Ms. Cynthia A. Bascetta Government Accountability Office

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Mr. Chairman and Members of the Committee:
Thank you for inviting me to discuss the Department of Veterans Affairs' (VA) efforts to provide disability benefits and health care to seriously injured servicemembers returning from Afghanistan and Iraq. Since the onset of U.S. operations in Afghanistan in October 2001 and Iraq in March 2003, more than 10,000 U.S. military servicemembers have sustained physical and psychological injuries. It is especially fitting, with the continuing deployment of our military forces to armed conflict, that we reaffirm our commitment to those who serve our nation in its times of need. Therefore, effective and efficient management of VA's disability and health programs is of paramount importance.
You expressed concerns about servicemembers and veterans who may seek services from VA. Today, I would like to focus on the steps VA has taken and the challenges it faces in providing services to those who have been seriously injured in these conflicts. Specifically I would like to highlight the findings of our work on VA's disability program and health care services for seriously injured servicemembers returning from Afghanistan and Iraq. My comments are based on our reviews of VA's programs for vocational rehabilitation and employment (VR&E) and health care, specifically post-traumatic stress disorder (PTSD) services. This work included visits to four Department of Defense (DOD) major military treatment facilities (MTF), including Walter Reed Army Medical Center where most seriously injured servicemembers are initially treated. We interviewed officials at VA's central office and at 12 of VA's 57 regional offices. We also interviewed officials at seven VA medical facilities where large numbers of servicemembers were returning from Afghanistan and Iraq to discuss the number of veterans currently receiving VA PTSD services and the impact that an increase in demand would have on these services. We did our work in accordance with generally accepted government auditing standards.
In summary, VA is taking steps to provide services to seriously injured servicemembers as a high priority but faces significant challenges in doing so. Specifically, VA has taken steps to expedite VR&E services to seriously injured servicemembers, but challenges such as the inherent differences and uncertainties in individual recovery processes make it difficult to determine when an individual may be receptive to services. VA has also faced difficulties in obtaining specific data from DOD about seriously injured servicemembers; instead, VA has had to rely on ad hoc regional office arrangements at the local level. Because such informal data sharing relationships could break down with changes in personnel at either the MTF or the regional office, we recommended that VA and DOD reach an agreement for VA to have access to information that both agencies agree is needed to promote servicemembers' recovery and return to work.
Similarly, VA requires that every returning servicemember from the Afghanistan and Iraq conflicts who needs health care services receive priority consideration for VA health care appointments, including PTSD services. VA, however, faces challenges such as developing accurate data on current workloads and estimating potential PTSD workloads. Without this information, VA will be unable to accurately assess its capacity to serve those servicemembers at

risk for PTSD. Based on our work, we recommended ways for VA and DOD to address these issues.

Background

VA offers a broad array of disability benefits and health care through its Veterans Benefits Administration (VBA) and its Veterans Health Administration (VHA), respectively. VBA provides benefits and services such as disability compensation and VR&E to veterans through its 57 regional offices. The VR&E program is designed to ensure that veterans with disabilities find meaningful work and achieve maximum independence in daily living. VR&E services include vocational counseling, evaluation, and training that can include payment for tuition and other expenses for education, as well as job placement assistance.

VHA manages one of the largest health care systems in the United States and provides PTSD services in its medical facilities, community settings, and Vet Centers. VA is a world leader in PTSD treatment and offers PTSD services to veterans. PTSD can result from having experienced an extremely stressful event such as the threat of death or serious injury, as happens in military combat, and is the most prevalent mental disorder resulting from combat.

Servicemembers injured in Afghanistan and Iraq are surviving injuries that would have been fatal in past conflicts, due, in part, to advanced protective equipment and medical treatment. However, the severity of their injuries can result in a lengthy transition involving rehabilitation and complex assessments of their ability to function. Many also sustain psychological injuries. Mental health experts predict that because of the intensity of warfare in Afghanistan and Iraq 15 percent or more of the servicemembers returning from these conflicts will develop PTSD.

VA Has Taken Steps to Provide Services to Seriously Injured Servicemembers as a High Priority

In our January 2005 report on VA's efforts to expedite VR&E services for seriously injured servicemembers returning from Afghanistan and Iraq, we noted that VA instructed its VBA regional offices, in a September 2003 letter, to provide priority consideration and assistance for all VA services, including health care, to these servicemembers. VA specifically instructed regional offices to focus on servicemembers whose disabilities will definitely or are likely to result in military separation. Because most seriously injured servicemembers are initially treated at major MTFs, VA has deployed staff to the sites where the majority of the seriously injured are treated. These staff have included VA social workers and disability compensation benefit counselors. VA has placed social workers and benefit counselors at Walter Reed and Brooke Army Medical Centers and at several other MTFs. In addition to these staff, VA has provided a vocational rehabilitation counselor to work with hospitalized patients at Walter Reed Army Medical Center, where the largest number of seriously injured servicemembers has been treated.

