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Statement of
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Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to discuss efforts of the Department of Veterans Affairs (VA) toward effecting a seamless transition for separating service members from the Department of Defense (DoD) health care system to the VA health care system.

First, let me assure you that interest in this issue comes from the highest reaches of the Department. Though only recently taking office, Secretary Nicholson has reaffirmed VA's determination to assure that maximum efforts to serve the needs of newly returning service members are undertaken by the Department. These issues include health care, rehabilitation adjustment and mental health care.

Deputy Secretary Mansfield is also deeply engaged in this endeavor. The Deputy co-chairs VA/DoD Joint Executive Council (JEC) with the Under Secretary for Defense for Personnel and Readiness. Last week, he addressed the Joint DoD/VA Conference on Post Deployment Mental Health.

I will, in my statement, address the Department participation, on two major aspects of the transition program and on one aspect that concerns the more 'administrative' efforts we have undertaken to achieve a seamless transition, such as coordination and outreach to Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans and their families. The second aspect involves the clinical care we have provided, the numbers we have seen, and the education and clinical tools we have developed for our health care providers. I will also discuss coordination with DoD and the Department's responses to the reviews of the Government Accountability Office (GAO) on VA's PTSD program and other aspects of transition.

Before I do that, however, let me just say that the Department is well positioned to receive and provide health care to returning OIF and OEF veterans. As the largest integrated health care organization in the United States, we can meet their needs through nearly 1,300 health care facilities throughout the country, which include 696 community-based outpatient centers that provide access to health care at points closer to the veterans' homes. We also have 206 Vet Centers which are often the first contact points for returning veterans seeking VA assistance. Because the extent and complexity of our network of facilities may seem daunting to some severely injured veterans, we have taken steps to ensure a smooth transition from DoD health care to VA health care. Therefore, we have assigned VA social workers and benefits counselors to intercede on behalf of injured OIF and OEF veterans and assisting them in negotiating the

challenges associated with transition. I will address this initiative in more detail later in my testimony.

VA offers comprehensive health care benefits to our enrollees, including the full range of primary care services and specialty care services. The quality of our care is second to none. In FY 2004, we led the nation for 18 health-care quality indicators in disease prevention and treatment where comparable data are available. We set the benchmark in patient satisfaction in the American Customer Satisfaction Index. The recent RAND study demonstrated that VA leads the nation for preventive health services and chronic disease management. This study, which appeared in the December 21, 2004, issue of Annals of Internal Medicine, found that VA patients received higher-quality care than comparable patients receiving care from other providers.

We are an acknowledged leader in providing specialty care in the treatment of such illnesses as post-traumatic stress disorder (PTSD); spinal cord injury (SCI); and traumatic brain injury (TBI). We are now leveraging and enhancing the expertise already found in our four TBI centers to create Polytrauma centers to meet the manifold needs of certain seriously injured veterans. We anticipate full implementation of the Polytrauma Center initiative by the end of this fiscal year, and we will provide the services of the centers to veterans from all parts of the country. Again, I will discuss the Polytrauma Centers in more detail later in my statement.

The TBI centers also collaborate with three military treatment facilities (Walter Reed Army Medical Center, Wilford Hall Air Force Medical Center, and San Diego Naval Medical Center) in the Defense and Veterans Brain Injury Center (DVBIC). Through DVBIC, VA and DoD provide state of the art clinical care, conduct research, and provide educational initiatives in the area of brain injury. A specialized referral network has been developed to facilitate smooth transitions both from military treatment facilities to VA and between VA facilities.

As part of VA's seamless transition process, we have greatly increased the number of outreach activities to returning service members and new veterans, including producing numerous pamphlets, brochures, and videos to more than 209,000 returning service members. VA has increased the overall briefings on VA benefits to returning service members, including Reserves and National Guard members, from 5,300 briefings with 197,000 attendees in FY 2003 to 7,200 briefings to over 261,000 attendees in FY 2004. In January 2005, we have already provided 2,260 briefings to 79,000 returning service members.

With the activation and deployment of large numbers of Reserve/Guard members following September 11, 2001, and the onset of military actions in Afghanistan and Iraq, VA outreach to this group has been greatly expanded. National and local contacts have been made with Reserve/Guard officials to schedule pre- and post-mobilization briefings for their members. Returning Reserve/Guard members can also elect to attend the formal 3-day Transitional Assistance Program (TAP) workshops provided by VA personnel.

