evaluated there by physicians, they realized the mistake and I was transferred to Walter Reed. After undergoing spinal surgery at Walter Reed, I was transferred to the VA Boston Healthcare System's West Roxbury Campus' spinal cord injury unit so that I could be closer to my family during that convalescence. Whatever coordination should have taken place between Walter Reed, West Roxbury, and the Fort Campbell WTU to which I'd been assigned apparently didn't occur, because Fort Campbell threatened to put me on AWOL if I didn't return. As a result, I was flown back to Fort Campbell. Later I was returned to Walter Reed to undergo bladder surgery.

After post-surgical convalescence at Walter Reed, I was assigned to a Warrior Transition Unit at Fort Meade, Maryland. That WTU experience involved little more than spending time in the barracks. Thanks to Senator Kerry's intervention, I was transferred to a Community Based Warrior Transition Unit (CBTWU) at Hanscom Air Force Base in Concord MA, which enabled me to live at home, work on the base, and finish up my medical care. I was assigned there for a period of 12 months. During that time, I underwent a Medical Evaluation Board which eventually assigned me a 40% permanent disability rating, 30% for my spinal injuries, and 10% for my neck injuries. That rating does not take account of my internal injuries. I was finally medically retired from the Army on October 27, 2010.

TRANSITION FROM MILITARY SERVICE TO VA

Let me try and explain the DOD/VA transition I experienced. Initially, the process seemed to begin well, with the CBTWU sending my paperwork to VA 180 days before my estimated separation date so that the claims-adjudication could be as timely as possible. I was contacted by VA soon after leaving the military to schedule compensation and pension examinations. But those examiners were backlogged, and I've had long waits to schedule the many exams I've had to undergo. I still have to have a neurosurgery exam, which had been delayed because of the apparent need for another MRI. As I understand it, VA cannot adjudicate my case until it has the results of all those exams.

While I could see some evidence of DOD/VA coordination as it related to establishing entitlement to VA compensation, something seemed to have fallen through the cracks in terms of getting VA medical care. While I've had multiple VA compensation examinations, it wasn't until earlier this month that anyone at VA approached me to discuss any treatment. At that time, I was contacted by a social worker, who arranged for me to get physical therapy. Unfortunately no one seemed to have been aware of my spinal cord injuries. Because of those injuries, physical therapy really isn't appropriate. I still have two herniated discs which are pinching nerves in my neck and causing great pain, but I am uncertain what additional treatment might still be possible. At this point, many months after becoming a veteran, I have yet to be assigned a VA primary care doctor.

TODAY AND THE FUTURE

I was asked recently, "How are you doing since getting out of service?" Now nearly seven months later, I would have to say, "I'm struggling." I'm not by nature a complainer. But I'm still living on my retirement pay of approximately \$699/month, not even half the pay I earned as an Army Specialist. All of that money goes to rent for my one bedroom apartment. I still have other bills which I cannot pay. I know I'm not the only soldier going through all of this, and that others must sometime wonder where their next meal will come from. Given the extent of my injuries, I'm

not physically able to work. My back and my neck are in constant pain. I applied for Social Security disability but was denied.

I grew up in Salem, but now live in Peabody just north of Boston, Massachusetts. It's close to home, but it isn't a low cost area. I expect to get additional compensation from the VA that takes into account of all my injuries. But the case still hasn't been finally adjudicated. As you can imagine, it is difficult to be in this kind of limbo, waiting many months for VA to adjudicate my case, and to live on so little for so long after going through so much.

People ask me about the future. I grew up poor and I've always been a hard worker. I'm 24 years old. I want to work! I completed my GED degree, and have worked as a roofer and a chef. But, with my injuries, I can't go back to either kind of work, and am not sure what jobs I can do. I did attend a Transition Assistance Program before leaving the Army. But that kind of program didn't allow for the one-on-one help I need, and didn't really answer my questions about vocational rehabilitation, or schooling, or prepare me for the rough transition I've faced. But I'm determined to persevere.

I was also recently asked, "Knowing everything that's happened to you, would you do it all over again?" My answer now and will always be, "of course." I joined the service after a close friend of mine was killed in Iraq. I understood the risks.

I know this country isn't perfect and I know things take time but I also know that I'm not alone in having to wait so long for all of our well deserved benefits to take effect. I understand it's not unusual for wounded warriors from Massachusetts who have been medically retired to wait 9 to 12 months for the VA to adjudicate their claims. In contrast, I'm told that Rhode Island warriors may get claims adjudicated in about six months.

As far as I know, the DOD's Disability Evaluation System, which aims to work with VA to simplify and streamline disability evaluations, is still not fully employed. Apparently the WTU where I was stationed was a pilot site, but that simply meant that a small percentage of servicemembers were processed through the pilot. Most face the same slow road I'm traveling.

The VA claims adjudication process alone has been complicated and I've been lucky to have a great advocate from Wounded Warrior Project who is now helping me with my claim. But I've wondered if this process could have gone differently. With injuries as extensive as mine, I think it was pretty clear early on that I would not be able to stay in the service. I understand that in those instances, VA/DOD policy calls for assigning a senior-level nurse or social worker to help coordinate all the complexities involved in the transition from military status to community reintegration. No one ever discussed with me or my family the possibility of having a Federal Recovery Coordinator assigned to my case. But I wonder if having had that kind of help might have made a difference.

This hasn't been an easy journey for me. I've had a long, difficult recovery. My spinal injuries still cause me a lot of pain and I will continue to undergo care and evaluation. Neurosurgeons warn me that my condition could deteriorate. I can understand and to some extent cope with all of that. What is more difficult to understand, and that causes me concern for the warriors who may sustain severe injuries in the days and months ahead, is why after so many years VA and DOD haven't solved the kind of transition problems I've experienced.

I hope this hearing will highlight and hopefully help resolve many of these problems, and spare other warriors the mental and financial anguish I've encountered.

Thank you for taking the time to listen to my experience and taking the time to care.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO
STEVEN BOHN, OEF VETERAN, REPRESENTING WOUNDED WARRIOR PROJECT

Mr. Bohn, the Wounded Warrior Project is an outstanding organization that most definitely has the best interest of our Wounded Warriors at heart. Your organization strives to ensure that no Wounded Warrior must overcome challenges and adversity alone.

One aspect of the transition process that I focus heavily on is employment. As you know, the unemployment rate for our returning veterans is completely unacceptable. Your Warriors to Work program, as well as several other programs, assist Wounded Warriors with the transition to civilian employment.

Question 1. In your opinion, what can be done to improve the civilian employability of our Wounded Warriors?

Question 2. Are the current DOD efforts such as TAP effective in your opinion? Why or why not?

Question 3. What is the employment success rate of your programs?

Response. Senator Begich, In my opinion to improve the employ-ability of other Wounded Warriors, would be to have a lot more companies reach out to us. A lot of us are not physically able to work with our injuries. If the government provided us with incentives, it would make it a lot easier for us to know what kind of jobs are out there.

The TAP program can be effective if we were going through it after all of our medical treatment. Like I said before, I don't think it was an appropriate time to go through it while I was still going through all my medical treatment. I was focused solely on how I was going to get better day to day.

I know that the Wounded Warrior Project has a TRACK program, which sends you to FL or TX to live with fellow wounded warriors for a year and go to school together. I have not gone through this program yet, but I hear a lot of good things about it. You would have to ask the Wounded Warrior Project about their success rate.

I thank you Senator for your concern about our futures and whatever you can do to help us. I have a strong passion for helping future soldiers overcome their obstacles because I've already been through all of the red tape. We definitely need more support from our government.

Chairman MURRAY. Thank you very much, Mr. Bohn. Really appreciate you sharing that with us. Mr. Horton.

STATEMENT OF TIM HORTON, OIF VETERAN

Mr. HORTON. Chairman Murray, Ranking Member Burr, Members of the Committee, thank you for the opportunity to be here today to speak about the challenges facing warriors as they transition from the military to the civilian world after experiencing what are often profound and life-changing injuries.

My name is Tim Horton, and I joined the U.S. Marine Corps in 2003. Just over a year after I enlisted, I was deployed to Ramadi, Iraq with the 1st Marine Division Fox 2-5, which at the time was the most decorated battalion in the Marine Corps. February 5th, 2005 marked the day my transition as a wounded warrior began when my Humvee detonated an improvised explosive device while I was on a patrol.

My injuries were severe and extensive. I suffered a Traumatic Brain Injury, left leg below the knee amputation, multiple fractures to my right and left arms, nerve damage to my hands, damage to my eyelid that required several surgeries, and still have shrapnel all over my body as a result of the explosion.

I was medivaced from Iraq to Landstuhl, Germany, and then taken to Bethesda National Naval Hospital where I completed the bulk of my rehabilitation. In June 2006, I was medically retired and returned to the Midwest with my family to begin my life post-injury.

I completed the VA compensation and pension process while I was still at Bethesda and was assigned a rating of 60 percent. While the rating came relatively quickly, it was deeply flawed. Most of my injuries were not evaluated to determine my rating despite being very clearly documented in my medical records. I did not learn until I reviewed my initial rating that the VA had not considered my Traumatic Brain Injury in my evaluation.

I am not sure how this happened as it was well documented in my records that I lost consciousness for a sustained period of time after the blast. Because of issues like this, I have had to reopen my claim more than three times to ensure all my injuries were taken into consideration.

Finally, after 6 years of examinations and providing documentation, the VA has assigned me a rating of 100 percent permanent and total disabled. Were it not for veterans looking out for other veterans, particularly Vietnam veterans I met at the VA medical centers, I would not have known how to advocate for myself and fight through the compensation and pension process. I know too many veterans who have grown tired of fighting the VA to receive just a rating for their severely injured bodies. It should not take three or four times to get this process right.

While my initial rating was deeply flawed, it did allow me to begin utilizing my VR&E benefits shortly after returning home. In August 2006, I enrolled in a four-year degree program at the University of Oklahoma Baptist College. The process up to the college enrollment was relatively smooth. I did not have to fight my counselor to establish an educational or employment goal. Our appointments were often brief and contained no real guidance concerning how to move ahead.

While I did not have to fight for what I wanted, I certainly was not advised of all the benefits that come with utilizing VR&E. Had I known the full extent of the benefits, it is very possible I would have pursued a path that led to a master's or doctorate degree. Today, one more combat veteran has a bachelor's degree. It is in education.

Although my VR&E counselor was very largely receptive to my requests and responsive to my calls, utilizing my benefits at Oklahoma Baptist College proved challenging. During my 4 years at college, I had difficulty getting the VA and the college on the same page regarding tuition payments. Each semester was a struggle, and had it not been for my persistence in ensuring the two institutions worked together, I am not sure I would have successfully stayed enrolled.

I was proud to graduate and receive my Bachelor of Science in May 2010, despite the prediction of a VA employee who I would characterize as less than supportive of my goals. While I was being trained to use a VA-issued Palm Pilot to help me keep my appointments straight and assist me with recording class assignments, a VA employee told me that because I had suffered a Traumatic Brain Injury, I would never be able to graduate college unless I cheated my way through.

Her comment and perceptions of my capabilities and life goals were inappropriate and not reflective of the type of veteran-centered focus the VA promotes in posters inside their buildings. Luckily, I have never been a person to allow other people to tell me what I am capable of, and I turned the anger I felt into drive and motivation to succeed.

But for many of my fellow veterans, that type of attitude and lack of understanding about TBI, one of the signature wounds of this war, is incredibly detrimental. In some, it disengages them from the very system that exists solely to help us fulfill our lives after fighting in war. I have worked hard to ensure my injuries and other people's perceptions of them do not define my way of life or limit what I am able to accomplish.

Receiving timely and quality prosthetic care is instrumental to maintaining my activity level. The quality of care I have received

through the Oklahoma City VA medical center is great. Their contracted prosthetic specialists were familiar with cutting-edge prosthetic technology and able to outfit me with the devices I need to maintain a high level of physical activity.

Most importantly, my prosthetics provider really took out the time to understand who I am as a person, not just as a wounded warrior, and how that shapes my medical needs. So while the quality of my prosthetics is good, the process of going from DOD to the VA to receive it, and my full benefits, takes far too long.

When I need adjustments or replacement equipment, I must schedule an appointment with the medical center to be seen by a member of the prosthetics team who will then write the prescription to my outside prosthetic specialist. Sometimes it can take weeks for the VA to actually send that prescription to the provider, further delaying my ability to get an appointment and ultimately receive the adjustments or equipment I need.

Why is this the case? I know other veterans who live in close proximity to Walter Reed who are able to walk in and out with the services and equipment they need within the same day, all without ever needing to go through their local VA. It would make sense to me if I were able to see my prosthetics specialist first who could then communicate with the VA about what I need and get the authorization, eliminating the wait time for an appointment.

While waiting weeks for an appointment might seem like a minor inconvenience for a warrior like myself, spending weeks without the necessary prosthetics equipment or sometimes even worse, equipment that causes extreme discomfort and other medical issues, can be wholly disruptive to our daily lives. The timeliness and consistency of care should not be a function of where warriors happen to live.

There are so many programs and benefits available to assist us; yet, often we are never informed of these programs, or the information is delivered at a time and place that is not conducive for wounded warriors to absorb it. What I can tell you from my experiences is that warriors need real help in discovering what benefits exist and how to utilize them so they can thrive in their lives post-injury.

Other veterans are out there spreading the word, but no one from the VA is reaching out. That needs to change. My hope is that by coming before you today and telling my issues in navigating through the system, things will continue to improve for the warriors coming behind me. I appreciate your time and efforts on improving the transition for my fellow wounded warriors and look forward to answering any questions you might have. Thank you.

[The prepared statement of Mr. Horton follows:]

PREPARED STATEMENT OF TIM HORTON, LANCE CORPORAL (RET)

Chairman Murray, Ranking Member Burr, Members of the Committee, Thank you for the opportunity to be here today to speak about the challenges facing warriors as they transition from the military to the civilian world after experiencing what are often profound and life changing injuries.

My name is Tim Horton and I joined the United States Marine Corps in 2003. Just over a year after I enlisted I was deployed to Ramadi, Iraq with the 1st Marine Division Fox 2-5, which at the time was the most decorated battalion in the Marine Corps. February 5, 2005 marked the day my transition as a wounded warrior began when my Humvee detonated an improvised explosive device while I was on patrol.

My injuries were severe and extensive. I suffered a Traumatic Brain Injury, left leg below the knee amputation, multiple fractures to my right and left arms, nerve damage to my hands, damage to my eye lid that required reconstructive surgery, and still have shrapnel in my body as a result of the explosion. I was medevaced from Iraq to Landstuhl, Germany and then taken to Bethesda National Navy Medical Center where I completed the bulk of my rehabilitation.

UTILIZING BENEFITS

My time at Bethesda drew to a close in June 2006 when I was medically retired and I returned to the Midwest with my family to begin my life post injury. I completed the VA compensation and pension process while I was still at Bethesda and was assigned a rating of 60%. While the rating came relatively quickly, it was deeply flawed. Many of my injuries were not evaluated to determine my rating, despite being very clearly documented in my medical records. For example, I did not learn until I reviewed my initial rating that the VA had not considered my Traumatic Brain Injury in my evaluation. I am not sure how this happened, as it was clear in my records that I lost consciousness for a sustained period of time after the blast. Because of issues like this, I have had to reopen my claim more than 3 times to ensure all my injuries were taken into consideration. Finally, after 6 years of examinations and providing documentation, the VA has assigned me a rating of 100% permanently and totally disabled. Were it not for the mentorship of other veterans—particularly Vietnam veterans I met at the VA medical centers—I would not have known how to advocate for myself and fight through the compensation and pension process to receive the benefits I have earned. I know other veterans who have grown tired of fighting VA to correctly adjudicate their claims. It should not take 3 or 4 times to get it right.

While my initial rating was deeply flawed, I was fortunate to receive it in a timely enough manner to begin utilizing my VR&E benefits shortly after returning home. In August 2006 I enrolled in a four year degree program at Oklahoma Baptist College. The process up to college enrollment was relatively smooth. I did not have to fight my counselor to establish an educational or employment goal. Our appointments were often brief and contained no real guidance concerning how to move ahead. While I didn't have to fight for what I wanted, I certainly was not advised of all the benefits that come with utilizing VR&E. Had I known the full extent of the benefits, it is very possible I would have pursued a path that led to a masters or doctorate degree in physical therapy. Instead, I pursued a bachelors degree in education. Although my VR&E counselor was largely receptive to my requests and responsive to my calls, utilizing my benefits at Oklahoma Baptist College proved challenging. During my four years at the college I had difficulty getting the VA and the college on the same page regarding tuition payment. Each semester was a struggle, and had it not been for my persistence in ensuring the two institutions worked together, I am not sure I would have successfully stayed enrolled.

I was proud to graduate and receive my Bachelor of Science degree in May 2010, despite the prediction of a VA employee who I would characterize as less than supportive of my goals. While I was being trained to use a VA issued palm pilot to help me keep appointments straight and assist me with recording class assignments, a VA employee told me that because I had suffered a Traumatic Brain Injury I would never be able to graduate college unless I cheated my way through. Her comment and perceptions of my capabilities and life goals were inappropriate and not reflective of the type of veteran centered focus the VA system claims to have. Luckily, I have never been a person to allow other people to tell me what I am capable of, and I turned the anger I felt as a result of those remarks into drive and motivation to succeed. But for many of my fellow veterans, that type of attitude and lack of understanding concerning one of the signature wounds of this war is incredibly detrimental and disengages them from the very system that is supposed to exist to help us thrive.

PROSTHETICS CARE

I have worked hard to ensure my injuries and other people's perceptions of them do not define my way of life or limit what I am able to accomplish. Receiving timely and quality prosthetics care is instrumental to maintaining my activity level. The quality of care I have received through the Oklahoma City VA Medical Center is outstanding. VA contracts with a number of prosthetics specialists who are familiar with cutting edge prosthetic technology and are able to outfit me with the devices I need to maintain a high level of physical activity. Most importantly, my prosthetics provider has really taken the time to understand who I am as a whole person—not just a wounded warrior—and how that shapes my medical needs.

So while the quality of care I am receiving is very good, the process of going through the VA to receive those benefits takes far too long. When I need adjustments or replacement equipment, I must schedule an appointment with the medical center to be seen by a member of their prosthetics team who will then write the prescription to my outside prosthetics specialist. Sometimes it can take weeks for VA to actually send that prescription to the provider, further delaying my ability to get an appointment and ultimately receive the adjustments or equipment I need. Why is this the case? I know other veterans who live in close proximity to Walter Reed who are able to walk in and out with the services and equipment they need within the same day, all without ever needing to go through their local VA. It would make sense to me if I were able to see my prosthetics specialist first, who could then communicate with VA about what I need and get the authorization, eliminating the wait time for an appointment. While waiting weeks for an appointment might seem like a minor inconvenience, for a warrior like myself, spending weeks without the necessary prosthetics equipment, or sometimes even worse equipment that causes extreme discomfort and other medical issues, can be wholly disruptive to our daily lives. The timeliness and consistency of care should not be a function of where warriors happen to live.

ACTING AS MY OWN ADVOCATE

The most important thing I have learned in navigating my own transition and helping my peers through their own journey is that you must act as your own advocate. There are so many programs and benefits available to assist us, yet often we are never informed of these programs or the information is delivered in a time and place that is not conducive for wounded warriors to absorb it. We receive so much information at the time when we are newly injured. When I was brought to Bethesda, I was completely reliant on my mother as my caregiver. It took me two and a half months to regain the ability to feed myself. My sole focus was on my physical recovery. It was impossible for me to take in the vast amount of information coming at me during that time. I understand that since I have been injured the Federal Recovery Coordination Program has been put into place for severely wounded warriors to assist with this challenge. This is not a program I benefited from, nor did I know of its existence before preparing for my testimony here today. What I do know is that warriors need real help in discovering what benefits exist and how to utilize them so that they can thrive in their lives post-injury. Other veterans are out there spreading the word, but no one from VA is reaching out. That needs to change. I have spent the last several years sharing the knowledge I've gained through my own recovery and plan to continue that work as an outreach worker with the Wounded Warrior Project, but there must be a more systematic VA effort.

My hope is that by coming before you today and testifying to some of my issues in navigating through the system, things will continue to improve for the warriors coming behind me. I thank you for taking the time to listen to my story and for your focus on improving the transition for my fellow wounded warriors. I look forward to answering any questions you might have.

Chairman MURRAY. Thank you very much. It is our intent that your words will help others coming behind you, sir. I really appreciate your testimony today.

Mr. Lorraine.

**STATEMENT OF JIM LORRAINE, LT. COL. USAF (RET.),
EXECUTIVE DIRECTOR, WOUNDED WARRIOR CARE PROJECT**

Colonel LORRAINE. Chairman Murray, Ranking Member Burr, Members of the Committee, thank you for inviting me to testify before you today. I request that my written statement be submitted for the record.

There are a lot of pieces to the DOD and VA system. When they work together, it is powerful. When they do not, it can be frustrating to the point of quitting. As Executive Director of the Central Savannah River Area Wounded Warrior Care Project, my focus is to expand community capabilities in warrior care while growing community-based partnerships to better serve their needs.

According to VA statistics, there are over 24,000 veterans between 17 and 44 years old living in the 13 counties of the Central Savannah River Area. In a speech, the Vice Chief of Staff of the Army, General Chiarelli, said, "The reality is, as we continue to draw down operations in Iraq and eventually in Afghanistan, we are going to see more and more soldiers return home, many of them dealing with PTSD, TBI, depression, anxiety, and other behavioral conditions."

The services estimate approximately 30,000 wounded, ill, or injured who are in the process of recovery or undergoing medical boards. This is significant, but I am concerned about the warrior who served in combat, always redeployed with their unit, and then just ended military service to return home. Estimates suggest over 300,000 servicemembers suffer from unseen injuries. That makes 30,000 warriors we know of just the tip of the iceberg.

Collaboration on warrior and veterans issues is not restricted to the Department of Defense and Veterans Affairs. Communities are part of this collaboration equation. One organization cannot do it alone. The Wounded Warrior Care Project has been a model to build communities' unity of effort. We have worked with the cities of Charlotte, Denver, Huntsville, New York, Dallas. These are the organizations—these are groups that the Department of Defense and Veterans Affairs can partner with to serve our veterans and their families.

History has shown us that with a reduction in combat, there is an associated reduction in government funding for defense- and veterans-related programs. When these programs are stretched thin, communities will play an integral role in supporting veterans. By easing restrictions in government partnering with community organizations, we can work closer to maximize our programs.

My greatest gap is not knowing when veterans are moving to Augusta after they leave military service. I think we have heard it here. Greater collaboration to know who is en route would assist focusing community efforts and allowing greater outreach, rather than waiting for the veterans to seek assistance.

In the military, when you move to a new base, you receive a sponsor at your destination. When a soldier transitions to the veteran status, there is not a sponsorship program. This initiative will go a long way to closing the gap between service and veteran status.

Augusta, Georgia's medical resources are under-utilized. A model of Defense and Veterans Affairs collaboration is the country's only active duty rehab unit located in the Charlie Norwood Veterans Affairs Medical Center. There are only 17 patients in a 30-bed unit.

In briefings from Fort Gordon's Eisenhower Medical Center leadership, their facilities have the capacity to provide a full spectrum of services such as the only dual track Post-Traumatic Stress Disorder and substance abuse program, a robust blind and spinal cord rehab center, and an extensive residential pain and addiction management program.

Augusta would be the ideal location to establish legislated Medical Centers of Excellence such as blind or psychological help, blind rehab or psychological help. Our extensive experience in these

areas would surely overcome our distance from the national capital region.

DOD and the VA must close the gap between medical care available to servicemembers and that available through TRICARE and Veterans Affairs programs. Families are choosing to forego increased financial benefits provided by veteran status in order to access emerging medical care available to active duty in hopes of improved quality of life. Examples are cognitive rehab of these—cognitive rehab, residential mental health care, and advanced spinal cord injury treatment.

Madam Chairman, I agree that more emphasis must be placed on transition assistance programs before the servicemember separates. Training must be mandatory. Servicemembers must be registered for all their VA benefits. When they finish their TAP program, they should walk out with everything signed and ready to go before they become a veteran.

Recognizing a need, our community launched a very successful, our Nation's first, Veteran's Accreditation Program, a collaborative program involving the Army, the VA, Department of Labor, which provides historical and Native American artifact preservation through veterans employment and training initiatives. We would ask for continued support for this program as it has changed the life for 83 participants in the last 2 years.

As I testified to the House Veterans' Affairs Subcommittee on Health, we fully support the Federal Recovery Coordinator Program and encourage its continued support and strengthening to include maintaining of their credentialing standards, greater access to make change, and greater access to work as a team.

Last, collaboration should occur at all levels of the community, from the community to Congress. A great deal of collaboration could be accomplished by establishing a subcommittee on warrior and veterans reintegration, providing joint oversight at DOD and VA efforts, as well as synchronizing the legislative effort impacting both departments.

In a letter from General Patton to his wife at the end of World War II, Patton wrote, "None of them, Americans, realizes that one cannot fight for two and a half years and be the same." Yet, you are expected to go back, to get back into an identical groove from which you departed. We have been at war for 10 years.

Thank you for providing me the opportunity to present before the Senate Veterans' Affairs Committee. I look forward to further questions.

[The prepared statement of Colonel Lorraine follows:]

PREPARED STATEMENT OF JAMES R. LORRAINE, EXECUTIVE DIRECTOR, CENTRAL SAVANNAH RIVER AREA—WOUNDED WARRIOR CARE PROJECT

Chairwomen Murray, Ranking Member Burr, and Members of this Committee, thank you for inviting us to testify before you today. I'd like to thank this Committee for its continuing efforts to support servicemembers, veterans, and their families as they navigate through the complex web of Department of Defense, Department of Veterans Affairs, and community programs. I've been a member of the military community my entire life; as a Reservist, Active Duty Air Force, Military Spouse, Retiree, Government Civilian, and Veteran. In my previous position as the founding Director of the United States Special Operations Command Care Coalition; an organization which advocates for over 4,000 wounded, ill, or injured special operations forces and has been recognized as the gold standard of non-clinical care man-

agement. Recognizing a gap in my Special Operations advocacy capabilities, I incorporated a Federal Recovery Coordinator as a team member in providing input to the recovery care plans for our severely and very severely wounded, ill, or injured servicemembers. This one Federal Recovery Coordinator dramatically improved how Special Operations provides transitional care coordination and made my staff more efficient in support of our special operations warriors and families throughout the Nation. I've found that when supporting our Servicemembers, Veterans, and their families there is always opportunity for improvement.

It's essential that our military and veterans have strong advocates, both government and non-government, working together at the national, regional, and community levels to improve the recovery, rehabilitation, and reintegration of our warriors and families. However, one program by itself is not enough when it comes to supporting our Nation's most valuable resource—the men and women of the Armed Forces, our veterans, and their families. I recently left government service to assume duties as the Executive Director of the Central Savannah River Area—Wounded Warrior Care Project, where my current position is to integrate services by developing a strong community based organization that maximizes the potential of government and non-government programs in Augusta and throughout our region. The Federal Recovery Coordinator Program is one of those resources.

From my experience, advocates or care coordinators require three attributes in order to be successful. The first attribute is the ability to anticipate need. This may sound simple, but staying ahead of a problem saves a lot of heartache, money, and time. Much like a chess master, thinking five to ten moves ahead, this assumes effectiveness and competence at various levels of the system. The second attribute is the authority to act. A case manager or advocate who anticipates needs and develops flawless transition plans, but doesn't have the authority to act is powerless to ensure success. In this complex environment of wounded warrior recovery, someone who can not act is an obstacle. The last attribute is the access to work as a team member. This is recognizing that it takes more than one person to reach the goal. Team work is probably the most complex of the three attributes, because it requires others to be inclusive, sharing of information, trust, and requires a great deal of time to coordinate and synchronize efforts. Federal Recovery Coordinators are a critical component to the successful reintegration of over a thousand wounded, ill, or injured and their families, but as I said there "there is always opportunity for improvement."

By design a Federal Recovery Coordinator has the education and credentials to anticipate need. Their level of professionalism, skill, and experience enables the coordinator to function at a high level of competence in supporting our warriors. They are the most clinically qualified of the warrior transition team. However, not everyone has the same clinical expertise and access to perform as a Federal Recovery Coordinator. We feel the development of a Federal Recovery Coordinator certification program is necessary to prepare these Veterans Affairs care coordinators to engage a broad spectrum of resources available in areas not only of health care, but with a focus on behavior health, family support, and benefits availability.

Innately, the FRC has the authority to act within the Veterans Affairs Health Care system and interface with Veterans' Benefits Administration representatives. By reporting to the Veterans Affairs Central Office the Federal Recovery Coordinator can influence across the Nation and regionally. This ability is unique and should be capitalized on by the Department of Defense Service Wounded Warrior programs and strengthened by the Veterans Benefits Administration. The Federal Recovery Coordinator must have the authority to act at the strategic level, to ensure case management is being accomplished, services are being provided, and that Veterans Affairs resources are being maximized, in concert with other government and non-government organizations.

The greatest challenge for the Federal Recovery Coordinator program is their access to work as a team member. As I mentioned earlier, team work requires inclusiveness. If the Coordinators do not have timely access to the warriors and families in need they can't be effective. As the saying goes "You only know what you know." Involvement in a case must be timely in order to shape an outcome, vice manage the consequences of bad decisions. We must work symbiotically to synchronize our efforts, operating transparently, and maximizing the capabilities of the Departments of Defense, Veterans Affairs, Labor, and Health and Human Services, as well as collaboration with non-government organizations at the national, regional, and local levels. Additionally, the Federal Recovery Coordinators must function in a coordination role, working by, through, and with Service Wounded Warrior Programs while also leveraging local Veterans Affairs case managers and benefits counselors. Relationships are critical and the Federal Recovery Coordinator must develop trusting

interchange with those individuals and organizations with the mission to assist the Servicemember, Veteran, and their family.

Last, the scope of the Federal Recovery Coordinator program should be expanded to assist those in the greatest need for a transitional care coordinator. We should not only support the most severely wounded, ill, or injured, but must include those less severe whose family dynamics, behavioral health issues, or benefit anomalies inhibit their smooth transition to civilian life. The current practice of providing “an assist,” which is short term without fully involved care coordination, has been successful. Additionally, those transitioning veterans at the greatest risk for homelessness should have a Federal recovery coordinator shepherd the veteran to success. By operating at a strategic level Federal Recovery Coordinators can affect the outcome of far more Veterans both regionally and locally.

In conclusion, we have three recommendations to improve the Federal Recovery Coordination program.

1. Maintain the high credential standards for the Federal Recovery Coordinator, but augment with a nationally recognized certification for Federal system care coordination in order to strengthen their ability to anticipate needs.
2. Ensure the Federal Recovery Coordinators have the authority to act on needs they've identified, both on a national and local level.
3. Make certain the Federal Recovery Coordinator has access to work as a team member. Incorporate Federal Recovery Coordinators early in the recovery process as strategic partners who can ensure the Veterans Affairs resources are maximized to a larger population of transitioning Servicemembers, veterans, and their families in need of someone to shepherd them through this complex system.

There is currently a very positive feeling in this country toward the service and sacrifice of our military, veterans, their families, and a desire to support them. One way to help is to utilize existing programs, especially at the local level. The Central Savannah River Area—Wounded Warrior Care Project stands as the model for many communities throughout the Nation who are at the front line of helping our veterans come all the way home from combat and fully reintegrate into our community. It's also important to educate the military and their families about their transition, but it's frequently too late after transition has occurred and life's daily pace takes over.

Thank you for providing us the opportunity to present before the Veterans Affairs Subcommittee on Health.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO JIM LORRAINE, EXECUTIVE DIRECTOR, CSRA WOUNDED WARRIOR CARE PROJECT

Specifically addressing the DOD/VA Federal Recovery Coordination Program, GAO published a report in March citing several areas that need improvement.

Question 1. Have you personally seen discrepancies in the FRCP enrollment process negatively affect a veteran's recovery and transition?

Response. Yes, I have personally seen discrepancies of exclusion from enrollment in the Federal Recovery Coordination program negatively affect a veterans recovery and transition. This is the type of program where inclusion would not have a negative affect on a Servicemembers recovery and transition to veterans status. Highlighting one or many similar examples, a Federal Recovery Coordinator (FRC) was not included in the case of a severely wounded soldier at Ft Bragg while the soldier was on active duty and in medical recovery. Upon the soldier's transition to veterans status he encountered access to care, access to benefits, and general case management—areas the Army could not assist in supporting. I became aware of the issue when one of our special operations soldiers referred this recovering soldier to our command programs for support. We immediately called in the FRC to provide strategic care coordination as this soldier navigated the VA and TRICARE system. Unfortunately, financial and benefits decisions had been made by the soldier and his family that could not be changed. I'm confident that had the FRC been involved while the soldier was on active duty, there would have been better coordination of services and access to medical care.

Question 2. Is the current number of FRCs adequate to properly meet the needs of our veterans?

Response. I believe more FRCs are needed, but their utilization and management must be changed.

The FRCs should be regionally based supporting a local population. Most of the FRCs manage cases far from their home station—occasionally coordinating care for a warrior who is recovering in the same city as another FRC. The FRC's must have

the ability to transfer cases between FRC—focusing on local support and regional knowledge.

