S. HRG. 109–109

BACK FROM THE BATTLEFIELD: ARE WE PROVIDING THE PROPER CARE FOR AMERICA'S WOUNDED WARRIORS?

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

MARCH 17, 2005

Printed for the use of the Committee on Veterans' Affairs

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

U.S. GOVERNMENT PRINTING OFFICE
22–551 PDF WASHINGTON : 2005

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

COMMITTEE ON VETERANS' AFFAIRS

LARRY E. CRAIG, Idaho, *Chairman*

ARLEN SPECTER, Pennsylvania
KAY BAILEY HUTCHISON, Texas
LINDSEY O. GRAHAM, South Carolina
RICHARD BURR, North Carolina
JOHN ENSIGN, Nevada
JOHN THUNE, South Dakota
JOHNNY ISAKSON, Georgia

DANIEL K. AKAKA, Hawaii, *Ranking Member*
JOHN D. ROCKEFELLER IV, West Virginia
JAMES M. JEFFORDS, (I), Vermont
PATTY MURRAY, Washington
BARACK OBAMA, Illinois
KEN SALAZAR, Colorado

LUPE WISSEL, *Majority Staff Director*
D. NOELANI KALIPI, *Minority Staff Director*

C O N T E N T S

THURSDAY, MARCH 17, 2005

SENATORS

WITNESSES

BACK FROM THE BATTLEFIELD: ARE WE PROVIDING THE PROPER CARE FOR AMERICA'S WOUNDED WARRIORS?

THURSDAY, MARCH 17, 2005

UNITED STATES SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:06 a.m., in room SR–418, Russell Senate Office Building, Hon. Larry E. Craig, Chairman of the Committee, presiding.

Present: Senators Craig, Burr, Ensign, Thune, Akaka, Rockefeller, Murphy, Obama, and Salazar.

OPENING STATEMENT OF HON. LARRY E. CRAIG, CHAIRMAN, U.S. SENATOR FROM IDAHO

Chairman CRAIG. Good morning, ladies and gentlemen, and welcome to the Veterans' Affairs Committee. This hearing will be convened.

We are here this morning in a hearing we call, "Back from the Battlefield: Are we Providing the Proper Care for America's Wounded Warriors?" I have called this hearing of the Senate Veterans' Affairs Committee to receive testimony on and review the experiences of our service men and women as they leave active duty in the Army, Navy, Air Force, Marine Corps and Coast Guard and transition back to civilian life in the big cities and small towns all over this great Nation.

And as the panel of witnesses suggest, I am not only interested in hearing about this experience from those who are charged with operating it from a managerial standpoint, but I also, want to hear from those who have gone through it themselves or even still going through it as we speak. I am particularly interested in two distinct, but equally important, populations of servicemembers.

First, for obvious reasons, I am interested in learning about the care and services provided to those who are physically injured fighting in the war on terror, in Iraq, Afghanistan and other dangerous places around the globe. I hasten to point out that many of them want to and may, in fact, return to active duty and continue their extraordinary service to this country. Others, however, may be faced with the reality of a transition to civilian life that is, sadly, involuntary. By that I mean some of those injured may be discharged from the Armed Services as a result of the serious injuries sustained in battle. Yet I am hearing, albeit anecdotal, that for many of those who are ultimately discharged, life in the months

and weeks leading up to that discharge consists of time spent away from home, families, children and the very support structure they will need to truly recover.

I am not suggesting that rushing the injured out of the Armed Services is an answer to our desire, but I am suggesting that perhaps the current practice of treating these servicemembers only in a medical treatment facility in Washington, DC., Georgia or Texas while they await medical board review may not be right either. I hope those here today, representing the military and VA, can begin to think about ways to use their many facilities smarter to bring these men and women closer to home for recovery services.

We must ensure that those highest-priority veterans are given all the tools, service and assistance necessary to seamlessly transition back to civilian life.

And, second, as I said, equally important, groups of servicemembers the Committee will hear about today are those who return from war whole, in body, but perhaps troubled in mind by the experiences they had while overseas protecting our freedom.

All of us are aware our country is relying more than in recent past on the activation of the National Guard and the Reserves to serve on the war on terror. Seventeen hundred of my fellow Idahoans with the Army National Guard's 116th Cavalry Brigade are now serving overseas in Iraq. In fact, next month, I will visit the regional medical center in Germany, as well as Iraq, with the Secretary of Veterans Affairs, to see firsthand the work done by these men and women.

These guardsmen and reservists who are fortunate to come back to us safely do not return to Army base in Georgia or an Air Force base in Colorado or Idaho, for that matter. Instead, they return to a Guard unit or Reserve unit in their home State, and most likely they go right back to work or they are expected to and go right back into their homes with their families. I need to know that the Department of Defense and the VA are working closely together to identify not only these men and women, but where they live and how we can reach out to them to ensure their transition is a smooth one.

We are privileged today to have two panels of witnesses to speak about all of our concerns and any concerns they may wish to express or concerns other Members of our Committee will have.

Our first panel is really a microcosm of those I have just spoken about in my statement. We have two distinguished veterans who now work for the Department of Veterans Affairs in a Veterans Readjustment Counseling Service. Mr. Joseph Costello, welcome, a veteran of Operation Enduring Freedom, who was awarded a Bronze Star, and David Hosking, a veteran from the Vietnam War and Operation Iraqi Freedom, who was also awarded the Bronze Star.

Also, joining us on Panel One is Major Tammy Duckworth, of the Illinois National Guard. She is accompanied by her husband Bryan Bowlsbey; is that correct? Major Duckworth is a Blackhawk helicopter pilot who was injured November 12th, in 2004, when the helicopter she was flying in Iraq was struck by a rocket-propelled grenade. Clearly, Major Duckworth's story of bravery and courage will inspire each and every one of us here in this room. But just

as important, her experience since sustaining her injuries will enlighten us on the difficult process of moving from the battlefield to our medical facilities overseas and I hope educate us on the grueling process of rehabilitation and recovery, once a servicemember returns to the United States.

Major Duckworth, we are honored by your presence this morning, and we thank you very much for being with us.

Joining us on the second panel will be Major General Kenneth Farmer, Commanding Officer at Walter Reed Army Medical Center, right here in Washington, DC; Ms. Cynthia Bascetta, the Director of Veterans' Health and Benefits at the U.S. General Accounting Office; Dr. Jonathan Perlin—and many of you are getting to know Dr. Perlin, the Acting Under Secretary of Health at the Department of Veterans Affairs—who is accompanied by Robert Epley, the Deputy Under Secretary of Benefits at the Department of Veterans Affairs.

Well, ladies and gentlemen, this will make up our panelists of the day and today's testimony. But before we hear from them, let me ask if there are any amongst us who would like to make opening comments. Let me turn to the Ranking Member, Senator Akaka.