VA/DoD Joint Executive Council

Overall support and guidance for joint VA/DoD initiatives detailed throughout my statement are provided VA/DoD Joint Executive Council (JEC). This council, co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary for Defense for Personnel and Readiness, ensures high level attention from both Departments to maximize opportunities to improve service to our mutual beneficiaries. JEC supported initiatives enhance resource utilization and sharing arrangements to produce high quality cost effective services for both VA and DoD beneficiaries. Through this forum, VA and DoD have achieved significant success in improving interagency cooperation in areas such as deployment health, pharmacy, medical-surgical supplies, procurement, patient safety, clinical guidelines, geriatric care, contingency planning, medical

education, information management/information technology, financial management and benefits coordination.

The revised VA/DoD Joint Strategic Plan (JSP), issued in conjunction with the 2004 Annual Report to Congress, highlights data-exchange opportunities and specifically identifies Seamless Coordination of Benefits as one of its six major goals. As a result of the JSP, enhanced efforts to educate active duty, reserve and National Guard personnel on VA and DoD benefits programs, eligibility criteria and applications processes are underway.

The VA/DoD Joint Executive Council Joint Strategic Plan supports the expansion of the Benefits Delivery at Discharge program. This effort includes the development of a cooperative physical exam process that would be valid for Military Service separation requirements and would also be acceptable for VA's disability compensation requirements. These efforts should further ease the transition for active duty service persons into civilian life.

VA/DoD Electronic Data Exchange

Our ability to provide care to returning OIF and OEF service members is enhanced to the extent that we can obtain accurate health care information from DoD in the shortest time frame possible. VA and DoD have made significant progress toward development of interoperable electronic health information systems that allow appropriate data sharing in compliance with applicable privacy protections.

In 2002, VA and DoD gained approval of their Joint Electronic Health Records Interoperability Plan ? HealthePeople (Federal). VA began implementation of Phase I of the plan, the Federal Health Information Exchange (FHIE) that same year.

The highly successful FHIE supports the one-way transfer of electronic military health data on separated service members to the VA Computerized Patient Record System (CPRS) for viewing by VA clinicians treating veterans. Since FHIE implementation in 2002, DoD has transferred records for over 2.4 million unique patients to the FHIE repository, where more than 1 million records have been viewed by VA clinicians. FHIE improves care and enhances patient safety for veterans by providing VA clinicians access to pertinent DoD healthcare data.

FHIE, implemented jointly by VA and DoD in 2002, provides historical data on separated and retired military personnel from the DoD's Composite Health Care System to the FHIE Data Repository for use in VA clinical encounters and potential future use in aggregate analysis. Data being shared, through one-way transmission from DoD to VA, include laboratory and radiology results; outpatient pharmacy data from military treatment facilities, retail network pharmacies, and DoD mail order pharmacy; allergy information; discharge summaries; admission, disposition, and transfer information; consult reports; standard ambulatory data record; and patient demographic information.

In October 2004, the Departments released Cycle 1 of the Bidirectional Health Information Exchange (BHIE), permitting DoD Military Treatment Facilities and VA Facilities to share patient demographic data, DoD and VA outpatient pharmacy data, and allergy information when a shared patient presents for care. BHIE Cycle I is operational at Madigan Army Medical Center (Tacoma, WA) and VA Puget Sound Healthcare System.

Work on BHIE Cycle II functionality, which adds other categories of data, began on November 1, 2004, with scheduled implementation by the 3rd Quarter of FY 2005 in El Paso, Texas.

VA and DoD are now developing interoperable data repositories that will support the bidirectional exchange of computable data between the DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR), known as Clinical Data Repository/Health Data Repository (CHDR). In September 2004, VA and DoD successfully demonstrated a CHDR

pharmacy prototype in a lab environment that supported the capability to conduct drug/drug and drug/allergy interaction checking across VA and DoD systems. The Departments are actively developing CHDR for production and anticipate completing the interface by October 2005.