The FRC must operate in a supporting role while the Servicemember is on active duty, supporting the Service/Department of Defense wounded warrior program. Then when the wounded warrior becomes a veteran the FRC becomes the supported care coordinator with the Department of Defense Service program in a supporting role. Much like the Department of Defense deconflicts missions across Geographic Combatant Commander Areas of Responsibility.

A properly managed and staffed FRC program will ease the transition of our wounded warriors from Servicemember to Veteran status.

Chairman MURRAY. Thank you very much to all of you for your very compelling testimony. Let me just start by saying, it has been 4 years since the news about Walter Reed broke. In that time, some has changed. Some of you talked about it, but I would like to ask each of you what you think the most important thing the two departments should focus on improving over the next 4 years is.

Mr. Lorraine, if you would like to start?

Colonel LORRAINE. Thank you, Madam Chairman. I think the most important thing is you have to know what you know. If you do not know it, you do not. So finding who the wounded warriors are, who the veterans are, identifying—if you want to change something, you have to know who the person is you need to engage with. Right now, I am not confident we know where the veterans are, nor do we know what their needs are. I think it is represented by my two colleagues here. That would be the number 1 action I would take, is find them.

Chairman MURRAY. I think it was you that said that right now, nobody reaches out to them, we are waiting for the veterans to reach out, too often?

Colonel LORRAINE. Yes, Madam Chairman. What I found is that when you talk to different government programs and non-government programs, my first question is, how do you find the veterans in need? Well, 100 percent of the answers are, "They come to us." I think in today's world, that is not the way we should be reaching to them.

We know where they are while they are on active duty. It is that move from active duty to veteran status where we lose them. And that should be tied in a little bit closer, because once you know where the folks are and you can maintain contact with them, then you can start providing services and offer assistance.

Chairman MURRAY. Mr. Horton, Mr. Bohn, what do you think we should focus on, or the two departments should focus on?

Mr. HORTON. I would say, Chairman Murray, that we should focus on, just like he was saying, finding the veterans. A lot of veterans get lost in the system when they move back. A lot of men and women are from small country towns, and there is no one there that can reach them, which is the huge problem.

Chairman MURRAY. Mr. Bohn?

Mr. BOHN. Chairman Murray, my only problem was they did not pay for my family to come visit me while I was getting my surgeries. My family had to come down out of their own pocket the first surgery, my spinal surgery. The second surgery, my family could not afford to come down so I went through my second surgery alone.

Chairman MURRAY. How far away was your family?

Mr. BOHN. Salem, Massachusetts.

Chairman MURRAY. I think many of us forget that it is not just the servicemember, but it is their family who is involved when somebody is deployed and, specifically, when they are injured. Mr. Bohn, let me ask you to expand on that a little bit, because we know families and loved ones go through stress at this time as well, as long as they are a family member. You mentioned just the travel. Tell me a little bit else about what difficulties your family had during treatment and share that with us.

Mr. BOHN. Oh, the communication was a big thing, also. They did not know—they were not contacted until about 3 hours after I woke up in intensive care, to see how I was doing. I know they were sitting there back when I was getting my surgery just panicking. It is a big communication error, which needs to be changed.

Chairman MURRAY. OK. Anything else that we should be focused on for families, communication, travel, being with the wounded warrior?

Mr. BOHN. Those are the main points that I can think of Madam Chairman.

Chairman MURRAY. Mr. Horton, I was particularly concerned to hear about your difficulties with your prosthetic care. It sounds like you got high quality care, but it was not timely or responsive and you shared a little bit about how it impacts your daily life. You said that—tell me what you mean by that if you have to wait months or weeks.

Mr. HORTON. The process is you go into the—you actually have to call the VA and set up—there is a certain day they have a prosthetics clinic and you have to be seen by them first, and you tell them exactly what you need, whether it is a new socket or a new ankle on your leg, anything like that. Then they write this down. Then they make a 'script and they send it to your outside provider. From there, it could take a couple months.

Chairman MURRAY. What are you experiencing in that time period? Is that pain, is it difficult?

Mr. HORTON. A socket that is not fitting right, which for an amputee, that is—I mean, it is horrible. Like a little rubbing spot on an amputee is like someone having their ankle broken like terribly. So it is a big deal to me. So the time in there is—that is something that really needs to be addressed.

Chairman MURRAY. And how long were you in this period where you had a problem and it took you to get care?

Mr. HORTON. It usually—I mean, it is usually a couple months between every time I go to the VA. Once I get the care, it is great, but the time it takes to get a prosthetic leg or a new prosthetic is too long. And I have talked to several veterans about this and they would agree on that. If you have to go through the VA, it is

Chairman MURRAY. So it is waiting for an appointment, waiting for a specialty? Is it waiting for the right person?

Mr. HORTON. Waiting for a phone call, basically, and a lot of times I call my prosthetics in the VA a couple times and say, Where is this 'script? I need to get in here and get a leg. And so, I have to advocate for myself a lot.

Chairman MURRAY. Not the way it should be.

Mr. HORTON. No.

Chairman MURRAY. OK. Mr. Bohn, your experience trying to make ends meet was really troubling to hear. I learned of another veteran recently, a Marine officer, who is recuperating right now in Bethesda and is receiving a housing allowance at Camp Lejeune rates. So Senator Burr knows what I am talking about when I am saying it is \$700 short, and that has a huge impact for a family.

In the case of that Marine, there was a military coordinator who went out and looked for non-profit resources to help him make up the difference for that, but we should be very concerned that this system was unresponsive to a military coordinator. At the very least, in this case, the military coordinator did take advantage of community resources, but I still found that story very troubling.

I wanted to ask you, Mr. Bohn, if anybody helped assist you in trying to access similar community or non-profit resources.

Mr. BOHN. The Wounded Warrior Project. They directed me to a company, Impact Players, out of Cincinnati, Ohio, which mailed me a check to help pay the difference in my bills that I could not pay. And the Wounded Warrior, they gave me food cards, gas cards so I can make my appointments to the VA, which is an hour away from where I live in Boston. So, you know, having no gas in your car, trying to get to a VA appointment, that is kind of a struggle on its own.

Chairman MURRAY. And your family, what kind of family do you have that you are responsible for?

Mr. BOHN. I am single. I live by myself, but I try to help out my family. Like I said, I grew up poor, so I try to help out my niece, my sister, my mom, my dad.

Chairman MURRAY. OK. Thank you very much for sharing your story. I appreciate all of your testimony. I do have more questions. We have a number of Committee members here, so I am going to turn it over to each of them for a round of questioning. I will start with Senator Burr.

Senator BURR. Thank you, Madam Chairman. Steve, let me just ask, were you ever offered a Federal care coordinator?

Mr. BOHN. Negative. Me and my family never—

Senator BURR. Government.

Mr. BOHN. I have never even heard of that until a couple days ago.

Senator BURR. Were you ever provided a reason about all the confusion in your care, what was the reason that you went—bypassed Walter Reed, the reason that you have sort of been in limbo?

Mr. BOHN. Once again it comes down to the communication, and someone needs to step up and take charge.

Senator BURR. But has anybody stood up and said, Here is what went wrong?

Mr. BOHN. Negative, sir.

Senator BURR. Anybody ever apologize?

Mr. BOHN. Negative, Senator.

Senator BURR. Well, let me apologize to you.

Mr. BOHN. I appreciate it.

Senator BURR. It should not happen. You talked a little bit about the Wounded Warrior Transition Unit that you first went to, and

then Senator Kerry helped you get to a second one. I think you said in the first one, they did not task you with anything?

Mr. BOHN. Negative.

Senator BARR. And in the second one, did they task you with activities that had some value to them?

Mr. BOHN. I went to an air show at Andrews Air Force Base and that was the only thing I was pretty much interested in doing.

Senator BARR. OK. Jim, let me just ask you real quickly, in a meeting with my staff several weeks ago, you shared with them a little bit about your wife's experience, and hers was separating from the Air Force. And as I understand it, when your wife was moved from the temporary disability retirement list to permanent retirement, the Air Force insisted she be examined by an Air Force neurologist at Eglin Air Force Base, an 8-hour drive from where you lived?

Colonel LORRAINE. Yes, sir.

Senator BARR. You asked could she see a neurologist closer to home, gave the options of Augusta VA facility or Eisenhower Army Medical Center. Is that an accurate account?

Colonel LORRAINE. Yes, sir. Yes, sir, it is accurate. My wife lives outside of Augusta in Aiken, and we had to drive to Eglin down in the Gulf Shores area. Drove past—drove past Eisenhower, drove past Augusta VA, drove past Benning, drove past a number of different facilities.

She was being treated at Augusta, but the requirement was that she see an Air Force neurologist who was a contract neurologist who saw her for 30 minutes, never laid a hand on her, and just took the records that we had brought and handed them back and said, I do not have time to look at these.

Then we waited for—we waited—we drove back, another 8 hours back, and waited for the decision.

Senator BARR. Did you say that the neurologist was a contract neurologist?

Colonel LORRAINE. Yes, sir.

Senator BARR. And did the Air Force ever explain to you why your wife needed to be examined at Eglin rather than a closer facility?

Colonel LORRAINE. No, sir. You know, this is what I do. This is what I was doing for business, so I knew all the people to call and the answer was, You have to go see an Air Force provider. I had lived in Tampa at the time working in Special Operations Command, and I offered to go to Tampa, because it would be more convenient for us, and the answer was no, Eglin is the place. So despite numerous requests, the answer was no, that it had to be an Air Force facility, Air Force provider that did the TDRL exam, TDRL, Temporary Disability Retired List exam.

Senator BARR. But, in fact, this was a contract neurologist for the Air Force?

Colonel LORRAINE. Yes.

Senator BARR. That even brings more insanity into it than I think one could comprehend.

Colonel LORRAINE. And, sir, at the time—my wife has epilepsy and she is not able to drive. So for me, I left SOCOM, drove to Augusta, picked my wife up, drove to Eglin, drove back to Augusta.

So it was 4 days of in-transit. And when you talk about a family, it does affect the family pretty significantly.

Senator BURR. The Chairman has been very kind to listen to me on occasion rant about the lack of veterans' abilities to get transportation to appointments. Steve, you talked about that and, Jim, you just alluded to it. I do not think this Committee really today even fully understands, and I certainly do not believe that VA understands the challenge it is for our country's warriors to meet the requirements that we set at the VA.

For anybody who did not need health care it would be challenging if you have no gas in your tank or they ask you to drive 8 hours when you can get the service 30 minutes away. Let me just ask you in conclusion, how would you improve the process of Temporary Disability Retirement List for servicemembers in the future that are faced with that?

Colonel LORRAINE. Based on the statistics that I understand, and I would have to get back to you specifically, but I would do away with TDRL. It is just not a—when you look at the number of people who are TDRL who are then permanently retired, the percentage is above 60 percent, maybe high 80s, and I would have to—I would have to ask the Department of Defense for the specifics.

But when you look at that, the cost of the benefit is—you have to question, why are we doing this when so few people return to duty from a TDRL status.

Senator BURR. Thank you.

Colonel LORRAINE. Yes, sir.

Chairman MURRAY. Senator Sanders.

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

Senator SANDERS. Thank you, Madam Chair, for holding this very important hearing, and thank you all very much for being here. It goes without saying that you have established your bravery on the battlefield, but let me tell you what you are doing here today in speaking out for your brothers and sisters, and raising issues is equally great. I know it is not easy. It is not what you trained to do, but it is very important, and we thank you very much for being here.

First point that I want to make, and I think Jim touched on this. You know, we go through periods where this country is in war. We are now in two wars. Then we do not have wars. Sometimes it is easy to forget about the people who fought in the wars when the parades are over and the media is not covering the issue.

So you have people who have got permanent injuries for the rest of their lives, and I think we should agree that if we go to war, that 30 years from now, or 50 years from now we do not forget about these people. Frankly, it is an expensive proposition, but that is what it is about. So I would hope that we make sure that for the rest of the lives of all of those people who have served that this Congress accepts the moral responsibility to make sure that they have all the care that they need. That is what it is about.

Number 2, let me give you, Madam Chair, maybe some positive news, if you like. I think what I have heard from Steve and Tim and Jim is, you have got men and women coming back from war,

they are injured physically, they are injured psychologically. They have to weave their way through a very difficult and complicated bureaucracy.

What I am hearing is that there is no entity out there which says, OK, we are with you, and it is complicated, but we are going to guide you through it. These are what your benefits are. We are going to deal with your transportation. You are a human being. You are not 18 silos. You are one person. We are going to deal with the needs of you and your family.

That is kind of what I have been hearing from Steve and Tim. And understand when people come back, they are in trauma already and we have to be aggressive in reaching out. Madam Chair, let me mention something to you which I think we can learn from.

In Vermont a couple of years ago—and we are a rural State so we do not have a large military base. We had a lot of people over in Iraq. We had a lot of people over in Afghanistan. These guys are coming home to a rural area without a military base.

What we established in Vermont was what we call an outreach program, and it was funded through the—we got money through the National Guard, who then accepts the responsibility of hiring a team of people, mostly veterans who served in the war, to go out knocking on doors, sitting down with the soldiers and their families, ascertaining what the problems are, using their own judgment, playing that role of getting people to the VA when they need it, playing the role of getting people to services that they needed. I am happy to say that that program has now expanded. I think there are eight States in the country which are doing something similar.

But let me ask, start off with Steve and Tim. Am I correct that assuming that maybe the main point that you are making is that when you come back, you want somebody to be at your side to deal with all of the many problems that arise? Steve, did you want to—

Mr. BOHN. That is correct. There is a lot of red tape when you come back, and after worrying about your health constantly and every day is a struggle, you know, just getting out of bed, you want someone to actually take care of the red tape and the paperwork and try to find out the best way to get your treatment.

Senator SANDERS. I mean, that seems clear. We are all Senators, and we have large staffs. It is hard for us to get through the bureaucracy. Imagine somebody coming back with a variety of problems all by himself or herself trying to get through the bureaucracy. Tim, did you want to maybe comment on that?

Mr. HORTON. When I was injured, I was pretty much strapped down to a bed for about two and a half months, and my mom was there, and if she was not there, I probably would have died because some of the nurses and the staff were going to put something in my IV that could have killed me. So definitely having somebody by your side is important, and I have heard that from numerous veterans. Like, just a simple error for us could kill us in that kind of shape. So definitely having somebody by our side would be very, very important.

Senator SANDERS. Within the system now, it would seem to me, I mean, call it a social worker or call him or her whoever you want, there should be somebody available 24 hours a day who can re-

spond to a problem that the family is having or whether the soldier is having. Jim, did you want to comment on that?

Colonel LORRAINE. Yes, sir. You know, I think that having come out of the Department of Defense doing this, there are a lot of people. You know, I have had families who have difficulty, and then when I finally get to them and say, Why did you not call me, they give me a stack of business cards that are this big and they say, Everyone in this—every card said call me if I need something. And when I called, very few people could act because it was a very specific thing.

Senator SANDERS. Right.

Colonel LORRAINE. And I think—I think, as I said, we talked about the Federal Recovery Coordinators, the linkage between what the services, DOD, are doing and what the Federal Recovery Coordinators have the ability to do in the VA, if they can work together as a team, they could provide this seamless advocacy. And really, that is what these guys are saying they needed, somebody who has advocacy who can anticipate needs, act on those needs, and then follow up with it.

Senator SANDERS. So I think the pity of it is, we spend a fortune, and sometimes, at the end of the road, the care is excellent if people can get to it. And yet, I suspect there are thousands of young men and women who have returned that do not even know what they are entitled to, what is available to them, how to access it. So on one hand, we spend a fortune; on the other hand, we do not connect the people to the services that are available.

I would hope, Madam Chair, as somebody who really has a strong detestation of bureaucracy in general, that we can work toward a system where these guys will have somebody who they trust that they can call up 24 hours a day who will help guide them through the system. I think that would be an important step forward. Thank you very much. And thank you.

Chairman MURRAY. Thank you very much. Senator Isakson.

Senator ISAKSON. Well, thank you, Madam Chairman. I want to call each member's attention to the last four paragraphs of Lieutenant Colonel Lorraine's testimony. I am going to read two sentences from that because I think it hits at the heart of what Bernie is talking about and what we are talking about.

It says, "Last the scope of the Federal Recovery Coordinator Program should be expanded to assist those in the greatest need for a transitional care coordinator. We should not only support the most severely wounded, ill, or injured, but must include those less severe whose family dynamics, behavioral health, or benefit anomalies inhibit their smooth transition to civilian life."

Those are two critical sentences that I think address everything raised by Tim and Steve. I want to ask you a couple of questions about this, Colonel Lorraine. It is my understanding—I know we have got well over 100,000 people deployed in the Middle East right now and we have 22 Federal Coordinators, Recovery Coordinators; is that right?

Colonel LORRAINE. Yes.

Senator ISAKSON. That is 22 coordinators, and we have got people coming home every day with the same needs that Tim and Steve have talked about.

Second, and I am not trying to put words in your mouth so correct me if I am wrong, Colonel, but in your recommendations on the Federal Recovery Coordinators, you state three things. We should strengthen their ability to anticipate needs, one. Two, give them the authority to act on those needs that they have identified both at a national and a local level. And finally, give them access to work as a team member.

What is so important about that is you have got LDRH, the Department of Labor, Veterans Affairs, the Department of—there are lots of agencies in the Federal Government that have programs available to help these guys, but Bernie is right. We cannot get through the maze. How in the world do we expect these guys to do it dealing with the injuries that they have?

So rather than ask a lot of questions or talk a lot, Colonel, I would just like you to expound on your recommendations on the Federal Recovery Coordinators because I think that strikes at the heart of the difficulties these two gentlemen have had.

Colonel LORRAINE. Yes. Thank you, Senator Isakson. The credentialing—the Federal Recovery Coordinators are really the most credentialed, most qualified in terms of clinically and, I would argue, non-clinically to transition to the VA. One thing that all of us have in common is that we were servicemembers and we are now veterans. It is like sort of death. If you are alive, you are some time going to die. If you are a servicemember, some time you are going to be veteran.

And so, that Federal Recovery Coordinator being involved in the DOD side, not primarily, but as a support to the Recovery Care Coordinators that DOD has, and then being part of that transition is important, but they have to have the authority to reach into the VA and push the VBA buttons and push the VHA buttons to provide the services that these wounded warriors receive.

Additionally, as I said in my testimony today, these are folks who we knew about. These are guys who were in the WTUs. There are far more who are leaving service, far more of their counterparts that were in their blast with them, that just redeployed and just got out, separated, and returned to their home. And we do not have any visibility of them at all. And their number far exceeds the number of wounded warriors that we have put through the program.

So that is why, sir, that expanding the program to go after those and help those who are having trouble just in the process is important.

Senator ISAKSON. Steve, you were in the Army, correct?

Mr. BOHN. Yes, sir.

Senator ISAKSON. Where did you exit from, what base?

Mr. BOHN. I was part of a community-based Warrior Transition Unit at Hanscom Air Force Base, but they were attached to Fort Dix, New Jersey. So I had to fly to Fort Dix for 3 days to actually out-process even though I never even stepped foot at Fort Dix.

Senator ISAKSON. You were in a Wounded Warrior Transition Unit; is that correct?

Mr. BOHN. Yes, sir.

Senator ISAKSON. I have been through the Wounded Warrior Transition Unit at Fort Stewart and at Fort Benning and at Fort

Gordon. I want to ask you this question. My recollection, each one of those, by the way, is different, and I want to focus just on my visit at Fort Stewart.

They had a separate barracks where the Wounded Warrior Transition soldiers stayed, and they had a one-stop shop, for lack of a better word, where you could go for resources pending your transition from the military. Did you go through that same thing?

Mr. BOHN. Yes, Senator, I did.

Senator ISAKSON. When you left, besides getting a DD-214, what did they give you to facilitate your communication as a veteran with those same services?

Mr. BOHN. All's they gave me was a flag and a retirement pin and said, Thank you for your service.

Senator ISAKSON. You know, you talk, Madam Chairman, about the number of calls to the Suicide Prevention Center. The reason we have that center is to have a place a veteran can seek help at a difficult time. The same thing is true at transition, and that may be something we think about asking DOD to look at—a phone number and a human being they can talk to in that critical time transitioning from active duty to veteran status.

I thank you for your service, all of you, and thank you for your time.

Chairman MURRAY. Excellent suggestion. Thank you very much for that.

Senator Begich.

**STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA**

Senator BEGICH. Thank you, Madam Chair. I sit here probably not as frustrated as you, but it is just very frustrating to hear what you had to go through and the lack of coordination at times on the part of the Federal Government to make sure those services are delivered.

Let me try a couple things, if I can. Lieutenant Colonel, let me ask you, in regards to your organization, can I just—give me a sense of, you know, the funding of it. How big is it, in other words? Give me a sense of it.

Colonel LORRAINE. The Central Savannah River Area Wounded Warrior Care Project is relatively small. There is myself and two other gentlemen. Our funding is privately funded and again, our energy is bringing people together, especially in Augusta in the Central Savannah River Area where you have two VA hospitals, a DOD medical center, large civilian medical community, and a large—a post, Fort Gordon, and a large veteran population.

Senator BEGICH. You know, I represent Alaska and I was hearing your story of your wife. We do not have roads in lots of areas, so about 80 percent of our State is not connected by roads. And we struggle up there, as you can imagine, with a veteran in a small village. But what we do have is incredible care facilities that are managed by our Native corporations. I mean, high quality. We are about to finish out a \$180 million facility in Nome, Alaska, to service the region, not paid for by State recovery money. It is going to be an incredible service.

But the veterans who are in that community will not be able to use it. They will have to go to Anchorage. And again, we do not drive from Nome to Anchorage; we fly. So I am curious, as I was listening to your story and about your program, do you think places like Alaska have an opportunity to partner with what you are doing and trying to figure out how—you know, it is frustrating.

The best stories I hear are organizations like yours, the Wounded Warrior organization, that are really bringing veterans to the services they need. How do we—maybe we have to have a radical change and look at organizations like yours and say, Look, you are going to be the group that helps us, because we are—I do not want to say incapable of, but we are not doing a really good job.

Colonel LORRAINE. Senator, as I said in my testimony, there are cities throughout our Nation that are coming together and recognizing that there are veterans who are returning and that they are really the ones who are going to lead the effort.

There is a small disparate group of us that are getting together right now, and talking on the phone, I think we would obviously welcome Alaska. But I think that is where the energy is. If you look 10 years from now and 15 years from now, it is really the communities who are going to have to—and Nome and Anchorage—who are going to have to take care of these veterans.

Senator BEGICH. That is right.

Colonel LORRAINE. And so, it is really—the Chairman of the Joint Chiefs of Staff laid out a Sea of Goodwill concept where there is a lot of support out there, it is just sort of harnessing it, and that is what we are trying to do, is harness all that goodwill that is out there.

Senator BEGICH. Do you think—and I have got one quick one here. Do you think the DOD culture—and I sit on the Armed Services Committee, and I would offer a recommendation to the Chair that maybe we should have a joint meeting with Armed Services Committee and Veterans on this issue because there is almost like a cultural shift you have to have, because as you describe, it is kind of like once you are done, they say, Thank you very much, here is your flag, here is your pin, thanks for your service, and then VA is out there trying to do it and you kind of get in the middle, or other groups like yourself, are trying.

Do you think we will be able to get DOD to take more responsibility earlier in the transition? Do you think that is possible? I know what I deal with over at Armed Services. I know Senator Brown probably has similar experiences.

Colonel LORRAINE. Sir, I think that, you know, the people that, you know, my counterparts in the Department of Defense, everyone wants to help. Everyone has a huge heart. They recognize that they want to do it. So is there the ability to do it? Absolutely.

Senator BEGICH. Let me ask, if I can. My time is almost up. First to you, Steve. You had indicated that you were denied Social Security disability benefits. Are you still in the process of trying to appeal that or what is your situation?

Mr. BOHN. I gave up on that.

Senator BEGICH. You gave up? OK. Well, I guess—I know Senator Kerry's office would probably be very helpful. I just—we are going to ask a question how it works with Social Security and vet-

erans in regards to disabilities, but I just wanted to follow up on you.

On the flip side, if I can, Tim, just a very quick one, when you said you had to get the university or the college you were at and VA on the same page on the funding, was it just—explain that just so I understand.

Mr. HORTON. Every semester, it seemed like that they knew the VA was paying for it, but it was a new financial aid counselor. That was the problem. Someone new would come in and they were not really a veteran-friendly school, so everything—they would say, “You owe us this.” I was like, “No, I do not.” The VA—I am going through the Voc Rehab Program. So that was the problem. They did not understand it. It was every semester.

Senator BEGICH. OK. Very good. Let me end there. Thank you, Madam Chair, for the moment there.

Chairman MURRAY. Thank you. Senator Brown.

**STATEMENT OF HON. SCOTT P. BROWN,
U.S. SENATOR FROM MASSACHUSETTS**

Senator BROWN OF MASSACHUSETTS. Thank you, Madam Chair, and I thank you again for holding this hearing. And thanks to our witnesses. I know Steve and I had a good meeting yesterday and I appreciate you sharing a lot of your experiences with regard to the transition from DOD to the VA. The goal is to be seen much sooner. If you are a Guard or Reservist in Massachusetts, we have kind of addressed this.

We actually have a one-shop stop for returning veterans where they get that A to Z transition. I know you brought this up before about trying to get that to happen in the regular Army, too, so we can get our heroes the care and coverage and treatment that they need. The first I am hearing about a lot of what you are going through and I am hopeful that we can work through a lot of the issues.

You know, obviously you are from Massachusetts and I would be happy to speak to Senator Kerry’s office and we will try to work together to work through these kind of mine fields.

When Senator Sanders said, You know, well, we have trouble as Senators getting through the bureaucracy, what does that tell us? We have too much bureaucracy, so let us fix it. So that is maybe one of the things we can try to do from here.

And with regard to the actual—the rating system, Steve, you were separated from the Army in October, but as of today, 7 months later, 7-plus, you still do not have an official VA rating, right?

Mr. BOHN. Negative. Actually, 2 days before I came here, they mysteriously called me and said they have the rating, but they cannot tell me over the phone. So when I get home, I will get it in the mail. But I do not know how much the rating was.

Senator BROWN OF MASSACHUSETTS. Well, we would appreciate you—

Senator BEGICH. Senator, you should invite everyone that is still on the list to the Committee, and I think they will be approved immediately.

Chairman MURRAY. I wish we could just have continuous hearings here, but that should not be what this Committee has to do.

Senator BROWN OF MASSACHUSETTS. I would appreciate you letting us know what it is, and if we are having a similar situation like Tim, we can continue to try to work through that. I am sure you being here actually played a role, and as you pointed out, that is not the way it should be.

In addition, what impact—and you were never assigned a Federal Recovery Care Coordinator either, right? So what impact did that have on you? I know you said you actually went to—they transferred you to the wrong base.

Mr. BOHN. I was supposed to, from Landstuhl, Germany, be transferred to Andrews Air Force Base, and from there, they were supposed to take me to Walter Reed. They ended up flying me back to Fort Campbell, assigning me to a WTU there, and then, they brought me to a hospital on base and the doctors were like, Why are you here? You obviously need surgery. So later on that week, they flew me to Walter Reed.

Senator BROWN OF MASSACHUSETTS. So at what point did you know that you were not going where you were supposed to go and, in fact, what did you do about it?

Mr. BOHN. There was nothing I could do.

Senator BROWN OF MASSACHUSETTS. Did you bring it up to your chain of command? Did you speak—

Mr. BOHN. My chain of command was still in Afghanistan at the time, and I know that I had a couple of guys on Rear D back there. I talked to them about it and they said, “Well, obviously the doctors corrected the mistake, so—”

Senator BROWN OF MASSACHUSETTS. So when you got to the second place where you really were not supposed to be and they recognized that, in fact, you needed surgery, can you explain what that was like? Was it like instantaneous? Was it like in a month? What happened?

Mr. BOHN. It was about a month period where I went to Kimbrough Hospital at Fort Campbell. After that, I was briefly assigned to the WTU, but they put me on TDY to Walter Reed so I was still attached to the WTU at Fort Campbell while I was in surgery. And the coordination after my spinal surgery, they sent me to the West Roxbury Unit, the Spinal Cord Injury Unit, so that I could be close to my family.

But the communication, like I was mentioning earlier, no one contacted the WTU at Fort Campbell to tell them that, so Fort Campbell threatened, you know, If you are not back here within 5 days, you are going to be AWOL.

Senator BROWN OF MASSACHUSETTS. So basically, there is a complete lack of communication—

Mr. BOHN. That is the main thing.

Senator BROWN OF MASSACHUSETTS [continuing]. When you get hurt and when you were transitioning. You are asking us to look into—you want a mentor. You want somebody there who is your career—not a career counselor, but your medical treatment counselor that says, OK, Steve, listen, this is where you are going, this is what you are doing, this is where you have got to go, this is what

you have got to do, this is who you are going to see, and there is nothing like that with you?

Mr. BOHN. There is nothing.

Senator BROWN OF MASSACHUSETTS. I understand, also, when your mom—I know your folks, they wanted to come down and they did not have a checking account and the DOD requires, for reimbursements for travel, to have a checking account.

Mr. BOHN. Exactly.

Senator BROWN OF MASSACHUSETTS. So as a result of them not having a checking account—

Mr. BOHN. My parents had to pay for their own hotel, and then once I woke up out of surgery, they had to leave to go right back home. Then my second surgery, I was completely alone. I did not have my family come down at all.

Senator BROWN OF MASSACHUSETTS. There was no one, through the DOD or any VA or any other, your unit, nobody that—because you were still with a unit, technically. Was there anyone in the unit that was keeping an eye on you or others like you?

Mr. BOHN. Well, at Walter Reed, we had a 101st Airborne liaison, but I met him twice the whole period I was there.

Senator BROWN OF MASSACHUSETTS. And when you were there, did you complain? Did you try to push the buttons at all? Or you just kind of gave up?

Mr. BOHN. Infantrymen do not complain, sir.

Senator BROWN OF MASSACHUSETTS. No, there is some truth—there is a lot of truth to that. I mean, it is kind of like you do not want to rock the boat. And, Tim, you on the other hand, you felt compelled to and I understand that as well. If I could ask one more question, Madam Chair?

Chairman MURRAY. Yes.

Senator BROWN OF MASSACHUSETTS. So, I mean, Jim, you hear these stories. Colonel, you are hearing these stories. I mean, what is up? I mean, where is the breakdown and what can we do? What can the Chairwoman do and us do to kind of make sure these things do not happen again?

Colonel LORRAINE. You know, Senator, where is the breakdown? I am not really sure. It surprises me that it happens. I know that when I was on active, when I was working for Special Operations Command, we had liaisons that were at the bedside, and honestly, I will tell you, in 6 years, I never had a need that did not get met, was not met.

We never had families that traveled not on invitational travel orders, and if they did not have a checking account, we would figure out a way to do it. It is really just taking the action. I think that is where it is the—it is going that next step to do whatever it takes to make sure that that servicemember and their family are taken care of, specifically the family, because they are getting the medical care.

The family is the ones who are sort of—they are the odd man out because you have to really focus on them. Everything is new, especially to a mom and dad who are not part of the service. They do not know the acronyms, they do not know their way around, and it may be completely new to them.

Senator BROWN OF MASSACHUSETTS. Thank you. Steve, thank you, and Tim and Colonel, we will be in touch, Steve.
Chairman MURRAY. Senator Boozman.

**STATEMENT OF HON. JOHN BOOZMAN,
U.S. SENATOR FROM ARKANSAS**

Senator BOOZMAN. Thank you, Madam Chair, and we appreciate you all being here. Your testimony is really very, very helpful and, you know, this is really what we need, is the view from somebody that has gone through this. I wish that—and I do not know how we get it done—but I would love to hear from the—you know, it is great that we have got the people that run the programs here, but I really would like, at some time, maybe if we could hear from the liaisons themselves, you know, that are actually doing this work, whether it is through a field hearing or bringing you up here, maybe an informal, to really see what we are doing, you know, if we are bogging down the system too much.

I know that the people that are dealing with you all are good people that are working hard, and as being part of a huge organization being in the military, you understand how things get bogged down.

But again, we are hearing firsthand from you that have gone through it and it would be good to hear firsthand from the group that is out there fighting the battle trying to minister to people like you.

Steve, you mentioned that you went through the TAP program and had some concerns, did not really feel like that program provided you the—in looking at your testimony, I do not want to put words in your mouth, you could comment, but maybe we are a little bit concerned that you did not really know, as a result of the program, that it really helped you as to what you were going to do in the future, you know, some of the skill sets you needed.

Can you comment about that, and then perhaps how we can improve that, because we talk about mental health and all of these things? One of the big things is just having the realization that you can get out, you know, get back in the real world and support yourself and support a family and make a living.

Mr. BOHN. At the time I was going through the TAP program, I was still going through all my medical treatment. I do not think that is really an appropriate time to be going through all that while you are seeing doctors every day and focused on how you are going to get better every day and how you are going to get through the next day. The last thing I was really focused on, was what I was going to do after. So I was just trying to get by day to day.

Senator BOOZMAN. So for somebody like yourself then, you would advocate that once you started feeling a little bit better and moving in that direction, you would do it then?

Mr. BOHN. Definitely.

Senator BOOZMAN. OK. Very good. Well, again, thank you all for your testimony. We really do appreciate your service and your advocacy.

With that, I yield back, Madam Chair.

Chairman MURRAY. Thank you very much. And I want to thank all three of you for your very important testimony. You have given

this Committee a lot to work on 10 years into these conflicts. I think it is important that as a country, we remember that we have men and women who are coming home who are injured, who are going through what you are going through. We cannot just figure we did it 4 years ago after the Walter Reed scandal broke. We have to be very vigilant and keep working.