Danny?

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

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

I am so pleased that we have this opportunity to talk about what our Government is doing to care for those who have served, and this is our effort this morning. It is a subject that deserves our most serious attention, and we are giving it that attention.

I, also, want to say that it was a pleasure to work with Chairman Craig in developing this hearing today. As Ranking Member, I appreciate the opportunity to provide input to the Chair on the topic at hand and on the witnesses we will hear from today.

VA and DOD seem to be doing a good deal to ensure a seamless transition for the men and women who serve. I applaud that, and I am sure we will hear much more about that this morning. My focus is very simple—to make sure that both departments are doing everything possible to guarantee that each and every soldier, whether Active duty or Reserve or Guard member, is receiving high-quality care without having to work to get it. All servicemembers, including the men and women who are coming back from Iraq and Afghanistan, should have nothing less than a seamless reintegration into society and their lives. It is my view that we need to be particularly attentive to the challenges faced by the Guard and Reserve in this transition.

Why am I so adamant about this? Because without a seamless transition, we will be failing our veterans. We have witnesses who will give us the macro view, how things should be working according to VA, DOD and the General Accounting Office, but our first panel of witnesses will provide the micro view. This is especially important, given that some experts have calculated that one in every eight soldiers reported symptoms of PTSD.

But, first, we will hear from Major Tammy Duckworth, a member of the Illinois National Guard, who is receiving care at Walter Reed. On a personal note, the State of Hawaii can claim her as one of its own. At this time, our esteemed friend and Senator from Illinois can, also, do the same.

[Laughter.]

Senator AKAKA. Once her story is told, you will see why I am so proud. I look forward and welcome her testimony.

Thank you very much, Mr. Chairman.

Chairman CRAIG. Danny, thank you.

So we have dueling jurisdictions this morning over you, Tammy. Let me introduce, next, for any comments that he would like to make, the Senator from Illinois, Senator Obama.

STATEMENT OF HON. BARACK OBAMA,
U.S. SENATOR FROM ILLINOIS

Senator OBAMA. Thank you very much, Mr. Chairman, Ranking Member Akaka. I congratulate you on setting up this important hearing and very much appreciate the opportunity to be here at least for a portion of it.

As of yesterday, 11,285 men and women have been wounded in Operation Iraqi Freedom. That is 11,285 husbands, wives, sons and daughters who will be returning home with scars that may change their lives forever. They are our heroes. They deserve our deepest gratitude and support. It is very much appreciated that Mr. Costello and Mr. Hosking are here to help us talk about how we are providing appropriate care not simply to heal wounds, but, hopefully, to also allow those who are returning home to continue to grow and prosper, whether they decide to remain in active duty or not.

I hope that we are setting a very high bar. I do not think it is sufficient for us simply to try to help our veterans achieve some semblance of normalcy. We want to be a service that is providing them the kind of care that allows them to thrive over the long term.

Yet we have, also, obviously, here today Major Duckworth and her husband, Bryan. As Senator Akaka mentioned, she is a helicopter pilot with the Illinois National Guard. She made her way to Illinois from what I understand was a pretty diverse set of homes. We were speaking beforehand, Senator Akaka, and it turns out that not only did she spend time in Ohio, but she also spent time in Southeast Asia, where I also lived in Indonesia for a time. So I have got you beat on this one.

[Laughter.]

Senator OBAMA. I have got the Illinois connection, I have got the Hawaii thing going, I have got Southeast Asia. Me and Major Duckworth, there is some cosmic thing going on here.

Four months ago, while piloting a Blackhawk helicopter over Iraq, Major Duckworth lost both her legs when a rocket was shot through the floor of her aircraft. Today, she sits before us by the grace of God. She does not just tell people that she hopes to fly again. She will fly again someday. I am just in awe of her courage and her contribution to our country. We are so grateful to you. I am very much looking forward to hearing your testimony. I have

had the opportunity to read it, and I am confident that you will be sharing a constructive, positive outlook on what significant achievements are already taking place in the VA system, but also areas where we can achieve some significant improvements. I think we should not feel defensive or embarrassed about the fact that even as we are doing a good job, we can always do a better job and figure out how to do that.

It is our obligation. The one thing I would point out before the testimony takes place, that we, in Congress, provide some oversight, but we also provide you the resources. One of the frustrating things, I assume, if I were in the VA system, would be insisting on performance and then not always getting the resources needed for performance. So part of what I hope is accomplished here today is, to the extent that there are things that are not happening, that you can tell us why they are not happening, and how we can fix them and how Congress can potentially provide help on that.

The only other comment I would make would be that I do hope that Ms. Duckworth's story and the story of thousands of others serve as a mandate for this Committee. We need to guarantee that these men and women will receive the care and services they need to carry on their lives. That means DOD and VA working together to provide more efficient vocational rehabilitation services. It means ensuring that we have the capacity to treat specific needs like soldiers returning with post-traumatic stress disorder. It means focusing on prosthetic research and innovation so the Armed Services can keep heroes like Major Duckworth in their ranks.

Mr. Chairman, again, I thank you for holding this hearing.

Chairman CRAIG. Senator, thank you very much.

Now, let me turn to Senator Burr. Richard, do you have any opening comment?

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

Senator BURR. Very quickly, Mr. Chairman. I am not sure I can compete with my two colleagues on this tie to the Major, but very few individuals will come through this Committee in uniform that will testify that have not spent some memorable experience in North Carolina, I can assure you.

[Laughter.]

Senator BURR. Mr. Chairman, the good news I think, today, for all of us is the VA is preparing. The VA is not within a shell. They are looking at the changing world not only of the mission that we are currently involved in, but the changing world of health care. Health care is a challenge to those of us that are legislators as it relates to seniors and to individuals who tend to fall through the cracks of coverage, but it is also a challenge to us from a standpoint of those who have the luxury of coverage.

Success will not be judged based upon funding alone. Success, as it relates to how we respond to those who come back, I truly believe is going to be a combination of the level of compassion and innovation, the level of funding and outreach, the level of access and education that not just the VA is going to do, but all of us are going to do.

I think that Barack said it very well. These are heroes, and they deserve the most focused effort on the part of all concerned to make sure that we do everything that we can to prepare for it. It is unfortunate sometimes that we cannot accelerate technology past where it has the capability to go, but certainly 2 years from now we will have options we do not have today, and it will be because of the preparation of this Committee and of the VA that we are able to take advantage of those technological breakthroughs when they are available.

The Major's testimony brings out one thing that I want to highlight, and it is not any of the points that she suggests that we need to go through. I think it was her testimony. But it was these are young lives that have a long life to live, and I think that is something that we cannot lose focus of. In many cases, we are dealing with young lives that have a long fruitful time that they will spend with us and our ability to address it, the ability of this Committee to make sure that not just the resources, but the blueprint is there to address this is ultimately the thing that will impact these lives.