Seamless Transition

Although I have chosen to discuss our transition program in two parts, these two aspects of transition are tightly intertwined. The success of our coordination and outreach efforts will affect what we do clinically. In turn, our clinical encounters with OIF and OEF veterans will inform and guide our future activities in coordination and outreach for these veterans to offer them all needed assistance.

Coordination Efforts and Oversight

In August 2003, VA's Under Secretary for Benefits and Under Secretary for Health created a new VA Taskforce for the Seamless Transition of Returning Service Members. This taskforce was composed of VA senior leadership from key program offices and the VA/DoD Executive Council and focused initially on internal coordination efforts to ensure that VA approached the mission in a comprehensive manner. The task force was charged with:

? improving communication, coordination, and collaboration, both within VA and between VA and DoD, in providing health care and benefits to returning veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF);

? ensuring that VA staff is educated about the needs of OIF/OEF veterans; and

? ensuring that policies and procedures are in place to enhance the seamless transition and veterans' access to health care and benefits.

In January of this year, VA established a permanent Seamless Transition Office. Composed of representatives from the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), as well as other offices within VA, the Seamless Transition Office now coordinates all activities related to the transition of returning service members. The office reports to the Acting Deputy Under Secretary for Health. The original Taskforce has been retained, however, and will serve the Seamless Transition Office in an advisory capacity.

Over the last 18 months, VA has achieved many successes in the areas of outreach and communication, trending workload, data collection, and staff education. We have worked hard, both internally and with DoD, to identify OIF and OEF veterans and to provide them with the best possible health care and access to benefits. VA has put into place a number of strategies, policies, and programs to provide timely, appropriate services to these returning service members and veterans. Throughout the process, we have greatly improved dialogue and collaboration between VA and DoD.

Many service members are returning from combat with severe injuries, requiring extensive hospitalization and rehabilitation. We must be situated where these veterans are to provide them immediate and continuing assistance as they are separated from active duty and enter the VA health care system.

To that end, VA has assigned full-time social workers and benefits counselors to seven major military treatment facilities (MTFs), including Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC) in Bethesda. They work closely with MTF treatment teams to ensure that returning service members receive information and counseling about VA benefits and programs. They also coordinate the transfer of active duty service members and recently discharged veterans to appropriate VA health care facilities and enroll them into the VA health care system. Through this collaboration, we have improved our ability

to identify and serve returning service members who have sustained serious injuries or illnesses while serving our country. VHA staff have coordinated more than 1,900 transfers of OIF/OEF service members and veterans from an MTF to a VA medical facility. VBA benefits counselors are also stationed at MTF's to provide benefits information and assistance in applying for these benefits. These counselors are generally the first VA representatives to meet with the veteran and family members. From October 2003 through mid-March 2005, VBA benefits counselors have interviewed almost 5,000 OIF/OEF service members hospitalized at MTFs. It is important to note that there are benefits such as the specially adaptive automobile grant and the specially adapted housing granted that can be authorized while the service member is still on active duty. For the most seriously injured, the military services now work with VA to determine the discharge date (usually three days prior to the end of the month), so that the separating military member can be awarded VA disability entitlement effective the first of the following month and paid at the end of that month.

For veterans whom we do not encounter in the MTF's, we have adopted other outreach strategies. These individuals may not have the same serious combat-related injuries we have seen in the MTFs; however, they may have other health care, readjustment issues, or benefits needs that require assistance. We must also reach out to these veterans to let them know that we are here to help them.

Each VA medical center and regional office has identified a point of contact to coordinate activities locally and to assure that the health care needs and benefits needs of returning service members and veterans are met and that additional contact is made should the veteran relocate. VA has distributed guidance on case management services to field staff to ensure that the roles and functions of the points of contact and case managers are fully understood, and that proper coordination of benefits and services takes place.

VA is also working with DoD to obtain a list of service members who enter the Physical Evaluation Board (PEB) process. The PEB list will identify those individuals who by virtue of their service sustained an injury or developed an illness that precluded them from continuing on active duty and resulted in medical separation or retirement. The list will enable VA to contact these service members to initiate benefit applications, and transfer of health care to a VAMC Medical Center prior to discharge from the military. Although the Seamless Transition initiative was initially created to support service members who served in OIF/OEF, it is intended to become an enduring process that will support all service members who, as a result of injury or illness, enter the disability process leading to medical separation or retirement.