To identify and monitor those whose injuries may result in a need for VA disability and health services, VA has asked DOD to share data about seriously injured servicemembers. VA has been working with DOD to develop a formal agreement on what specific information to share. VA requested personal identifying information, medical information, and DOD's injury classification for each listed servicemember. VA also requested monthly lists of servicemembers being evaluated for medical separation from military service. VA officials said that systematic information from DOD would provide them with a way to more reliably identify and monitor seriously injured servicemembers. As of the end of 2004, a formal agreement with DOD was still pending.

In the absence of a formal arrangement for DOD data on seriously injured servicemembers, VA

has relied on its regional offices to obtain information about them. In its September 2003 letter, VA asked the regional offices to coordinate with staff at MTFs and VA medical centers in their areas to ascertain the identities, medical conditions, and military status of the seriously injured.
In regard to psychological injuries, our September 2004 report noted that mental health experts have recognized the importance of early identification and treatment of PTSD. VA and DOD jointly developed a clinical practice guideline for identifying and treating individuals with PTSD. The guideline includes a four-question screening tool to identify servicemembers and veterans who may be at risk for PTSD. VA uses these questions to screen all veterans who visit VA for health care, including those previously deployed to Afghanistan and Iraq. The screening questions are:

Have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you

? have had any nightmares about it or thought about it when you did not want to?
? tried hard not to think about it or went out of your way to avoid situations that remind you of it?
? were constantly on guard, watchful, or easily startled?
? felt numb or detached from others, activities, or your surroundings?

DOD is also using these four questions in its post-deployment health assessment questionnaire (form DD 2796) to identify servicemembers at risk for PTSD. DOD requires the questionnaire be completed by all servicemembers, including Reserve and National Guard members, returning from a combat theater and is planning to conduct follow-up screenings within 6 months after return.

VA Faces Significant Challenges in Providing Services to the Seriously Injured

VA faces significant challenges in providing services to servicemembers who have sustained serious physical and psychological injuries. For example, in providing VR&E services, individual differences and uncertainties in the recovery process make it inherently difficult to determine when a seriously injured servicemember will be most receptive to assistance. The nature of the recovery process is highly individualized and depends to a large extent on the individual's medical condition and personal readiness. Consequently, VA professionals exercise judgment to determine when to contact the seriously injured and when to begin services.
In our January 2005 report on VA's efforts to expedite VR&E services to seriously injured servicemembers, we noted that many need time to recover and adjust to the prospect that they may be unable to remain in the military and will need to prepare instead for civilian employment. Yet we found that VA has no policy for maintaining contact with those servicemembers who may not apply for VR&E services prior to discharge from the hospital. As a result, several regional offices reported that they do not stay in contact with these individuals, while others use various ways to maintain contact.
VA is also challenged by DOD's concern that outreach about VA benefits could work at cross purposes to military retention goals. In our January 2005 report, we stated that DOD expressed concern about the timing of VA's outreach to servicemembers whose discharge from military service is not yet certain. To expedite VR&E services, VA's outreach process may overlap with the military's process for evaluating servicemembers who may be able to return to duty. According to DOD officials, it may be premature for VA to begin working with injured servicemembers who may eventually return to active duty. With advances in medicine and

prosthetic devices, many serious injuries no longer result in work-related impairments. Army officials who track injured servicemembers told us that many seriously injured servicemembers overcome their injuries and return to active duty.

Further, VA is challenged by the lack of access to systematic data regarding seriously injured servicemembers. In the absence of a formal information-sharing agreement with DOD, VA does not have systematic access to DOD data about the population who may need its services. Specifically, VA cannot reliably identify all seriously injured servicemembers or know with certainty when they are medically stabilized, when they are undergoing evaluation for a medical discharge, or when they are actually medically discharged from the military. VA has instead had to rely on ad hoc regional office arrangements at the local level to identify and obtain specific data about seriously injured servicemembers. While regional office staff generally expressed confidence that the information sources they developed enabled them to identify most seriously injured servicemembers, they have no official data source from DOD with which to confirm the completeness and reliability of their data nor can they provide reasonable assurance that some seriously injured servicemembers have not been overlooked. In addition, informal data-sharing relationships could break down with changes in personnel at either the MTF or the regional office.