We obviously have work in front of us, and your testimony today helps highlight that so that this Committee and this Congress can continue to do what we need to do to make sure we are not letting anybody fall through the cracks. So I really appreciate your being here and your testimony, and I want to thank you for that today.

With that, we are going to move on to our second panel, so this panel can go ahead and get up. As our second panel is coming to us, I want everyone to know that we now do have the departments in front of us. They have had the opportunity to hear this testimony. We will be asking them about that. Also, I know we have got several Members of the Committee who will be coming in and out.

I would like to ask the second panel to come and sit down. I will give you just a minute to settle in. If we could have our witnesses in the second panel please take their seats, and I will do the introductions while you are doing that.

We have Dr. Toni Zeiss, who is the Acting Deputy Chief Officer, Mental Health Services for the Office of Patient Care Services for the Department of Veterans Affairs. She is accompanied by two specialists from the Department, Dr. Shane McNamee, the Chief of Physical Medicine and Rehab at the Richmond VA medical center, and Dr. Jan Kemp, VA's National Suicide Prevention Coordinator.

Following the VA, we have Dr. George Peach Taylor, Jr., the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness. Dr. Taylor is accompanied Philip Burdette, DOD's Deputy Director of the Wounded Care and Transition Policy Office.

I do want to mention again that I am very disappointed by the lateness of your testimony, Dr. Taylor. The Department has known about this hearing since May 9th and this is a continuation of the discussion that we had with Deputy Secretary Lynn last week. As you heard earlier from Senator Burr, the rules of this Committee do require that testimony be received 48 hours in advance.

We received your testimony very close to the end of business last evening, and it is very difficult for Members to prepare for a hearing when testimony is received so late. As I indicated, however, given how strongly I feel about this issue, I will let you testify today and answer the serious questions that were raised by the first panel.

The Ranking Member and I will be reaching out to DOD and to OMB to address this issue because in the future the Department does need to get their testimony in on time.

Dr. Zeiss, with that, I would like to begin with you and your testimony.

STATEMENT OF ANTONETTE ZEISS, Ph.D., ACTING DEPUTY CHIEF OFFICER, MENTAL HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY SHANE McNAMEE, M.D., CHIEF OF PHYSICAL MEDICINE AND REHABILITATION; HUNTER HOLMES McGUIRE (RICHMOND) VA MEDICAL CENTER; DEBORAH AMDUR, CHIEF CONSULTANT CARE MANAGEMENT AND SOCIAL WORK, OFFICE OF PATIENT CARE SERVICES; AND JANET E. "JAN" KEMP, RN, Ph.D., VA NATIONAL SUICIDE PREVENTION COORDINATOR

Ms. ZEISS. Good morning, Chairman Murray, Ranking Member Burr, and members of the Senate Veterans' Affairs Committee. I am Dr. Antonette Zeiss, Acting Deputy Chief, Patient Care Services Office for Mental Health at VA Central Office.

I am pleased to be here today with my colleagues from the Department of Veterans Affairs and from the Department of Defense to discuss how VA and DOD are meeting the needs of returning and injured veterans and servicemembers and certainly welcome the opportunity to think about how we can do that better. I appreciate also the important testimony that we heard in the panel before this.

We will always need to continue to try to improve our efforts and increase the amount of collaboration that is going on, and we welcome the chance to think with you about that process.

Accompanying me from VA and joining me at the witness table are Dr. Janet Kemp, the National Mental Health Director for Suicide Prevention in the Office of Mental Health Services, and Dr. Shane McNamee, Chief of Physical Medicine and Rehabilitation Service at Hunter Holmes McGuire VA medical center in Richmond, Virginia. I would ask that our combined written statement be included in the record.

Also from VA, seated immediately behind us in the first row of the audience are Deborah Amdur, the Chief Consultant for Care Management and Social Work in Patient Care Services; Mr. Cliff Freeman, the Director for VA/DOD Health Information Sharing; Mr. Larry Fink, the Director of the IDES Program Management Office; and Mr. Tom Pamperin, Deputy Under-Secretary for Disability Assistance. And they will help us when it is time for questions.

Again, it is a pleasure for me to be here today. I have worked for VA over 28 years and have been at VA Central Office for almost 6 years. My area of expertise is treatment of eligible veterans with mental health problems, and VA's policies and procedures for providing such care.

In my statement today, I will particularly focus on the new integrated mental health strategy developed collaboratively by VA and the Department of Defense. That strategy was developed to address the growing population of servicemembers and veterans with mental health needs.

Mental health care provides challenges for the two organizations. We have separate missions in that we serve the same population, but at different times in their lives and careers. Therefore, the integrated mental health strategy centers on a coordinated model to

improve access, quality, effectiveness, and efficiency of mental health services across the departments.

Recipients of services include active duty servicemembers, National Guard and Reserve component members, veterans, and their families. The development of the strategy was a major focus of the two departments in fiscal year 2010 and was improved in final form in October, 2010. It followed from the first ever National Mental Health Summit co-hosted by VA and DOD in October 2009, designed to make recommendations for how the departments can work more effectively together to meet mental health needs.

The strategy derives from the summit and subsequent joint efforts of subject matter experts from both departments. It identifies 28 strategic actions that fall under four strategic goals. The first is to expand access to behavioral health care in VA and DOD. Second is to ensure quality and continuity of care across the departments for servicemembers, veterans, and their families.

Third, to advance care through community partnership and education and reduce stigma through successful public communication and innovative technological approaches. And fourth, promote resilience and build better behavioral health care systems for tomorrow. All of these actions have been developed into full implementation plans and are underway.

Each one of the actions has defined end states to define success, and those actions were developed with metrics related to those end states. Some are outcomes, some are process depending on the structure of the activity. The most objective and measurable of the metrics will be tracked in next year's joint strategic plan metrics, and progress in implementation is tracked bimonthly in the VA/DOD Health Executive Council.

This collaboration is providing unique opportunities to better coordinate our mental health efforts across the two departments for the benefit of all our servicemembers, veterans, and eligible family members. Thank you again for the opportunity to appear before your Committee, and I look forward to your questions.

[The prepared statement of Ms. Zeiss follows:]

PREPARED STATEMENT OF ANTONETTE ZEISS, PH.D., ACTING DEPUTY CHIEF OFFICER, MENTAL HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Murray, Ranking Member Burr, Members of the Senate Veterans' Affairs Committee: I am pleased to be here today to discuss how the Department of Veterans Affairs (VA) and the Department of Defense (DOD) are meeting the needs of returning and injured Veterans and Servicemembers. I am accompanied today by Ms. Deborah Amdur, Chief Consultant, Care Management and Social Work, Office of Patient Care Services; Mr. Cliff Freeman, Director, VA/DOD Health Information Sharing; and Shane McNamee, M.D., Chief of Physical Medicine and Rehabilitation Service at the Hunter Holmes McGuire (Richmond) VA Medical Center.

You heard last week from Deputy Secretary Gould about many of our efforts in this area, and my testimony will re-emphasize some of the points he made while expanding on several key areas of collaboration and support such as mental health services, prosthetics and rehabilitation, electronic health records, and care coordination, per your request.

MENTAL HEALTH SERVICES

VA offers mental health services to eligible Veterans through medical facilities, community-based outpatient clinics (CBOC), and in VA's Vet Centers. VA has been making significant advances in its mental health services since 2005, beginning with implementation of the VA Comprehensive Mental Health Strategic Plan uti-

lizing special purpose funds available through the Mental Health Enhancement Initiative. In 2007 implementation of the strategic plan culminated in development of the VHA *Handbook on Uniform Mental Health Services in VA medical centers and Clinics*, which defines what mental health services should be available to all enrolled Veterans who need them, no matter where they receive care, and to sustain and extend the enhancements made up to that point. VA is still in the process of fully implementing this Handbook, and has made extensive progress to date. We continue to emphasize additional areas for final development.

VA's enhanced mental health activities include outreach to help those in need to access services, a comprehensive program of treatment and rehabilitation for those with mental health conditions, and programs established specifically to care for those at high risk of suicide.

VA ensures that treatment of mental health conditions includes attention to the benefits as well as the risks of the full range of effective interventions, with emphasis on all relevant modalities, including psychopharmacological care, evidence-based psychotherapy, peer support, vocational rehabilitation, and crisis intervention. Making these treatments available incorporates the principle that when there is evidence for the effectiveness of a number of different treatment strategies, the choice of treatment should be based on the Veteran's values and preferences, as well as the clinical judgment of the provider.

To reduce the stigma of seeking care and to improve access, VA has integrated mental health into primary care settings to provide much of the care that is needed for those with the most common mental health conditions, when appropriate. Mental health services are incorporated in the evolution of VA primary care to Patient Aligned Care Teams (PACT), an interdisciplinary model to organize a site for holistic care of the Veteran in a single primary health care location. In parallel with the implementation of these programs, VA has been modifying its specialty mental health care services to emphasize psychosocial as well as pharmacological treatments and to focus on principles of rehabilitation and recovery. VA also has a full range of sites of care, from inpatient acute mental health units, to extended care Residential Rehabilitation Treatment Programs, to outpatient specialty mental health care (as well as care in the PACT), to mental health care in geriatrics and extended care settings, to mental health staff as a component of Home-Based Primary Care, delivering mental health services to eligible home-bound Veterans and their caregivers in their own homes.

VA/DOD INTEGRATED MENTAL HEALTH STRATEGY

The development of the VA/DOD Integrated Mental Health Strategy (IMHS) was a major focus of the Departments in fiscal year (FY) 2010 and was approved in final form in October 2010. In October 2009, VA and DOD convened the first-ever joint Summit meeting to make recommendations for how the two Departments can more effectively work together to meet the mental health needs of America's military personnel, Veterans and their families. The IMHS derives from this Summit and subsequent joint efforts of subject matter experts. It was developed to address the growing population of Servicemembers and Veterans with mental health needs. Mental health care provides unique challenges for the two organizations with separate missions in that they serve the same population, but at different times in their lives and careers. As such, the IMHS centers on a coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services. Recipients of these services include Active Duty Servicemembers, National Guard and Reserve Component members, Veterans, and their families.

The IMHS identifies 28 Strategic Actions that fall under the following four strategic goals: (1) Expand access to behavioral health care in VA and DOD; (2) Ensure quality and continuity of care across the Departments for Servicemembers, Veterans, and their families; (3) Advance care through community partnership and education and reduce stigma through successful public communication and use of innovative technological approaches; and (4) Promote resilience and build better behavioral health care systems for tomorrow. The first goal of expanding access to behavioral health care includes specific actions such as integrating mental health services into primary care settings; expanding eligibility to Vet Center services to members of the Armed Forces who served in Operations Enduring Freedom, Iraqi Freedom, or New Dawn (OEF/OIF/OND); sharing mental health staff between the Departments; and developing processes for implementing joint DOD and VA tele-mental health services. The second goal of ensuring quality and continuous care includes specific actions such as coordinating and standardizing training in evidence-based psychotherapies; developing quality measures for mental health services based on VA/DOD Clinical Practice Guidelines; evaluating patient outcomes and using this

data to support clinical decisions and improve our programs; and implementing the “inTransition” mental health coaching program. The third goal of advancing care through community partnerships, education, and successful public communication includes specific actions such as exploring methods to help family members identify mental health needs through education and coaching; coordinating the Departments’ communications plans to improve public health messaging; facilitating access to Web-based resources; and promoting a better understanding of military culture for providers. The final goal of promoting resilience includes specific actions such as exploring methods to distribute knowledge on suicide risk and prevention; recommending and promoting family resilience programs; building from lessons learned in DOD’s resilience programs; and translating mental health research into innovative programs. This unprecedented level of collaboration is providing unique opportunities to coordinate our mental health efforts across the two Departments, for the benefit of all of our Servicemembers, eligible Veterans, and their eligible family members.

SUICIDE PREVENTION/VETERANS CRISIS LINE

The VA Suicide Prevention Program is based on the concept of ready access to high quality mental health care and other services. All VA Suicide Prevention Program elements are shared with DOD, and a joint conference is held annually to encourage use of all strategies across both Departments, including educational products and materials. One of the main mechanisms to access enhanced care provided to high risk patients is through the Veterans Crisis Line. The Crisis Line is located in Canandaigua, New York and partners with the Substance Abuse and Mental Health Services Administration National Suicide Prevention Lifeline. All calls from Veterans, Servicemembers, families and friends calling about Veterans or Servicemembers are routed to the Veterans Crisis Line. The Call Center started in July 2007, and the Veterans Chat Service was started in July 2009. To date the Call Center has:

- Received over 400,000 calls;
- Initiated over 15,000 rescues;
- Referred over 55,000 Veterans to local VA Suicide Prevention Coordinators for same day or next day services;
- Answered calls from over 5,000 Active Duty Servicemembers; and
- Responded to over 16,000 chats.

READJUSTMENT COUNSELING SERVICE: VET CENTERS

Vet Centers are community-based counseling centers that provide community outreach, professional readjustment counseling for war-related readjustment problems, and case management referrals for combat Veterans. Vet Centers also provide bereavement counseling for families of Servicemembers who died while on Active Duty. Through March 31, 2011, Vet Centers have cumulatively provided face-to-face readjustment services to more than 525,000 OEF/OIF/OND Veterans and their families. As outlined in Section 401 of Public Law 111–163, VA is currently drafting regulations to expand Vet Center eligibility to include members of the Active Duty Armed Forces who served in OEF/OIF/OND (includes Members of the National Guard and Reserve who are on Active Duty).

In addition to the 300 Vet Centers that will be operational by the end of 2011, the Readjustment Counseling Service program also has 50 Mobile Vet Centers providing outreach to separating Servicemembers and Veterans in rural areas. The Mobile Vet Centers provide outreach and direct readjustment counseling at active military, Reserve, and National Guard demobilization activities. To better serve eligible Veterans with military-related family problems, VA is adding licensed family counselors to over 200 Vet Center sites that do not currently have a family counselor on staff.

OTHER SIGNIFICANT VA/DOD MENTAL HEALTH COLLABORATIONS

The Defense Centers of Excellence (DCoE) for Psychological Health (PH) and Traumatic Brain Injury (TBI) was created in November 2007 to assess, validate, oversee and facilitate prevention, resilience, identification, treatment outreach, rehabilitation and reintegration programs for psychological health and Traumatic Brain Injury to ensure DOD meets the needs of Servicemembers, eligible Veterans, military families and communities. VA personnel occupy three key leadership positions within DCoE: Deputy Director for VA, VA Senior Liaison to DCoE for Psychological Health, and VA Senior Liaison to DCoE for TBI. DCoE and VA also collabo-

ratively plan and participate in multiple continuing education conferences each year, including the joint suicide prevention conference.

Under the auspices of the VA/DOD Evidence Based Practice Guidelines Work Group, personnel from VA and DOD serve on clinical practice guidelines committees for developing, updating and deploying joint clinical practice guidelines for mental health conditions. The VA/DOD guideline for evidence-based management of Post-Traumatic Stress was updated in 2010. Other evidence-based clinical practice guidelines for mental health include Major Depressive Disorder, Substance Use Disorders and Bipolar Disorder.

PROSTHETICS AND REHABILITATION

VA is vigilant in its search for new technologies that will benefit the men and women with medical needs who have served our country. Any technology that is commercially available and medically indicated may be provided to eligible Veterans. These devices cover every aspect of a Veteran's life, including wheeled mobility, aids for the blind, artificial limbs and bracing, and vehicular and home adaptations. Serving those eligible Veterans and Servicemembers with amputation is an area of extensive collaboration between VA and DOD. We evaluate new technologies, develop joint VA/DOD patient and family education materials, and produce Clinical Practice Guidelines related to care. VA and DOD have further partnered with the Amputee Coalition of America (ACA) to establish Peer Visitation Programs for Veterans and Servicemembers with amputation. The principal mechanism for delivery of these services is through the new VA Amputation System of Care.

VA's Amputation System of Care began rollout in 2009, and is expected to be fully operational by the end of FY 2011. This model of care provides specialized expertise in amputation rehabilitation, incorporating the latest practice in medical rehabilitation management, rehabilitation therapies, and technological advances in prosthetic componentry. The System is comprised of four distinct tiers that mirror the hub-and-spoke model of VA's Polytrauma System of Care. These tiers include:

- Seven (7) Regional Amputation Centers, which provide comprehensive rehabilitation care through interdisciplinary teams and which serve as a resource across VA for tele-rehabilitation. These Centers provide the highest level of specialized expertise in clinical care and technology and are located in the Bronx (NY), Denver (CO), Minneapolis (MN), Palo Alto (CA), Richmond (VA), Seattle (WA), and Tampa (FL).
- Fifteen (15) Polytrauma Amputation Network Sites, which provide a full range of clinical and ancillary services to eligible Veterans closer to home.
- One hundred (100) Amputation Clinic Teams, which provide outpatient amputation care and services;
- Thirty-one (31) Amputation Points of Contact, who facilitate referrals and access to services. At least one person at these facilities is knowledgeable of the Amputation System of Care and can provide appropriate consultation, assessments and referrals based on this knowledge.

The Amputation System of Care is available to all eligible Veterans and Servicemembers and provides the appropriate level of care and expertise based on the specific rehabilitation needs of each individual. While the System is not yet fully operational, our efforts to date have increased access for eligible Veterans in need of specialty amputation care. We have seen a 55 percent increase in workload and a 40 percent increase in the number of Veterans served by the Regional Amputation Centers through the end of FY 2010. Moreover, VA has served 191 percent more Veterans requiring amputation or prosthetic services through telehealth because of expansions in these programs. VA has 65 Prosthetic Labs that are accredited by the Board for Orthotist/Prosthetist Certification or American Board for Certification in Orthotics and Prosthetics. The Department also maintains more than 600 contracts with private prosthetics companies and two national providers of upper extremity prosthetics to ensure eligible Veterans have access to any commercially available and prescribed technologies.

As of April 30, 2011, VA's cohort of Veterans from OEF/OIF/OND includes a total of 1,228 Servicemembers who have sustained major limb amputations. While these patients' initial rehabilitation and recovery has mainly been completed within DOD medical treatment facilities, 748 of these members have transitioned to Veteran status and have received prostheses and amputation care services from VA. Based on a mutually recognized need to better serve this new cohort of combat injured Servicemembers, VA and DOD are establishing a 3 year pilot program at the Hunter Holmes McGuire VA Medical Center in Richmond, VA, to provide residential transitional rehabilitation. This pilot program will focus on improving the health and wellness outcomes of patients with amputations and facilitating successful transi-

tion of active duty Servicemembers to return to unrestricted military duty, or civilian vocations.

Another key area of collaboration between VA and DOD is research to identify and incorporate, the best practices and technological advancements for amputation care. In 2003, clinicians and researchers from both departments outlined joint initiatives to further prosthetics research and improve care for military and Veteran amputees. This meeting was held in response to the needs of an increasing number of soldiers suffering limb loss due to combat in Iraq and Afghanistan, resulting in a number of research projects that are now underway.

One such project is the Defense Advanced Research Projects Agency (DARPA) "Revolutionizing Prosthetics" research program initiated in 2005, which has culminated in development of the first prototype advanced prosthetic arms for clinical testing in VA. The first VA research subject was studied in April 2009. The Next-Generation DARPA Prosthetic Arm System incorporates major technological advances such as flexible socket design and innovative control features, hardware, and software that together enable enhanced functionality that promises to surpass any currently available prosthetic device. Ongoing results of this VA clinical research are informing design efforts leading to the optimization of a revised version of the Next-Generation DARPA Prosthetic Arm System. VA will employ a similar design to conduct usability research on the revised arm system. The expectation is that the results of these efforts will lead to commercialization of a refined, highly usable product. Since April 2009, 26 research subjects have been fitted with the arm during their participation in the VA research study.

Establishment of the DOD Center of Excellence on Traumatic Extremity Injuries and Amputations (CoE) will also be a key collaboration between DOD and VA to further advance amputation care and services. A joint Memorandum of Understanding (MOU) for establishment of the Center was signed by the Assistant Secretary of Defense for Health Affairs (ASD (HA)) and Under Secretary of Health (VA) on August 18, 2010. A primary focus of this CoE will be on research efforts aimed at saving injured extremities, avoiding amputations, and preserving and restoring function of injured extremities.

A working group comprised of representatives from the Services, VA, and Health Affairs has developed the concept of operations for the structure, mission and goals for the Center. Pending final approval by DOD, this plan will be sent to VA for review and concurrence prior to implementation.

ELECTRONIC HEALTH RECORDS

In the last 2 years, we have made major strides in sharing health and benefits data between our two Departments, and made significant progress toward our long-term goal of seamless data sharing systems. Our objective is to ensure that appropriate health, administrative, and benefits information is visible, accessible, and understandable through secure and interoperable information technology to all appropriate users. For the past several years, we have shared increasing amounts of health information to support clinicians involved in providing day-to-day health care for Veterans and Servicemembers. Our clinicians can now access health information for almost four million Veterans and Servicemembers between our health information systems. Veterans and Servicemembers are able to access increasing amounts of personal health information from home or work sites through our "Blue Button" technology, using VA and DOD secure Web sites.

For the last 2 years, we have worked together on a Virtual Lifetime Electronic Record (VLER). This project takes a phased approach to sharing health and benefits data to a broader audience, including private health clinicians involved in Veteran/Servicemember care, benefits adjudicators, family members, care coordinators, and other caregivers. We are in the first phase of this project, with five operational "pilot" sites where we are sharing health information between VA, DOD, and private sector health providers. VLER will be fully developed by 2014, providing health and benefits data to all authorized users in a safe, private, secure manner, regardless of the user's location.

More recently, Secretary Gates and Secretary Shinseki formally agreed that our two Departments would work cooperatively toward a common electronic health record. We call this effort the "integrated Electronic Health Record," or iEHR. As I speak to you today, our functional and technical experts are meeting to develop and draft detailed plans on executing an overall concept of operations that the two Secretaries will utilize to determine the best approach to achieving this complex goal. Once completed, the iEHR will be a national model for capturing, storing, and sharing electronic health information.

CARE COORDINATION

The two Departments continue to drive toward providing a comprehensive continuum of care to optimize the health and well being of Servicemembers, Veterans, and their eligible beneficiaries. Our joint efforts to provide a “single system” experience of life-time services are supported by three common goals: 1) efficiencies of operations; 2) health care; and 3) benefits. The goal of efficiencies of operations describes the Department’s efforts to reduce duplication and increase cost savings through joint planning and resource sharing. Our health care goal is a patient-centered health care system that consistently delivers excellent quality, access, and value across the Departments. We also strive to anticipate and address Servicemember, Veteran, and family needs through an integrated approach to delivering comprehensive benefits and services. There are five key areas where VA and DOD are collaborating to promote better care coordination for transitioning Servicemembers and Veterans: the Federal Recovery Coordination Program, the VA Polytrauma/Traumatic Brain Injury System of Care, VA Liaisons for Health Care, OEF/OIF/OND Care Management, and caregiver support.

FEDERAL RECOVERY COORDINATION PROGRAM (FRCP)

The Senior Oversight Committee (SOC established FRCP, in October 2007, as a joint VA and DOD program designed to coordinate access to Federal, state, and local programs, benefits, and services for severely wounded, ill, and injured Servicemembers, Veterans, and their families. The SOC maintains oversight of the FRCP. The program was specifically charged with providing seamless support from the time a Servicemember arrived at the initial Medical Treatment Facility in the United States through the duration of care and rehabilitation. Services are now provided through recovery, rehabilitation, and reintegration into the community. Federal Recovery Coordinators (FRC) are Masters-prepared nurses and clinical social workers who provide for all aspects of care coordination, both clinical and non-clinical. FRCs are located at both VA and DOD facilities.

FRCs work together with other programs designed to serve the wounded, ill, and injured population including clinical case managers and non-clinical care coordinators. FRCs are unique in that they provide their clients a single point of contact regardless of where they are located, where they receive their care, and regardless of whether they remain on Active Duty or transition to Veteran status.

FRCs assist clients in the development of a Federal Individual Recovery Plan and ensure that resources are available, as appropriate, to assist clients in achieving stated goals. More than 1,300 clients have participated in the FRC program since its inception in 2008. Currently, FRCP has more than 700 active clients in various stages of recovery. There are currently 22 FRCs with an average caseload of 33 clients. A satisfaction survey conducted in 2010 reported that 80 percent of FRCP clients were satisfied or very satisfied with the program.

VA/DOD COLLABORATIONS FOR POLYTRAUMA/TRAUMATIC BRAIN INJURY (TBI)

VA and DOD share a longstanding integrated collaboration in the area of TBI. Providing world-class medical and rehabilitation services for Veterans and Servicemembers with TBI and polytrauma is one of VA’s highest priorities. Since 1992, VA and the Defense and Veterans Brain Injury Center (DVBIC) have been integrated at VA Polytrauma Rehabilitation Centers (PRC), formerly known as Lead TBI Centers, to collect and coordinate surveillance of long-term treatment outcomes for patients with TBI. From this collaboration, VA expanded services to establish the VA Polytrauma/TBI System of Care to provide specialty rehabilitation care for complex injuries and TBI.

Today, this system of care spans more than 100 VA medical centers to create points of access along a continuum, and integrates comprehensive clinical rehabilitative services, including: treatment by interdisciplinary teams of rehabilitation specialists; specialty care management; patient and family education and training; psychosocial support; and advanced rehabilitation and prosthetic technologies. In addition to specialty services, eligible Veterans and Servicemembers recovering from TBI receive comprehensive treatment from clinical programs involved in post-combat care including: Primary Care, Mental Health, Care Management and Social Work, Extended Care, Prosthetics, Telehealth, and others.

VA’s provision of evidence-based medical and rehabilitation care is supported through a system-wide collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for VA rehabilitation programs. Collaboration with the National Institute on Disability and Rehabilitation Research TBI Model Systems Project enables VA to collect and benchmark

VA rehabilitation and longitudinal outcomes with those from other national TBI Model Systems rehabilitation centers. With clinical and research outcomes that rival those of academic, private sector, and DOD facilities, VA leads the medical and scientific communities in the area of TBI and polytrauma rehabilitation.

Since April 2007, VA has screened more than 500,000 Veterans from Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) entering the VA health care system for possible TBI. Patients who screen positive are referred for comprehensive evaluation by a specialty team, and are referred for appropriate care and services. An individualized rehabilitation and community reintegration plan of care is developed for patients receiving ongoing rehabilitation treatment for TBI. Veterans who are screened and report current symptoms are evaluated, referred, and treated as appropriate.

Additionally, 1,969 Veterans and Servicemembers with more severe TBI and extensive, multiple injuries were inpatients in one of the specialized VA Polytrauma Rehabilitation Centers between March 2003 and December 2010. VA and DOD collaborations in the area of TBI include: developing collaborative clinical research protocols; developing and implementing best clinical practices for TBI; developing materials for families and caregivers of Veterans with TBI; developing integrated education and training curriculum on TBI for joint training of VA and DOD health care providers; and coordinating the development of the best strategies and policies regarding TBI for implementation by VA and DOD.

Recent initiatives that have resulted from the ongoing collaboration between VA and DOD include:

- Development and deployment of joint DOD/VA clinical practice guidelines for care of mild TBI;
- A uniform training curriculum for family members in providing care and assistance to Servicemembers and Veterans with TBI (“Traumatic Brain Injury: A Guide for Caregivers of Servicemembers and Veterans”);
- Implementing the Congressionally-mandated 5-year pilot program to assess the effectiveness of providing assisted living services to Veterans with TBI;
- Integrated TBI education and training curriculum for VA and DOD health care providers (DVBIC);
- Revisions to the International Classification of Diseases, Clinical Modification (ICD-9-CM) diagnostic codes for TBI, resulting in improvements in identification, classification, tracking, and reporting of TBI;
- Collaborative clinical research protocols investigating the efficacy of various TBI treatments; and
- Development of the protocol used by the Emerging Consciousness care path at the four PRCs to serve those Veterans with severe TBI who are slow to recover consciousness.

VA LIAISONS FOR HEALTH CARE

VA has a system in place to transition severely ill and injured Servicemembers from DOD to VA’s system of care. Typically, a severely injured Servicemember returns from theater and is sent to a military treatment facility (MTF) where he/she is medically stabilized. A key component of transitioning these injured and ill Servicemembers and Veterans are the VA Liaisons for Health Care, who are either social workers or nurses strategically placed in MTFs with concentrations of recovering Servicemembers returning from Iraq and Afghanistan. After initially having started with 1 VA Liaison at 2 MTFs, VA now has 33 VA Liaisons for Health Care stationed at 18 MTFs to transition ill and injured Servicemembers from DOD to the VA system of care. VA Liaisons facilitate the transfer of Servicemembers and Veterans from the MTF to the VA health care facility closest to their home or the most appropriate facility that specializes in services that their medical condition requires.

VA Liaisons are co-located with DOD Case Managers at MTFs and provide onsite consultation and collaboration regarding VA resources and treatment options. VA Liaisons educate Servicemembers and their families about VA’s system of care, coordinate the Servicemember’s initial registration with VA, and secure outpatient appointments or inpatient transfer to a VA health care facility as appropriate. VA Liaisons make early connections with Servicemembers and families to begin building a positive relationship with VA. VA Liaisons coordinated 7,150 transitions for health care in FY 2010, and have facilitated more than 25,000 transitions since the program began in 2003.

VHA OEF/OIF/OND CARE MANAGEMENT

As Servicemembers recover from their injuries and reintegrate into the community, VHA works closely with FRCs and DOD case managers and treatment teams

to ensure the continuity of care. Each VA Medical Center has an OEF/OIF/OND Care Management team in place to coordinate patient care activities and ensure that Servicemembers and Veterans are receiving patient-centered, integrated care and benefits. Members of the OEF/OIF/OND Care Management team include: a Program Manager, Clinical Case Managers, and a Transition Patient Advocate (TPA). The Program Manager, who is either a nurse or social worker, has overall administrative and clinical responsibility for the team and ensures that all OEF/OIF/OND Veterans are screened for case management. Clinical Case Managers, who are either nurses or social workers, coordinate patient care activities and ensure that all clinicians providing care to the patient are doing so in a cohesive and integrated manner. The severely injured OEF/OIF/OND Veterans are automatically provided with a Clinical Case Manager while others may be assigned a Clinical Case Manager if determined necessary by a positive screening or upon request. The TPA helps the Veteran and family navigate the VA system by acting as a communicator, facilitator, and problem solver. VA Clinical Case Managers maintain regular contact with Veterans and their families to provide support and assistance to address any health care and psychosocial needs that arise.

The OEF/OIF/OND Care Management program now serves over 54,000 Servicemembers and Veterans including over 6,300 who have been severely injured. The current caseload each OEF/OIF/OND case manager is managing on a regular basis is 54. In addition, they provide lifetime case management for another 70 Veterans by maintaining contact once or twice per year to assess their condition and needs. This is a practical caseload ratio based on the acuity and population at each VA health care facility.

VA developed and implemented the Care Management Tracking and Reporting Application (CMTRA), a Web-based application designed to track all OEF/OIF/OND Servicemembers and Veterans receiving care management. This robust tracking system allows clinical case managers to specify a case management plan for each Veteran and to coordinate with specialty case managers such as Polytrauma Case Managers, Spinal Cord Injury Case Managers, and others. CMTRA management reports are critical in monitoring the quality of care management activities throughout VHA.

OEF/OIF/OND Care Management team members actively support outreach events in the community, and also make presentations to community partners, Veterans Service Organizations, colleges, employment agencies, and others to collaborate in providing services and connecting with returning Servicemembers and Veterans.

CAREGIVER SUPPORT

Caregivers are a valuable resource providing physical, emotional, and other support to seriously injured Veterans and Servicemembers, making it possible for them to remain in their homes. Recognizing the significant sacrifices made by family caregivers of certain Veterans and Servicemembers who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001, the new Caregivers and Veterans Omnibus Health Services Act of 2010, signed into law by President Obama on May 5, 2010, enhances existing services for caregivers of Veterans who are currently enrolled in VA care. It also provides unprecedented new benefits and services to family caregivers who care for certain eligible Veterans and Servicemembers undergoing medical discharge who are in need of personal care services. These new benefits, which are being implemented through an Interim Final Rule published earlier this month, include, for designated primary family caregivers of eligible Veterans and Servicemembers, a stipend, mental health services, and health care coverage if the primary family caregiver is not otherwise entitled to care or services under a health plan contract.

Starting May 9, 2011, VA began accepting applications for this program; we processed more than 625 applications in the first week. Caregiver Support Coordinators at each VA medical center are available to assist Veterans and their family caregivers with the application process, which can be done online, in person, or by telephone. The benefits under this program are in addition to the range of benefits and services that support Veterans and their family caregivers. These include such things as in-home care, specialized education and training, respite care, equipment and home and automobile modification, and financial assistance for eligible Veterans. VA is enhancing its current services and developing a comprehensive National Caregiver Support Program with a prevention and wellness focus that includes the use of evidence-based training and support services for caregivers. VA's Caregiver Support Coordinators are the clinical experts on caregiver issues; these Coordinators are most familiar with the VA and non-VA support resources that are available to support family caregivers in successfully caring for Veterans at home.

VA has a Caregiver Support Web site (www.caregiver.va.gov) and Caregiver Support Line (1-855-260-3274) that provide a wealth of information and resources for Veterans, families, and the general public. More than 6,000 Veterans and caregivers have received assistance from the clinical social workers staffing the Support Line since its inception on February 1, 2011.