Outreach

VA has developed and distributed pamphlets, brochures, and educational videos designed for returning service members, VA employees, and others involved in this important effort. Working with DoD, we developed a brochure entitled 'A Summary of VA Benefits for National Guard and Reserve Personnel.' The brochure summarizes the benefits available to this group of veterans upon their return to civilian life. We have distributed over a million copies of the brochure to ensure the widest possible dissemination through VA and DoD channels. It is also available online at http://www.va.gov/environagents/docs/SVABENEFITS.pdf and http://www.defenselink.mil/r2/mobile/pdf/va_benefits_rs.pdf.

VA also actively participates in discharge planning and orientation sessions for returning service members, and we have expanded our collaboration with DoD to enhance outreach to returning

members of the Reserves and National Guard. Since FY 2002 through the 1ST quarter of the FY 2005, VBA military services coordinators have conducted more than 19,000 briefings, reaching a total of more than 700,000 active duty service members. These briefings include 1,795 pre- and post-deployment briefings attended by over 88,000 activated Reserve and National Guard service members. During FY 2004 alone, VBA military services coordinators provided more than 7,200 benefits briefings to separating and retiring military personnel, including briefings aboard some Navy ships returning to the United States. Almost 1,400 of these briefings were conducted for reserve and guard members.

Other outreach activities include the distribution of flyers, posters, and information brochures to VA medical centers, regional offices, and Vet Centers. VA has, in fact distributed more than 1.5 million brochures to DoD demobilization sites and USO's. VA has also produced and distributed one million copies of a VA health care and benefits wallet/pocket card. The card lists a wide range of VA programs, and provides relevant phone numbers and email addresses.

VA has also produced media aimed specifically at OIF and OEF veterans. Examples of these include:

? The first issue of the "OIF & OEF Review." This provides a wide range of information about health and other benefits issues to veterans and their families. The first issue was only distributed to medical centers (VAMCs), Regional Offices (ROs) and Vet Centers. The upcoming issue will be mailed out to all returning OIF/OEF veterans.

? Two information sheets, one each on OIF and OEF, summarizing health issues for those two deployments were published. These were distributed to all VAMCs, RO, and Vet Centers.

? A video targeted at OIF/OEF veterans returning home from overseas titled 'We're by Your Side.' The video thanks service members for their service and introduces some of the services VA can provide as they readjust to civilian life. The video can be used in a variety of settings such as waiting rooms, new employee orientations, and at off-site functions such as health fairs.

As service members separate from the military, VA contacts them to welcome them home and explain what local VA benefits and services are available. Furthermore, in order to make a wide selection of general information available to OIF and OEF veterans online, we have created a direct 'Iraqi Freedom' link from VA's Internet page (www.vba.va.gov/EFIF). This website provides information on VA benefits, including health and mental health services, DoD benefits, and community resources available to regular active duty service members, activated members of the Reserves and National Guard, veterans, and veterans' family members.

Last year, VA began sending 'thank-you' letters together with information brochures to each OIF and OEF veteran identified by DoD as having left active duty. These letters provide information on health care and other VA benefits, toll-free information numbers, and appropriate VA web sites for accessing additional information. The first letters and information brochures were mailed in April 2004, and thus far, VA has mailed letters to more than 230,000 returning OIF/OEF service members through this medium. Secretary Nicholson has enthusiastically agreed to continue this valuable initiative.

A critical concern for veterans and their families is the potential for adverse health effects related to military deployments. VA has produced a brochure that addresses the main health concerns for military service in Afghanistan, another brochure for the current conflict in Iraq, and one that addresses health care for women veterans returning from the Gulf region. These brochures answer health-related questions that veterans, their families, and health care providers have about these military deployments. They also describe relevant medical care programs that VA has developed in anticipation of the health needs of veterans returning from combat and

peacekeeping missions abroad. These are widely distributed to military contacts and veterans service representatives; they can also be found on VA's website.
Another concern is the potential health impact of environmental exposures during deployment. Veterans often have questions about their symptoms and illnesses following deployment. VA generally addresses these concerns through such media as newsletters and fact-sheets, regular briefings to veterans' service organizations, national meetings on health and research issues, media interviews, educational materials, and websites, like www.va.gov/environagents.