I thank you, Mr. Chairman.

Chairman CRAIG. Richard, thank you very much.

Senator Salazar, any opening comment you would like to make?

STATEMENT OF HON. KEN SALAZAR,
U.S. SENATOR FROM COLORADO

Senator SALAZAR. I will submit my opening comment for the record, but I would like to just make a brief comment here, if I may, Mr. Chairman. Thank you.

Major Duckworth, I very much applaud you for your courage and what you have done for our country. Shortly after I got sworn in, in the first week of January, I had the pleasure and honor of meeting you at Walter Reed Army Hospital. I can tell you that you not only inspired me that day, but you inspire me here again today. Your bravery over the skies of Iraq, and your return back to the United States and to be here before the Veterans' Affairs Committee of the U.S. Congress is just another indication of how courageous you are and how determined you are to make a difference.

So your contribution to this Committee, as we deal with the issues of veterans, is very important, and I think especially in the context of where we are today, for we know that in Afghanistan and in Iraq we now have had some 11,000 men and women who have been injured. What we do here in the Veterans' Affairs Committee will, obviously, very much affect their lives. As Senator Burr said, it is, in many cases, many years of your lives that we will be affecting.

So I very much look forward to your testimony, and I also know that Ambassador Nicholson, now Secretary Nicholson, who is heading up the Veterans Administration, is also looking very much forward to figuring out ways in which we can make sure that we have the right kind of transition between DOD and the VA, with respect to information sharing that I think is very important to make sure that we are taking care of our veterans in the veterans system.

So, again, I thank you for being a part of this panel today.

[The prepared statement of Senator Salazar follows:]

PREPARED STATEMENT OF HON. KEN SALAZAR,
U.S. SENATOR FROM COLORADO

Thank you Mr. Chairman, Senator Akaka, Members of the Committee and our panelists.

The issue of smoothing the transition from active duty service to veterans' care has always been an administrative challenge, but now, with the large number of seriously injured soldiers returning home, it has the potential to become a crisis.

More than 11,000 troops have been injured in Iraq and Afghanistan. More than 6,000 of these were unable to return to duty within 3 days. During Korea, Vietnam and the 1991 Gulf War, about one servicemember in four died from their wounds. Today's battlefield-wounded are surviving at twice the rate, but many are coming back with very severe disabilities, including missing limbs.

One of the first things I did when I was sworn in as a Senator this year was visit Walter Reed Army Medical Center to say thank you to the courageous men and women there who have given parts of themselves so that our country can remain strong. These injured soldiers represent the best in America and we owe them more than our gratitude.

The VA offers outstanding rehabilitative services, and the sooner this treatment begins, the more successful injured veterans are in their recovery. Unfortunately administrative gaps have led to delays and many veterans have fallen through the cracks.

The VA has recognized this problem and has done its best to make it better. The VA has set up task forces and dispatched case workers to military medical treatment facilities. They have tried to reach incoming veterans earlier and better coordinate with the DOD.

These efforts have done a lot of good. As we will hear from those who have been through the system, it does work for many people. But independent analysis has consistently shown that there are still huge gaps.

The VA is having trouble getting the information they need from the DOD. The sharing of information and quality of casework management varies greatly from region to region. In some cases the DOD only gives the VA the names of new patients, with no information on severity of injury. In other cases, injured soldiers who do not apply for VA services immediately are lost to the system.

This is an administrative problem with huge implications for our fighting men and women. It is also a problem that will not be fixed with half-measures.

It is clear that the DOD needs to work more closely with the VA to share medical information. The VA also needs to redouble its efforts to fill the gaps in its outreach to make sure that seriously injured veterans are never lost to the system.

I look forward to the testimony of the panelists today. I want to share a special thank you to Major Duckworth, who is appearing after a recent family tragedy. Your bravery in the skies above Iraq is matched by the courage and strength you are showing here today. Thank you for your service.

Chairman CRAIG. Thank you very much.

Senator Ensign, any opening comment you would like to make?

STATEMENT OF HON. JOHN ENSIGN, U.S. SENATOR FROM NEVADA

Senator ENSIGN. Just very briefly, Mr. Chairman. Thank you for holding this hearing, and I thank all of you for being here and your service to our country.

I had a personal experience not too long ago over at Walter Reed. We had a soldier from Nevada, returning home from Iraq. Wounded, he had been hit in the leg and had an open abdominal wound. I asked him, "How are you being treated? How is the care? How is the support system? How are they dealing with the emotional, mental aspects, as well as the physical aspects?" It seems to be, at least from his reports, he had a wonderful experience.

I guess the purpose of this hearing, Mr. Chairman, is to determine if we are really taking care of our veterans and do we have the resources required. I also want to caution us that there is a lot of focus on this issue right now. What is it going to be 2 years, 3 years, 4 years, 10 years from now? We can never afford to neglect

the people who have sacrificed for all of us, those of you who have sacrificed for all of us. When the cameras are on and the bright lights are shining, everybody wants to step up to the table, but are we going to continue that physical, emotional, mental support that seems to at least be there at this current time? That is one of the things that I hope that we continue looking at this into the future.

Thank you, Mr. Chairman, for holding this hearing.

Chairman CRAIG. John, thank you very much. That is the ultimate challenge. You have said it well.

With that, let us turn to our first panel. Again, we thank you all so very much for being here. We would ask Major Tammy Duckworth, United States Army National Guard, if she would lead off the panel this morning.

STATEMENT OF MAJOR L. TAMMY DUCKWORTH, UNITED STATES ARMY NATIONAL GUARD

Major DUCKWORTH. Good morning. Mr. Chairman, Senior Ranking Member Akaka, and distinguished Members of the Committee, thank you for the opportunity to come before you today to discuss the care of wounded servicemembers injured in Operations Enduring Freedom and Iraqi Freedom and our efforts to facilitate the transition between the military and Veterans' Affairs health care facilities and between military and veteran status.

The medical efforts at Walter Reed Army Medical Center, as well as the medical team at Landstuhl, the Combat Area Surgical Hospital, and the in-theater Medevac helicopter crew have been extraordinary. In any previous conflict, I would not be alive today. It is a testament to the superior protective equipment that I was wearing and to the medical care pipeline from the front lines to Walter Reed that I can be here.

I would like to take a moment to stress the unique nature of the military health care system. While civilian professionals are an important component in that system, there is no substitute to being treated by and recovering with fellow soldiers. Only a fellow servicemember can understand the stresses and wounds of combat. The CASH in Baghdad is the target of frequent rocket attacks. I have met physicians and nurses at Walter Reed who were there. They know, on a personal level, what the foot soldier faces. Additionally, I doubt that doctors at a stateside civilian hospital would be as familiar with the damage caused by rocket-propelled grenades, improvised explosive devices or the dangers of theater-specific bacterial infections. Soldiers, whether they are physicians or other wounded soldiers, understand the warrior ethos that drives my recovery.