CONCLUSION

VA and DOD continue to work together diligently to resolve transition issues while aggressively implementing improvements and expanding existing programs. While we are pleased with the quality of effort and progress made to date, we fully understand our two Departments have a responsibility to continue these efforts. We appreciate the opportunity to discuss these programs with you and to hear your recommendations.

Thank you again for your support to our wounded, ill, and injured Servicemembers, Veterans, and their families and your interest in the ongoing collaboration and cooperation between our Departments. My colleagues and I are prepared to respond to any questions you may have.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO ANTONETTE ZEISS, PH.D., ACTING DEPUTY CHIEF OFFICER MENTAL HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Please provide a list of the number of claims of recently separated veterans who were awarded compensation benefits under section 4.28 of title 38, Code of Federal Regulations for each regional office during FY 2010. Please separately state the number of prestabilization ratings of 50 percent and 100 percent for each regional office.

Response. In fiscal year 2010, 143 Veterans (52 at 50 percent and 91 at 100 percent) were awarded compensation benefits under 38 CFR 4.28 (pre-stabilization ratings). Please see Enclosure 1 for the breakdown of pre-stabilization ratings for 50 percent and 100 percent by regional office.

Question 2. The Departments have numerous programs and projects to inform servicemembers of their rights and benefits upon separation from the military. Yet, there are repeated reports from young men and women that the transition assistance was not available or they were given too much information at a time when their focus was on returning to their family.

Question 2a. What are the Departments doing to jointly manage the information flow related to separation?

Response. The Department of Veterans Affairs (VA) and the Department of Defense (DOD) teams collaborate to coordinate care to ensure that Servicemembers, Veterans, their families, and caregivers have comprehensive information regarding benefits and services available in VA, DOD and local communities. Together, the Departments ensure that Servicemembers and Veterans access the right care and services at the right time in the right place. The Departments recognize that a multi-faceted approach is necessary to ensure that information about benefits and services is delivered to all Servicemembers in a timely and understandable manner. Together, VA and DOD have implemented a comprehensive process and put complimentary resources in place that serve as a layered approach to transition.

VA's participation in outreach activities increases access to VA healthcare and benefits. VA believes that information provided to Servicemembers, Veterans and their families at scheduled, regular intervals enhances and reinforces understanding of the content and promotes retention. Thus, VA, in partnership with DOD, reaches out to Veterans at multiple venues throughout the deployment cycle (from pre-deployment, at demobilization, post-deployment, and separation from service). The goal is to help them recognize that it is in the best interest of their health to seek VA care soon after returning from combat, to ensure timely addressal of their combat-related conditions.

The key to managing the flow of information related to military separation is the Transition Assistance Program (TAP). This program is a joint effort by the Departments to ensure all separating Servicemembers understand and have access to their earned benefits. Departments participate in quarterly TAP steering committee meetings. These meetings discuss program operations and plan enhancements. In late 2011, VA will implement a TAP online courseware curriculum and a survey tool to determine participation and assess the effectiveness of the information presented for continual process improvements.

VA medical centers (VAMCs) support outreach efforts with DOD partners. Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/

OND) Care Management team members host outreach events including annual Welcome Home events, which are held in the community and serve as outreach to Veterans and family members. OEF/OIF/OND Care Management team members also participate with DOD in demobilization, Yellow Ribbon Reintegration Program (YRRP), Post Deployment Health Reassessment events (PDHRA), and Individual Ready Reserve (IRR) musters.

VA actively participates in DOD's mandated PDHRA, a health care screening for all National Guard and Reserve Servicemembers returning from deployment. The PDHRA is conducted between 90 and 180 days post-deployment, allowing for Servicemembers to have time with their families and then more readily engage in post-deployment care. The intent of the PDHRA is to identify deployment-related physical health, mental health and readjustment concerns, and to identify the need for follow-up evaluation and treatment.

VA and DOD partner at demobilization sites to inform reserve component combat Veterans of their enhanced VA health care and dental benefits during mandatory demobilization separation briefings where they are introduced to VA. Servicemembers are enrolled in VA healthcare onsite and provided with contact information for their local OEF/OIF/OND Program Managers, who coordinate initial health and dental appointments at the VAMC. Similarly, VA partners with the US Marine Corps and US Army Reserve to provide the same services to Soldiers and Marines during their mandatory IRR Muster.

The YRRP is a DOD-wide effort, in which VA is a major participant, to support National Guard and Reserve Servicemembers and their families to increase awareness and utilization of VA benefits, programs, and services throughout the deployment cycle, i.e., before, during and after deployments. YRRP events are hosted by military units and held throughout the year in every state. VA staff provides support and information on benefits, services, and programs available to Guard and Reserve members; enroll Veterans in VA's health care system; and coordinate referrals to other VA services and/or programs. VA staff may also provide specialized briefings on issues such as PTSD and TBI. Additionally, VA has placed a dedicated, full-time liaison in the YRRP Office at the Pentagon.

To support VA programs and services, VA maintains an internet webpage for OEF/OIF/OND Veterans. In addition to providing information about VA benefits and services, this site contains blogs and other social media tools to engage this new generation of Veterans. This site includes a section for family members as well as links to other Federal and military resources. The Website is www.oefoif.va.gov.

National Guard Transition Assistance Advisors (TAAs) serve in the field at the state level. TAAs assist National Guard Servicemembers and their families in accessing VA benefits and services, VA medical centers, and VBA regional offices.

Question 2b. How do E-Benefits and the Veterans Relationship Management program fit into a joint VA/DOD plan to keep all separating servicemembers informed?

Response. The eBenefits portal is a collaborative effort between VA and DOD to provide Veterans, Servicemembers, and their families personalized access to benefit information, resources, and self-service capabilities.

The eBenefits portal deployed a communication tool in December 2010. This tool enables VA and DOD to provide messages throughout an individual's military career and after separation. These messages provide Servicemembers with important benefit and health services information, state and local government information, employment, education, housing, or any other relevant demographic information as the separating Servicemembers transition back into their communities' and civilian employment.

Veterans Relationship Management (VRM) is a broad multi-year initiative to improve Veterans' secure access to health care and benefits information and assistance. VRM will provide VA employees with up-to-date tools to better serve Veterans and their families, and will empower Veterans through enhanced self-service capabilities such as those found within the eBenefits portal.

Question 3. In the Department's view, how will a single electronic health record strengthen the transition for servicemembers leaving active duty?

Response. The integrated Electronic Health Record (iEHR) is a key strategic resource in improving the care of Servicemembers before, during and after the transition from active duty to Veteran status. The implementation of common medical terminology will greatly enhance the ability to exchange computable, interoperable patient-centered data. A single record for each Servicemember and Veteran will add new capabilities for clinicians at both the DOD and the VA to quickly find needed information, improve operational efficiency and reduce the need for redundant evaluations and testing. Jointly developed decision support resources and evaluation measures will help maintain a similar high standard of care and patient safety across both Departments while improving the ability to both benchmark and iden-

tify patterns and trends over time. A common record for each Servicemember and Veteran will provide a foundation for improved communication across Departments in the form of electronic referrals, consultation requests, orders portability, and provider-provider messaging enhancing the continuity and timeliness of patient care. Transition for Servicemembers includes not only medical care, but evaluation for disability and benefits, which will also be enhanced as both Departments adopt matching terms and a common language to describe the care received by our beneficiaries. Our future electronic health record will contain not only resources for providers and clinical teams, but provide rich access to information for both Servicemembers and Veterans. Patient-facing resources in the form of web portals, personal health records, eHealth and mobile applications which will remain consistent and familiar across the continuum from active duty to Veteran status, will highly increase the engagement of the Servicemember and Veteran in his or her care, and as a result, improve the patient care experience and improve health.

Question 4. Over the years, VA and DOD have increased servicemembers' opportunities to file a "pre-discharge" disability claim, yet the Departments estimate that less than half of all servicemembers currently have access to file a claim. With the use of contractors and the potential of filing an electronic claim, it is reasonable that 100 percent of servicemembers would be able to participate in this process.

Question 4a. Do both Departments intend to provide 100 percent of transitioning servicemembers with the opportunity to file a "pre-discharge" disability claim, and if so, what is the timeline for completion of this goal?

Response. Currently, VA has programs that allow 100 percent of transitioning Servicemembers the opportunity to file a pre-discharge claim. In July 2008, VA expanded the Benefits Delivery at Discharge (BDD) program to accept claims from any Servicemember who is within 60 to 180 days of separation or retirement from active duty and is able to report for a VA examination prior to discharge. VA also has the Quick Start program, which provides Servicemembers within 59 days of separation, or Servicemembers within 60–180 days of separation who are unable to complete all required examinations prior to leaving the point of separation, to be assisted in filing their disability claim. Servicemembers in the DOD Integrated Disability Evaluation System (IDES) complete VA Form 21–0819, the VA/DOD Joint Physical Disability Evaluation Board Claim, which initiates a claim for VA compensation. The Seriously Injured Program was implemented to solicit pre-discharge claims from Servicemembers who are seriously injured in OEF/OIF/OND and awaiting discharge for these disabilities. Therefore, 100 percent of transitioning Servicemembers have the opportunity to file pre-discharge disability claims.

Question 4b. What obstacles stand in the way of providing 100 percent of transitioning servicemembers with the opportunity to file a "pre-discharge" disability claim?

Response. As noted in response to question 4a, 100 percent of transitioning Servicemembers have the opportunity to file a pre-discharge claim. However, some Servicemembers decide not to file a pre-discharge claim. VA defers to DOD to address mission-essential obstacles which may make it difficult for Servicemembers to attend these program briefings.

Question 5. VA recently briefed the Committee on a plan to provide servicemembers in the IDDES process with early eligibility for the Vocational Rehabilitation and Employment (VR&E) program. As you know, a prerequisite for services under VR&E is a VA disability rating. However, many veterans in the IDDES process do not receive their disability ratings prior to discharge. How does VA plan to enroll servicemembers for VR&E without a disability rating?

Response. VR&E provides outreach and transition services to Servicemembers transitioning through the IDDES. By physically placing VR&E counselors at IDDES locations, benefits delivery timeliness will be improved. VR&E services range from a comprehensive rehabilitation evaluation that determines abilities, skills, and interests for employment purposes to support services that identify and maintain employment. The objective is to have every Servicemember attend a mandatory appointment with a Vocational Rehabilitation Counselor at the point of referral to a Physical Evaluation Board. These services can be provided through the use of Chapter 36 Educational and Vocational Counseling services, which can be provided to transitioning Servicemembers within six months of discharge from active duty, within one year following discharge from active duty, or at any time an individual is eligible for one of VA's educational benefit programs. Therefore, the complete evaluation, including the development of a proposed employment objective, can be completed under Chapter 36 authority without the need for a rating. VR&E service delivery may commence with a memorandum rating (the rater establishes this based on service medical records that the final rating will be at least 20%) or an

IDES proposed rating. VA and DOD are working to identify sites to test the concept prior to larger scale implementation in FY 2012. Memorandums of understanding have been drafted between VA and DOD to formalize this expansion initiative.

Question 6. The Department's budget submission for FY 2012 includes among its performance measures that VA will screen patients at required intervals for PTSD, and that final data for FY 2011 indicate 97 percent performance for that measure. Another measure calls for a specified percentage of OEF/OIF Veterans with a primary diagnosis of PTSD to receive a minimum of 8 psychotherapy sessions within a 14-week period; but actual performance for FY 2010 was that only 11 percent of patients received that minimum amount, which is only about half the (20 percent) projection for that year made in the FY 2011 Budget Submission. (10P4: a-d)

Question 6a. Why, relative to the high expectations for screening, is the bar for receiving that minimum number of psychotherapy sessions within 14 weeks set as low as it is?

Response. The higher target established for Post Traumatic Stress Disorder (PTSD) screening than for the utilization of specific treatments reflects important and inherent differences between the targeted focus and goals for screening and for specific interventions. Screenings are typically universally applied to a specific group or subgroup to identify the possible presence of a condition or illness in as many people as possible. Further, because screening is not the same as a full assessment, screening commonly identifies individuals as being "positive" on the screener for a specified condition who, after a full psychodiagnostic evaluation, are determined not to have the condition. Thus, one would not expect the target established for screening to be equivalent to the target set for intensive treatment.

In addition, the target established for psychotherapy is designed to reflect a full course of evidence-based psychotherapy (EBP); however, not all Veterans will initially engage in a full course of psychotherapy, sometimes for appropriate or understandable reasons. For example, some Veterans may not be psychologically ready to engage in a full course of exposure-based psychotherapy for PTSD and may start out with a briefer course of psychotherapy to build coping skills. Further, the target set for the psychotherapy performance measure reflects the fact that many Veterans with PTSD choose to receive psychotherapy or counseling services at Vet Centers. These Veterans may be included in the denominator of this measure, if a diagnosis was made at a VA facility or clinic, but they would not be included in the numerator, since VHA administrative databases do not usually include Vet Center service utilization data. The Vet Center program closely maintains confidentiality of services it provides, in order to promote a sense of comfort among Veterans seeking their services.

Other Veterans may initially receive medication, particularly selective serotonin reuptake inhibitors (SSRIs) or selective norepinephrine reuptake inhibitors (SNRIs). SSRIs and SNRIs are evidence-based psychopharmacotherapies with a Grade A level of evidence in the VA/Department of Defense (DOD) Clinical Practice Guideline for PTSD. Data from a VA-sponsored research project examining the use of evidence-based medication practices for PTSD indicate that in Fiscal Year (FY) 2009, 59 percent of all patients with a PTSD diagnosis received a SSRI or SNRI. This is up from 50 percent of Veterans with a PTSD diagnosis in 1999. Veterans opting to receive only medication would typically be included in the denominator of this measure, but they would not be included in the numerator.

Furthermore, some Veterans may choose not to participate in weekly psychotherapy due to difficulties with obtaining time off from work or due to transportation or related physical access challenges. VA is working to promote the delivery of evidence-based psychotherapies through telemental health modalities to try to further increase access to these services and help Veterans overcome such challenges. VA's efforts in this area are unique. VA is currently in the process of developing an EBP for PTSD Telemental Health Toolkit, to help program managers and front-line staff who implement these services.

In summary, Veteran choice is critical to providing patient-centered care and some Veterans may, at least initially, choose not to receive a sustained course of psychotherapy for PTSD or choose to receive services at Vet Centers. These factors appropriately are reflected in the target for the measure of minimum number of psychotherapy sessions. However, VA is committed to making these important services widely available to Veterans so that when they do wish to receive such services, they can do so. VA's efforts utilized to implement that commitment include:

- VA has established policy in VHA Handbook 1160.01, *Uniform Mental Health Services in VA medical centers and Clinics*, that requires that all Veterans have access to Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy (PE) for PTSD, as designed and shown to be effective;

- VA has developed national initiatives to disseminate and implement CPT and PE (Karlin et al., 2010). As part of this effort, VA has implemented national competency-based staff training programs in these therapies. To date, VA has provided training in these therapies to more than 3,400 VA mental health staff;

- A national survey of VA facilities conducted in July 2010 evaluated the extent to which these therapies were being provided by facilities. The survey found that all facilities are providing CPT or PE, and 98 percent of facilities are providing both of these therapies. Survey results further indicate that the level of capacity to provide these therapies varies throughout the system;

- Training in CPT and PE in FY 2011 is using a targeted approach placing important focus on sites that have fewer trained staff; and

- The availability of clinics with weekly 60–90 minute sessions, as these therapies require, is also an important requirement. VA is working to ensure such clinics are consistently available throughout the system.

VA also would like to increase the proportion of Veterans who receive a full course of evidence-based psychotherapy for PTSD; the above efforts are designed to take steps to do exactly that, and VA is exploring other ideas about how to encourage more Veterans to fully participate in this important approach to care. VA will be progressively increasing the target for this performance measure in each of the next three fiscal years, as VA continues its ongoing dissemination of and training in evidence-based psychotherapies for PTSD.

Question 6b. Emphasizing provision of evidence-based psychotherapy for PTSD does not appear to have resulted in high percentages of Veterans completing these recommended courses of therapy. Are Veterans not entering these treatment programs, or are they discontinuing participation in such treatment programs? Please provide data to support this.

Response. Current Procedural Terminology codes used for tracking health care services do not allow distinction of different types of psychotherapy, nor do they provide information about an individual's level of participation, such as the number of therapy sessions received as compared to the number recommended within a given therapy protocol. VA's Office of Mental Health Services has developed documentation templates for each of the evidence-based psychotherapies (EBP) and is disseminating these templates nationally. These templates will allow for precise tracking of EBP delivery and treatment completion, as well as facilitate documentation of session activity, promote fidelity to therapy protocols, and capture data elements to help track more detailed information about participation in EBP activities than is available through standard encounter form data. The templates have been piloted at several facilities and are scheduled for full system deployment in FY 2012.

While awaiting development of these new informatics processes, VA has conducted surveys of the field to obtain information on the extent to which Operation Enduring Freedom/Operation Iraq Freedom/Operation New Dawn (OEF/OIF/OND) Veterans with PTSD have been offered and provided Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy (PE), as well as the extent to which these Veterans have completed a full course of one of these treatments. As reported above, responses to this survey indicated that all facilities are providing either CPT or PE, as required by VHA Handbook 1160.01, *Uniform Mental Health Services in VA medical centers and Clinics*, and all but two facilities reported providing both CPT and PE. Further, the survey results revealed that approximately between October 1, 2009 and May 31, 2010, 30 percent of Veterans offered CPT or PE began treatment at that time. Of those Veterans that initiated treatment, 51 percent completed a full course of therapy. It is important to note that these survey data are approximations reported by facilities based on locally available data collected by facility staff, since centralized administrative data for tracking specific types of psychotherapy are not available. These data are comparable to data in published literature; one of the most extensive reviews of psychotherapy completion rates in the published literature, conducted in 1993, showed that the average completion rate for psychotherapy was 53 percent (average from a meta-analysis of 125 studies; Wierzbicki & Pekarik, 1993). This meta-analysis of studies conducted outside VA provides a baseline against which to measure VA's success in sustaining Veterans in psychotherapy.

Various factors, as noted above, contribute to Veterans not completing a course of psychotherapy, including the emotional challenges of full participation, as well as logistical issues such as transportation difficulties, employment-related issues, child care responsibilities, and other factors. Seal et al. (2010) reviewed the factors that contributed to failure of OEF/OIF/OND Veterans to engage in mental health treatment; these included: (1) having a new diagnosis of PTSD from a non-mental health clinic (VA primary care or VA specialty clinic other than mental health); and (2) living more than 50 miles from a VA facility. As was noted earlier about 56 percent

of mental health diagnoses originate in non-mental health clinics (Seal, et al., 2010). Veterans diagnosed with PTSD in these non-mental health clinics were less likely to meet the 8 sessions in 14 weeks measure, during the time of her study. Factors that Seal and colleagues found were associated with increased treatment engagement were: (1) having other comorbid diagnoses in addition to PTSD thus likely to be more distressed and more functionally impaired; (2) being 25 years of age or older, and (3) receiving care through a VA community-based outpatient clinic (CBOC). The reasons for the associations she reports between various factors and completion of treatment are unclear, although it is important to note that Dr. Seal collected data only up through 2008, and much of the major effort in dissemination of these therapies, integration of mental health staff into primary care clinics, and expansion of telemental health in CBOCs has occurred since 2008.

We also have examined internal VA data to explore other issues related to completion of psychotherapy. For example, we examined patients with diagnoses of both PTSD and a substance use disorder (SUD), a common pattern of comorbidity, and found that those seen within specialty SUD treatment programs are about 2 times more likely to receive a full course of psychotherapy for PTSD than those seen only in general mental health. Additional data indicate that patients who did not manage to complete a full-course of psychotherapy in a first attempt often came back later and completed a full-course of treatment. In FY 2008, 40 percent of SUD and 48 percent of PTSD patients who attempted outpatient psychotherapy had at least two outpatient psychotherapy episode starts in a single year. Among those who completed at least 9 outpatient psychotherapy visits within 15 weeks, between 22 percent of SUD to 26 percent of PTSD patients failed to complete at least 9 sessions within a 15-week timeframe from the start of treatment in their first therapy attempt but were successful in their second or later attempt. This suggests that even though life circumstances or difficulties handling symptomatology or treatment may abort initial treatment attempts, patients do come back. Thus, performance measures that look for treatment completion over a year will not reflect the true level of care that patients may be receiving, due to the actual pattern of treatment initiation, which suggests that Veterans should be followed not only on their first participation in psychotherapy, but over time as they become better able to sustain participation. Accordingly, VA is working to adjust its performance measure to account for and capture psychotherapy utilization that may occur across multiple fiscal years.

Question 6c. What factor or factors account for the dramatic shortfall from the 20 percent projection for FY 2010 to an actual performance for that fiscal year of only 11 percent? Specifically, what role does access to care—in terms of difficulty in getting timely appointments, transportation challenges, lack of evening hours for those who work, and other such factors—play in the high number of Veterans who discontinue treatment?

Response. We would like to clarify that the 20 percent figure was not a “projection for FY 2010.” Rather, the 20 percent projection was set as an aspirational target for OEF/OIF/OND Veterans, since VA is still in the process of its unprecedented efforts to nationally disseminate and implement evidence-based psychotherapies for PTSD, but was designated without a true baseline on which to gauge an appropriate target or to make a “projection” of expected utilization. The 11 percent figure referenced in the question refers to the subset of OEF/OIF/OND Veterans with a primary diagnosis of PTSD who had at least one visit in a mental health clinic (the measure denominator). The typical standard for mental health performance measures is to include a two-visit requirement, such that the measure would include only OEF/OIF/OND Veterans with a primary diagnosis of PTSD who had at least two visits in a mental health clinic as the measure denominator. The two-visit criterion is a better measure of those who are appropriate for and willing to be treated in a mental health clinic. Actual national performance on the measure in FY 2010 using this criterion was 14 percent, with the facility range 2.4 percent to 38 percent. Notably, 55 facilities exceeded the national average, and many exceeded the aspirational projection. As noted in the answer to Question 6a, this does not include Veterans who may have received one of the EBPs at a Vet Center, whose staff also have been trained to provide evidence-based therapy EBP for PTSD.

With respect to your specific query about possible barriers to access to care, barriers to receiving a full course of EBP for PTSD include transportation and physical access difficulties for some Veterans, difficulty obtaining time off for work, and other life demands. Anecdotally, clinicians indicate that given recent gas prices, Veterans report that the cost of travel can be prohibitive for many Veterans, especially when weekly attendance to treatment is required. OEF/OIF/OND Veterans who do not yet have service connection do not qualify for travel pay.

Other barriers remain, though we cannot put statistical values to their role. Stigma of receiving mental health care is still a factor. Related to stigma, many Veterans may prefer taking medications versus receiving psychotherapy, believing that it implies less “fault” and that PTSD is due to factors outside their control without chemical correction. As noted before, committing to an individual therapy that asks for intense emotional participation can be difficult.

In addition, clinic scheduling procedures have been barriers to fully implementing EBPs at some sites. Specifically, it is essential that appointment scheduling systems allow for the scheduling of 60-, 90-, or 120-minute sessions as EBPs require. Older scheduling systems based on case management, medication management, or other service models have often not been set up to support appointment lengths of this type. Many facilities have successfully addressed this, for example, by developing clinic profiles with a default time increment of 30 minutes, which allows the clinician to specify to the scheduler whether a 30-, 60-, 90-, or 120-minute session is required. In addition, scheduling practices must be appropriately flexible to enable clinicians to deliver full courses of EBP, which typically require that the same clinician be available on a weekly basis through the length of the therapy protocol. A scheduling strategy that has often been successful for addressing this is to schedule the entire course of weekly EBP sessions prior to the initiation of treatment (using a specific function of the scheduling software). This ensures the therapist does not have their schedule otherwise fully booked with other appointments, which would prevent the therapist from implementing an EBP protocol. VHA will continue to closely monitor the performance of its sites on this issue and has developed detailed guidance that will be sent to all VISNs related to scheduling and other local requirements and strategies for fully implementing EBPs. We will continue to try to address all possible barriers and to increase the availability of and acceptability of these therapies to Veterans. Additional details on these efforts are provided in response to Question 6d.

Question 6d. What specific actions has VA taken by way of a national strategy to materially increase the number of Veterans both enrolling in and staying in recommended psychotherapy programs?

Response. Increasing utilization of these therapies is a very high priority for VA. VHA has taken a number of actions to try to increase the number of Veterans enrolling in and remaining in recommended psychotherapy programs:

- VA expanded core mental health staff by over 6,600 full-time equivalent staff between the end of FY 2007 and May 31, 2011, to increase availability of staff and decrease difficulty getting timely appointments. VA’s tracking of outpatient appointments for new and established patients demonstrates that standards for accessible care—within 14 days of referral for patients new to mental health or within 14 days of desired next appointment for established patients—are met 95 percent of the time;
- VA requires that all medical centers have extended hours for mental health services;
- VA has developed a national evidence-based psychotherapy (EBP) staff and public awareness campaign. As part of this campaign, the Office of Mental Health Services has developed EBP brochures, fact sheets, and posters designed to provide education on and promote awareness of evidence-based psychotherapies among staff and Veterans at VA facilities and community agencies. This is designed to promote requests for evidence-based psychotherapy and asking of questions of patients to their providers (e.g., primary care providers) and other staff that ultimately will promote engagement in treatment;
- VA has appointed a local EBP Coordinator at each VA medical center to serve as a champion for EBPs at the local level and provide longer-term consultation and clinical infrastructure support to allow for the full implementation and ongoing sustainability of evidence-based psychotherapies at each VA site. These Coordinators also share success stories of Veterans who have successfully participated in EBP to promote interest and engagement among other Veterans.
- VA has developed and just launched a national initiative to disseminate and implement Motivational Interviewing (MI) to promote initial and ongoing engagement in treatment. MI is a collaborative, person-centered form of guiding that is used to elicit and strengthen motivation for change. MI has strong empirical support for facilitating treatment and promoting initial and ongoing behavioral change (see Hettema, Steele, & Miller, 2005 for a review). MI can be incorporated into evidence-based psychotherapy and has particular utility and value for promoting ongoing engagement in this context. As part of VA’s MI dissemination initiative, the Office of Mental Health Services has developed a national, competency-based MI training program, which began training in July 2011.

- VA, in coordination with the Department of Defense, has developed a mobile phone PTSD application, called “PTSD Coach.” This app is designed to promote skills for managing PTSD and can serve as a complementary tool to evidence-based psychotherapy for PTSD. It is also designed to promote interest and engagement in evidence-based psychotherapy. This app, which was just recently launched, has already been downloaded over 14,000 times and is available in both iPhone and Android formats.
- VA is working to promote initial and ongoing engagement in evidence-based psychotherapy for PTSD by promoting the implementation of these therapies through telemental health modalities. EBP for PTSD telemental health services offer an opportunity to overcome physical and related access barriers (e.g., physical distance, transportation costs and difficulties, job responsibilities) to initial and ongoing participation in EBP.
 - As part of this effort, VA formed a Task Force that has issued recommendations for a national strategy to promote the implementation of evidence-based psychotherapy for PTSD telemental health services, which are already provided at some facilities and have been shown to be effective with Veterans (Tuerk et al., 2010).
 - VA is currently in the process of developing an EBP for PTSD Telemental Health Toolkit to help program managers and front-line staff implement these services.
 - An all-day workshop on the delivery of CPT and PE via telemental health will be conducted at VA’s national mental health conference in August 2011.
 - Finally, as noted before, VHA will send a letter shortly to direct having appointment scheduling options that match the requirements of the evidence-based psychotherapies. In addition, plans for site visits of mental health programs in the field will include review of the scheduling practices.

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Question 7. Data indicate (a) that only about half of returning OEF/OIF Veterans have been seen in VA health care facilities, (b) that high percentages of those who have not sought VA care are at risk of war-related mental health conditions, and (c) that—of those whom VA has diagnosed as having PTSD—large numbers have dropped out of treatment. Please comment on those observations and the potential conclusion that VA’s effectiveness in actually reaching and successfully treating the very large number of OEF/OIF Veterans with PTSD (as measured by the Department’s own performance indicator) is very limited.

Response. (a & b) As of the end of the first quarter of FY 2011, approximately 51 percent of all separated OEF/OIF/OND Veterans had obtained VA health care since 2002. This rate of treatment engagement is higher than that reported in the National Vietnam Veterans Readjustment Study (Kulka, et al., 1988), which was conducted in 1986–87. Specifically, Kulka and colleagues found that only 30 percent of Vietnam Veterans reported ever using VA mental health services; for physical health problems, 26 percent and 12 percent reported ever using VA outpatient and inpatient care, respectively.

Epidemiological research suggests that approximately 15 percent of OEF/OIF/OND Servicemembers and Veterans have current PTSD. VA administrative data show that, of those OEF/OIF/OND Veterans who have utilized VHA healthcare, over 50 percent of those individuals have a provisional diagnosis of a mental disorder with just over half of those being provisionally diagnosed with PTSD (Healthcare

Utilization data as of First Quarter FY 2011, VA Environmental Epidemiology Service). It is important to recognize that the OEF/OIF/OND Veterans utilizing VA health care very likely are not a representative sample of the entire returning Veteran population, and thus VA may well be reaching most of those OEF/OIF/OND Veterans with significant mental health problems—i.e., those who need mental health care are seeking VA services disproportionately. It is also important to note that those OEF/OIF/OND Veterans who do not seek care from VA may be seeking care for mental health outside VA (i.e., preferring local community or State resources). In order to enhance mental health care for returning Veterans both within and outside VA, VA has actively collaborated with DOD and other State and community partners through such activities as the Federal Partners Senior Workgroup on Returning Veterans and their Families, the VA/DOD Integrated Mental Health Strategy, and the Substance Abuse and Mental Health Services Administration (SAMHSA) Policy Academy programs of the Department of Health and Human Services in 2008 and 2010 that served to enhance coordinated care for returning Veterans and their families in 16 States and two U.S. Territories.

From VHA administrative data, a potential conclusion can be drawn that VA may be very effective in actually reaching and successfully treating the very large number of OEF/OIF/OND Veterans with PTSD. Of those Veterans treated in FY 2010 for PTSD, 83,864 (20.5 percent) were OEF/OIF/OND Veterans. VA continues to improve rates of treatment for OEF/OIF/OND Veterans; VA data indicate that the number of OEF/OIF/OND Veterans engaging in PTSD treatment has increased annually. Specifically, between FY 2007 and FY 2010, the number of Veterans treated for PTSD has increased by an average of 17,000 additional Veterans per year. Data from the Office of Environmental Epidemiology indicate that for OEF/OIF Veterans who had a primary diagnosis of PTSD in the years between 2007 and 2010, 70 percent had three or more clinical encounters for PTSD each year. This suggests that the majority of OEF/OIF Veterans are engaged in treatment.

Response. (c) As noted in the response to question 6 above, dropping out of a specific treatment is not a clear indication that the Veteran will leave the treatment process. Some Veterans may not be psychologically ready to engage in a full course of exposure-based psychotherapy for PTSD and may start out with a briefer course of psychotherapy to build coping skills. As noted in that response, data indicate that patients who did not manage to complete a full-course of psychotherapy in a first attempt often came back later and completed a full-course of treatment. In FY 2008, 40 percent of SUD and 48 percent of PTSD patients who attempted outpatient psychotherapy had at least two outpatient psychotherapy episode starts in a single year. Among those who completed at least 9 outpatient psychotherapy visits within 15 weeks, between 22 percent (SUD) to 26 percent (PTSD) patients failed to complete at least 9 sessions within a 15-week timeframe from the start of treatment in their first therapy attempt but were successful in their second or later attempt. This suggests that even though life circumstances or difficulties handling symptomatology or treatment may abort initial treatment attempts, patients do come back. Thus, performance measures that look for treatment completion over a year will not reflect the true level of care that patients may be receiving, due to some Veterans having multiple episodes of psychotherapy initiated before a single course of treatment is actually completed.

Dropping out of mental health treatment is a problem throughout all health care. In the response to 6b above, we note that comparable data in the research literature show that the average completion rate for psychotherapy is 53 percent (average from a meta-analysis of 125 studies; Wierzbicki & Pekarik, 1993). VA is addressing this reality and will continue to seek and implement strategies to increase our ability to deliver the best possible treatments to Veterans. We are confident those efforts are crucial, because of the very positive outcomes being obtained for those who do complete therapy. Data indicate successful outcomes for the majority of the many OEF/OIF/OND Veterans who complete evidence-based treatment for PTSD experience significant symptom reduction. Clinical outcome data from VA's Prolonged Exposure Therapy (PE) therapy and Cognitive Processing Therapy (CPT) staff training programs are summarized below.

1. *PE Results:* Veterans who completed PE decreased from an average pre-treatment PTSD Checklist (PCL) score of 62.1 to an average post-treatment PCL score of 42.1. This reduction is statistically significant and indicates a 32 percent drop in self-reported PTSD symptoms. At pre-treatment, 14 percent of Veterans in PE had a PCL score below 50, the clinical cutoff for PTSD. At post-treatment, 67 percent of the Veterans fell below the PCL clinical cutoff for PTSD. Improvement as a result of treatment was similar across Veteran cohorts. The average pre-treatment Beck Depression Inventory-2 (BDI-2) score was 28.0, and the average post-treatment

BDI-2 was 17.3. This reduction is statistically significant and indicates a 38 percent drop in self-reported symptoms of depression.