Employee Education
The distribution of information, however, must not stop with letters, and brochures, and websites aimed at the returning veterans. We must ensure that our commitment is understood and shared at every level of the Department as well. Therefore, we have developed a number of training materials and other tools for our front line staff to ensure that they can identify veterans who have served in a theater of combat operations and take the steps necessary to ensure the veterans receive appropriate care.
To aid VA employees in their efforts to assist OIF/OEF veterans, we produced and distributed a video in DVD format entitled 'Our Turn to Serve' to all VHA and VBA field facilities. The video helps VA staff better understand the experiences of military personnel serving in Operations Iraqi Freedom and Enduring Freedom, and explains how they can provide the best possible service to these newest combat veterans. We have also provided copies of this video to Military Treatment Facilities. Additionally, we have created a web page for VA employees on the activities of VA's seamless transition initiative. Included are the points of contact for all VHA health care facilities and VBA regional offices, copies of all applicable directives and policies, press releases, brochures, posters, and resource information.

VA Health Care
Up to this point, Mr. Chairman, I have focused on the accomplishments we have achieved to effect a seamless transition from DoD health care to VA health care. I would now like to turn my attention to the clinical side of the transition issue.

General Data
Veterans who have served, or are now serving in Afghanistan and Iraq, may enroll in the VA health care system and, for a two-year period following the date of their separation from active duty, receive VA health care without co-payment requirements for conditions that are or may be related to their combat service. Following this initial two-year period, they may continue their enrollment in the VA health care system but may become subject to any applicable co-payment requirements.
As of December 2004, 244,054 OIF and OEF veterans had separated from active duty. Approximately 20 percent of these veterans (48,733) have sought health care from VA. A very small number (930) have had at least one episode of hospitalization. Reservists and National Guard members make up the majority of those who have sought VA health care (27,766, or 57 percent). Separated active duty troops have accounted for 43 percent (20,967). Thus, OIF/OEF veterans have accounted for only slightly more than one percent of our total veteran patients (4.7 million in FY 2004); however, many of them will, of course, have suffered much greater acute trauma.
OIF and OEF veterans have sought VA health care for a wide-variety of physical and

psychological problems. The most common health problems have been musculoskeletal ailments (principally joint and back disorders) and diseases of the digestive system, with teeth and gum problems predominating. No particular health problem stands out among these veterans at present. The medical issues we have seen to date are those we would expect to see in young, active, military populations. However, we caution that these data are health care utilization data. They do not represent a formal epidemiological study. Consequently, recommendations cannot be provided for particular testing or evaluation. These war veterans should be assessed individually to identify all outstanding health problems. We will continue to monitor the health status of recent OIF and OEF veterans to ensure that VA aligns its health care programs to meet their needs.

Mental Health Issues

As you are aware, Mr. Chairman, there has been particular interest about mental health issues among OIF and OEF veterans and VA's current and future capacity to treat these problems. At the outset, let me make clear that nearly every service member who is exposed to the horrors of war comes away with some degree of emotional distress. Many will have some short-term adjustment reactions. But, thankfully, the majority of them will not suffer long-term consequences from their combat experience. Moreover, in view of the current efforts at early identification of the wide range of adjustment reactions by DoD and VA clinicians, it may be possible to lower the incidence of long-term mental health problems through a concentrated effort at early detection and intervention.

As of December 2004, the most frequent mental health diagnosis we had seen at VA health care facilities was adjustment reaction, which was diagnosed in 6,268 patients. Our data also indicate that 13,657 OIF/OEF veterans have received Vet Center services for readjustment counseling. Allowing for those veterans who have been seen at both Vet Centers and VAMCs, a total of 19,070 OIF/OEF veterans sought VA care for issues associated with readjustment to civilian life. Adjustment reaction is, in fact, the mental health diagnosis that we would expect to find most often in troops returning from Iraq and Afghanistan. The disorders in this category may result in temporary impairment in social or occupational functioning or in symptoms and behaviors that are beyond normal expected responses to stressors. Adjustment disorders resolve either when the stimulus is removed or when the patient reaches a higher level of adaptivity through supportive therapy. Post-traumatic stress disorder (PTSD) is itself classified using the same code as adjustment disorders. However, PTSD differs from other adjustment disorders in that it is not necessarily time-limited in its course and almost always requires a higher level of intervention. As of December 2004, 4,783 patients at VAMCs were coded with a diagnosis of suspected PTSD. In addition, 2,082 veterans received services for PTSD through our Vet Centers. Allowing for those who have received services at both VAMCs and Vet Centers, a total of 6,386 individual OIF/OEF veterans had been seen with potential PTSD at VA facilities following their return from Iraq or Afghanistan.