As disabled soldiers transition to veteran status, we will look to the VA to provide continued access to health care, health technology, assisted living devices and social services. The VA will have to face a challenge of providing care at the high level set by the military health care facilities. This is a challenge that the VA can meet if it is given enough resources, and if it listens to disabled servicemembers, and puts forth the effort to put our needs.

The first most easily identified need that the VA will have to support is continued access to technology. Disabled veterans will require access to different devices as they age and as the tech-

nology undergoes innovation. The VA will need to track ongoing changes in medical technology such as in prosthetics research and inform the veteran of the availability of the new technology.

I am certain that while the American people are focused on injured soldiers from the global war on terrorism, the funds to aid those soldiers will continue to be forthcoming. I am concerned that during peacetime, funds for research, such an in the fields of prosthetics, will be reduced. The VA needs to continue to support the cutting-edge research that is underway as a result of the current conflict's wounded. In order to do so, the VA itself will need continued funding earmarked for this purpose.

Second, as I look around at the other wounded soldiers, it is clear that the majority of them are young with long lives ahead of them. Whether we will continue to have the honor of serving in uniform or return to productive civilian lives, we will require continued access to high-quality VA services as we age. The VA will need to support this need over the long term, as currently wounded soldiers will be accessing its programs over a lifetime.

Third, in order to provide ongoing care to veterans, the VA will have to identify and develop specific programs and cultivate professionals to implement them. Experience is, as we say in combat terms, a force multiplier. The technologies that make recovery possible from such severe wounds require experienced professionals to assess and apply them to the veteran. Patients benefit from long-term relationships with highly trained and experienced specialists. This is especially true of the therapists that specialize in amputee care who grow to know the peculiarities of residual limbs and the use of prosthetics. The level of care provided by the VA will be enhanced by a commitment to the programs and professionals who will interact with the patient.

Fourth, disabled soldiers will need access to assisted living devices such as high-tech prosthetic care; orthopedic care and rehabilitation; home modifications; vehicle modifications; specialty equipment such as wheelchairs, bathroom equipment, hand cycles, adaptive sports equipment, specialty equipment for blinded soldiers, such as talking appliances or computers, and smart home technology.

Fifth, the VA will need to provide access to social services, such as job counseling and psychological support. Many of the young, wounded soldiers today need advice on which jobs or educational programs will be most suited to them. Such career counseling will allow the soldier to maximize the educational and job-training benefits provided by the VA. Additionally, those that sustained brain injury as well as those that develop psychological trauma will need long-term counseling and support.

Finally, it does the disabled veteran no good if he or she is unable to access the various programs provided by the VA. While still assigned to Walter Reed, I have immediate access to the prosthetics care that is part of my recovery process. This access will continue for me through the new amputee center. However, for disabled veterans living in areas far from VA hospitals and facilities, travel itself is a significant obstacle to their continued care. These disabled veterans will need regular, easy transportation support from the VA.

I applaud the VA and the Department of Defense partnership that assists military servicemembers who have served in combat and aims to provide them with a seamless transition to civilian life and veteran status.

Those select individuals from amongst the American people who would willingly serve in the Armed Services are a limited resource. Our warriors are expensive and indispensable. I believe we must jealously guard this resource, retaining as many as possible in the service, and sparing little effort to return one of them to service. For example, the cost to make another Military Police Captain in order to replace a wounded one is prohibitive when compared with the medical costs to fix wounded soldiers and return them to duty.

I would urge you to think of the efforts of the Army Medical Department and the VA as a force multiplier for two reasons. First, these organizations can help us retain good soldiers, Marines, airmen and sailors who would have otherwise not been able to continue to physically accomplish their missions and remain in the service of the United States. These wounded have already been trained at great expense, as well as been tested and gained invaluable experience in the crucible of combat.

Further, I believe we want to ensure that our warriors are secure in the knowledge that, when and if their comrades are hurt, we will take care of them. The front-line soldiers should not expend a moment of time to worry about a fallen comrade. We must ensure that he knows "My buddy made it to Walter Reed, he will be OK, they have the best doctors and cutting-edge technology there."

We will maintain the optimal morale and performance from our soldiers through ensuring that these medical facilities are adequately funded.

I have experienced firsthand the excellence of the Army's medical system for the combat wounded. Because of the type of injuries and the geographic location of my home, I have been treated at Walter Reed. Had I been burned badly, I would have been sent to a different facility. For example, an amputee center has been opened at Fort Sam Houston's Brooke Army Medical Center. I believe it is just as important to fund all of those facilities. I can only hope and implore that the VA steps up to receive disabled veterans as we transition into its care from the military medical system. In order to continue to provide care at the level provided by the military health care system, these programs will have to be funded into the future.

On behalf of our injured, wounded or ill servicemembers and their families, I thank members of this great institution for providing us with the funding and resources to take care of some of the finest citizens of this Nation. These are the men and women in uniform who have committed their lives and well being to the defense and protection of this great Nation. Thank you for the funding that provides invitational travel orders for family members, allowing my husband and mother to be at Walter Reed. They are an important part of my rehabilitation team.

The AMEDD, with Walter Reed Army Medical Center on the cutting edge, has provided world-class health care to the injured and wounded members of all the services. A strong partnership between the military health care system and the Department of Veterans

Affairs will provide the optimal care for the needs of our servicemembers and their families.

Thank you.

[The prepared statement of Major Duckworth follows:]

PREPARED STATEMENT OF MAJOR L. TAMMY DUCKWORTH,
UNITED STATES ARMY NATIONAL GUARD

Mr. Chairman and distinguished Members of the Committee, thank you for the opportunity to come before you today to discuss the care of wounded servicemembers injured in Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF) and our efforts to facilitate the transition between the Military and Veteran Affairs (VA) Health Care Facilities, and between military and veteran status.

The medical efforts of Walter Reed Army Medical Center, as well as the medical team at Landstuhl, the Combat Area Surgical Hospital and the in-theater Medevac helicopter crew have been extraordinary. In any previous conflict I would not be alive today. It is a testament to the superior protective equipment that I was wearing and to the medical care pipeline from the front lines to Walter Reed that I can be here.

I would like to take a moment to stress the unique nature of the military healthcare system. While civilian professionals are an important component in that system, there is no substitute to being treated by, and recovering with fellow soldiers. Only a fellow servicemember can understand the stresses and wounds of combat. The CASH in Baghdad is the target of frequent rocket attacks. I have met physicians and nurses at Walter Reed who were there. They know on a personal level what the foot soldier faces. Additionally, I doubt that doctors at a stateside civilian hospital would be as familiar with the damage caused by a rocket propelled grenades, improvised explosive devices, or the dangers of theater-specific bacterial infections. Soldiers, whether they are physicians or other wounded soldiers understand the warrior ethos that drives my recovery.