In our review of 12 regional offices, we found that they have developed different information sources resulting in varying levels of information. The nature of the local relationships between VA staff and military staff at MTFs was a key factor in the completeness and reliability of the information the military provided. For example, the MTF staff at one regional office provided VA staff with only the names of new patients and no indication of the severity of their condition or the theater from which they were returning. Another regional office reported receiving lists of servicemembers for whom the Army had initiated a medical separation in addition to lists of patients with information on the severity of their injuries. Some regional offices were able to capitalize on long-standing informal relationships. For example, the VA coordinator responsible for identifying and monitoring the seriously injured at one regional office had served as an Army nurse at the local MTF and was provided all pertinent information. In contrast, staff at another regional office reported that local military staff did not until recently provide them with any information on seriously injured servicemembers admitted to the MTF.

DOD officials expressed their concerns about the type of information to be shared and when the information would be shared. DOD noted that it needed to comply with legal privacy rules on sharing individual patient information. DOD officials told us that information could be made available to VA upon separation from military service, that is, when a servicemember enters the separation process. However, prior to separation, information can only be provided under certain circumstances, such as when a patient's authorization is obtained.

Based on our review of VA's efforts to expedite VR&E services to seriously injured servicemembers, we recommended that VA and DOD collaborate to reach an agreement for VA to have access to information that both agencies agree is needed to promote recovery and return to work for seriously injured servicemembers. We also recommended that VA develop policy and procedures for regional offices to maintain contact with seriously injured servicemembers who do not initially apply for VR&E services. VA and DOD generally concurred with our recommendations. VA also told us that its follow-up policies and procedures include sending veterans information on VR&E benefits upon notification of disability compensation award and 60 days later. However, we believe a more individualized approach, such as maintaining personal contact, could better ensure the opportunity for veterans to participate in the program when they

are ready.

In dealing with psychological injuries such as PTSD, VA also faces challenges in providing services. Specifically, the inherent uncertainty of the onset of PTSD symptoms poses a challenge because symptoms may be delayed for years after the stressful event. Symptoms include insomnia, intense anxiety, nightmares about the event, and difficulties coping with work, family, and social relationships. Although there is no cure for PTSD, experts believe that early identification and treatment of PTSD symptoms may lessen the severity of the condition and improve the overall quality of life for servicemembers and veterans. If left untreated it can lead to substance abuse, severe depression, and suicide.

Another challenge VA faces in dealing with veterans with PTSD is the lack of accurate data on its workload for PTSD. Inaccurate data limit VA's ability to estimate its capacity for treating additional veterans and to plan for an increased demand for these services. For example, we noted in our September 2004 report that VA publishes two reports that include information on veterans receiving PTSD services at its medical facilities. However, neither report includes all the veterans receiving PTSD services. We found that veterans may be double counted in these two reports, counted in only one report, or omitted from both reports. Moreover, the VA Office of Inspector General found that the data in VA's annual capacity report, which includes information on veterans receiving PTSD services, are not accurate. Thus, VA does not have an accurate count of the number of veterans being treated for PTSD.

In our September 2004 report, we recommended that VA determine the total number of veterans receiving PTSD services and provide facility-specific information to VA medical centers. VA concurred with our recommendation and later provided us with information on the number of Operation Enduring Freedom and Operation Iraqi Freedom veterans that has accessed VA services in its medical centers, as well as its Vet Centers. However, VA acknowledged that estimating workload demand and resource readiness remains limited. VA stated that the provision of basic post-deployment health data from DOD to VA would better enable VA to provide health care to individual veterans and help VA to better understand and plan for the health problems of servicemembers returning from Afghanistan and Iraq. In February 2005, we reported on recommendations made by VA's Special Committee on PTSD; some of the recommendations were long-standing. We recommended that VA prioritize implementation of those recommendations that would improve PTSD services. VA disagreed with our recommendation and stated the report failed to address the many efforts undertaken by the agency to improve the care delivered to veterans with PTSD. We believe our report appropriately raised questions about VA's capacity to meet veterans' needs for PTSD services. We noted that, given VA's outreach efforts, expanded access to VA health care for many new combat veterans, and the large number of servicemembers returning from Afghanistan and Iraq who may seek PTSD services, it is critical that VA's PTSD services be available when servicemembers return from military combat.

Concluding Observations

VA has taken steps to help the nation's newest generation of veterans who returned from Afghanistan and Iraq seriously injured move forward with their lives, particularly those who return from combat with disabling physical injuries. While physical injuries may be more apparent, psychological injuries, although not visible, are also debilitating. VA has made seriously injured servicemembers and veterans a priority, but faces challenges in providing services to both the physically and psychologically injured. For example, VA must be mindful to balance effective outreach with an approach that could be viewed as intrusive. Moreover,

overcoming these challenges requires VA and DOD to work more closely to identify those who need services and to share data about them so that seriously injured servicemembers and veterans receive the care they need.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions that you or Members of the Committee might have.

Contact and Acknowledgments
For further information, please contact Cynthia A. Bascetta at (202) 512-7101. Also contributing to this statement were Irene Chu, Linda Diggs, Martha A. Fisher, Lori Fritz, and Janet Overton.

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