I am often asked whether VA has the capacity required to care for 'all the OIF and OEF veterans with PTSD.' To assess that, we must put the number of OEF and OIF veterans with potential PTSD in perspective. In FY 2004, we saw approximately 279,000 patients at VA health care facilities for PTSD and 63,000 in Vet Centers. Thus, OIF and OEF veterans account for only about two percent of VA's PTSD patients.

So, it is in that context that I assure the Committee that VA has the programs and resources to meet the mental health needs of returning OIF and OEF veterans. Furthermore, to position VA

for future needs, this fiscal year we have allocated $100 million to implement initiatives contained in the Department's Mental Health Strategic Plan. The President's FY 2006 budget submission proposes to supplement this with an additional $100 million. These initiatives will benefit all veterans receiving mental health care from VA. We are, in fact, confident that the Presidents' FY 2006 budget request contains sufficient funding to allow us to continue to provide for all the health care needs of OIF and OEF veterans. Meeting the comprehensive health care needs of returning OIF and OEF veterans who choose to come to VA is one of the Department's highest priorities.

Treatment

VA's approach to the provision of health care, in general, is guided by an emphasis on the principles of health promotion and preventive care. It focuses on supporting the patient's autonomy and self-determination through an inclusive process of education and good health practices.

In caring for veterans with mental health problems, VA applies concepts of rehabilitation that address a patient's strengths as well as his or her deficits. We emphasize recovery of function to the greatest degree possible for each patient. This approach is designed to identify and resolve problems in readjustment to civilian life, before they progress to problems requiring more intensive clinical intervention. VA's Readjustment Counseling Service frequently takes the initial lead in providing this level of care through our 206 community-based Vet Centers located throughout the United States. Intervention at this local level is often all that is needed to resolve a veteran's symptoms and allow a return to normal functioning.

Vet Centers have played an important role in providing outreach and assistance to veterans since 1979. The Vet Centers see approximately 130,000 veterans every year and provide more than one million visits to veterans and family members. They continue to perform this critical function for OIF and OEF veterans. More than 15,000 OIF and OEF veterans have made more than 35,000 visits to Vet Centers. VA has hired 50 outreach workers from among the ranks of recently separated OIF and OEF veterans to help meet the needs of their fellow veterans at targeted Vet Centers across the country. In concert with VBA's Casualty Assistance Program which offers personalized outreach services to surviving family members, the Vet Centers provide bereavement counseling for the families of OIF and OEF service members who have died as a result of combat.

For veterans with mental illness who require more intensive or specialized clinical intervention, VA provides comprehensive care through a continuum of services designed to meet the patients' changing needs. The intensity of care ranges from acute inpatient settings, to residential services for those who require structured support prior to returning to the community, to a variety of outpatient services. Outpatient care includes mental health clinics; 'partial hospitalization' programs such as day hospitals and day treatment centers that offer care 3 - 5 days a week to avert the need for acute or extended inpatient care; and intensive case management in the community. Long-term inpatient or nursing home care is also available, if needed.

VA's specialized mental health programs include programs designed to meet the needs of patients with disorders such as schizophrenia, major depression, PTSD, and addictive disorders. To take one example, VA provides care through 144 specialized PTSD programs located in every state. These programs consist of specialized inpatient PTSD units, Residential Treatment units, and Outpatient PTSD clinical teams (PCTs).