As disabled soldiers transition to veteran status, we will look to the VA to provide continued access to healthcare, health technology, assisted living devices and social services. The VA will have to face the challenge of providing care at the high level set by the military healthcare facilities. This is a challenge that the VA can meet if it is given enough resources and if it listens to disabled servicemembers and puts forth the effort to meet our needs.

The first, most easily identified need that the VA will have to support is continued access to technology. Disabled veterans will require access to different devices as they age and as the available technology undergoes innovation. The VA will need to track ongoing changes in medical technology such as in prosthetics research and inform the veteran of the availability of this new technology.

I am certain that while the American people are focused on injured soldiers from the Global War on Terrorism, the funds to aid those aoldiers will continue to be forthcoming. I am concerned that during peacetime, funds for research such as in the field of prosthetics will be reduced. The VA needs to continue to support the cutting edge research that is underway as a result of the current conflict's wounded. In order to do so, the VA itself will need continued funding earmarked for this purpose.

Second, as I look around at the other wounded soldiers, it is clear that the majority of them are young with long lives ahead of them. Whether we will continue to have the honor of serving in uniform, or return to productive civilian lives, we will require continued access to high quality VA services as we age. The VA will need to support this need over the long term as currently wounded soldiers will be accessing its programs over a lifetime.

Third, in order to provide ongoing care to veterans, the VA will have to identify and develop specific programs and cultivate professionals to implement them. Experience is, as we say in. combat terms, a force multiplier. The technologies that make recovery possible from such severe wounds require experienced professionals to assess and apply them to the veteran. Patients benefit from long-term relationships with highly trained and experienced specialists. This is especially true of the therapists that specialize in amputee care who grow to know the peculiarities of residual limbs and the use of prosthetics. The level of care provided by the VA will be enhanced by a commitment to the programs and professionals who will interact with the patient.

Fourth, disabled soldiers will need access to assisted living devices such as:

- High tech prosthetic care.

- Orthopedic care and rehabilitation.
- Home modifications e.g. ramps, thresholds, lifts and wide doors.
- Vehicle modifications/hand controls.
- Specialty equipment such as wheelchairs, bathroom equipment, hand cycle, adaptive sports equipment.
- Specialty equipment for blinded soldiers such as talking appliances or computers.
- Smart home technology:

Fifth, the VA will need to provide access to social services such as job counseling and psychological support. Many of the young wounded soldiers today need advice on which jobs or educational programs will be most suited to them. Such career counseling will allow the soldier to maximize the educational and job training benefits provided by the VA. Additionally, those that sustained brain injury as well as those that develop psychological trauma will need long term counseling and support.

Finally, it does the disabled veteran no good if he or she is unable to access the various programs provided by the VA. While still assigned to Walter Reed I have immediate access to the prosthetics care that is part of my recovery process. This access will continue for me through the new amputee center. However, for disabled veterans living in areas far from VA Hospitals and facilities, travel itself is a significant obstacle to their continued care. These disabled veterans will need regular, easy transportation support from the VA.

I applaud the VA and Department of Defense (DOD) partnership that assists military servicemembers who have served in combat and aims to provide them with a seamless transition to civilian life and veteran status.

Those select individuals from amongst the American people who would willingly serve in the armed services are a limited resource. Our warriors are expensive, and indispensable. I believe we must jealously guard this resource, retaining as many as possible in the service, and sparing little in the effort to return one of them to service. For example, the cost to "make" another Military Police Captain in order to replace a wounded one is prohibitive when compared to the medical costs to fix wounded soldiers and return them to duty.

I would urge you to think of the efforts of the Army Medical Department (AMMED) and the VA as a force multiplier for two reasons. First, these organizations can help us retain good soldiers, Marines, airmen and sailors who would have otherwise not been able to continue to physically accomplish their missions and remain in the service of the United States. These wounded have already been trained at great expense, as well as been tested and gained invaluable experience in the crucible of combat.

I believe we want to ensure that our warriors are secure in the knowledge that, when and if their comrades are hurt we will take care of them. The frontline soldier should not expend a moment of time to worry about a fallen comrade. We must ensure that he knows, "My buddy made it to Walter Reed, he will be OK, they have the best doctors, and cutting edge technology there." We will maintain the optimal morale and performance from our soldiers through ensuring that these medical facilities are adequately funded.

I have experienced first hand the excellence of the Army's medical system for the combat wounded. Because of the type of injuries, and the geographical location of my home, I have been treated at Walter Reed. Had I been burned badly I would have been sent to a different facility. For example, an amputee center has been opened at Fort Sam Houston's Brooke Army Medical Center. I believe it is just as important to fund all of those facilities. I can only hope and implore that the VA steps up to receive disabled veterans as we transition into its care from the military medical system. In order to continue to provide care at the level provided by the military health care system these programs will have to be funded into the future.

On behalf of our injured, wounded or ill servicemembers and their families, I thank members of this great institution for providing us with the funding and resources to take care of some of the finest citizens of this Nation. These are the men and women in uniform who have committed their lives and well being to the defense and protection of this great Nation. Thank you for the funding that provides invitational travel orders for family members, allowing my husband and mother to be at Walter Reed. They are an important part of my rehabilitation team. The AMEDD, with WRAMC on the cutting edge, has provided world class health care to injured and wounded members of all the Services. A strong partnership between the military healthcare system and the Department of Veterans Affairs will provide the optimal care for the needs of our servicemembers and their families.

Chairman CRAIG. Major, thank you very much for that testimony. It is truly appreciated.

Now, let me turn to Joseph Costello, Team Leader, Vets Center, Vista, California.

Joe, welcome. We will need to have you bring that microphone over to you and be sure it is on.

STATEMENT OF JOSEPH COSTELLO, M.A., TEAM LEADER, VET CENTER, VISTA, CALIFORNIA

Mr. COSTELLO. Mr. Chairman, and Members of the Committee, Senator Akaka, I am privileged to appear you today to discuss the role of the Vista Vet Center in providing care and services to veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom. Although this statement will focus on the activities of the Vista Vet Center, our efforts are typical of the 206 Vet Centers nationwide.

Under the leadership of Dr. Alfonso Batres, Chief of Readjustment Counseling Service, and Mr. Richard Talbott, the Pacific Western Regional Manager, the Vista Vet Center, located in Vista, California, endeavors to provide the highest-quality readjustment counseling and outreach services in an expeditious and cost-effective manner to eligible veterans and their families, especially to those who are suffering from readjustment problems related to combat trauma or military sexual trauma experienced while on active duty.