2. *CPT Results:* Veterans who completed CPT decreased from an average pre-treatment PCL score of 63.8 to an average post-treatment PCL of 45.5. This reduction is statistically significant and indicates a 29 percent drop in self-reported PTSD symptoms. At pre-treatment, 9.9 percent of Veterans in CPT had a PCL score below the PTSD cutoff of 50. At post-treatment, 59.0 percent of the Veterans fell below the PCL clinical cutoff. Treatment gains were similar across Veteran cohorts. The average pre-treatment BDI-2 score was 30.4, and the average post-treatment BDI-2 was 19.2. This reduction is statistically significant and indicates a 37 percent drop in self-reported symptoms of depression.

Question 8. What steps—other than those cited in the Department’s testimony, and other than programs that have long been in place—has the Department taken (a) to reach the approximately half million OEF/OIF Veterans who have not been seen at VHA facilities, (b) to identify methodically the factors that lead OEF/OIF Veterans to discontinue treatment for PTSD, and (c) to improve very substantially the rate of sustained retention in treatment of OEF/OIF Veterans with PTSD?

Response. VA has many additional longstanding programs as well as new programs that are designed to reach OEF/OIF/OND Veterans who have not been seen at VHA facilities. The following list of mental health specific outreach efforts is extensive, but not fully exhaustive of all efforts. Many local VA facilities provide outreach to returning Veterans; not all of these efforts are tracked by VA Central Office.

Question 8a. Outreach to Veterans not seen at VHA facilities:

- The Services for Returning Veterans-Mental Health (SeRV-MH) teams have been established across the VA system since 2005. These programs focus on outreach, early identification and management of stress-related disorders and may decrease the long term disease burden on returning troops. Since FY 2005, 93 SeRV-MH teams have been established across the VA system. They work in close collaboration with the OEF/OIF/OND post-deployment primary care teams.

- VA continues to actively participate in activities and presentations related to Post Deployment Health Reassessment (PDHRA) and Yellow Ribbon Reintegration Program (YRRP) events, which continue to enroll and refer Veterans to VA health care.

- VA has been actively collaborating with DOD and other State and community partners through such activities as the Federal Partners Senior Workgroup on Returning Veterans and their Families, the VA/DOD Integrated Mental Health Strategy, and the SAMHSA Policy Academy programs, which help promote mental health services for those Veterans who prefer to seek their care outside of the VHA system of care.

- New web-based mechanisms designed to reach OEF/OIF/OND Veterans include an enhanced VA presence on social media sites such as Facebook and Twitter. In April 2011, VA launched the first in a suite of VA/DOD mobile apps—the PTSD Coach. This app can be downloaded free from iTunes and was downloaded over 6,000 times in 28 countries within hours of its release. As of July 11, 2011 the app had been downloaded over 16,000 times in 43 countries. The app is free and available in Android and iPhone formats.

- The Readjustment Counseling Service Call Center is a relatively new effort that is increasingly being utilized by Veterans. Additionally the rebranding of VA Crisis Line, formally the VA Suicide Hotline, has had a subsequent upsurge of calls.

- VA has a new initiative to place VA staff in colleges and universities where Veterans are attending with funding from the GI Bill. These efforts are being developed in collaboration with student Veteran organizations, such as Student Veterans of America. This initiative is currently being implemented at sites in five VISNs. These are VISN 1: Bedford VA Medical Center (VAMC) , VISN 7: Tuscaloosa VAMC, VISN 11: Ann Arbor Healthcare system, VISN 17: Central Texas Veterans Healthcare System: Austin Clinic, and VISN 21: San Francisco VAMC. Eventual implementation in all VISNs is planned, but broad implementation will be designed based on results of the pilot project.

- Another strategy for increasing the number of Veterans who are accessing VA care will launch in the fall of 2011. This is a national mental health anti-stigma campaign to reduce stigma associated with mental illness and promote acceptance of and Veteran comfort with accessing mental health care. This also will remind Veterans that VA care is quickly available for them.

Question 8b. Efforts to identify factors that lead OEF/OIF/OND Veterans to discontinue treatment for PTSD:

- While VHA does not have comprehensive, national data on specific factors that lead OEF/OIF/OND Veterans to discontinue treatment for PTSD, VA has utilized structured surveys of subsets of Veterans to obtain such information (e.g., the New York State RAND Study, 2011). These surveys suggest that barriers to continuing treatment include time away from work or school, distance from home to treatment sites, concerns about stigma should employers learn about the Veteran being in treatment, and concerns about efficacy of treatment.

- Numerous initiatives currently exist to address these potential barriers. In addition to programs and initiatives mentioned in the replies to questions addressed within this set of questions and replies, the VA Uniform Mental Health Services Handbook is designed to reduce potential distance barriers as well as the time away from work or school by requiring PTSD care to be available at CBOCs (either on site or via telemental health) and by requiring that all VAMCs provide some evening or weekend hours.

- For PTSD care available at medium to very large size CBOCs, national compliance rates are between 96.08 percent and 97.67 percent.

- For provision of evening and weekend hours, national compliance rates are at 97.1 percent.

Question 8c. Efforts to improve participation in evidence-based care:

- VA has developed a national evidence-based psychotherapy staff and public awareness campaign. As part of this campaign, the Office of Mental Health Services has developed evidence-based psychotherapy (EBP) brochures, fact sheets, and posters designed to provide education on and promote awareness of evidence-based psychotherapies among staff and Veterans at VA facilities and community agencies. This is designed to promote requests for evidence-based psychotherapy and asking of questions of patients to their providers (e.g., primary care providers) and other staff that ultimately will promote engagement in treatment.

- VA has appointed a local EBP Coordinator at each VA medical center to serve as a champion for evidence-based psychotherapies at the local level who provide education to Veterans and staff in evidence-based psychotherapies and share success stories of Veterans who have successfully participated in evidence-based psychotherapy to promote interest and engagement among other Veterans.

- VA has incorporated Veteran testimonials on VA social media sites and videos about efficacy of treatment.

- As stressed in the reply to Question 6, VA is working to promote engagement in evidence-based psychotherapy for PTSD through telemental health modalities which remove several barriers to treatment. As part of this effort, VA has formed a Task Force that has issued recommendations for a national strategy to promote the implementation of evidence-based psychotherapy for PTSD telemental health services, which are already provided at some facilities and have been shown to be effective with Veterans (Tuerk, Yoder, Ruggiero, Gros, & Acierno, 2010). VA is currently in the process of developing an EBP for PTSD Telemental Health Toolkit to help program managers and front-line staffs implement these services. An all-day workshop on the delivery of CPT and PE via telemental health will be conducted at VA's national mental health conference in August 2011. Again, as mentioned above, VA has also launched a national initiative to disseminate and implement competency-based Motivational Interviewing (MI), a promising treatment approach with strong evidence to suggest it enhances Veterans' engagement in initial and ongoing psychotherapy.

- VA has requirements for close follow-up on missed appointments, which is designed to ensure the safety of Veterans who do not show for planned appointments, address problems or dissatisfactions with care, and maintain clinical continuity and engagement. At least three separate attempts must be made to reach Veterans who miss appointments, and each attempt is required to be documented in the patient's medical record.

Question 9. VHA Handbook 1160.03 (relating to VA PTSD services) issued in March 12, 2010 states, "All new patients requesting or referred for mental health services must have an initial assessment within 24 hours and their first full evaluation appointment within 14 days. Established patients require follow-up appointments within 30 days." How often in the most recent fiscal year did VA meet these timeliness standards? Where it did not, in what percentage of instances were Veterans afforded needed evaluation or treatment through fee-basis or other contract mechanisms?

Response. VHA administrative data from May, 2011 indicates that 95 percent of new mental health patients are seen for a full mental health evaluation appoint-

ment within 14 days. VHA administrative data as of May, 2011 also indicates that 96 percent of established mental health patients are seen for a follow-up mental health appointment within 30 days of the desired date. The metric pertaining to whether or not a new mental health patient is seen for an initial assessment within 24 hours is not a metric that is readily available in current VHA administrative databases.

VHA currently is meeting its performance standards for new patient access (as evidenced by VHA administrative data). VA does not have data regarding whether fee-basis or other contract mechanisms were used in the 4 percent to 5 percent of cases where the access timeliness standards were not met. It should be noted that this 4–5 percent bracket includes patients who failed to show up for scheduled appointments or who asked to be scheduled for a time later than the VHA timeliness standard.

While language regarding fee-basis or other contract mechanisms is not specifically mentioned in VHA Handbook 1160.03, VHA Handbook 1160.01 (VA Uniform Mental Health Services Handbook) includes required PTSD services, and that Handbook is the primary document guiding VA mental health services. It specifies the services that must be “available,” i.e., those that must be made accessible when clinically needed to patients receiving health care from VHA. They may be provided by appropriate facility staff, by telemental health, by referral to other VA facilities, or by sharing agreements, contracts, or non-VA fee basis care to the extent that the Veteran is eligible. Further data are not immediately available on the proportion of patients who receive care through fee basis or contract means, since such decisions are made at the local level. More specific data is currently being gathered by the VHA business office as pertains to the use of fee basis/contracts for outpatient mental health and PTSD care.

Question 10. VA is still in the process of implementing the VHA Handbook on Uniform Mental Health Services, issued in 2007, which defines the mental health services that should be available to all enrolled Veterans. That Handbook directs that where VA facilities are unable to provide needed services directly they are to provide them through fee-basis or other contractual arrangements. This is a very basic element of ensuring access to care.

What is the status of implementation of the directive that care be provided under fee or contract arrangements when VA cannot provide it directly (whether as a matter of geographic inaccessibility, lack of VA specialists, etc.)?

Response. To date, the rate of implementation of the VHA Uniform Mental Health Services Handbook across networks is 91.68 percent. While current handbook implementation data exist, data only indicate whether or not a facility provides a service; Handbook implementation survey data do not indicate how that service was provided (i.e. on site, telemental health, or fee basis and contract). Of note, implementation rates of the Uniform Services Handbook have increased steadily over time, with national implementation rates increasing 5.8 percent between August 2009 and June 2010. While there are some networks that are below other networks in terms of implementation rates, the Office of Mental Health Services, the Office of Mental Health Operations, and the Improve Veterans Mental Health Initiative, a major effort by the Department to ensure that all Veterans have access to a full continuum of recovery-oriented, evidence-based, integrated mental health services, provide technical assistance to assure that all networks achieve at least 95 percent implementation by second quarter, FY 2012.

VHA Handbook 1160.01 (VA Uniform Mental Health Services Handbook) specifies the services that must be “available” are those that must be made accessible when clinically needed to patients receiving health care from VHA. They may be provided by appropriate facility staff, by telemental health, by referral to other VA facilities, or by sharing agreements, contracts, or non-VA fee basis care to the extent that the Veteran is eligible.” Processes for authorizing fee basis and contract care are fully in place and used frequently by VA facilities and their CBOCs and data regarding use of fee basis or contract agreements for mental health care are tracked by VA’s business office. As pertains to all mental health care, in FY 2010, the VA disbursed \$176,433,666.42 in fee basis or contract services for mental health and served a total of 68,911 unique Veterans. As pertains to PTSD-specific care, in FY 2010 VHA nationally disbursed \$10,774,144.00 for fee or contract services and served 8,975 unique Veterans.

Question 11. Please provide data by VISN to document the extent to which VA has provided ambulatory mental health treatment for Veterans with service-connected PTSD or other mental health conditions in the most recent year for which such data is available.

Response. The following table provides the requested data. Some data definitions:

a. The unique Veterans in column B are Veterans who are alive, have an active service-connected (SC) disability claim for a mental health condition, and have a home zip code in the VISN in question. Note that 5,412 either have no zip code (e.g., live out of country) or have a zip code that did not match with the current zip code in data from the Planning Systems Support Group (PSSG), a field unit of the VA Office of Policy and Planning.

b. The Veterans in column C are those from B who received any mental health outpatient care in FY 2010, defined according to current business rules established by the VHA Mental Health (MH) Program Evaluation Center that produces these data.

c. The Veterans Integrated Service Networks (VISN) numbers are unduplicated, in that a Veteran can only reside in one VISN (column B). Care did not have to occur in the VISN where they live. Therefore, column C will have duplicates across VISNs, when Veterans get care in a different VISN than their residence, or in more than one VISN. This happens frequently for some Veterans, e.g., those who may have different summer and winter residences.

A	B	C	D
VISN	Unique Veterans SC for MH who live in the VISN	Unique Veterans from column B who receive any VA ambulatory mental health services in FY 2010	Percent Unique Veterans who receive any VA ambulatory mental health services in FY 2010
1	37,014	20,968	56.65%
2	16,459	10,863	66.00%
3	26,443	15,631	59.11%
4	34,744	21,203	61.03%
5	18,818	9,723	51.67%
6	54,422	29,746	54.66%
7	57,873	35,222	60.86%
8	59,087	37,579	63.60%
9	39,140	24,582	62.81%
10	21,929	14,160	64.57%
11	29,164	16,534	56.69%
12	25,632	16,131	62.93%
15	27,029	17,276	63.92%
16	76,093	41,952	55.13%
17	46,761	26,212	56.06%
18	36,367	21,702	59.67%
19	30,040	16,666	55.48%
20	46,936	22,848	48.68%
21	35,852	21,672	60.45%
22	40,969	22,505	54.93%
23	34,642	20,302	58.61%
Nationally	800,826	451,158	56.34%

Question 12. At the Richmond, Virginia VA Medical Center, officials earlier this year terminated on-site clinician-led PTSD support groups and encouraged participants instead to join yet-to-be-established peer-led community-based groups. (We understand that in response to advocates' concerns, you advised that similar actions had taken place at other VAMCs around the country.) We understand that the changes at Richmond, in particular, have been traumatic for many of those who had participated in the group sessions, and in one documented instance, attendance at the new community-based, peer-led groups dropped from 40 to an average of 2-7 individuals per session. In this regard:

Response to the general issues in Question 12:

We will respond to each of the sub items below, but it is important to begin by clarifying the actual situation at Richmond, and nationally, as VA understands it. We also would be very interested in arranging briefings with the SVAC staff to review the situation and to discuss any concerns you have. The following overall points are essential to understand VA's rationale for supporting changes along the lines of those made at Richmond and as context for the following specific answers:

- Groups like the one that was previously held at Richmond are a vestige of PTSD care offered when there was little knowledge about appropriate treatment of PTSD. They were created as a well-meaning option at a time when staff had no empirical literature on which to base effective treatments. They have not proved to be effective and are not recommended in the VA/DOD PTSD Clinical Practice Guidelines (CPGs), by the Institute of Medicine in their review of treatment for PTSD, by VHA's Handbook 1160.01—Uniform Mental Health Services in VA medical centers and Clinics, or by any other scholarly or professional group to our knowledge. VA's National Center for PTSD has never promoted the continuation of such programs and has instead emphasized psychosocial and psychopharmacological approaches with known efficacy.

- Consequently, VA has encouraged facilities to transform care from this longstanding but ineffective model to models that have been shown to have positive impact and which are presented in the VA Uniform Mental Health Services Handbook. VA agrees that the process of transition at any facility from older, ineffective, but familiar models of care to newer models with greater potential, but which are unfamiliar, can be a difficult one. VA's national, system-wide PTSD Mentoring Program, led by the National Center for PTSD, has provided guidance on such transitions, and that mentoring program now includes a PTSD Consultation Service, that can help guide sites in orchestrating such change. In the process, the Consultation Center also can guide facilities in how best to assure Veterans that their needs will continue to be met, with care that can optimally treat their PTSD and support the psychosocial challenges they face.

- There have been several presentations to the PTSD Mentors as well as PTSD Clinic Managers nationally on the successful implementation of the transition from clinician-led, supportive therapy groups to those led by peers. These presentations have emphasized best practices in making this transition. This is an ongoing topic for discussion: presentations have been made on PTSD Mentor conference calls and also at the PTSD Mentor Meeting at the July 2010 Mental Health Conference. This issue also will be addressed at the September 2011 PTSD Mentor Conference, in a presentation titled, "Identifying need for transition to peer-led groups, best practices for implementing the transition and clinical outcomes of the transition."

- The question suggests that the decrease in attendance for this group from 40 (and we have heard higher numbers in other contexts) to 2–7 individuals is a negative result. In fact, a group of 40 or more absolutely cannot be considered "psychotherapy" and there is no evidence anywhere that such a group can improve psychological functioning. Such groups can be useful for education, and that was the original function of the Richmond group. Local clinical decisions about transition were based on the facts that the stable larger membership of the group had received a full scope of psychoeducational training about PTSD and therefore it was appropriate to transition attendees to individual therapies or other therapy options. In addition, because members expressed positive value in the social connections within the group, Richmond offered to support a transition to a peer-led ongoing support (not therapy) group that would take place in a suitable venue off VA grounds. That process is ongoing in phases, with the group currently still led by a VA mental health professional, not a peer, but with the group now meeting off VA grounds, at a nearby American Legion post building. Richmond will continue to provide regular updates on next steps as the transition continues.

- Because of concerns expressed by the Wounded Warrior Project about the transition at Richmond, VA Central Office has worked closely with the site leadership to track actions and suggest further actions to enhance the transition. VA supports the Richmond VAMC in continuing to transform their PTSD treatment program; they offer a full spectrum of effective PTSD services and are engaged individually with each Veteran to ensure an individualized plan of care drawing on the VA/DOD PTSD CPGs to guide their portfolio of care.

- In summary, Richmond and VA facilities throughout the system are engaged in an important transformation of care for PTSD to models that have been shown to be most effective, with broad support from local Veterans and many VSOs.

Question 12a. Other than the Richmond VAMC, what other VA medical centers within the last two years have terminated or otherwise ended a PTSD support group (or other PTSD therapy group) that was situated at a VA facility?

Response. Decisions about such transitions are under the guidance of local VISN and facility mental health leadership. VA's tracking of service delivery is focused on whether facilities are providing the mandated PTSD resources required in the Uniform Mental Health Services Handbook.

Question 12b. Where Veterans have made a transition from a VAMC-based provider-led group to a community-based peer-led group, what steps has VA taken to

track the attendance of Veterans in the peer-led groups, and what steps will the VA take if participation significantly diminishes?

Response. Such details are best tracked at the local level. As noted above, decreased participation would not be seen as an intrinsic problem, since groups of the sizes noted (40, and in some cases more) cannot be considered group psychotherapy. We would instead have concern if the Veterans who had been participating were not transitioning to more appropriate forms of care. We do have IT projects in place to develop a national ability to track many of these issues—requiring symptom-level monitoring, using the PTSD Check List, plus an item on level of psychosocial functioning, utilizing progress note templates to track delivery of evidence-based psychotherapies, and tracking of numbers of therapy sessions for those newly diagnosed with PTSD. The Information Technology (IT) projects to support these new tracking abilities are expected to be completed in FY12.

Based on information provided by the Richmond VAMC, we do know that at every community-based, peer-led group (Vietnam and post-Vietnam eras) since the transition in January 2011, a VA representative (Dr. Benesek) has monitored and guided the proceedings and maintained a record of participant attendance. The Vietnam group has grown from 40 to 60 Veterans, while the post-Vietnam group now has grown from 6 to 13. Steps taken to increase participation include: regular e-mails sent to the participants one to two days before the scheduled group; reminder phone calls; public posting and reminders on the PTSD bulletin board located in a central location; and word of mouth.

Question 12c. Where consideration is being given to ending a VAMC-based, provider-led program and referring patient-participants to a non-VA community program, would VA policy require that those Veterans be evaluated individually for their preparedness for such a change? Please advise as to whether such individual evaluations were conducted at Richmond and each of the other VAMCs discussed in (a) above.

Response. Yes, we would expect an individual evaluation to design an appropriate regimen of treatment for any Veteran when treatment changes are considered. That might be conducted by a single provider or by an interdisciplinary team following the Veteran. Our understanding is that this was not initially done at Richmond; however, we have provided guidance on including this step in transition, and the latest information provided by the Richmond VAMC is that this has been done. Although the question cites an initial group size of 40, Richmond's records indicate that there were 45 original members of the post-Vietnam Veterans group; of those, 44 have been individually interviewed and assessed regarding their current function and needs (one could not be reached). Of these, approximately 10 indicated that they would be interested in a transition-type group at the VAMC and upon completion, would go to the peer-led group. The Richmond evidence-based psychotherapy coordinator (Dr. Lynch) has agreed to conduct a time-limited group of this nature. A majority of the remaining Veterans indicated that they were either agreeable with the current arrangement or were interested in other groups such as anger management, stress management, or insomnia, for which they were referred. The remainder opted for either individual follow-up or no additional follow-up.

This topic also is included in the discussions led by the national PTSD Mentoring Program described above, to guide transitions at other medical facilities. The presentations have made the point that individual assessment of the Veteran's skills and stability are essential to a smooth transition to peer-support led groups, as well as always ensuring the Veteran has had the opportunity to receive an individual evidence-based PTSD treatment. Veterans are also informed that we have learned a lot about treating PTSD in the last decade, that we now know that large support groups aren't the best way to manage PTSD symptoms, and that there are individual treatments that are effective.

Question 12d. How does the termination of a PTSD support group at a VA medical facility, over the unanimous objection of the participants in the Richmond case, align with the recovery model's principle of care being individualized and Veteran-centered?

Response. In Richmond's case, they actually have not terminated any mental health support groups. The PTSD group has moved locations, and is still led by the same Psychologist. Several of the participants were agreeable to the proposed model. There needs to be a differentiation between active treatment and support. Richmond's active treatment component has actually been expanded to include 10 new PTSD Recovery groups, including within the OEF/OIF/OND program and with providers from other areas of the hospital. Active treatment includes groups that address current PTSD symptomatology and functioning as well as trauma work through the use of PTSD Recovery groups, skills groups, evidence based therapies

(Prolonged Exposure [PE]; Cognitive-Processing Therapy [CPT]; Eye-Movement Desensitization and Reprocessing [EMDR]), and individual follow-up. The Vietnam and post-Vietnam (Young Guns) groups were originally designed as “drop-in” support groups allowing Veterans who had completed the PTSD program to be able to touch base for “booster” sessions as needed. There has been a national movement to better prepare our Veterans to go back to their communities more educated and equipped with the skills to effectively manage their symptoms without the need to indefinitely attend VA-sponsored groups.

The question cites as a potentially compelling reason not to discontinue such groups the fact that it was done “over the unanimous objection of the participants in the Richmond case.” It is helpful to consider other examples of discontinuing treatments that are familiar and well-liked by the recipients, but in fact are not helpful. The most salient example is Critical Incident Stress Debriefing, an approach to responding rapidly to the experience of potentially traumatic events with the intention of preventing long-term problems, such as PTSD. This approach rapidly became popular and widely used, for example by the military and first responder organizations such as firefighters and police. Both those who offered the approach and those who received it reported high satisfaction with it. However, when well-designed research was conducted, not only did it show that the approach was no more effective than no response at all, but that it also had the potential to increase the likelihood of long-term problems, including PTSD, in an uncomfortably high proportion of recipients. It is no longer widely used, but in many circles, there was great resistance to discontinuing this approach and using other approaches with more evidence of effectiveness, with supporters citing the satisfaction rates, rather than demonstrating any positive outcomes for recipients. We believe the situation in Richmond is very analogous to this history.

The question also asks how decisions at Richmond are consistent with the Recovery model of care. VHA has adopted the definition of recovery as developed by SAMHSA, which states: “Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.” Recovery-oriented care is strengths-based, individualized, and person-centered. By participating in recovery-oriented care, Veterans are able to realize their goals and gain hope that symptoms of mental illness can be managed and that integration into the community can be achieved. They rely on support from clinical staff, family, friends, and the community to achieve their treatment goals.

Veteran-centered care focuses on the unique strengths and abilities of the Veteran in addition to any needs and challenges he or she faces. In a collaboration between the Veteran and his/her treatment providers, a unique set of goals and objectives is developed that will result in improved mental and physical health functioning. Recovery-oriented care is typically divided into two categories: recovery-oriented services, and recovery-oriented supports.

Recovery-oriented services are time-limited, needs-based, and typically delivered by health care professionals to achieve short-term goals. Recovery-oriented services transition to recovery-oriented supports, which are often ongoing and strengths-based. They are usually delivered in community settings and may include coaching and mentoring, peer support, and the use of self-care tools. Therefore, it is common for recovery-oriented PTSD treatment to be transitioned from VA medical center-based services provided by mental health professionals to community-based support provided by peers. Such a transition enables ongoing support for Veterans with PTSD and facilitates integration with the Veteran’s community.

In summary, we believe the transition at Richmond, and in other VAs where PTSD care is being transformed, are in full alignment with the goals of recovery-oriented, Veteran-centered care. As noted in the opening bullets, recipient satisfaction with a treatment approach is one consideration, and when evidence suggests that the approach does not, in fact, have demonstrated effectiveness, Veteran-centered care requires that clinicians and Veterans discuss this and that the Veteran be guided in choosing care from among options that have a reasonable chance of helping the Veterans reduce symptoms and improve function.

Question 12e. In attempting to explain decisionmaking in the Richmond instance, VA officials suggested the lack of an evidence base for PTSD groups. However, the VA/DOD *Clinical Practice Guidelines for Management of Post-traumatic Stress*, adopted in the fall of 2010, state, “The empirical literature on group treatment for PTSD has grown since the publication of the first edition of the Treatment Guidelines for PTSD, although there remain methodological weaknesses in study designs, and there is no empirical evidence to support a conclusion that group treatment is superior to individual treatment for trauma. Nonetheless, it does appear that group-based treatment for individuals diagnosed with PTSD is associated with improve-

ments in symptoms of PTSD, and there is growing belief that some unique attributes of the group treatment format provide benefits that are superior to individual treatment for trauma. Identified benefits include efficiency in treatment provision and development of support and understanding between group members that may counteract isolation and alienation.” Please explain the apparent inconsistency between these guidelines and actions and explanations afforded in the Richmond matter.

Response. To address this matter, it is useful, first, to discuss group therapy. There are three different kinds of group therapies: those based on cognitive behavioral therapeutic (CBT) principles, those which utilize a psychodynamic focus, and those designed to provide emotional support (e.g., supportive group therapy). In all cases, trauma survivors learn about PTSD and support each other, usually with the aid of a professional clinician. Group therapy has been particularly popular for individuals who have all survived the same type of trauma, such as Veterans who have served in a war zone. As members share experiences, they become connected to one another by recognizing their common human fears, frailties, guilt, shame, and demoralization. Validation and normalization of these thoughts, feelings, and behaviors can occur, and group members may acquire more adaptive coping strategies, symptom reduction, and/or derivation of meaning from the traumatic experience.

With that background, there are three major issues in this component of the question, 12e:

- i. The evidence base for group therapy
- ii. The value of peer led support groups for PTSD, and
- iii. What constitutes “group therapy”

i. Evidence-base for group therapy

Group therapy is not recognized as first-line evidence-based treatment for PTSD, although some evidence suggests that group therapy may be beneficial in some circumstances, and with a clear understanding of what constitutes “group therapy.” Based on this, the 2010 VA/DOD PTSD Clinical Practice Guidelines (CPG) rates group therapy as a second-line approach in the “somewhat helpful” category and encourages clinicians to “consider group therapy as a useful treatment” if first line treatments have been unsuccessful. In this regard, current research suggests that the group, itself, seems to be the major vehicle through which benefits are mediated since all types of groups (e.g., CBT, psychodynamic, and supportive) appear to perform equally well. It is also recognized that one of the major benefits provided by Group Therapy appears to be peer support which “may counteract isolation and alienation.” It must be emphasized that nowhere in the 2010 VA/DOD PTSD CPG is group therapy recommended as a first-line treatment for PTSD. Whereas the Guideline does acknowledge that group therapy may alleviate some symptoms of PTSD, it strongly recommends Prolonged Exposure, Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing, and Stress Inoculation Therapy as the treatments of choice for PTSD.

ii. The value of peer-led support groups for PTSD

As stated, participation in either clinician- or peer-led group therapy may have benefit, though neither constitutes first-line therapy. At this time, the benefits of group therapy are best understood where the primary objective is not remission of symptoms but rather improving the quality of the Veteran’s life. We have learned through the PTSD Mentoring Program that peer-led groups are a good fit for the principles of the Recovery Model as implemented in the utilization of one approach to group therapy—i.e., supportive group therapy. It appears that this has also been the case at Richmond. The high attrition noted among OEF/OIF/OND Veterans is a pervasive problem with this cohort of Veterans and probably has much less to do with the specific treatment offered to them, and more to do with their general ambivalence toward treatment. Such ambivalence would be expected to be amplified by the avoidance symptoms of PTSD which can suppress treatment seeking behavior among Veterans with this disorder. We expect that these Veterans will continue to need contact with VA clinicians and to utilize the spectrum of effective first-line treatments offered at Richmond, while the peer-led group being developed can provide a context for ongoing mutual support.

iii. What constitutes “group therapy”

Finally, as noted above, group size is an important factor that has significant impact on the value of a group labeled as “group therapy.” Psychotherapy literature recommends no more than 8–10 members for optimal treatment (Yalom, 1995) in any such group, in order to sustain group cohesion, to ensure the group leader can sensitively attend to the specific emotional/psychological status of each group mem-

ber, and to offer the opportunity for active participation by group members who want to speak up. For many groups doing cognitive-behavioral treatment work, an even smaller size is optimal, 5–8. Thus, we expect that as Richmond and other VA sites successfully transform care, Veterans will be able to obtain the benefits of 1) clinician-led individual or group therapy that has fidelity to known effective treatment models, 2) appropriate psychoactive medication, and 3) support groups led by peers that are of manageable size with clear goals that focus on mutual support and understanding. Active, diagnosis-focused treatment would be provided in the first two options, but would not be provided in the third option.

In Richmond's case, in their active treatment component, they have actually increased the number of treatment groups made available to Veterans, including the use of staff outside of the core PTSD team. The bulk of active clinical activity at Richmond consists of group therapy, as defined in option 1) above. Rather than eliminate the support groups altogether, the mental health services program at Richmond has decided to coordinate with a local Veterans Service Organization, with whose Commander the Richmond VAMC has a solid relationship, for space for our Veterans to continue to meet in a supportive environment free from any obligation to join or participate in that particular organization's activities.

Richmond VAMC believes that this has been an effective mechanism that will continue to grow and help our Veterans become more self-reliant. It should also be noted that no matter what course a Veteran chooses (recovery group, skills group, evidence-based treatment, support group, individual follow-up, taking a break from treatment), all are reminded that their primary mental health provider will remain their point of contact should they have any additional needs or requests in the future. Should their primary mental health provider be unavailable (no longer with the program or VAMC), a new one will be assigned.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO ANTONETTE ZEISS, PH.D., ACTING DEPUTY CHIEF OFFICER MENTAL HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. According to a report by GAO on the Federal Recovery Coordination Program, Federal Recovery Coordinators (FRC) "cannot readily identify potential enrollees using existing data sources." The Senior Oversight Committee developed a categorization system to identify those servicemembers that would benefit from an FRC. However, these are purely administrative categories and do not line up with VA or DOD's medical and benefits systems.

What steps have been taken to align the categories set out by the Senior Oversight Committee with the medical and benefits system of VA?

Response. Department of Veterans Affairs (VA) has not set out specifically to align its systems with the categories outlined by the Senior Oversight Committee. The categories established by the Senior Oversight Committee are administrative not operational. They were intended to be used as a guideline for making referrals to the Federal Recovery Coordination Program. However, as currently structured, FRCP is a voluntary referral program and, as such, relies on the identification and referral of those who might benefit from the FRCP services by others (case managers, Command, Wounded Warrior Programs, etc.).

VA medical and benefits systems do not rely on these categories for eligibility, enrollment, or entitlement decisions with respect to VA benefits and services.

What is needed is a mechanism that will trigger an automatic referral to FRCP when certain conditions are met. The Senior Oversight Committee in early 2011 requested that the Line of Action 3 Co-chairs develop such an automated referral system. The development of the system was deferred pending the outcome of a joint executive committee assembled to identify potential for a joint recovery program.

Question 2. The GAO report points to challenges coordinating with other programs supporting the FRC program. Although, these programs are not just for the most severely injured servicemembers, they have similar case management functions and many recovering servicemembers are enrolled in more than one program. This has led to a duplication of efforts and could lead to confusion for the servicemember.

What steps have been taken to better share information on servicemembers enrolled in the Federal Recovery Coordination Program to reduce confusion and redundancy in the recovery process?

Response. The Federal Recovery Coordination Program (FRCP) has a comprehensive data management system. In January of this year, FRCP completed the System of Records Notice necessary to share information with other coordinating organizations including Service wounded warrior programs. FRCP is currently updating

Data use Agreements to provide access to appropriate individuals. FRCP is also updating the data management system to allow for such role-based access.

Additionally, FRCP is engaged in an Information Sharing Initiative (ISI) with DOD. The first deliverable planned for ISI is a data exchange of names of case managers, selected benefit information, and problem lists among participating programs. The first exchange is scheduled to take place by the end of FY11.

Question 3. The United States Court of Appeals for the 9th Circuit Court recently ruled “that unchecked incompetence” by the Department of Veterans Affairs led to poor mental health care and slow processing of disability claims for Veterans.

Question 3a. Does VA have access standards for behavioral health services?

i. If so, what are they?

ii. What happens if you don’t meet those access standards?

iii. How often do you not meet the access standards?

Response. VA does have access standards for behavioral health services. New patients to mental health are required to have an initial assessment within 24 hours and their first full evaluation appointment with 14 days. Established patients are required to have follow-up appointments within 30 days.