Providing care for mental disorders comprises two core elements of treatment, evidence-based

psychotherapy, psychosocial rehabilitation, and state-of-the-art psychopharmacology. Evidence-based practices are outlined in joint VA/DoD clinical practice guidelines (CPGs) on major depression, serious mental disorders, substance use disorder, and PTSD. VA has also incorporated an OIF/OEF clinical reminder tool in our computerized patient record system (CPRS). This reminder advises clinicians that they are seeing an OIF or OEF veteran who needs to be screened for both medical and mental health problems associated with deployment to Iraq and Afghanistan. VA's guidance for prescribing medications recommends that physicians use their best clinical judgment, based on clinical circumstances and patients' needs.

Polytrauma Centers

One of the harshest realities of combat in Iraq and Afghanistan is the number of service members returning from Iraq and Afghanistan with loss of limbs and other severe and lasting injuries. We recognize that we must provide specialized care for military service members and veterans who have sustained severe and multiple catastrophic injuries. Since the start of OIF/OEF, VA's four regional Traumatic Brain Injury (TBI) Lead Rehabilitation Centers (located in Minneapolis, Palo Alto, Richmond, and Tampa) have served as regional referral centers for individuals who have sustained serious disabling conditions due to combat. These programs are specially accredited to provide comprehensive rehabilitation services and TBI services. Patients treated at these facilities may have a serious TBI alone or in combination with amputation, blindness, or other visual impairment, complex orthopedic injuries, auditory and vestibular disorders, and mental health concerns. Because TBI influences all other areas of rehabilitation, it is critical that individuals receive care for their TBI prior to, or in conjunction with, rehabilitation for their additional injuries.

In accordance with section 302 of Public Law 108-422, we have developed a plan to expand the scope of care at these four centers and create Polytrauma Centers. This plan builds on the capabilities of the regional referral centers but adds additional clinical expertise to address the special problems that the multi-trauma combat injured patient may face. Such additional services include intensive psychological support treatment for both patient and family, intensive case management, improvements in the treatment of visual disturbance, improvements in the prescription and rehabilitation using the latest high tech specialty prostheses, development of a clinical database to track efficacy and outcomes of interventions provided, and provision of an infrastructure for important research initiatives. Additionally, the plan addresses services for patients in the outpatient setting for ongoing follow-up care not requiring hospitalization. The plan provides for enhancements to existing rehabilitation outpatient clinical services to ensure that necessary services can be provided within easier access to the patient's home.

We currently are anticipating full implementation of the Polytrauma Center initiative by the end of this fiscal year.

Clinical Tools

If we are to provide effective health care, we must first provide our clinicians with the tools necessary to do the job. I have alluded to two of these tools above, the clinical reminder tool in our CPRS and the clinical practice guidelines on mental health issues. In addition to the guidelines on mental health, VA and DoD have developed two post-deployment guidelines, a general purpose post-deployment guideline and a guideline for unexplained fatigue and pain. These evidence-based clinical practice guidelines give health care providers the needed structure, clinical tools, and educational resources that allow them to diagnose and manage patients with

deployment-related health concerns. Our goal is that all veterans will find their VA doctors well informed about specific deployments and related health hazards.
Another important clinical tool is the Veterans Health Initiative (VHI), a program designed to increase recognition of the connection between military service and certain health effects; better document veterans' military and exposure histories; improve patient care; and establish a database for further study. The education component of VHI prepares VA healthcare providers to better serve their patients. A module was created on 'Treating War Wounded,' adapted from VHA satellite broadcasts in April 2003 and designed to assist VA clinicians in managing the clinical needs of returning wounded from the war in Iraq. Also available are modules on spinal cord injury, cold injury, traumatic amputation, Agent Orange, the Gulf War, PTSD, POW, blindness/visual impairment and hearing loss, radiation, infectious disease risks in Southwest Asia, military sexual trauma, and traumatic brain injury.
VA's National Center for PTSD has also developed an Iraq War Clinician's Guide for use across VA. The website version, which can be found at WWW.NCPTSD.ORG, contains the latest fact sheets and available medical literature and is updated regularly. The first edition was published in June 2003, and the second edition was published in June 2004. These important tools are integrated with other VA educational efforts to enable VA practitioners to arrive at a diagnosis more quickly and accurately and to provide more effective treatment.

GAO Reports
I will now turn my attention to recent GAO reports.