The services we provide for veterans include community outreach, referral to Department of Veterans Affairs medical and benefits providers; individual, group and family readjustment counseling; military sexual trauma counseling; and onsite employment assistance and vocational rehabilitation counseling via out-stationed ancillary staff. Vista Vet Center staff provides ongoing outreach to newly returning veterans of combat operations in Iraq and Afghanistan. Additionally, for more than a year, Vista Vet Center counselors have provided bereavement counseling to family members of military personnel killed on active duty in Iraq or Afghanistan.

The Vista Vet Center is located approximately 10 miles from the Camp Pendleton Marine Corps Base. We serve the communities of North San Diego County and Southern Riverside County. This community-based location of the Vista Vet Center provides maximum accessibility for our veteran clients. The Vista Vet Center is co-located with a VA Community-Based Outpatient Clinic. Many of our veteran clients also receive VA medical care at this facility. We are fortunate to have a close and cooperative relationship with our colleagues in the San Diego VA health care system, a relationship we nurtured by providing office space for medical staff before the CBOC was actually established.

The Vista Vet Center maintains non-traditional hours in an effort to ensure that veterans, whether employed or not, have access to services at a time that is convenient for them. The center is staffed from 7 a.m. until 8:30 p.m., Monday through Thursday, and from 7 a.m. until 4:30 p.m. on Friday. We, also provide outreach assistance to newly returning veterans and family members and participating community activities on weekends. If a military or veterans service organization requests our presence at a function

during non-traditional hours, it can be assured of our enthusiastic participation.

The Vista Vet Center has a core staff of four persons, a team leader, two counselors and an office manager. The staff has also been augmented by the addition of one half-time military sexual trauma counselor, one full-time global war on terrorism outreach worker. All of the team members are veterans, and four hold various mental health licensure and/or certifications to include social work, psychology, marriage and family therapy and alcohol and drug abuse counseling.

Ancillary staff members onsite weekly at the Vet Center include a full-time licensed psychiatric nurse clinical specialist volunteer, a County of San Diego Veterans Services representative who provides benefits assistance to our veterans, a VA vocational rehabilitation counselor, a VA homeless outreach counselor, and employee assistance counselors from the State of California. The Vista Vet Center also participates in the VA work study program. This program allows recently discharged veterans an opportunity to earn money doing supportive work for veterans and the Vista Vet Center staff while attending school. Two of our current work study staff members are also Operation Iraqi Freedom veterans. All of the members of the ancillary staff are instrumental to the success of the Vet Center mission.

The Vista Vet Center continues to provide readjustment counseling and supportive social services to a large percentage of Vietnam veterans. At the same time, we provide readjustment counseling services to all combat veterans who request our services who include an increasing number of OEF and OIF veterans and to victims of military sexual trauma. Over the past year, we have also provided bereavement counseling for three family members of two marines and one soldier killed in action in Iraq. During fiscal year 2004, the Vista Vet Center served 635 individual veterans and had 6,849 visits from veterans and family members. Nearly 50 percent—or 312—of the individual veterans served in fiscal year 2004 were either OEF or OIF veterans.

The Vista Vet Center provides intense and comprehensive counseling opportunities for North San Diego County veterans and their families. Our goal is to assist combat veterans and veterans who have suffered military sexual trauma to achieve a productive transition from military to civilian life. Counseling services available through the Vet Center include individual, couples, family and group centers. Specific, focused group counseling activities include anger management, stress management, trauma-focused group therapy, post-traumatic stress disorder process groups, spouse and significant other groups, and family education groups. The Vista Vet Center staff also coordinates with Veterans Benefits Administration locally to participate in weekly transitional assistant program briefings at Camp Pendleton and Naval Station San Diego.

In August 2004, the Vista Vet Center became the first Vet Center in the Pacific Western Region to hire a global war on terrorism outreach counselor. This counselor immediately implemented an aggressive outreach effort. To date, Vista Vet Center has conducted outreach and provided information on Vet Center services to every National Guard, Armory, and Reserve Center in San Diego County.

The Vista Vet Center also conducts outreach activities to nearly every veterans' service organization and college campus in the county. These organizations, as well as military and the veteran community, have enthusiastically embraced our efforts. We have also developed an effective working relationship with the Family Readiness Program of the California National Guard and with various Army Reserve Units. Vet Center staff members participate in family presentations and recreational activities with family members of deployed National Guard troops.

Our outreach efforts, also extend to active duty military activities in San Diego County. Of particular note is a recent collaboration undertaken with Naval Medical Center, San Diego. Naval Medical Center personnel have agreed to provide Vet Center staff with office space one day a week to assist OEF/OIF veterans in achieving seamless transition from military to VA care. The Vista Vet Center also has an excellent collaborative relationship with Naval Hospital Camp Pendleton and the Family Service Center at Camp Pendleton. We are discussing similar "office space" arrangements with these military providers to enhance further collaborative support for newly returning veterans.

The intent of the Vista Vet Center's aggressive outreach effort is to ensure that all veterans in San Diego County are aware of the services they are entitled to receive at the Vet Center. We will continue to strive to serve our veterans on their terms. A cup of coffee is always available and veterans are always welcome to stop by with or without an appointment. I can state without reservation that the Vista Vet Center staff is uniformly dedicated to helping all veterans who seek assistance through our center.

Mr. Chairman, Senator Akaka, this concludes my statement. I look forward to answering any questions you or other Members of the Committee might have.

[The prepared statement of Mr. Costello follows:]

PREPARED STATEMENT OF JOSEPH J. COSTELLO, M.A., TEAM LEADER, VISTA VET CENTER, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee: I am privileged to appear before you today to discuss the role of the Vista Vet Center in providing care and services to veterans returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Although this statement will focus on the activities of the Vista Vet Center, our efforts are typical of the 206 Vet Centers nationwide.

Under the leadership of Dr. Alfonso Batres, Chief of the Readjustment Counseling Service, and Mr. Richard Talbott, the Pacific Western Regional Manager, the Vista Vet Center, located in Vista, California, endeavors to provide the highest quality readjustment counseling and outreach services in an expeditious and cost-effective manner to eligible veterans and their families, especially those who are suffering from readjustment problems related to combat trauma or military sexual trauma experienced while on active duty.

The services we provide for veterans include community outreach; referral to Department of Veterans Affairs (VA) medical and benefits providers; individual, group and family readjustment counseling; military sexual trauma counseling; and onsite employment assistance and vocational rehabilitation counseling via out-stationed ancillary staff. Vista Vet Center staff provides ongoing outreach to newly returning veterans of combat operations in Iraq and Afghanistan. Additionally, for more than a year, Vista Vet Center counselors have provided bereavement counseling to family members of military personnel killed on active duty in Iraq or Afghanistan.