VISNs and facilities review access data for all clinics on a regular basis to develop action plans as needed. If these access standards are still not met, technical assistance is available through the VA Mental Health Operations Office (MHO) in the VA Office of Operations and Management. As well, MHO is currently developing a process to independently monitor compliance with the access standards at a more granular level.

Performance standards for mental health are currently being met nationally. Data as of May, 2011, indicate that 95 percent of new patients are seen for a full evaluation appointment within 14 days and 96 percent of established patients are seen for a follow-up appointment within 30 days of the desired date. The metric regarding whether a new patient is seen for an initial assessment within 24 hours is not a metric that is readily available.

Question 3b. Does VA have performance metrics that measure the effectiveness of their mental health services? If so, can you please explain how this is measured?

Response. VA has evidence-based psychotherapy protocols in place for PTSD that incorporate weekly symptom monitoring with the PTSD Checklist (PCL). In addition, current standards require the administration of the PCL every 90 days for all OEF-OIF Veterans in active treatment for PTSD, as defined by at least 2 visits to an outpatient mental health clinic within the previous 6 months. PCL data have recently been extracted into a national database allowing for total population sampling for clinical review and aggregate analyses. While symptom monitoring is an important element in measuring treatment effectiveness, broader, systematic outcome evaluation is also critical for evaluating program effectiveness. Outcome measures for evaluation of symptom level during treatment for substance abuse and depression are under development and will be available dependent on availability of informatics tools which is scheduled for deployment in FY 2012. In addition to monitoring patients receiving active mental health treatment, an aspirational goal that is in development would involve centralized tracking of patient functioning through systematic symptom monitoring that would occur regardless of whether the Veteran was in active treatment.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO ANTONETTE ZEISS, PH.D., ACTING DEPUTY CHIEF OFFICER MENTAL HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Ms. Zeiss, in Alaska, the HUD-VASH Voucher Program has been a success. I know that mental health issues are a major contributing factor in veteran homelessness. I would love to see the HUD-VASH voucher program continue and expand to provide much needed relief to Alaska’s homeless veterans.

Question 1a. In your opinion, is the HUD-VASH voucher program part of the answer to eliminating veteran homelessness?

Response. Yes, the HUD-VASH program’s permanent supportive housing is a critical part of VA’s Plan to End Homelessness Among Veterans. The primary goal of HUD-VASH is to move Veterans and their families out of homelessness. A key component of the HUD-VASH program is VA’s case management services. These services are designed to support the Veteran’s recovery goals by providing stability in safe, decent, affordable, and permanent housing of the Veteran’s choice. While VA provides case management services, HUD provides permanent housing stability to

Veterans and their immediate families by allocating rental subsidies from its Housing Choice Voucher (HCV) Program.

Question 1b. What is the future plan for HUD-VASH vouchers? Will Alaska receive a larger share of vouchers in future years?

Response. For FY 2011, Congress appropriated \$50 million for approximately 7,000 additional HUD-VASH vouchers. This is a reduction from the approximately 10,000 vouchers that were allocated in each of the three previous fiscal years. Voucher allocation is based on the “relative need” of the state and local community. VA and HUD identify “relative need” by utilizing VA Homeless outreach data and HUD Point In Time (PIT) data. Adjustments in voucher allocation are made based on past performances by both the VA medical center and the Public Housing Authority that administers the housing vouchers. HUD (with VA input) then makes the final adjustment of voucher allocation based on priorities such as rural communities or high priority target communities. It is VA’s goal to assist states and local communities to obtain the needed resources to end Veteran homelessness.

Question 1c. Will you explain how VA allocates the vouchers?

Response. HUD utilizes a relative need-based formula and performance data in determining how the HUD-VASH vouchers will be allocated. HUD heavily relies on the most recent Point in Time data which indicates by state the number of homeless Veterans on any given night. The latest information was released in Veteran Homelessness: A Supplemental Report to the 2009 Annual Homeless Assessment Report (AHAR) to Congress. VA does provide input based on local reports from the medical centers, but HUD makes the final determination of where the vouchers will be allocated.

Question 2. Ms. Zeiss, the Grant and Per Diem (GPD) Program assists eligible entities in establishing new community-based programs to furnish outreach, supportive services, and transitional housing to homeless Veterans. Anything community-based that directly benefits veterans helps Alaska because of the extreme isolation of many Alaska communities.

Can you explain how the Grant and Per Diem Program is benefiting Alaska?

Response. The VA’s Homeless Providers Grant and Per Diem (GPD) Program is a critical part of the VA’s Plan to End Homelessness Among Veterans; the GPD Program benefits homeless Veterans and the state of Alaska by providing per diem payments and a capital grant to homeless providers in Anchorage and Fairbanks, Alaska. Presently, there are two GPD Programs that are operational and provide transitional housing to homeless Veterans in Alaska. The Fairbanks Rescue Mission is a 30-bed Per Diem Only program in Fairbanks, Alaska that began receiving a per diem in October 2008. Salvation Army, Inc. was awarded a 20-bed Capital Grant in Anchorage, Alaska that became operational in December 2007.

Question 3. Mr. McNamee, I have heard great things about your facility and rehabilitation services down in Richmond. There are currently several Alaska Soldiers recovering in Richmond, and we wish them a speedy recovery. In Alaska, there is no advanced care facility for treating and rehabilitating veterans with TBI beyond mild exposure.

Question 3a. I know the Defense and Veteran Brain Injury Center has received high marks, so I would like to hear what sets it apart from other brain injury rehabilitation programs.

Response. VA and DOD share a longstanding integrated collaboration in the area of Traumatic Brain Injury (TBI) through the Defense and Veterans Brain Injury Center (DVBIC). Since 1992, DVBIC staff members have been integrated with VA Lead TBI Centers (now Polytrauma Rehabilitation Centers) to collect and coordinate surveillance of long-term treatment outcomes for patients with TBI. In clinical partnership with DVBIC, VA coordinates the referral and admissions process to community integration and vocational rehabilitation programs at the four VA Polytrauma Transitional Rehabilitation Programs, and the two DVBIC Clinical Rehabilitation sites. VA providers coordinate regularly with DVBIC’s Regional Care Coordinators to ensure access to services for Veterans who are diagnosed with TBI. The TBI screening tool utilized by VA providers to evaluate OEF/OIF Veterans, and the DOD/VA Clinical Practice Guidelines for Mild TBI, were developed in collaboration with DVBIC.

With respect to education and training, VA worked with DVBIC to create a uniform training curriculum for family members in providing care and assistance to Servicemembers and Veterans with TBI: “Traumatic Brain Injury: A Guide for Caregivers of Servicemembers and Veterans.” The distribution of this valuable tool to caregivers is being coordinated by both VA and DOD providers. Finally, VA works closely with DVBIC in TBI education and training curriculum development, with as-

sistance in planning and presentations at the annual DVBIC TBI Training Conference and co-sponsorship of the annual Blast Injury Conference.

Question 3b. What are some of the current cutting-edge brain injury rehabilitation treatments that you use?

Response. The Richmond VA Medical Center (VAMC) and other lead Polytrauma Centers continually seek to provide effective, cutting edge treatments and technologies to our Veterans and Servicemembers recovering from TBI and polytrauma. All Veterans and Servicemembers receiving care in VA for TBI receive evidence-based, and consensus-based standardized treatments for TBI, developed in collaboration with DOD, academic and private sector clinicians. Treatment varies by the type and severity of the initial injury and subsequent residual symptoms, and is delivered within the context of an individualized treatment plan for each Veteran.

Specific examples of these progressive brain injury treatments and resources at Richmond and other Polytrauma Rehabilitation Centers (PRC) include:

- Assistive Technology Center that offers comprehensive evaluations and employs state-of-the-art technologies including environmental control units, adaptive communication devices, and a host of computer interface devices and software to support the individual patient during recovery;
- Provision of effective cognitive rehabilitation practices and interventions in accordance with recent literature guidelines published by Dr. Cicerone in March 2011. Systematic delivery of cognitive rehabilitation services in VHA began in 1992 at the TBI Lead Centers (Minneapolis, Palo Alto, Richmond, Tampa) in conjunction with the implementation of the Defense and Veterans Brain Injury Center (DVBIC) clinical trials. The cognitive rehabilitation protocols developed for those clinical trials served as a model for future innovative cognitive interventions spearheaded by our rehabilitation specialists;
- The Emerging Consciousness program for patients with disorders of consciousness utilizes both high technology (assistive communication devices, advanced seizure monitoring and quantitative EEG analysis) and state-of-the-art sensory stimulation and regulation techniques;
- Transitional Rehabilitation Programs developed and implemented at each PRC. These residential units provide rehabilitation in a home-like environment to facilitate community reintegration for Veterans and their families; and
- The Richmond Polytrauma Program is the leader in educating the next generation of polytrauma rehabilitation specialists through the only approved Polytrauma/TBI medical fellowship in the country.

Question 3c. How would you handle transitioning Alaska servicemembers with moderate and severe TBI injuries provided that there are very few treatment options in Alaska, and therefore few treatment options once they depart your facility?

Response. Discharge planning for all Veterans and Servicemembers at the Richmond PRC is intensive and individualized. It is always our goal to return the patient back to the community of choice. Fortunately, our continuum of care at the Richmond VAMC includes a Polytrauma Transitional Rehabilitation Program on campus to support the community re-entry needs of our patients with Moderate-Severe TBI. A rehabilitation plan is formulated for each patient and matched to regional resources within the patient's home community. Typically, support comes from a network of providers across VHA, DOD and the private sector.

Telehealth also provides VA with a useful means of extending medical care services and support to more than 260,000 Veteran patients, including Veterans in Alaska and in rural locations in other states. VHA Telehealth has increased access to VA medical center service and support to 500 Community-Based Outpatient Clinics (CBOCs), and to 41,000 Veteran patients at home. Staff from the Veteran Integrated Service Network (VISN) for Alaska participates in the Alaska Brain Injury Network, a non-profit organization created by the Alaska mental health trust to provide resources to Alaska residents with TBI and integrate and share services from different sectors (Federal, State, Native, Private) for individuals with TBI.

Telehealth is also used to provide follow-up comprehensive TBI evaluations from a VA Medical Center provider to Veteran patients at rural clinics. Such a telehealth link has been established with the community based outpatient clinic (CBOC) in Fairbanks, Alaska, with plans for the Kenai and Juneau CBOCs. In total, we make it our goal to support each patient through a comprehensive continuum of care based upon their needs and regional resources both on campus and following discharge.

Question 3d. GEN Chiarelli stated that as of February 1, 2011, 64 percent of the Army's Wounded Warrior population suffered from brain injury or PTSD. Are VA and DOD doing enough to fully care for and address the needs of our Wounded Warriors suffering from these injuries?

Response. While there are always opportunities to improve services, VHA has moved rapidly to anticipate and implement support for the critical needs of our Veterans and Servicemembers with TBI and Post Traumatic Stress Disorder (PTSD). For over 7 years VA has routinely screened new Veterans entering VA for health care for possible PTSD, depression, and alcohol abuse. Since 2007, VA screens all OEF/OIF/OND Veterans entering VA for health care for possible TBI. Further, VA has implemented clinical practice guidelines, case management, and dedicated treatment programs such as the Emerging Consciousness Program, Polytrauma Transitional Rehabilitation Program, and Amputation System of Care over the past decade. VA continues to expand and coordinate its broad-based efforts in collaboration with DOD and academic medical institutions to advance our understanding, and provide the best services that science and clinical practice has to offer to America's Veterans.

Significant expansions in existing TBI services being implemented in FY 2011 and planned for FY 2012 include:

- Improving access to specialized TBI care by using diverse methods such as telehealth and improved efficiencies;
- Leverage technological advances to reduce the impact of disabilities on community re-integration, including living independently and return to work;
- Provide continued education opportunities to providers, both VA and private sector, on recognizing signs and symptoms of PTSD and concussion (since only 50% of Veterans from OEF/OIF/OND have accessed the VA for services);
- Increase use of the VA/DOD Clinical Practice Guidelines for mild TBI/concussion to guide treatment based on the best medical evidence available;
- Continue efforts to screen for TBI in order to identify issues early and provide appropriate treatment;
- Continue to educate health care providers to limit fragmentation of care, and promote team approach to care and awareness of co-occurring symptoms associated with TBI and PTSD.

Chairman MURRAY. Dr. Taylor.

**STATEMENT OF GEORGE PEACH TAYLOR, JR., M.D., M.P.H.,
DEPUTY ASSISTANT SECRETARY FOR FORCE HEALTH PROTECTION AND READINESS, U.S. DEPARTMENT OF DEFENSE;
ACCOMPANIED BY PHILIP A. BURDETTE, PRINCIPAL DIRECTOR,
OFFICE OF WOUNDED WARRIOR CARE AND TRANSITION POLICY**

Dr. TAYLOR. Chairman Murray, Ranking Member Burr, on behalf of myself and Phil Burdette, I wanted to thank you for the opportunity to appear in front of you today to discuss the Department of Defense's collaboration with the VA and our shared efforts to improve the transition of veterans, particularly those injured while serving.

I would like to start off with personally apologizing for the lateness of the written testimony. I assure you I am going to investigate the reasons for that and take the appropriate action to better ensure that does not happen again in the future.

In every arena of our shared engagement strategy the two departments have made significant demonstrable progress, and we are poised to continuing to improve upon the achievements of the past several years. Our efforts cut across virtually every aspect of our operations, clinical care, medical facilities, the disability evaluation, medical research, and central to all these activities are electronic health records.

Our clinical experts are learning and sharing critical information from each other. The DOD and VA research into prevention, identification, diagnosis, and treatment of Traumatic Brain Injury is informing not just our own systems, but the larger American medical

community on what evidence indicates the best approaches in protecting and caring for our servicemembers and veterans.

Our mental health experts are working closely in disseminating joint clinical practice guidelines for a number of clinical conditions. PTSD, depression, and suicide prevention are serious issues with which both the DOD and the VA are addressing, both immediate and long-term issues for our servicemembers and veterans.

Together we have identified, as Dr. Zeiss mentioned, 28 strategic actions to better align and coordinate those mental health services across the two departments, including near-term, mid-term, and long-term solutions. I am personally deeply engaged in our efforts to further integrate, on behalf of the patients we serve, the vast amounts of medical information in our respective health information systems.

At the critical point of transition from one system to the other, the Federal Health Information Exchange has served as a critical path, ensuring that important medical information is passed from the DOD to the VA. More than 5½ million veterans have benefited from this data transfer since 2001. For those beneficiaries who receive care from both the DOD and VA facilities, we have introduced significant enhancements to the Bidirectional Health Information Exchange in January of this year, and we are very pleased with the results of that effort.

For the most severely wounded servicemembers who are transitioning into the VA's polytrauma centers, we have instituted a number of record transfer processes to ensure the right information gets to the right people quickly and securely.

The DOD is also working with the VA to move forward on the implementation of the Integrated Disability Evaluation System. There are several primary goals for this system that we have been striving to meet to solve many of the problems that you heard earlier today.

Servicemembers in IDES receive their disability benefits as soon after discharge as the VA is legally permitted to provide them. We know before discharge what level of VA disability paying benefits they and their families will receive. They only have to go through the evaluation process once. They receive ratings that are consistent between the VA and the military services, and they complete an integrated process more quickly than they would in the Legacy system.

We are discovering obstacles as we deploy IDES through the entire force, but we are working hard to bring the time of completion down to the 295-day goal. As of May 15, the cumulative dual-eligibles enrollment is 23,350 servicemembers with 7,546 completing the program by medical separation, retirement, or return to duty.

We are working to strengthen our Transition Assistance Program, TAP, and reinforce its values to servicemembers and their families. DOD and our partners in the VA and the Department of Labor are committed to moving TAP from a traditional event-driven approach to a modern life-cycle approach.

We are shifting from events at the end of military service to an outcome-based model that will assist servicemembers and their families with their life goals, military career progression, and even

new careers or meaningful employment outside the uniform service.

I am grateful for the leadership of Secretary Gates and Secretary Shinseki to move our systems down a path that is more cohesive, more servicemember focused, and also more cost effective and less bureaucratic. We are heading in the right direction.

Thank you for the opportunity to be here today, with you today, on behalf of the Department of Defense, and we look forward to answering your questions.

[The prepared statement of Dr. Taylor follows:]

PREPARED STATEMENT OF DR. GEORGE TAYLOR, DEPUTY ASSISTANT SECRETARY OF DEFENSE, FORCE HEALTH PROTECTION AND READINESS; AND PHILIP BURDETTE, PRINCIPAL DIRECTOR, WOUNDED WARRIOR CARE AND TRANSITION POLICY OFFICE

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

DISABILITY EVALUATION SYSTEM/INTEGRATED DISABILITY EVALUATION SYSTEM

The genesis of the Disability Evaluation System (DES) is the Career Compensation Act of 1949, after which the system went relatively unchanged for 58 years, until 2007. As a result of concern within the Department of Defense (DOD) and the Department of Veterans Affairs (VA), as well as Congressional and public concern, the Senior Oversight Committee (SOC) chartered the DES Pilot in November 2007.

We have several goals for the DES Pilot. We are determined to stop making Servicemembers go through the disability evaluation process twice—once before discharge and once after discharge while awaiting benefits. The DES Pilot accomplished this by assigning the Military Services the tasks they do best—determining fitness for duty—and VA the tasks they do best—performing medical evaluations in accordance with the VA Schedule for Rating Disabilities and assigning proposed disability ratings for use by DOD and VA—all while the Servicemembers and their families were receiving military pay and benefits.

We are also determined to eliminate inconsistent disability ratings between VA and the Military Services. The Pilot achieves this because VA provides a proposed disability ratings that can be used to determine eligibility for both military and VA compensation and benefits. This was effective because the conditions the Military Services are allowed by law to include in their disability ratings are a subset of the disabilities for which VA is allowed to compensate. In the Pilot, both ratings were presented and explained to Servicemembers to ensure transparency.

And, we are determined to enable Servicemembers to complete the integrated processes more quickly than they could complete the processes one after the other. The DES Pilot accomplished this, cutting out steps that Servicemembers previously had to perform twice.

To test our ability to meet these goals consistently, we expanded the DES Pilot from the original three major military treatment facilities (Walter Reed, Bethesda, and Malcolm Grow) in the National Capital Region to 18 more locations in October 2008. The Pilot continued to meet all five of these goals. In January 2010, we expanded the test to six more locations. The Pilot continued to meet all five of these goals.

DOD and VA found the integrated DES to be a faster, fairer, more efficient system and, as a result, the SOC Co-chairs (the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs) on July 30, 2010, directed worldwide implementation of the process beginning in October 2010 to be completed at the end of September 2011. On December 15, 2010, the first Integrated Disability Evaluation Sys-

tem (IDES) site became operational, which marked the end of the pilot, and the name was formally changed to the IDES.

As in the Pilot, the IDES continues to meet the five primary goals. Servicemembers in the IDES receive their disability benefits as soon after discharge as VA is legally permitted to provide them, know before discharge what level of VA disability compensation and benefits they will receive, they only have to go through the process once, receive ratings that are consistent between VA and the military Services, and complete the integrated processes more quickly than they could complete them one after the other.

In designing the integrated system, we tried to move Servicemembers through the integrated processes even faster than they move through just the military process in the existing system. At first, we succeeded. However, we are discovering obstacles as we deploy IDES through the entire force. Thus far in May 2011, Active Component Servicemembers completed the IDES process in an average of 404 days from referral to post-separation VA Benefits decision, including Service-department appeals and pre-separation leave. This exceeds the 295-day IDES goal, but is still 27 percent faster than the 540 day benchmark for the Legacy disability process. We attribute the lengthening queue time to the fact that more complex and intricate cases are matriculating in the system, and Servicemembers are opting for more due process and administrative reviews, as well as opting to take leave while on active duty versus selling it back at date of separation. However, the Servicemembers and families who are methodically processing through the IDES continue to receive full pay, allowances, compensation, medical and base support care and benefits as they prepare transition to civilian life and VA care. As of May 15, 2011, cumulative IDES enrollment is 23,350 Servicemembers with 7,546 completing the program by medical separation, retirement, or return to duty.

We will never rest on the fact that we have historically improved the DES in almost four short years. We know we can and ought to do even better. The Departments are continuously exploring new ways to improve the current system. The Secretaries of Defense and Veterans Affairs are currently exploring several options to shorten the overall length of the disability evaluation process from its current goal of 295 calendar days. We are looking closely at the stages of the IDES that are outside of timeliness tolerances and developing options to bring these stages within goal. Examples of items we are working on are: streamlining medical case narrative summary to improve Medical Evaluation Board (MEB) timeliness; improving IDES disability examination timeliness by increasing VA capacity; and providing better expectation management service and transparency to Servicemembers. The Secretaries have also commissioned a group of operational subject matter experts to take a fresh look at additional avenues (both requiring changes in statute and those that can be accomplished with quick policy changes) to make the system more efficient. The group hopes to conclude their work in October of this year and provide the Secretaries with actionable recommendations.

Nonetheless, the IDES, which has proven to be faster, fairer (based on customer satisfaction surveys) and substantially reduced the DOD/VA benefits gap, constitutes a major improvement over the legacy DES and both DOD and VA are fully committed to the worldwide expansion of IDES. Both Departments are partnering closely as we aggressively move toward IDES implementation at all 139 CONUS and OCONUS sites by September 30, 2011.

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

- Stage I—West Coast & Southeast (October–December 2010)—(Completed)—58%
- Stage II—Rocky Mountain & Southwest Region (January–March 2011)—(Completed)—74%
- Stage III—Midwest & Northeast (April–June 2011)—90%
- Stage IV—Outside Continental United States (OCONUS)/CONUS (July–September 2011)—100%

We are committed to working closely with Congress in exploring new initiatives that can further advance the efficiency and effectiveness of the disability evaluation process.

RECOVERY COORDINATION PROGRAM

The DOD Recovery Coordination Program (RCP) was established by Section 1611 of the FY 2008 National Defense Authorization Act. This mandate called for a comprehensive policy on the care and management of covered Servicemembers, including the development of comprehensive recovery plans, and the assignment of a Recovery Care Coordinator for each recovering Servicemember. In December 2009, a Department of Defense Instruction (DODI 1300.24) set policy standardizing non-

medical care provided to wounded, ill and injured Servicemembers across the military departments. The roles and responsibilities captured in the DODI are as follows:

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

There are currently 147 DOD trained RCCs in 69 locations placed within the Army, Navy, Marines, Air Force, United States Special Operations Command (USSOCOM) and Army Reserves. Care Coordinators are hired and jointly trained by DOD and the Services' Wounded Warrior Programs. Once placed, they are assigned and supervised by Wounded Warrior Programs but have reach-back support, as needed, for resources within the Office of Wounded Warrior Care and Transition Policy. DOD RCCs work closely with FRCs as members of a Servicemember's recovery team.

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

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

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

In March 2011, DOD also conducted an intense 2½ day Wounded Warrior Care Coordination Summit that included focused working groups attended by subject matter experts who discussed and recommended enhancements to various strategic wounded warrior issues requiring attention. One working group focused entirely on collaboration between VA and DOD care coordination programs. Another group focused on best practices within recovery care coordination and a third group focused on wounded warrior family resiliency, employment and education. Actionable recommendations are currently being reviewed, have been presented to the Overarching Integrated Product Team (OIPT) and will continue to be worked until approved recommendations and policies are implemented.

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

TRANSITION ASSISTANCE FOR SERVICEMEMBERS

Transition Assistance Program (TAP)

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

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

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

In addition to the Toolkit, we began offering a series of virtual learning opportunities to transitioning Servicemembers and military spouses on March 1st of this year. The free online classes are available to any Servicemember worldwide and provide them with an interactive educational forum to delve into employment and career related topics, such as “Building Better Resumes” and “Financial Planning for a Career Change.” The classes are highly encouraged for any Servicemembers looking bolster their transition-related knowledge, especially rurally located members of the National Guard and Reserves and Wounded Warrior in recovery. To date, there have been more than 900 hundred registrations for these online seminars including registrations by military personnel stationed overseas in Diego Garcia, BIOT; Guantanamo Bay, Cuba; Italy, Japan, Korea, Germany and members deployed to Afghanistan and Iraq. Military spouses are also among the many participants who have enjoyed this new delivery methodology.

The TAP Virtual Learning Seminars have also been enthusiastically embraced by senior military leadership and prominent figures in business and academia. Some of which now participate in online seminars as “surprise celebrity guests.” Leaders such as Army Reserve Command Sergeant Major Michael D. Schultz; Navy Reserve Force Master Chief Ronney A. Wright; Philip Dana, Amazon’s Military Recruiting H.R. Manager; and Dr. Timothy Butler, Harvard Business School’s Director of Career Development Programs have made guest appearances to motivate the attendees, stress the importance of proper transition planning, and also to participate in the online classes along with the Servicemembers and families.

The Toolkit and the virtual classes are just the beginning of our effort to move TAP into the digital spectrum. We are developing an “end-to-end” virtual TAP delivery vehicle delivery platform that will provide the back-bone of the transformed TAP program, integrating the Guard and reserve components, as well as expanding services available to family members.

DOD is partnering with the Office of Personnel Management and the Departments of Labor, Veterans Affairs and Homeland Security on President Obama’s Veteran’s Employment Initiative. The Initiative directs 24 large and independent Federal agencies to improve employment opportunities for veterans in their agencies.

TAP is one of the programs we will use to educate and inform Servicemembers about Federal Service career opportunities.

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

Focus on Credentialing

The Department continues to provide licensure and certification information in a range of ways and in different formats in order to appeal to individual learning styles and ensure the widest possible dissemination. It is important to note, the Department of Defense does not serve as a credentialing body. These bodies are typically well-defined for licensure requirements by Governmental agencies—Federal, state, or local—who grant licenses to individuals to practice a specific occupation, such as a medical license for doctors. State or Federal laws or regulations define the standards that individuals must meet to become licensed.

Non-governmental agencies, associations, and even private sector companies grant certifications to individuals who meet predetermined qualifications. These qualifications are generally set by professional associations (for example, National Commission for Certification of Crane Operators) or by industry and product-related organizations (for example, Novell Certified Engineer). Certification is typically an optional credential; although some state licensure boards and some employers may require certification. For many occupations, more than one organization may offer certifications.

Verification of Military Experience and Training

The Verification of Military Experience and Training (VMET) document was established by Public Law 101-510, Section 1143(a), 5 November 1990, National Defense Authorization Act for Fiscal Year 1991 to assist departing servicemembers transitioning to civilian life by providing a verification of their military skills and training and translating them into civilian terms. Eligibility was all military (Army, Navy, Marine Corps, and Air Force) members on active duty on or after 1 October 1990. The Defense Manpower Data Center (DMDC), a Department of Defense activity that supports the Office of the Under Secretary of Defense for Personnel & Readiness (OUSD/P&R), has the responsibility for producing the VMET documents and maintaining the VMET Web site.

The issuance of the DD Form 2586 Verification of Military Experience and Training has been enhanced and now available on demand directly from the Defense Manpower Data Center Web site at www.dmdc.osd.mil/vmet. Access to the document is protected by secure login protocols. The document is an "all-services" integrated form which displays demographic, training, and experience information that is retrieved from various automated sources, including the master military personnel records of each Service.

The VMET document lists military experience and training which may have application to employment in the private sector. The document was designed as a tool to prepare resumes and job applications, in concert with evaluation reports, training certificates, awards, transcripts, and other pertinent documents. It is not an official transcript for purposes of granting college credit, but it can be used to support verification of having met training and/or course requirements to qualify for civilian occupations, certificates, licenses, or programs of study. Credit recommendations from the American Council of Education (ACE) for occupations and/or courses are listed when they are available; academic institutions determine which credits are applicable to a program of study.

A Lifecycle of Credentialing Education

The Department has realized that the key feature of effective licensure and certification programs are that they are introduced to Servicemembers early in their careers, not just at the time of separation. We continue to provide licensure and certification information in a range of ways and in different formats in order to appeal to individual learning styles and ensure the widest possible dissemination. The information is provided through classroom delivery from an instructor, by online interaction and internet research, and through one-on-one coaching. This ensures that Servicemembers have current and accurate information at their fingertips in order to make informed decisions about their future. We are taking full advantage of the Department of Labor's Career One Stop (www.careeronestop.org) online resource as promoting utilization throughout the entire military lifecycle to reinforce the value of military training and experience. In this application, Servicemembers link to the

Credentials Center, which they can use to locate State-specific occupational licensing requirements, agency contact information and information about industry-recognized certifications. There are also associated workforce education and examinations that test or enhance knowledge, experience and skills in related civilian occupations and professions.

WOUNDED, ILL AND INJURED SERVICE MEMBER EMPLOYMENT INITIATIVES

Operation Warfighter (OWF)

OWF is a DOD-sponsored internship program that offers recuperating wounded, ill and injured Servicemembers meaningful activity that positively impacts wellness and offers a process of transitioning back to duty or entering into the civilian workforce. The main objective of OWF is to place recuperating Servicemembers in supportive work settings that positively benefit the recuperation process.

OWF represents a great opportunity for transitioning Servicemembers to augment their employment readiness by building their resumes, exploring employment interests, developing job skills, benefiting from both formal and on-the-job training opportunities, and gaining valuable Federal Government work experience that will help prepare them for the future. The program strives to demonstrate to participants that the skills they have obtained in the military are transferable into civilian employment. For Servicemembers who will return to duty, the program enables these participants to maintain their skill sets and provides the opportunity for additional training and experience that can subsequently benefit the military. OWF simultaneously enables Federal employers to better familiarize themselves with the skill sets of wounded, ill and injured Servicemembers as well as benefit from the considerable talent and dedication of these transitioning Servicemembers.

To date, the program has placed approximately 1,800 Servicemembers across more than 100 different Federal employers and sub-components. The program currently has 390 active internship placements.

Education and Employment Initiative (E2I)

Contributing factors to unemployment among wounded warriors include the lack of a focused employment, educational, and rehabilitation process that engages Servicemembers as soon as they begin treatment at a Medical Treatment Facility (MTF), as well as a lack of qualified career counselors who can administer career assessments and match Servicemembers to careers. DOD, in collaboration with VA, DOL, and the Office of Personnel Management (OPM), is developing E2I to address these shortfalls. E2I will leverage best practices and the good work already being done from existing employment and training initiatives in both Federal and private sectors. The first phase is a tiered pilot program scheduled to launch in by this summer.

The goal of the E2I pilot is to engage Servicemembers early in their recovery to identify skills they have, the skills they need and the employment opportunities where those skills can be put to good use. The E2I process will begin within 30–90 days of when a Recovering Servicemember (RSM) arrives at a MTF, taking advantage of a recovery time that averages 311 days but can be as long as five years. At the very beginning of the E2I process, all applicants will be administered a comprehensive skills assessment that includes understanding their current disability, Military Occupational Specialty (MOS) experience, career desires, education and training background, and special accommodations that may be required for a particular type of position. This assessment will be conducted by a trained career and vocation counselor who has extensive knowledge of the issues facing wounded warriors.

The E2I counselor will work with the RSM from the initial stages of creating an individual development plan (IDP), setting goals, course selection, and education requirements, through to the completion of training/certification and their return to duty or an alternate job placement. A Mentor and Coach will be assigned to all E2I applicants at the beginning of the process to provide personalized assistance and guidance throughout the E2I process from recruitment at the MTF into the program, through placement in their new MOS or chosen career.

Our plan is to evaluate the E2I program over the next 12 months to 18 months and refine the process with new ideas and best practices. Once this evaluation is complete, our plan is to continue our E2I roll-out, which will include partnering with OPM, VA and DOL to ensure we have standardized practices and comprehensive handoffs as the RSM leaves the responsibility of the DOD.

INTERAGENCY ELECTRONIC HEALTH RECORD

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

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

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

The Blue Button is another example of how DOD and VA are working together to shape the future of health care IT collaboration, interoperability and transparency for the patients and families we serve. The Blue Button allows beneficiaries to safely and securely access personal health data at TRICARE Online, the Military Health System's Internet point of entry.

The Blue Button capability allows beneficiaries to safely and securely access and print or save their demographic information, allergy and medication profiles, lab results, patient history and diagnoses, and provider visits. The level of data available is dependent on where treatment occurs—with the most data available to those who regularly get care at military hospitals and clinics.

Transmission of Data from Point of Separation

At separation, the Federal Health Information Exchange (FHIE) provides for the one-way electronic exchange of historic healthcare information from DOD to VA for separated Servicemembers since 2001. On a monthly basis DOD sends: laboratory results; radiology reports; outpatient pharmacy data; allergy information; discharge summaries; consult reports; admission/discharge/transfer information; standard ambulatory data records; demographic data; pre- and post-deployment health assessments (PPDHAs); and post-deployment health reassessments (PDHRAs). DOD has transmitted health data on more than 5.6 million retired or separated Servicemembers to VA. Of these 5.6 million patients approximately 2.1 million have presented to VA for care, treatment, or claims determination. This number grows as health information on recently separated Servicemembers is extracted and transferred to VA monthly.

Access to Data on Shared Patients

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

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

To increase the availability of clinical information on a shared patient population, VA and DOD collaborated to further leverage BHIE functionality to allow bidirectional access to inpatient discharge summaries from DOD's inpatient documentation system. Use of the inpatient documentation system at Landstuhl Regional Medical Center plays a critical role in ensuring continuity of care and sup-

porting the capture and transfer of inpatient records of care for wounded warriors. Information from these records is accessible stateside to DOD providers caring for injured Servicemembers and inpatient discharge summaries are available to VA providers caring for injured Servicemembers and Veterans. As of April 2011, discharge summaries are available for all DOD inpatient beds. DOD's inpatient documentation system is now operational at all 59 DOD inpatient sites.