GAO Study on Implementation of Special Committee Recommendations
First I will discuss GAO's study, 'VA HEALTH CARE: VA Should Expedite the Implementation of Recommendations Needed to Improve Post-Traumatic Stress Disorder Services,' (GAO-05-287).
GAO conducted this review to determine whether VA has complied with recommendations of the Under Secretary for Health's Special Committee on Post-Traumatic Stress Disorder (Special Committee) to improve VA's PTSD services. GAO concluded that VA had not fully met any of the 24 recommendations reviewed related to clinical care and education. GAO recommended that VA should work with the Special Committee to expedite VA's timeframes for fully implementing the recommendations needed to be in compliance.
VA strenuously disagrees with this report and has not concurred with its conclusions and recommendation. It should be noted that while this report acknowledges that VA is a world leader in treating PTSD. The report data do not allow extrapolation to any statements on capacity of the PTSD program. The report also does not address the many efforts undertaken by VA to improve PTSD care.
Rather, this report is one of limited focus, measuring only the literal comportment with the Special Committee' recommendations to the Under Secretary for Health. Even in this regard, the report fails to address the fact that the Under Secretary and the members of the Special Committee met and agreed upon a plan of action that embodied the spirit and intent of the Advisory Committee recommendations.
In separate letters, the Co-Chairs of the Special Committee outlined their support for VA's implementation of the Committee's recommendations. They expressed their 'discomfort' at the negative tone of the GAO report and point out that the report fails to address the many efforts undertaken by VA to improve PTSD care. We provided copies of these letters to GAO as part of

our initial response to their report, and wish to submit at this time as part of the hearing record. Mr. Chairman, we strongly believe that the report leaves a grossly inaccurate picture of PTSD services and does a great disservice to the 2,700 men and women who provide these important services. To the average reader, the report implies that VA services for veterans with PTSD is woefully inadequate and undermines the quality of VA care. This implication is simply incorrect. GAO's findings and conclusions do not accurately portray either VA's provision of PTSD services to veterans over the past 20 years or VA's ability to provide these services to veterans in the future. For example, as I stated earlier, the number of OIF and OEF veterans to whom VA has provided PTSD services is but a small percentage of the total number of veterans treated for PTSD in the VA health care system. This indicates that VA does indeed have sufficient capacity to provide care to veterans with PTSD.

GAO Study on Availability of PTSD Services

In an earlier study, 'VA AND DEFENSE HEALTH CARE: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services' (GAO-04-1069), GAO reviewed DoD's efforts to identify service members who have served in Iraq and Afghanistan and are at risk for PTSD, and VA's efforts to ensure that PTSD services are available for all veterans. GAO concluded that VA lacks the information it needs to determine whether it can meet an increase in demand for VA PTSD services. GAO found that VA does not have a count of the total number of veterans currently receiving PTSD services at its medical facilities and Vet Centers. GAO stated that without this information, VA cannot estimate the number of additional veterans its medical facilities and Vet Centers could treat for PTSD. GAO recommended that VA determine the total number of veterans receiving PTSD services and provide facility-specific information to VA medical facilities and Vet Centers.

VA has concurred with this recommendation and in October 2004 consolidated the necessary data into a national report and distributed the report to all VISNs, medical centers, and Vet Centers to assist them in estimating potential PTSD workload expansion. VA will update and distribute this report on a quarterly basis. At the same time, we caution that this narrow scope of analysis does not account for the multiple health concerns that are associated with veterans returning from combat. PTSD cannot be effectively treated in isolation. The complexity of problems associated with veterans' military experiences and post-deployment adjustment requires that we focus on all associated health issues. GAO's study also does not address the resources that VA subsequently is dedicating through the implementation of its Mental Health Strategic Plan and the additional $100 million in each of FY 2005 and FY 2006 to support mental health care, which includes the $25 million mandated to be available for mental health programs by Public Law 108-170.

Conclusion

A service member separating from military service and seeking health care through VA today will have the benefit of VA's decade-long experience with Gulf War health issues as well as the President's commitment to improving collaboration between VA and DoD. VA has successfully adapted many existing programs, improved outreach, improved clinical care through practice guidelines and educational efforts, and improved VA health provider's access to DoD health records. VA's commitment to returning combat veterans is firm. Mr. Chairman, this concludes my statement. I will be happy to respond to any questions that you or other members of the Committee might have.