The Vista Vet Center is located approximately 10 miles from the Camp Pendleton Marine Corps Base. We serve the communities of North San Diego County and Southern Riverside County. The community-based location of the Vista Vet Center provides maximum accessibility for our veteran clients. The Vista Vet Center is co-

located with a VA Community Based Outpatient Clinic (CBOC). Many of our veteran clients also receive VA medical care at this facility. We are fortunate to have a close and cooperative relationship with our colleagues in the San Diego VA Healthcare System, a relationship that we nurtured by providing office space for medical staff before the CBOC was actually established.

The Vista Vet Center maintains non-traditional hours in an effort to ensure that veterans, whether employed or not, have access to services at a time that is convenient for them. The center is staffed from 7 am until 8:30 pm Monday through Thursday, and from 7 am until 4:30 pm on Friday. We also provide outreach assistance to newly returning veterans and family members and participate in community activities on weekends. If a military or veterans service organization requests our presence at a function during non-traditional hours, it can be assured of our enthusiastic participation.

The Vista Vet Center has a core staff of four persons: a Team Leader, two Counselors, and an Office Manager. The staff has also been augmented by the addition of one half-time Military Sexual Trauma Counselor and one full-time Global War on Terrorism (GWOT) Outreach Worker. All of the team members are veterans, and four hold various mental health licensure and/or certifications, to include social work, psychology, marriage and family therapy, and alcohol and drug abuse counseling.

Ancillary staff members onsite weekly at the Vista Vet Center include a full-time licensed psychiatric nurse clinical specialist volunteer, a County of San Diego Veterans Services Representative who provides benefits assistance to our veterans, a VA Vocational Rehabilitation Counselor, a VA Homeless Outreach Counselor, and Employment Assistance Counselors from the State of California. The Vista Vet Center also participates in the VA Work Study program. This program allows recently discharged veterans an opportunity to earn money doing supportive work for veterans and the Vista Vet Center staff while attending school. Two of our current work-study staff members are also Operation Iraqi Freedom veterans. All of the members of the ancillary staff are instrumental to the success of the Vet Center mission.

The Vista Vet Center continues to provide readjustment counseling and supportive social services to a large percentage of Vietnam veterans. At the same time, we provide readjustment counseling services to all combat veterans who request our services (who include an increasing number of OEF/OIF veterans) and to victims of military sexual trauma. Over the past year, we have also provided bereavement counseling for three family members of two Marines and one soldier killed in action in Iraq. During fiscal year 2004, the Vista Vet Center served 635 individual veterans and had 6,849 visits from veterans and family members. Nearly 50 percent (312) of the individual veterans served in fiscal year 2004 were either OIF or OEF veterans.

The Vista Vet Center provides intense and comprehensive counseling opportunities for North San Diego County veterans and their families. Our goal is to assist combat veterans and veterans who have suffered military sexual trauma to achieve a productive transition from military to civilian life. Counseling services available through the Vet Center include individual, couples, family, and group sessions. Specific, focused group counseling activities include anger management, stress management, trauma-focused group therapy, post-traumatic stress disorder (PTSD) process groups, spouse and significant other groups, and family education groups. The Vista Vet Center staff also coordinates with Veterans Benefits Administration locally to participate in weekly Transitional Assistance Program (TAP) briefings at Camp Pendleton and Naval Station San Diego.

In August 2004, the Vista Vet Center became the first Vet Center in the Pacific Western region to hire a GWOT outreach counselor. This counselor immediately implemented an aggressive outreach effort. To date, the Vista Vet Center has conducted outreach and provided information on Vet Center services to every National Guard Armory and Reserve Center in San Diego County.

The Vista Vet Center also conducts outreach activities to nearly every veteran's service organization and college campus in the county. These organizations, as well as the military and veteran community, have enthusiastically embraced our efforts. We have also developed an effective working relationship with the Family Readiness Program of the California National Guard and with various Army Reserve units. Vet Center staff members participate in family presentations and recreational activities with family members of deployed National Guard troops. Our outreach efforts also extend to active duty military activities in San Diego County. Of particular note is a recent collaboration undertaken with Naval Medical Center (NMC) San Diego. NMC personnel have agreed to provide Vet Center staff with office space 1 day a week to assist OEF/OIF veterans in achieving seamless transition from mili-

tary to VA care. The Vista Vet Center also has an excellent collaborative relationship with Naval Hospital Camp Pendleton and the Family Service Center at Camp Pendleton. We are discussing similar "office-space" arrangements with these military providers to enhance further our collaborative support for newly returning veterans.

The intent of the Vista Vet Center's aggressive outreach effort is to ensure that all veterans in San Diego County are aware of the services they are entitled to receive at the Vet Center. We will continue to strive to serve our veterans on their terms. A cup of coffee is always available and veterans are always welcome to stop by with or without an appointment. I can state without reservation that the Vista Vet Center staff is uniformly dedicated to helping all veterans who seek assistance through our center.

Mr. Chairman, this concludes my statement. I look forward to answering any questions that you or other Members of the Committee might have.

Chairman CRAIG. Joe, thank you very much.

Let us turn now to David Hosking, a Counselor at a Vet Center, Madison, Wisconsin.

STATEMENT OF DAVID J. HOSKING, GLOBAL WAR ON TERRORISM OUTREACH READJUSTMENT COUNSELOR, MADISON WISCONSIN VET CENTER

Mr. HOSKING. Mr. Chairman and Members of the Committee, it is an honor to come before you today to speak about my role as a Global War on Terrorism Outreach Readjustment Counselor. With the guidance of the Vet Center program's leadership, we have created a much-needed link between the returning veteran and the support systems that will help them readjust to their life at home with their loved ones. My assigned duties perfectly exemplify the Vet Center program's statement of purpose:

"We are the people in VA who welcome home war veterans with honor by providing them quality readjustment counseling in a caring manner. Vet Centers understand and appreciate veterans' war experiences while assisting them and their family members toward a successful postwar adjustment in or near their community."

Now, I would like to provide you some specific examples of what I do as a GWOT counselor. Most weeks I start with a trip to Fort McCoy, Wisconsin, where I am part of a demobilization process for troops returning from overseas. Some weeks I may go to McCoy two or three times. I always start my presentations and briefings with, "Good morning, veterans," or "Good afternoon, veterans." My heart fills with pride when I see the look on their faces as they smile and they look at each other. I ask them, "Am I the first person to refer to you as veterans?" They say, "Yes," and I tell them what an honor it is for me to have that privilege. I go on to tell them that I have sat in the chairs they are sitting in, that I am a Vietnam veteran and an Iraqi Freedom veteran, and it is my privilege to provide them with a PowerPoint presentation and a Vet Center briefing to make them aware of what is available to them in benefits and counseling if they should want or need our service. Yes, I like to tell them my standard joke, which I must say gets a laugh, and I always say laughter is the fuel for morale.