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

Exchange of Computable Pharmacy and Allergy Data

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

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

Wounded Warrior Image Transfer

To support our most severely wounded and injured Servicemembers transferring to VA Polytrauma Rehabilitation Centers for care, DOD sends radiology images and scanned paper medical records electronically to the VA Polytrauma Rehabilitation Centers. Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Brooke Army Medical Center are providing scanned records and radiology images electronically for patients transferring to VA Polytrauma Rehabilitation Centers in Tampa, Richmond, Palo Alto, and Minneapolis. From 2007 to the present, images for more than 375 patients and scanned records for more than 470 severely wounded warriors have been sent from DOD to VA at the time of referral.

Virtual Lifetime Electronic Record

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

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

Modernizing the EHR—The Foundation for Interagency Data Sharing

We believe there are many benefits in pursuing a joint way ahead for EHR. The Departments will be able to deliver a seamless health record from accession through

end of life for all servicemembers and veterans. Improvements to the quality of care delivery will reduce errors and improve adherence to care guidelines. Strategic organizational use of health information, including evidence-based alerts and reminders, will improve effectiveness. Improved enterprise-wide use of health information will also lead to enhanced management of population health, resulting in improved health status and reduced need for health care services. Savings in staff time and materials associated with system support of transactional tasks will be achieved by replacing manual, paper-based processes.

While significant data sharing has existed between DOD and VA for years, until recently both Departments were embarked upon separate paths to replace our legacy EHR systems. Faced with a need to modernize these systems to enhance clinical decisionmaking capabilities and improve the quality of care for servicemembers and veterans, DOD and VA have agreed to implement a joint, common EHR platform going forward, purchasing commercially available components for joint use whenever possible and cost effective.

The Departments expect to benefit from increased interoperability and reduced sustainment costs by implementing a common architecture, data and services, data centers, interface standards, and presentation layer. Alignment to a common data model will enable the exchange of information at unprecedented levels between the Departments and serve as an example for the Nation. Both Departments will use common data centers run by our Defense Information Systems Agency, which is tasked with continuously operating and assuring DOD's global net-centric enterprise. We have also agreed to use common measures of success and establish standard end-to-end business processes.

In order to oversee the planning and execution of this critical endeavor across both Departments, we have agreed to a high-level joint governance structure. The effort will be led by a Program Executive and Deputy Director selected by the Secretary of Defense and Secretary of Veterans Affairs, and will leverage existing statutory authorities. An Advisory Board will be established and co-chaired by the DOD Deputy Chief Management Officer and the VA Assistant Secretary for Information and Technology, and will also include key stakeholders and functional leaders from both DOD and VA.

North Chicago

Activated in October 2010, the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois is currently testing a unique management concept of full vertical integration of all DOD and VA health care functions in a single location. On an annual basis, the JAL FHCC in North Chicago will be responsible for ensuring the medical readiness of nearly 40,000 Navy recruits and caring for nearly 67,000 eligible military and retiree beneficiaries.

In standing up the JAL FHCC, the Departments developed reusable capabilities to address challenges in both DOD and VA health systems. Joint Patient Registration enables users to register and search for patients using a common graphical user interface. Medical Single Sign On with Context Management enables role-based access to both DOD and VA systems using a single login process with the ability to maintain patient context. Orders Portability enables users to order laboratory or radiology procedures from one Department's system and have that order fulfilled in the other's with the status and results returned to the ordering system. These groundbreaking capabilities are in demand throughout our respective enterprises, and will be fully leveraged by our joint EHR modernization activities.

Traumatic Brain Injury (TBI)

The DOD has made significant advancements in TBI management and has implemented numerous programs during the past several years to ensure early detection and state of the science treatment in those who sustain a TBI from concussion to more severe and penetrating brain injuries. The Department is aggressively working to improve the diagnosis and treatment of TBI in-theater. In June 2010, the Directive Type Memorandum (DTM) 09-033, "Policy guidance for the management of concussion/mild TBI in the deployed setting" was released. This guidance ensured comprehensive evaluation of servicemembers who were exposed to potential concussive events.

TBI research continues to be fast-tracked to assist our Servicemembers with close collaboration among the line, medical, and research communities. Key areas of promise include understanding blast dynamics, rapid field assessment of mild TBI to include objective biomarkers to be used in the diagnosis of concussion and TBI innovative treatment modalities. In addition, the DOD created the National Intrepid Center of Excellence (NICoE), a new state-of-the-art facility dedicated to advancing

the treatment, research, and diagnosis of complex combat related psychological health and TBI conditions.

Clinical care instructions, representing the state-of-the-art care, for all levels of TBI severity have been developed and cover both the deployed and the non-deployed environments. Educational materials include a pocket guide for CONUS TBI care, Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health, and web-based case studies in TBI diagnosis and treatment and education modules. Family resources for TBI include an Online Family Caregiver Curriculum and educational materials available at dvbic.org, brainline.org and www.traumaticbraininjuryatoz.org. All materials are aimed at line commanders, providers, Servicemembers and their families.

MENTAL HEALTH

Maintaining and enhancing the psychological health of Servicemembers and their families is a top priority for DOD. Screening for mental health conditions before and after deployment on a periodic basis is essential for force health protection and readiness and for the well-being of Servicemembers. We recently established guidance to administer a person-to-person mental health assessment for each member of the Armed Forces who is deployed in connection with a contingency operation. The purpose of the mental health assessment is to identify mental health conditions including Post-Traumatic Stress Disorder, suicidal tendencies and other behavioral health conditions that require referral for additional care and treatment.

To ensure that suicide prevention is a coordinated, joint Service effort, we have consolidated standard surveillance information about suicide events, risk and protective factors across the Services. In addition, we have strengthened the Suicide Prevention and Risk Reduction Committee (SPARRC), and have created a Web-based information clearinghouse called www.suicideoutreach.org.

The Department has developed clinical support tools and guidance that establish DOD standards of care for mental health. Clinical guidance packages have been created for depression, substance abuse, and mild TBI and co-occurring psychological health disorders. In addition, there are clinical tools such as the VA/DOD Major Depressive Disorder Toolkit and the Co-occurring Conditions Toolkit.

DOD and VA are working together on the Integrated Mental Health Strategy—a joint effort to implement 28 strategic actions, to provide ready access to quality clinical services, and to better align and coordinate the mental health services of the two Departments.

Training for health care providers is offered on topics such as: PTSD, sleep disorders, depression, substance misuse, virtual reality, and prolonged exposure therapy. We have developed guidelines for training providers in evidence-based practices for PTSD. In addition, clinical consultation, education and dissemination of deployment health care best practices are available from the Deployment Health Clinical Center (DHCC). DHCC developed the RESPECT-Mil program, a collaborative care model, to enable health care providers to screen patients for posttraumatic stress and depression in primary care clinics.

The Department is exploring the use of telehealth services to increase access to care for Servicemembers and their families, focused on establishing a collaborative network to rural and underserved locations. We have developed Mobile Telehealth Units to expand mental health care services to DOD beneficiaries who might not otherwise have access to or seek care; developed a web-based assistance program; developed smart phone applications to aid in the management and treatment of PTSD, and fielded the Virtual PTSD Experience—an immersive, interactive learning activity that educates users about combat-related post-traumatic stress.

Servicemember and family services include: the Defense Centers of Excellence for Psychological Health and TBI (DCoE) Outreach Center, a 24/7 resource available by phone, online chat or email; online self-help tools at www.militarypathways.org and www.afterdeployment.org; and inTransition, a coaching and assistance program to bridge the potential gaps in mental health treatment during transitional periods for Servicemembers and veterans. DCoE partnered with Sesame Workshop to develop outreach programs to help children cope with deployments and injured parents, including the Sesame Street Family Connections Web site, which allows families and friends to stay in touch throughout deployments.

The Real Warriors Campaign and Military Pathways online self-screening program are two of DOD's public education initiatives that encourage help-seeking behavior among Servicemembers and veterans for psychological health concerns. Both campaigns provide regular public service announcements—featuring real Servicemembers who have reached out, obtained care, and continue to lead productive military and civilian careers—reach over 1.5 million servicemembers each week.

SUICIDE PREVENTION

DOD is very concerned about the number of suicides in the Total Force over the past decade. While the overwhelming majority of Servicemembers effectively cope with the stress of serving in a military at war, there are those who have difficulty adapting to the stress and strain that an increased operational tempo often places on them and their families. The loss of even one life to suicide is heartbreaking; it degrades the readiness of the force and has a profound impact on both the unit and the family members left behind. In 2010 there were 293 Servicemembers who died by suicide while on active duty, down from a total of 310 in 2009. While this is not a significant decrease, we have slowed the steady increases in overall active duty suicides that began in 2006. We believe this is due largely to the focus of Service senior leaders on this issue and the increasing emphasis on resilience across the Department highlighted by programs such as the Army's Comprehensive Soldier Fitness. This program is designed to develop and institute a holistic fitness program for Soldiers, families, and Army civilians in order to enhance performance and build resilience. To date, the Army has trained 3,253 Master Resilience Trainers to facilitate this goal. The other Services are developing or enhancing similar programs.

We are concerned as well about the number of suicides recently in our Reserve Component. The Army National Guard and Reserve reported a combined 145 suicides in 2010 which was up significantly from the previous year (80 total Army Guard/Reserve). This already complex issue becomes even more complex when dealing with our Reserve Component because of their continuous transition from military to civilian life. Nevertheless, the Department is committed to addressing this issue. We currently have a Director of Psychological Health in each of our 54 states and territories who acts as the focal point for coordinating the psychological support for Guard members and their families. We have also embedded behavioral health counselors in a small number of our high risk Guard units and are exploring the possibility of increasing this practice much more widely. The National Defense Authorization Act (NDAA) for Fiscal Year 2010 mandated that the Department expand suicide prevention and community healing and response training under the Yellow Ribbon Reintegration Program. We have made some progress here and are in the process of reinvigorating this effort with input from a Reserve Component Stakeholder Group comprised of all of the Reserve and National Guard Components, Reserve Affairs Yellow Ribbon representatives and members of the Defense Centers of Excellence. Additionally, we are examining "peer-to-peer" programs to see what role these types of programs can play in reducing suicides.

There have been several studies and task force reports (DOD, Army and RAND) released over the past year, each with multiple observations and recommendations. The Deputy Assistant Secretary of Defense for Readiness is currently leading a team of senior Officers and Executives from the Department in an effort to examine these reports and devise an implementation plan based on the recommendations that will enhance our suicide prevention efforts across the Department. We plan to act quickly on one of the main recommendations contained in the Congressionally mandated Final Report of the DOD Task Force on the Prevention of Suicide by Members of the Armed Forces and establish an OSD office on suicide prevention to provide strategic direction, oversight, and policy standardization to enhance and better coordinate the Department's efforts in this area with a focus on the Total Force.

BURN PIT SMOKE EXPOSURES IN THEATER

A topic of concern over the past several years has been the possibility of long-term health risks to our Servicemembers and other deployed individuals associated with inhalation of burn pit smoke. DOD fully understands the importance of addressing this issue and takes very seriously the concerns of our Servicemembers and veterans concerning burn pit smoke exposures. Because accumulated solid waste can result in health risks by attracting disease-carrying insects and vermin, engineers determined it was necessary to implement an expedient means of waste disposal. Burn pits provided the means with the lowest risk to personnel.

Over the past four years, there has been an ongoing and very successful effort in US Central Command to reduce the number of burn pits and replace them with incinerators or other waste disposal technologies and practices. All U.S. operated burn pits in Iraq at locations with greater than 100 U.S. personnel were closed effective December 31, 2010. There are presently 29 incinerators operating in Afghanistan, an additional 58 on order, and 11 in the planning stages.

U.S. Central Command Regulation 200-2, "Contingency Environmental Guidance," requires that when a basing location exceeds 100 U.S. personnel for at least 90 days, a plan must be developed for installation of adequate waste management technologies, including incinerators, to replace any burn pits. On February 15, 2011,

the DOD published DOD Instruction 4715.19 "Use of Open Air Burn Pits in Contingency Operations" that established policy for burn pit use in contingencies and implements Section 317 of Public law 111-84. When burn pits are used, they must be located away from occupied areas and where prevailing winds blow smoke away from those areas. In addition, there is a prohibition against burning any hazardous materials in the burn pits that might generate any hazardous exposures.

Epidemiological studies accomplished in May 2010 by the Armed Forces Health Surveillance Center and the Naval Health Research Center entitled "Epidemiological Studies of Health Outcomes among Troops Deployed to Burn Pit Sites" do not provide evidence at this time on a population-wide basis that burn pit smoke exposures pose long-term health risks for smoke-exposed individuals. While no long-term health risks have yet been identified, we believe it is plausible that some Servicemembers may be affected by long-term health effects, possibly due to combined exposures (such as sand/dust, industrial pollutants, tobacco, smoke and other agents) and individual susceptibilities, such as preexisting health conditions or genetic factors. This population will continue to be followed and monitored for any future health effects that have not yet manifested.

In the meantime, DOD is continuing to reduce exposures to burn pit smoke by closing burn pits, installing incinerators and ensuring the elimination of potentially harmful materials from the waste streams. DOD will continue to study inhalational exposures in theater, including the contribution from the smoke and any resulting health conditions in our Servicemembers in order to determine the extent of any long-term health risks that may exist. DOD is working closely with VA to ensure care for those who are possibly affected.

Additional monitoring of burn pit emissions in Afghanistan is planned for 2011. The Defense Health Board and the Institute of Medicine are reviewing the Armed Forces Health Surveillance Center's report, and we are looking forward to their suggestions on how we can improve our studies as well as the frequency that they should be repeated.

CONCLUSION

We cannot overstate how far DOD has come with our VA partners in the past four years since the SOC and other governance processes were put in place. Each of the Services has stood up a very comprehensive and 'stand alone' Wounded Warrior Care program. Yet we still have much progress to make. And as we close, we would like to be clear: One mistake, undue delay or any other aberration in the care or transition of our wounded ill or injured servicemembers is one too many. We will continue to work with our team-mates at the VA and throughout the interagency to do anything and everything we can to provide our Servicemembers with the absolute best care and treatment that they so rightfully deserve in return for their selfless service and sacrifice to our Nation. We continue to be awed and grateful for their service and that of their Families.

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

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

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO U.S. DEPARTMENT OF DEFENSE

Question 1. The Departments have numerous programs and projects to inform servicemembers of their rights and benefits upon separation from the military. Yet repeated reports from young men and women state that the transition assistance was not available or they were given too much information at a time when their focus was on returning to their family.

a. What are the Departments doing to jointly manage the information flow related to separation?

b. How do E-Benefits and the Veterans Relationship Management program fit into a joint VA/DOD plan to keep all separating servicemembers informed?

Response. a. The three agencies are working together to update TAP. Each agency has revamped its curriculum, and DOD recently developed a new pre-separation counseling checklist. DOD's TurboTAP.org Web site was specifically developed to be a readily available resource to manage the information flow related to separation. Transitioning Servicemembers are referred to this Web site as one of the primary reference sources should they need further information in the future. The Web site provides retiring and separating Servicemembers, as well as veterans, access to pre-separation guides covering topics such as employment assistance, education and training, health care and life insurance, and veterans benefits; it also contains a Career Decision Toolkit covering every aspect of career transition, from exploring career options to negotiating the ideal compensation package for a new job.

b. To keep all separating Servicemembers informed, the eBenefits portal is a collaborative effort between the Department of Veteran Affairs (VA) and the Department of Defense (DOD) to provide Servicemembers, veterans, and their families personalized access to benefit information, resources, and self-service capabilities. This Servicemember/veteran-centric portal focuses on the health, benefits, and support needs, consisting of both a public Web site and a secure portal that allows for multiple self-service capabilities along with personalization by the user and customizes benefits related information based on user profile. This enables Servicemembers, veterans, and their authorized designees to find benefits related information and services in one location. The eBenefits portal and Web site design is user-friendly and helps Wounded Warriors to easily locate the information and services needed. Specifically, transitioning Servicemembers will be able to locate Transition Assistance Program (TAP) information and utilize the self service capabilities to know and apply for eligible benefits on a persona-based platform.

The VA's Veterans Relationship Management (VRM) initiative is to be integrated with the eBenefits portal to aid proactive messaging for outreach to Servicemembers and veterans regarding their eligibility to benefits and entitlements, benefits assistance, and delivery. VRM is a broad multi-year initiative to improve veterans' secure access to health care and benefits information and assistance. VRM will provide VA employees with up-to-date tools to better serve veterans and their families, and will empower veterans through enhanced self-service capabilities such as those found within the eBenefits portal.

Question 2. The Department's testimony stressed the importance of information technology to improve services and programs for all of our men and women in uniform. In the Department's view, what role will a single DOD/VA modernized electronic health record play in delivering services to these departing servicemembers?

Response. In the Department's view, the role of a common electronic health record (EHR) in delivering services to departing Servicemembers is to better enable secure, seamless, cross-boundary sharing of health, benefits, and administrative information for Servicemembers and Veterans to those with the need to know.

It is evident that efficient access to health, benefits, and administrative records of Servicemembers and Veterans can help reduce or eliminate delays in care due to unnecessary red tape and lack of access to needed records. To this end, the Department of Defense (DOD) partnered with the Department of Veterans' Affairs (VA) and other agencies to create an electronic capability to share a virtual record of health, benefits, and administrative information of Servicemembers and veterans, beginning the date of entry into military service and extending beyond their lifetime. Implementation and use of this Virtual Lifetime Electronic Record (VLER) will improve continuity of care, administration of benefits, and accessibility of service records for Servicemembers, veterans, and their authorized designees.

DOD and VA are also collaborating on a common framework and approach to modernize the Departments' EHR applications. Secretary Gates and Secretary Shinseki met on May 2, 2011, and reaffirmed their commitment to pursue a joint, common platform enabled through appropriate governance for EHR. Synchronization of EHR planning activities will accommodate the rapid evolution of healthcare practices and data sharing needs, and speed fielding of new capabilities.

Question 3. Over the years, VA and DOD have increased servicemembers' opportunities to file a "pre-discharge" disability claim, yet the Departments estimate that less than half of all servicemembers currently have access to file a claim. With the use of contractors and the potential of filing an electronic claim, it is reasonable that 100 percent of servicemembers would be able to participate in this process.

a. Do both Departments intend to provide 100 percent of transitioning servicemembers with the opportunity to file a "pre-discharge" disability claim, and if so, what is the timeline for completion of this goal?

b. What obstacles, if any, stand in the way of providing 100 percent of transitioning servicemembers with the opportunity to file a "pre-discharge" disability claim?

Response. a. Yes. DOD and VA intend to provide 100% of transitioning Servicemembers with the opportunity to file a pre-discharge disability claim. The Benefits Delivery at Discharge (BDD) and Quick Start Programs are Department of Veterans Affairs (VA) programs that allow Servicemembers to apply for disability compensation benefits from VA prior to retirement or separation from military service.

Servicemembers can apply for disability benefits through the BDD program at 131 military installations in the Continental United States (CONUS), Germany, Italy, Portugal, the Azores, and Korea. Additionally, Servicemembers can apply for disability benefits through the Quick Start program at all installations.

b. At this time, we are not aware of any obstacles in the way of providing 100% of transitioning Servicemembers to file pre-discharge disability claims.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO
U.S. DEPARTMENT OF DEFENSE

Question 1. According to a memorandum signed by the Secretary of Defense and the Secretary of Veterans Affairs, the two Departments have agreed to move forward with a plan to revise the Integrated Disability Evaluation System (IDES) so that the entire process could be completed within 150 days, instead of the current target of 295 days. At the same time, the Departments have agreed to look at options for reducing that timeframe to 75 days.

a. Does this suggest that the Departments consider the existing IDES process not to be an effective way to handle the transition for wounded servicemembers?

b. How would the IDES process potentially be revised?

c. Could these potential revisions be done administratively or will legislation be needed?

d. What is the timeline for rolling out a revised IDES process in some fashion?

e. In the meantime, please explain why the Departments plan to continue rolling out the existing IDES process to additional sites. Why not improve the process first?

f. Does the decision to move forward with the IDES rollout take into account what impact the delays and uncertainties of the IDES process may be having on injured military personnel before they are discharged? Please explain.

g. Does this suggest that the Departments consider the existing IDES process not to be an effective way to handle the transition for wounded servicemembers?

Response. a–g. No, the Department considers the Integrated Disability Evaluation System (IDES) to be the most effective system currently available to handle transitioning Wounded Warriors. Although we are continuously looking for ways to improve, the IDES has proven to be faster, fairer and substantially reduced the DOD/VA benefits gap. This constitutes a major improvement over the legacy DES and we, along with the VA, are committed to the worldwide expansion.

Although IDES has yet to meet performance goals, our continuous process improvement efforts are beginning to show signs that some of the stages/phases of the process are becoming more timely. Even as the worldwide IDES rollout is completed in the next few months, DOD continues to actively pursue greater efficiencies in process timeliness. The ultimate goal will always be to provide the best possible Disability Evaluation System for every wounded, ill or injured Servicemember.

h. How would the IDES process potentially be revised?

The IDES process would potentially be revised processing current sequential steps that can be accomplished in parallel to each other. For example, the Servicemember being able to request a VA rating reconsideration while they are out-processing from the unit, allowing better handoffs between DOD and VA. By reorganizing elements of the process, streamlining elements like the Medical Evaluation Board, and testing other innovative disciplines such as information technology and paperless/electronic records transfers, we continue to improve timeliness and move closer to achieving performance goals. Using parallel processes and innovative technology will continue to reduce the transition time for Servicemembers.

i. Could these potential revisions be done administratively or will legislation be needed?

These potential revisions to the IDES under consideration can be accomplished within the existing laws.

j. What is the timeline for rolling out a revised IDES process in some fashion?

The timeline for rolling out a revised IDES process is January through September 2012. This revised IDES process is entitled IDES Remodel Proof-of-Concept and will be conducted at designated sites for each Military Department. This will allow the Departments to determine its effectiveness toward improving the timeliness of the IDES process.

k. In the meantime, please explain why the Departments plan to continue rolling out the existing IDES process to additional sites. Why not improve the process first?

The Departments plan to continue rolling out the existing IDES because the Departments would not want to unduly delay benefits of our Servicemembers. Unlike the “Legacy DES,” the IDES provides a Servicemember with their military and VA compensation shortly after separation or retirement from active service. DOD and VA are fully committed to IDES as an improvement over the Legacy DES. The benefits achieved thus far outweigh the alternative of not continuing with the plan to expand the IDES to all locations. The Departments are committed to looking at every alternative to continue improving the delivery of benefits to our valued Servicemembers and their families.

l. Does the decision to move forward with the IDES rollout take into account what impact the delays and uncertainties of the IDES process may be having on injured military personnel before they are discharged? Please explain.

Yes, the focus is making sure that every plan is Servicemember centric. The Departments are committed to continually improving IDES to make it more efficient. While the current process continues to be improved, it is important to note that the Servicemember receives their full pay and allowances throughout the entire IDES transition process. Once a date of separation from service is established, the Servicemember and/or their family are able to receive their military and VA compensation much sooner than with the Legacy DES.

The Departments are committed to getting the system to a more reasonable timeframe, and to complete every step in the process as quickly as is fair to Servicemembers. As new delays are discovered, solutions are developed. The Departments are also exploring ways to further reduce that process time.

Question 2. In a September 2010 report, the Department of Veterans Affairs and the Department of Defense identified timeliness and customer satisfaction as key indicators of performance for the IDES and found that it was, at that time, a “success” with “proven performance.” Now, IDES sites are collectively missing the 295-day timeliness goal by over 100 days and some sites—like Camp Lejeune—are missing that goal by well over 200 days. In fact, only 15% of servicemembers are completing the process within the target timeframe. Also, customer satisfaction goals are not being met. At Lejeune, satisfaction is only 60%—20% lower than the target.

a. In light of these statistics, how would the Department of Defense rate the performance of the Integrated Disability Evaluation System now?

b. What impact do these delays have on the military in terms of readiness and resources for each branch of the military?

c. Please explain the root causes of these delays and what steps are being taken in the near term, while the IDES process is being revised, to improve timeliness and customer satisfaction.

d. Until those revisions are complete, please provide the Committee with weekly updates on the average time it is taking military-wide to complete the IDES process and the percent of servicemembers who are completing the process within the 295-day goal.

Response. a. In light of these statistics, how would the Department of Defense rate the performance of the Integrated Disability Evaluation System now?

The Department would rate the performance of IDES as improving. The Departments set ambitious goals and are striving to meet them. IDES still outperforms Legacy DES processing in efficiency, time, and satisfaction while eliminating the benefits gap. These measures suggest a successful program that is continuing to improve. Surveys collected during April, 2011, show overall improvement with IDES from previous months. Air Force and Navy Servicemembers reported satisfaction at or above the 80% DOD goal. For the same period, Soldiers reported 72% satisfaction and Marines reported 65%. Guard and Reserve Servicemembers reported 78% satisfaction with the IDES process in April 2011.

b. What impact do these delays have on the military in terms of readiness and resources for each branch of the military?

While in the IDES, Servicemembers are not available, which has an impact on readiness. These are real challenges, and our efforts to decrease time in system will assist the Services better manage their available end strength.

The Army found that consistent growth in the Physical Disability Evaluation System (PDES) population, does pose a risk to Army readiness over the coming fiscal years. The Navy population concerned is not large enough to have a significant effect on overall readiness. For the Air Force, individuals processing through IDES are not deployable assets, and though they may remain in deployable positions, they may not be able to be utilized for deployment tasking by their unit Commander.

c. Please explain the root causes of these delays and what steps are being taken in the near term, while the IDES process is being revised, to improve timeliness and customer satisfaction.

The root causes of the delays were found to be Medical Evaluation Board (MEB) processes and the processing and development of initial ratings. We have studied the IDES process and know where delays are occurring. We have put together a team from the Services to address those Servicemembers dealing with delays at various stages in the IDES process. They have reported and customer satisfaction is now trending in the right direction.

DOD solutions include the Army and Navy implementing streamlined Medical Evaluation Board (MEB) processes to reduce time required for that stage of the process. VA has also added an additional rating site in Rhode Island to speed up the processing and development of initial ratings by augmenting the existing work being done in Baltimore and Seattle.

d. Until those revisions are complete, please provide the Committee with weekly updates on the average time it is taking military-wide to complete the IDES process and the percent of servicemembers who are completing the process within the 295-day goal.

As DOD continues to expand IDES worldwide to 139 sites we will provide the Committee with the requested status reports.

Question 3. Information recently obtained by the Committee reflects that at least 280 servicemembers going through the IDES process have received an Administrative Discharge and 40 others have been court-martialed. Worse, at least 17 servicemembers going through the IDES process have died from non-natural causes, including suicide, overdoses, a motorcycle accident, and gunshot wounds.

a. Has the Department of Defense made any attempts to figure out what went wrong for these particular servicemembers? If so, please explain.

b. Are any efforts being made to gauge the personal toll the delays and uncertainties of the IDES process may be taking on wounded servicemembers?

c. What is the Department of Defense doing to identify and provide help for IDES participants having suicidal thoughts, having problems with drugs, or engaging in risky behavior?

d. What more can be done to make sure wounded servicemembers going through the IDES process have the supports and services they need to cope with the transition process and go on to successful civilian lives?

e. Until the IDES process has been revised, please provide the Committee with monthly updates on the number of servicemembers going through the IDES process who have received Administrative Discharges, been court-martialed, or died from non-natural causes.

Response. a. Has the Department of Defense made any attempts to figure out what went wrong for these particular servicemembers? If so, please explain.

The Department as a whole is doing everything it can to address these issues. As Servicemembers are transitioning they remain subject to disciplinary actions and the Uniformed Code of Military Justice. As such, there are a myriad of behaviors or varied actions that require Administrative Discharges, non-judicial punishment or court-martials. All deaths are reviewed to ensure standards of medical care are met. The Armed Forces Medical Examiner is notified of all Active Duty deaths that occur outside DOD and makes a determination of whether to accept the findings of local officials or whether further investigation is required and warranted.

b. Are any efforts being made to gauge the personal toll the delays and uncertainties of the IDES process may be taking on wounded servicemembers?

Soldiers are surveyed at various points throughout the disability evaluation process to determine their satisfaction with the IDES process, the results of which are reviewed at all levels of leadership. Currently, the Army has the one of the highest satisfaction rates within the DOD.

The Department of the Navy is also committed to supporting all Servicemembers throughout the IDES process. Servicemember satisfaction surveys are requested throughout the process to formally evaluate their experience. Additionally, Healthcare Providers, Physical Evaluation Board Liaison Officers, Recovery Care Coordinators and Medical Case Managers work with patients to assist them and to reduce burdens. As problems are identified, local commands work quickly to address these issues to reduce the burden to the Servicemember.

c. What is the Department of Defense doing to identify and provide help for IDES participants having suicidal thoughts, having problems with drugs, or engaging in risky behavior?

To help identify and provide help for IDES participants, every Recovery Care Coordinator has received training on suicide prevention. Servicemembers dealing with

suicidal thoughts have multiple programs and intervention/treatment avenues, to include the National Suicide Prevention Lifeline, Military OneSource, and the ability to seek immediate care without the need for referral. Each Service also has an active suicide prevention program, designed to minimize suicide behavior.

d. What more can be done to make sure wounded servicemembers going through the IDES process have the supports and services they need to cope with the transition process and go on to successful civilian lives?

In addition to the DOD-wide efforts of Disabled Transition Assistance Program, Operation Warfighter internship program, and the Education & Employment Initiative, each Service has specific programs for Servicemembers as they go through the transition process.

The Army has multiple programs in place to ensure that Soldiers have the support and resources they need to prepare for their transition out of the military. The most seriously wounded, ill, and injured Soldiers are assigned to Warrior Transition Units, where soldiers are afforded a triad of leadership focused on ensuring they are connected with the programs and support systems needed based upon their individualized needs. Navy Safe Harbor seeks to focus upon the transition process for seriously wounded, ill and injured Sailors and Coast Guardsmen. To enhance community reintegration, the Marine Corps Wounded Warrior Regiment's Transition Support Cell, manned by Marines and representatives from the Departments of Labor and Veterans Affairs, proactively reaches out to identify employers and job training programs that help WII Marines obtain positions in which they are most likely to succeed and enjoy promising and fulfilling careers. The Air Force Airman and Family Readiness Center (A&FRC) is the initial point of contact for all separating Airmen and their families, and its staff provides services, counseling, training, workshops, employment assistance, and educational information throughout the transition process.

e. Until the IDES process has been revised, please provide the Committee with monthly updates on the number of servicemembers going through the IDES process who have received Administrative Discharges, been court-martialed, or died from non-natural causes.

As of June 21, 2011, the Veterans Tracking Application indicates the following IDES cumulative dispositions: a total of 324 Administrative Discharges, plus 51 court-martials, plus 41 deaths. The Office of Wounded Warrior Care and Transition Policy (WWCTP) will work with the Services to compile the data and provide a monthly report.

Question 4. The Government Accountability Office (GAO) has reported that some servicemembers going through the IDES process are not given meaningful employment and, if left idle, are more likely to engage in behavior that could result in a discharge for misconduct. Recently, the Department of Defense informed the Committee that it plans to publish a guide that will direct commanders to make sure servicemembers going through the IDES process have meaningful work.

a. Do the large number of court-martials and Administrative Discharges for those going through the IDES process suggest that there is a real problem with some wounded servicemembers being left idle? Please explain.

b. Has the new guide been published and distributed yet? If not, when will it be?

c. How will the Department of Defense track whether military bases are complying with the requirement to provide meaningful work for IDES participants?

d. Has the Department of Defense considered whether the surveys given to IDES participants should include questions to gauge whether idleness or lack of meaningful work is seen as a problem?

Response. a. Do the large number of court-martials and Administrative Discharges for those going through the IDES process suggest that there is a real problem with some wounded servicemembers being left idle? Please explain.

No, from our records, the rates do not suggest a problem. IDES cumulative rate for these categories is less than 1.5%. Through leadership from squad leaders and commanders, the Services work to keep Servicemembers active and engaged throughout the transition process.

Soldiers who are on active duty during the course of their disability evaluation process are, under the direction of their unit commander and assigned work that is appropriate based upon their physical limitations. Of those Soldiers found "fit" over the past three fiscal years, only 3% went on to be administratively separated but none were separated for the same reason that they were originally boarded. The reasons for the administrative separations were varied, and represent instances that would have resulted in the separation of the Soldier regardless of the physical condition that prompted the referral to the disability evaluation process.

b. Has the new guide been published and distributed yet? If not, when will it be?

No, the new guide has not been published and distributed yet. At this time, the forthcoming IDES Directive Type Memorandum (DTM) is in final review and we anticipate publication soon.

c. How will the Department of Defense track whether military bases are complying with the requirement to provide meaningful work for IDES participants?

The Department will be alerted as appropriate by unit Commanders. DOD believes that the unit Commander is responsible for ensuring that each Servicemember is assigned appropriate and meaningful work at all times.

d. Has the Department of Defense considered whether the surveys given to IDES participants should include questions to gauge whether idleness or lack of meaningful work is seen as a problem?

Yes, the IDES Satisfaction surveys included questions on Idleness beginning in May 2011. As of May 18, 2011, all IDES and Legacy DES survey respondents are asked specific questions about opportunities to engage in meaningful work or activities, whether they participated or not, and, if not, why. Although it will be several months before sufficient data can be compiled to provide an analysis on this subject, early results show that Servicemembers are engaged and satisfied with their work or activities.

Question 5. According to written testimony provided by the Department of Defense in connection with a November 2010 Committee hearing, "The Services face challenges adequately staffing the IDES process, ensuring transportation to and from and timely disability examinations, and the impacts of the extra time on active duty during the IDES on force structure and readiness, housing and billeting, and command and control." Despite these challenges, the Departments plan to rollout the IDES process worldwide by September 2011, a timeframe GAO described as "ambitious in light of substantial management challenges and * * * deteriorating case processing times."

a. In light of these challenges, what factors initially led the Department of Defense to conclude that the number of IDES sites should be aggressively expanded?

b. Will these challenges be tackled before either the existing IDES process or a revised IDES process is rolled out to any more sites?

c. What impact do these challenges have on wounded servicemembers?

Response. a. In light of these challenges, what factors initially led the Department of Defense to conclude that the number of IDES sites should be aggressively expanded?

The Department concluded that sites should be expanded due to the fact that the IDES outperforms Legacy DES in processing efficiency, time, and satisfaction, and eliminates the benefits gap. Surveys and performance metrics, taken during evaluation of the Pilot and subsequent stages, suggest a successful program, which is expanding in careful sequence as potential improvements are explored.

b. Will these challenges be tackled before either the existing IDES process or a revised IDES process is rolled out to any more sites?

Yes. The Services and VA are actively engaged in hiring additional staff, determining solutions to transportation and other efforts to minimize impacts on force structure, which is why we are also actively pursuing faster processes.

c. What impact do these challenges have on wounded servicemembers?

The Services and VA provide an extensive support network and are aggressively pursuing several process improvements, which reduce the challenges that were alluded to in the November 2010 hearing.

Question 6. Last month, the Senate Committee on Veterans' Affairs held a hearing on employment. The Committee heard several complaints from veterans regarding service records containing military training information that is difficult for potential private employers to understand. According to your testimony before the Committee on May 25th, the Department of Defense has undertaken a number of initiatives to translate military experience to jobs in the private sector, and has been doing so for some time. Yet, it appears these initiatives are still not working for many servicemembers transitioning to civilian jobs.

Please explain what DOD is doing so that civilian employers understand the military skills and are able to transfer them into private sector jobs.

Response. The Department's approach is to prepare our transitioning Servicemembers by providing them with the training, tools and information to be well prepared as they enter the civilian job market. During pre-separation counseling, Servicemembers are informed about several resources that can assist them in translating their military training and skills into civilian equivalent occupations and terminology.

The first resource is the Verification of Military Experience and Training (VMET) document that translates military skills and occupations into civilian equivalents,

and can be used as a source document to verify job skills, education, training, and experience acquired while on active duty that has application to employment in the civilian sector. Other resources include the Service's Credentialing on Line, or COOL Web sites, and the Occupational Information Network, or O*NET Web sites. These Web sites allow Servicemembers to crosswalk their Military Occupational Specialty code to its civilian equivalency through O*NET's Standard Occupational Classifications. An additional resource for Servicemembers is a skills translator to use to identify Federal jobs related to their military occupations. DOD, the Departments of Labor and Veterans Affairs collaborated with The State of Maryland to develop the Military to Federal Jobs Crosswalk. The web site can be found at: <http://www.mil2fedjobs.com/>.

In August 2010, the Office of Wounded Warrior Care and Transition Policy also launched the Career Decision Tool kit, accessible via interactive CD and TurboTap.org Web site, which includes a tutorial on translating military skills and experience to civilian occupations. In March 2011, we also began a series of online webinars that includes two offerings, "Building a Better Resume" and "Decoding Military Skills for Civilian Employers" to specifically assist transitioning Servicemembers in this area.

Additionally, Servicemembers receive instructions during the Department of Labor's TAP Employment Workshop on how to use the above resources to eliminate "military jargon" and develop resumes that translate their skills and experience into language that employers understand.

Question 7. According to a report by GAO on the Federal Recovery Coordination Program, Federal Recovery Coordinators (FRC) "cannot readily identify potential enrollees using existing data sources." The Senior Oversight Committee developed a categorization system to identify those servicemembers that would benefit from an FRC. However, these are purely administrative categories and do not line up with VA or DOD's medical and benefits systems.

a. What steps have been taken to align the categories set out by the Senior Oversight Committee with the medical and benefits system of DOD?

b. What steps has DOD taken to better identify potential servicemembers that can benefit from a Federal Recovery Coordinator?

c. The Special Operations Command's Care Coalition has been recognized to be the "gold standard" by Admiral Mike Mullen, the Chairman of the Joint Chiefs of Staff, for helping wounded servicemembers. What is this program doing right and could this model be replicated?

Response. a. What steps have been taken to align the categories set out by the Senior Oversight Committee with the medical and benefits system of DOD?

DOD hosted a Wounded Warrior Care Coordination Summit in March 2011, bringing together representatives from care coordination programs throughout the Services, VA, and Department of Labor to participate in working groups.

The direct result of the FRC/RCC Collaboration Working Group was the recommendation to eliminate care categories (1, 2, and 3) eligibility criteria and establish appropriate assessment criteria for care coordination.

The DOD/VA Executive Committee also recommended refining the referral criteria to ensure appropriate referrals are made. As a result of this recommendation, the Case Management Workgroup will be reconvened to address the matter. These categories are administrative in nature and are primarily used to determine what type of care coordination is provided by DOD and the VA.

In addition, the RCCs are currently serving those recovering Servicemembers within Category 2 and 3, and include FRCs within Category 3. Recovery Care Coordinators and Federal Recovery Coordinators (FRCs) are all highly trained and skilled in Federal, local, and private resources, benefits, and compensation, as well as the Disability Evaluation System process for our wounded, ill, and injured Servicemembers in both categories.

b. What steps has DOD taken to better identify potential servicemembers that can benefit from a Federal Recovery Coordinator?

First, if a wounded, ill, or injured Servicemember receives an acuity assessment score in the Category 3 level, there is an automatic referral to a Federal Recovery Coordinator (FRC). In addition, we are currently including the FRC Leadership and FRCs in the RCC orientation training to educate RCCs on the FRCs' function, where they are located, their contact information, and how to best utilize their talents. Some service programs have FRCs collocated with RCCs at major Military Treatment Facilities, which has enhanced the collaborative relationship and allowed for earlier identification and referral to an FRC.

RCCs are trained to provide outreach briefs of the programs and what services they offer, how to access them, and key points of contacts. We are also working to

improve marketing the FRC program and benefits to other Federal agencies and private sector agencies that serve our Servicemembers, families and veterans.

c. The Special Operations Command's Care Coalition has been recognized to be the "gold standard" by Admiral Mike Mullen, the Chairman of the Joint Chiefs of Staff, for helping wounded servicemembers. What is this program doing right and could this model be replicated?

USSOCOM's Care Coalition, like other Service Wounded Warrior Programs, is involved very early after incident or injury and acts as a "gatekeeper" to the dozens of assisting services provided to the Servicemember while they are still hospitalized. USSOCOM also matches a Servicemember and family/caregiver with a mentor who has had the same injury or illness. It is a way for the wounded, ill, or injured to build a relationship with someone who understands, is happy to help and has gone through similar experiences. The recovering Servicemember and their family/caregiver respond very well in this environment of care.

This USSOCOM model has been included in overall best practices for helping our Wounded Warriors. As a result of our Wounded Warrior Care Coordination Summit in March 2011, many of these strategies are now included in all Wounded Warrior Programs.

Question 8. The GAO report points to challenges coordinating with other programs supporting the FRC program. Although, these programs are not just for the most severely injured servicemembers, they have similar case management functions and many recovering servicemembers are enrolled in more than one program. This has led to a duplication of efforts and could lead to confusion for the servicemember.

What steps have been taken to better share information on servicemembers enrolled in the Federal Recovery Coordination Program to reduce confusion and redundancy in the recovery process?

Response. In order to better share information on Servicemembers enrolled in the FRCP, Recovery Care Coordinators (RCCs) work collaboratively with the Soldier and Family Assistant Centers, Warrior and Family Assistance Centers, Warrior Transition Units, and Federal Recovery Coordinators to avoid duplication of efforts. They also educate recovering Servicemembers and their families/caregivers on the services available to assist in whatever issues may arise.

To reduce confusion and redundancy, RCCs transition recovering Servicemembers, who then become Veterans, and begin to work with the Veteran Administration's Liaisons and OIF/OEF/OND case managers, as well as being tracked by VA Nurse Case Managers (NCMs) and the FRCs. All the Services and United States Special Operations Command (USSOCOM) work with the FRCs, VA Liaisons and OEF/OIF/OND Case Managers.. USSOCOM's Care Coalition has a VA Advisor and a FRC who are both co-located with the RCCs in the Care Coalition office at their Tampa Headquarters.

While it is a challenge when it comes to sharing information between DOD and the VA on Servicemembers, the Deputy Assistant Secretary of Defense for Wounded Warrior Care and Transition Policy co-chairs the Information Sharing Initiative (ISI) to support the coordination of non-clinical care. The increased ability to share information electronically across DOD and VA will improve the process as we move forward.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO
U.S. DEPARTMENT OF DEFENSE

Question 1. Mr. Taylor, TRICARE Management Activity has worked with me over the last 2 and half years to make TRICARE serve its beneficiaries better in Alaska. Together, we have made a lot of progress. A critical component of making TRICARE—and all other Federal health care options—work for patients in Alaska is an appropriate reimbursement rate that reflects the higher cost of providing care in Alaska. Recognizing this, all Federal entities currently pay reimbursements higher than Medicare rates. However, since all the Federal agencies pay a higher but different rate, often times they end up creating competition amongst themselves for the primary care physicians and specialists. Keep in mind; many of our communities have one physician. For some specialties it may only be practiced by one person in the entire state. So having a single, appropriate Federal reimbursement rate is key to ensuring all Federal health care beneficiaries are served. A Federal task force I commissioned validated the need for a single rate.

- a. Will you look in to this issue? Will you work with your VA counter-parts?
- b. Do the VA witnesses have any comment?

Response. Yes, in fact the Department of Defense representatives met with our Department of Veterans' Affairs (VA) counterparts on May 12, 2011. During this initial meeting, we committed to ongoing meetings with the VA on the issue and to work toward a solution.

Question 2. Mr. Taylor, there is a lack of trauma care in Alaska. There is no Level 1 trauma center in the state—the nearest is in Seattle—4 hours away. There is only one Level 2 Trauma center in Anchorage. Trauma is the leading cause of death for Alaskans between the ages of 15–24. Military medics have to travel to the lower 48 to maintain skills. With the high deployment tempo for military medics from Alaska to combat zones and need for trauma care in Alaska, it seems a civilian-military partnership would be a mutually beneficial relationship, may even save the Department of Defense some training money. More importantly it will save lives. A military and civilian partnership for trauma care exists in Washington at the Tacoma Trauma Care Center.

Has the Department of Defense explored a trauma center partnership in Alaska? Why or why not? Will you look in to this?

Response. Yes, the DOD has explored a trauma center partnership in Alaska. Due to the need for military medics to maintain their trauma skills, military leadership has expressed interest in partnering with the Anchorage community to provide the level of care found in similarly sized cities in the 48 contiguous states. The Air Force hospital at Elmendorf has been working on an agreement for its surgeons to begin covering emergency trauma care in the civilian community in order to obtain trauma and other experience. A shortage of key specialists in the civilian community who are willing or able to provide trauma care continues to impede efforts to move forward and could be mitigated through collaboration. Governor Parnell of Alaska has included the military on the state trauma commission as of this year, and the Services are partnering as much as time and resources allow. The trauma partnership will be a topic of discussion at the State Healthcare Commission. We agree that more work remains to be done, but efforts are underway.

Question 3. Mr. Burdette, establishing a seamless transition process for wounded warriors is critical.

a. Can you explain why there isn't a seamless case manager that follows the warrior from DOD to VA system?

b. What can be done to make the process more fluid and more user-friendly to our veterans and their families?

c. Can you explain why the Social Security determination unit does not accept the DOD and VA's disability determination? For example, if the vet is deemed unable to work by the VA, why does the rating not automatically carry over to the SSA?

Response. a. Can you explain why there isn't a seamless case manager that follows the warrior from DOD to VA system?

While not called seamless transition case managers, there are several people in the process who work with transitioning Servicemembers to ensure their transition is as smooth and seamless as possible, and RCCs are on the frontline in this area. The RCCs seek to develop a good rapport with the Servicemember and family/caregivers, and work to prepare them for transition by working with Physical Evaluation Board Liaison Officers (PEBLOs) to successfully move them through the Integrated Disability Evaluation System. They also work with the VA Military Service coordinators (MSCs) to explain VA benefits, ensure Servicemembers and families attend Transition Assistance Briefings, discussing options for education and employment for the entire family, housing and vehicle adaptations, State veteran's benefits, and other resources. The RCCs are trained in all these areas, not to be the expert, but to possess general knowledge and then reach out to the experts in each of these areas and ensure that contacts are made, followed up on, and Servicemembers and their families/caregivers understand the benefits and resources, know how to access them, and have the point of contacts who can assist if necessary.

b. What can be done to make the process more fluid and more user-friendly to our veterans and their families?

To strive for excellence and to continue to use the resources listed above. Properly allocating resources, providing timely information and open lines of communication will improve the process.

c. Can you explain why the Social Security determination unit does not accept the DOD and VA's disability determination? For example, if the vet is deemed unable to work by the VA, why does the rating not automatically carry over to the SSA?

The VA defines someone as unemployable if they are unable to engage in a "substantial gainful occupation." This term has been defined by the VA to "that which is ordinarily followed by the nondisabled to earn their livelihood with earning common to the particular occupation in the community where the veteran resides." The

VA does not consider marginal employment (defined as earned income that does not exceed the poverty level for one person as defined by the U.S. Department of Commerce and the Bureau of the Census) as substantial gainful employment. Thus, a veteran marginally employed may still be considered unemployable for VA purposes.

The Social Security Administration uses different criteria for establishing who is unemployable. Under their regulations to be considered unemployable, a person cannot engage in any work activity for pay or profit. Thus, a Servicemember who is marginally employed would be considered unemployable for VA purposes but employable for SSA purposes.

Since the criteria for what is considered unemployable varies between the two agencies, SSA cannot accept the finding of the VA as a binding decision. However, DOD will work with VA and SSA to determine if we can come to a better governmentwide approach to defining those who are considered "unemployable."

Chairman MURRAY. Thank you very much, Dr. Zeiss, for your testimony.

Before I get into my systemic issues, I just want to implore you, someone, to look into Mr. Bohn's situation and get him back on track. Obviously, it should not take a veteran coming here to testify before this Committee to be able to get the help and support they need. So, I want to ask each of you, how do you begin to explain what went wrong in his case?

Senator BURR. Madam Chairman?

Chairman MURRAY. Yes.

Senator BURR. I have to leave for an engagement that I cannot change. I would ask unanimous consent that I have the ability to send my questions in writing, some of which I have not written yet because of today's testimony. And I would conclude with one thing, Dr. Taylor: you made a promise to check up on why the testimony did not get here in time. Is this your testimony or is this somebody else's?

Dr. TAYLOR. This is our testimony, our combined testimony.

Senator BURR. I am lost for the reason that you would have to check up to figure out why it did not get here on time.

Dr. TAYLOR. Well, sir, there is a process when you write the testimony. There is a series of approvals through the Department and OMB before it is cleared to come here, and I need to figure out where the delay was.

Senator BURR. Well, I would appreciate you sharing it with us.

Dr. TAYLOR. Yes, sir. I will be happy to show you, in this particular case, what happened.

Senator BURR. I think I know what we are going to find out, but I would reiterate what the Chairman said. This is not the first time.

Dr. TAYLOR. Yes, sir.

Senator BURR. I hope it is the last time.

Dr. TAYLOR. Yes, sir.

Senator BURR. Thank you, Madam Chairman.

Chairman MURRAY. Thank you very much, and your questions will be submitted for the record.

But let me go back and ask you again. How do we begin to explain what happened in Mr. Bohn's situation and why he was not cared for appropriately?

Mr. BURDETTE. Madam Chair, I think a number of things from both of our heroes' stories today were immensely troubling. I think it is largely a function, and there is good news at the end of this story. A lot of the absolutely heartbreaking data points that they

presented to us are really programs and actions that we are fixing across the board.

For example, the Recovery Care Program, we mention 20 or 22 Federal Recovery Coordinators on the VA side. We have almost 150 care coordinators on the DOD side, and if you even look more expansively than that, the Army has 4,000 people in a support mode for their entire Warrior Transition Units. Those 4,000 people are charged, from the minute that we know they are coming from the battlefields of Afghanistan, from the hospitals in Landstuhl, they have the manifests of the people that are coming, they know where the families are going to come from, and we connect with those servicemembers and their families to make it better than it was.

Chairman MURRAY. Do we not have enough coordinators?

Mr. BURDETTE. We are training more right now. There are 28 more coordinators in class today and those coordinators are going to connect with those servicemembers and their families. The 4,000 people across the network are doing a better job than our heroes reported today.

Chairman MURRAY. Do we have more soldiers coming home wounded than we are prepared for?

Mr. BURDETTE. I think that the infrastructure is there. I think that the people who are trained are there. The stories they reported in 2007 and 2008 were really troubling. In 2011, in 2012, we are much better. When I toured the—he referenced the Warrior Transition Unit at Fort Meade. I was there last Wednesday.

It is a radically different unit than when he went through. They are not just getting air show tickets today. We were there with an intern program where we signed up 13 servicemembers into Federal internships last Wednesday. They have squad leaders that know where they live, they know where their families live. They are concerned with housing issues for them and their families.

That is also true across the board, whether you are at Randolph Air Force Base in Texas. We are particularly focused on the closing of Walter Reed on September 15th, and as I meet with Admiral Matson and get his briefs, and they can tell you exactly who is going to Belvoir, exactly who is going to New Bethesda.

I have toured the facilities that are there. They are designed for family members to be in the rooms with these servicemembers. The housing, I just know off the top of my head, there are 12 exceptional families that are going to be housed at Belvoir. I have seen the facilities where those families will live.

We asked the same tough questions that you would expect, and I hope that you ask today and continue to ask, and by name, these leaders at every level are prepared, they are trained, and they are providing for these servicemembers.

Chairman MURRAY. Dr. Kemp, Dr. McNamee, do either of you have any comments or suggestions as to Mr. Bohn's and Mr. Horton's treatment?

Dr. MCNAMEE. You know, obviously those are very troubling stories that were told, and specifically on Mr. Bohn, I would like to defer to Debbie Amdur, who is behind us here from the Office of Social Work in the VA. I would like her to answer this question for us.

Ms. AMDUR. Thank you. First, I would like to start by thanking Specialist Bohn, Lance Corporal Horton, and Lieutenant Colonel Lorraine for coming today and sharing their experiences with us. I can tell you that as a clinical social worker with 20-some years experience, most of it spent working directly with veterans, their families, and caregivers, I was extremely disturbed to hear about the experiences that they shared, and consider them absolutely unacceptable.

They certainly fall short, very short of the service that we strive for. I do think that we have made progress since 2007. Since 2007, we have implemented the Federal Recovery Coordination Program in collaboration with our colleagues in Department of Defense. They are designed to address the needs and provide that one-on-one care coordination for the most severely injured of our returning servicemembers.

We have also put in place an OEF/OIF/OMD post-deployment team at each of our 152 medical centers around the country. Those teams are designed to welcome our returning servicemembers into the VA, to make sure that they are aware of the resources, that they do get linked appropriately to the services that they need.

We also have put in place an additional 16 VA liaisons for health care. We have 33 of them total stationed at 18 military treatment facilities, and their role is to ensure that those leaving Department of Defense facilities and requiring ongoing medical care do leave with not only a name and contact information, but also an appointment in hand at a VA medical center.

I can tell you that in 2010, the 7,000-plus individuals that these liaisons helped to transition, 85 percent of them—our goal, of course, is 100 percent—but 85 percent of them did leave with an appointment at a VA medical center in hand.

This being said, we clearly still have a very long way to go. I think that it is clearly now a time that we need to revisit, to streamline, to make sure that we are addressing the issue of too many case managers. I can tell you that on the VA side, our teams at the VA medical centers, we have 400-plus case managers, and they currently provide case management services to 54,000 of our returning servicemembers and veterans.

Chairman MURRAY. Are we unprepared for the number of soldiers coming home wounded today?

Ms. AMDUR. I think that we do have adequate resources. I think that we have an opportunity to streamline the services so that we do not have as much redundancy. Now, a certain level of redundancy, I feel, is beneficial because it is one of the things that does keep people from falling through the cracks.

We also have a lot of experience, that there is benefit to having that continued DOD involvement after someone moves to veteran's status. On a regular basis, our teams in the field call on the Recovery Care Coordinators to work with them, because sometimes you have an individual who is very resistant to coming in for VA care, but they need it, and it is not uncommon to have our case manager pick up the phone and call the Marine liaison and have the Marine liaison send someone in uniform out to that veteran's home to get them into treatment. That kind of collaboration we need to really expand upon.

As our Deputy Secretary, Deputy Secretary Gould said, there has been an executive committee which has been put together by the SOC, and it is reviewing the care management system. I am serving on that committee which is under the leadership of Dr. Karen Geiss and Robert Carrington, and I think we all recognize in that group the importance of us continuing to improve and enhance our collaborative efforts. Clearly there is work ahead to be done which we take very, very seriously.

Chairman MURRAY. Who is going to intervene on Mr. Bohn's situation?

Ms. AMDUR. I will take responsibility for that. Absolutely.

Chairman MURRAY. OK. And I want to follow up with you on what happens. Again, there are good people out there working everywhere. You see them every single day. But when soldiers are falling through the cracks, either we do not know enough about the injuries that they are coming home with and do not have the resources because we have not been told that we need more resources.

If this Committee is not told that we need more resources or that there are people falling through the cracks, we do not know enough to ask for it. So we have got to have honest answers back from all of you. If we need additional resources, if we need more trained people, whether the facilities are ready to take our soldiers—we need honest answers from all of you, and I expect that.

I also wanted to follow up on Mr. Horton's testimony. He talked about his waiting for VA care for his prosthetic, the pain that he went through. Dr. McNamee how do you say it—McNamee?

Dr. MCNAMEE. McNamee.

Chairman MURRAY. McNamee.—if you could please respond to that, because it is extremely painful when they need service for that. Waiting 2 months is intolerable. It is like, as I think Mr. Horton explained to us, walking around on a broken bone. Can you talk to me a little bit about that?

Dr. MCNAMEE. Yeah, absolutely, and I want to thank Lance Corporal Horton for those illuminating comments. Specifically, coming from the perspective of a physician who manages individuals with amputations and prosthetic limbs, I know that these individuals really rely on us to literally give them their legs and the ability to interact with the world and to move through the world. The pain associated with this, the potential skin breakdown, the time that individuals have to spend off of their limbs because of these issues are very, very real, and I have seen them throughout my career.

I am terribly disappointed in the fact that there is potentially a clinic out there where this gentleman did not have the access and does not have the access that he needs. That is not acceptable. I do not think anybody would disagree with that.

I can look at our own system in Richmond where I have worked and run the amputee clinics there for years and when we have had government contractors, we will always have them actually in the clinics with us to be able to hand the prescription over to them and to coordinate with them directly.

Knowing that I am here to discuss the amputation system of care in the rollout and we are not quite complete with the rollout, we will be looking into these issues and we will be making sure that

the access is there, because as I say, it is not acceptable. This gentleman relies on us to give him his legs, period, and if we cannot do that in a timely fashion, we need to figure that out and we will.

Chairman MURRAY. I appreciate that. I am encouraged by your work. I know you are doing some really good work there, and one of the outcomes of the review that you are doing was the creation of the Amputee and Polytrauma Transitional Care Unit being piloted at the Richmond clinic. Will more of that transitional units be created?

Dr. MCNAMEE. So we now have four of them in the polytrauma field specifically dedicated to individuals with Traumatic Brain Injuries. The way that the amputee transitional program is set up right now is as a pilot program. So it is a singular pilot program at this time. We recognize that we had extra, in a sense, bed space in Richmond. We had met with the folks at the Military Advanced Training Center in Walter Reed and they requested something along these lines, and we are working very, very quickly to get it up and running.

You know, our goal is to admit the first patient October 1st of this year. The need was just identified just this past October on our task force, and to prove to both systems, the Defense—the Veterans Affairs and DOD that this really is effective in getting people through the dual eligibles quickly and back to work very quickly. So it is our hope that we can prove benefit with this program through the servicemembers that come through and that this pilot program is taken out to the system.

Chairman MURRAY. I know my staff was there visiting earlier. Is there anything missing that you need?

Dr. MCNAMEE. At this point, no. We have got good connections with—from a resource standpoint, we have been very well resourced both by VACO as well by our local facility. From a flow perspective, we are on target, I said, October 1, potentially also help with the transition, the BRAC transition, from Walter Reed over to Bethesda. Have worked very closely with Colonel Pasquina and Dr. Scoville at Walter Reed, as well.

There are some issues as we begin to kind of unpack this and understand how we get the vocational rehab resources to our active duty servicemembers prior to transitioning out of the military. The one thing that predicts return to work after significant injury is early return to work. The quicker you go back to work, the more likely you are to work over time.

So with this program, we are really going to be trying to push the needle back and get people into active vocational settings while they are on active duty still. The ultimate goal, honestly, is that a servicemember becomes a veteran on Friday. On Monday morning, they report to a full-time paying job in which they have had an unpaid internship in that facility for months up to that period of time. So there are some issues that we are beginning to unpack and trying to understand to make that as smooth as possible.

Chairman MURRAY. We want to work closely with you and please let us know if there is anything else you need. I appreciate that.

Dr. MCNAMEE. Very much appreciate that.

Chairman MURRAY. I want to turn to an issue that I am deeply concerned about and that is the issue of suicide. The number of

servicemembers and new veterans we have lost to suicide is now on par with the number of those who have been killed in combat. That should be disturbing to everyone in this room.

Last week at this hearing, we talked about the very high rate of suicide among those participating in the joint disability evaluation process. Those servicemembers are actually under constant supervision of the department and that occurred.

We do know that there is progress being made in suicide prevention and mental health treatment. Dr. Kemp, your program has been outstanding. I have heard good reviews of that, but there is a lot of work that remains to be done, and I want to ask on behalf of this Committee, what do we need to do to address this problem?

Ms. KEMP. Yeah. First, Chairman Murray, I want to say the numbers are appalling and we know that and recognize that, and no one who serves their country and comes back alive should die by suicide, ever, and I think that we have worked very hard in the past few years to put programs into place.

One of the things that you mentioned earlier was the crisis line which we have opened up now to servicemembers and families and friends of servicemembers and continue to get calls from that population. But we need to continue to communicate its availability. We need to make sure that people know that there is someone there 24 hours a day, 7 days a week.

We need to work more closely with our DOD partners and we are in the process of doing this, to be able to communicate to our suicide prevention coordinators in the VA sooner and earlier that someone may be released and someone needs services, and we need to start that care ahead of time.

We also need to do more work, and this is also in progress, in the area of training all providers and all people who do these disability exams to do screening, to ask the right questions; that just because someone is being evaluated for a physical injury, we have to ask the emotional need questions, also.

Chairman MURRAY. How long will it take to train all the providers?

Ms. KEMP. We have started the process with the providers who do the exams in the VA, and we will start the contracting—

Chairman MURRAY. At every facility across the country?

Ms. KEMP. Yes, yes. And we have also started training all of our primary care providers across the country to really work with emotional issues as well as regular mental issues. So I anticipate that this is something we can do rather quickly, and I will make a promise to you to move that process along.

Chairman MURRAY. OK. And we will be following that and I want to know when those people have been trained.

Ms. KEMP. Exactly.

Chairman MURRAY. The data released at the end of April show that the number of Iraq and Afghanistan veterans who are now utilizing VA care for mental health needs is now more than half of all Iraq and Afghanistan veterans who are using the VA. In a way, that is a positive sign that more veterans are willing to come forward and ask for care, but I want to know if the system is adequately equipped now to handle those rising numbers and meet the criteria that we have set out.

Ms. ZEISS. We are resourced to be able to provide that care in mental health, but certainly I can defer to other staff members here for some of the other physical health concerns that are also very much a part of what they bring to us. But in terms of mental health, in 2004, VA recognized that there were gaps in staffing and in services, developed the Comprehensive Mental Health Strategic Plan, began to implement that in 2005, and really with a stronger pace in 2006.

And since then, we have increased our staffing for mental health services to over 21,000. It is an increase of over 40 percent in our core mental health staff. As we track the number of veterans who are receiving mental health services, those also have increased greatly during that time period, but have not increased to the same proportion as the percent of staff that we have added.

We think that is the right balance, because as I said, we had gaps when we started. So we have been able to fill gaps for those patients who were seeking VA care and intensive VA care earlier in this decade, and to enhance our staff such that currently we can continue in a proactive way to meet the needs of returning servicemembers who come to us as veterans while sustaining care for those veterans who are with us for their lifetimes.

We will continue to track that very carefully, of course, because we do not know when there may be significant additional numbers of servicemembers returning. We look forward to working with you and keeping pace in terms of the data on whether we are adequately resourced to provide care.

Chairman MURRAY. OK. We have been notified by the floor that there is going to be an objection to any Committee hearings going past noon. I have a number of questions that I want to get through, so I am going to go really fast here. I am concerned about the veterans who do not come in to the VA. The statistics that I just talked about are for those who come in.

We heard about reaching out and the concerns about that, so what about those veterans who are not seeking care? I am going to ask you to respond to that in writing because I do have one other question I want to ask before we hit noon.

Because we have discussed some of the problems with the gaps in the amputee system of care last week when I raised this issue about the Centers of Excellence with the Deputy Secretaries, and as I mentioned again then and this morning, we need those Centers online to improve the quality of care. So, Dr. Taylor, or anyone else, can you or any of you help me identify, what is the problem with getting this going?

Dr. TAYLOR. Senator Murray—and Dr. McNamee can probably help out—last summer, the two departments signed a Memorandum of Understanding on standing up the Center. There has been an ongoing Center of Excellence work group between the VA, the DOD, and the services to make sure that we are doing the core aspects of the Center of Excellence.

You are not going to find a Center of Excellence with a sign and a receptionist. It is operating virtually right now until we finish the transition this summer in the national capital area, and then we can have a permanent location for a Center of Excellence.

In the meantime, I am sure Dr. McNamee has participated in some of these activities where the DOD, VA, and the services are assuring that they are bringing the most advanced technologies and the most advanced rehabilitative processes in the standardization of care across the DOD and the VA.

Chairman MURRAY. Dr. McNamee.

Dr. MCNAMEE. Thank you for the question, Chairman. There is no question that there is a need here for us to help tie the departments together from a research, education, and clinical care perspective, as well as the traumatic registry. I know that the VA has been at the table in terms of developing the concept of operations, and we look forward to being full partners with the DOD in this in terms of pulling this together.

The amputation system of care is ready to jump fully into this once that concept of our operations comes out and this becomes a reality past from what Dr. Taylor said, it is a virtual center into a bricks and mortar center.

Chairman MURRAY. OK. I would like you to give me a timeline in writing on when this is going to occur.

Dr. TAYLOR. Yes, ma'am; be glad to do that.

Chairman MURRAY. OK. I have a number of questions. I am really disappointed that somebody has objected to Committee hearings going because this is really important. None of you are off the hook. I am going to give these questions to you. I want answers back. I know Senator Burr has as well. I want to know about the Federal Recovery Coordinators. You heard the concerns about that.

I want to hear about the compensation, that we know that Mr. Bohn had to receive \$700 less. That is a serious issue for families. The ratings issue are questions that I have about as well, and a number of others. But this hearing is going to have to shut down.

I just want to say, as we do that, that Deputy Secretary Lynn and Deputy Secretary Gould last week highlighted the challenges and successes as well that DOD and VA have encountered on this path toward a seamless transition. I want to thank all of our witnesses today for sharing first-hand their accounts with the perils of this path.

I especially want to thank Mr. Bohn, Mr. Horton, Mr. Lorraine for sharing with us their views and stories. And I want to thank our Government witnesses who, at the program level, are working very hard to deal with both the visible and invisible wounds of war.

In particular I want to mention Tom Pamperin, who is VA's Deputy Secretary for Disability Assistance who has given us nearly 40 years of Government service, and wish him well on his retirement. I look forward to working with all of you.

I know there are a lot of good people out there working, but as you know, we still have some challenges. This Committee needs to know what those challenges are. We do not have the capability of talking to every single person going through this or not going through this that is lost, and we need to get this right.

But before I close, I do want to mention again the wounded warrior that I talked about in my opening statement. I told you I am keeping him in mind as he goes through his very difficult transition, knowing how important it is that we do not forget a single warrior as we provide them services.

His girlfriend is actually in the audience today. I am not going to single her out. But I want her to know that our thoughts and our prayers and our support are with her, and I thank her for her courage and to pass on to her servicemember who is in surgery today our very best wishes.

With that, we are required to shut this hearing down, but I will be submitting our questions and I want responses back from all of you. Thank you very much.

[Whereupon, at 11:59 a.m., the Committee was adjourned.]