In the last 8 weeks, I have provided outreach to 3,500 veterans returning from the war through Fort McCoy, Wisconsin. The veteran population processing through Fort McCoy includes veterans returning home to the States of Wisconsin, Minnesota, Tennessee, Illinois, Alabama, Kentucky, Pennsylvania, Iowa, Michigan, Ohio,

and more. My outreach responsibility is my first priority. When the troops are coming home through Fort McCoy, I reschedule all my other appointments. Do I get tired of doing that same thing over and over? Never. There are always new faces from new places. They have new things to tell me that make me glad that I was there on that day to meet them.

The military behavioral staff person at Fort McCoy told me, after my first presentation, "Wow, Dave, you sure bond easily with these troops."

I told her, "Ma'am, I am a veteran. It is veteran-to-veteran. It is like trucker-to-trucker or biker-to-biker. We are on the same level from the word go. We know how each other feels and what we have been through. We do not have to explain it. We just know."

At Fort McCoy, the soldiers do evaluations of our briefings, and I get to see how they feel about them. Based on these outcomes, I am happy to report that our outreach effort is effective. Here are some examples of what they have to say:

"Do not change a thing."

"The VA briefing was great."

"The best I have ever had. He was funny, and it was nice to have a briefing from someone who was over there."

"Outstanding. He took the time to help us and give us a welcome home."

"He was too long."

"It was too short."

[Laughter.]

Mr. HOSKING. So I guess that tells me it is not perfect, and I will keep working on it.

On the first 2 weekends of the month, depending on their drill schedule, I travel to National Guard and Reserve units throughout the State. As of March 1st, I have visited 20 units. Over 1,500 additional troops are to be visited at 14 other units not counting the ones that are still deployed. It makes no difference whether they are Navy, Air Force, Marines or Army—a veteran is a veteran. We also have units who returned before my outreach position was created. So I try and make sure to get to every veteran and make them aware of the Vet Centers and the VA benefits they may need.

On the other weekends we go to Family Readiness meetings. The Family Readiness group is made up of families from the National Guard and Reserve units whose service men and women are deployed. The Family Readiness is under the National Guard Bureau, though it consists of both Guard and Reserve families. We have attended eight of the meetings so far. When I say "we go," I am referring to my wife and I. My wife is a Vet Center volunteer. She has been asked by the Readiness groups to come along so the wives of the deployed soldiers can ask her questions. She can relate to what they are dealing with.

My role is to provide information about VA health care and benefits, be with soldiers' families, tell them how important they are and what a great job they do caring for the homes and families of the deployed service men and women. I find that family members write down and keep good notes on any information you may give them and make sure that the information is shared with their veterans.

In my outreach program, I also regularly speak to VFWs, American Legions, County Veterans Service Officers, as well as other civic groups. I like to network with these organizations, which may have our new veterans as their members and can contact us if one of them should need our help. We also know that these groups and organizations include moms, and dads, and other relatives or friends of returning veterans who can serve as resources to give those veterans support and direction if they should need our help. I like to post Vet Center information in the community to promote the Vet Center's services, to make more people aware of the support we have for veterans.

As you can see, I have a very active and fulfilling job, where working a weekend is not like working a weekend, where talking to veterans is like meeting a new friend, and where Family Readiness meetings are like a family reunion.

I would like to conclude by telling you that outside of my family, this is the most gratifying thing that I have ever had the pleasure of being part of.

I thank you, Mr. Chairman, and your Committee for allowing me to talk about the greatest job a veteran like myself could ever have. Thank you.

[The prepared statement of Mr. Hosking follows:]

PREPARED STATEMENT OF DAVID J. HOSKING, GLOBAL WAR ON TERRORISM OUTREACH READJUSTMENT COUNSELOR, MADISON WISCONSIN VET CENTER, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee: It is an honor to come before you today to speak about my role as a Global War on Terrorism (GWOT) Outreach Readjustment Counselor. With the guidance of the Vet Center program's leadership, we have created a much needed link between the returning veteran and the support systems that will help them readjust to their life at home with their loved ones. My assigned duties perfectly exemplify the Vet Center program's statement of purpose:

We are the people in VA who welcome home war veterans with honor by providing quality readjustment counseling in a caring manner. Vet Centers understand and appreciate veterans' war experiences while assisting them and their family members toward a successful post-war adjustment in or near their community.

Now I would like to provide you with some specific examples of what I do as a GWOT Outreach Counselor. Most weeks I start with a trip to Fort McCoy Wisconsin., where I'm part of the de-mobilization process for troops returning from overseas. Some weeks I may go to Fort McCoy two or three times. I always start my presentation and briefing with "Good morning, veterans" or "Good afternoon, veterans." My heart fills with pride to see the look on their faces as they smile and look at each other. I then ask them if I'm the first person to refer to them as veterans. They answer "Yes!" and I tell them what an honor it is for me to have that privilege. I go on to tell them that I have sat in the chairs they are sitting in, that I am a Vietnam veteran and an Iraqi Freedom veteran and it is my privilege to provide them with a PowerPoint presentation and Vet Center briefing to make them aware of what is available for them in benefits and counseling if they should want or need services. Yes, I also like to tell them my standard joke, which I must say gets a laugh, and I've always said "laughter is the fuel for morale."

In the last 8 weeks, I have provided outreach to over 3,500 veterans returning home from the wars through Fort McCoy, Wisconsin. The veteran population processing through Fort McCoy includes veterans returning home to the States of Wisconsin, Minnesota, Tennessee, Alabama, Kentucky, Pennsylvania, Iowa, Michigan, Ohio and more. My outreach responsibilities are my first priority. When the troops are coming home through Fort McCoy, I reschedule all my other commitments. Do I get tired of doing the same thing over and over? Never! There are always new faces from different places. They have new things to tell me and make me glad that I was there on that day to meet them.

The military behavioral health staff person at Fort McCoy told me after my first presentation "Wow, Dave, you sure bond easily with these troops." I told her "I'm

a veteran; it's veteran-to-veteran like trucker-to-trucker or biker-to-biker. We're on the same level from the word go. We know how each other feel and what we've been through. We don't need to explain it, we just know.

At Fort McCoy, the soldiers do evaluations of our briefings and I get to see how they feel about them. Based upon these outcomes, I am happy to report that our outreach efforts are effective. Here are some examples of what they have to say:

"Don't change a thing!"

"The VA briefing was great!"

"The best I've had yet; he was funny, and it was nice to have a briefing from someone that was over there."

"Outstanding, he took the time to help us and gives us a WELCOME HOME!!!"

"He was too long!"

"It was too short."

So, I guess that tells me it's not perfect, and we'll keeping working on it.

On the first two weekends of the month, depending on their drill schedule, I travel to National Guard and Reserve units throughout the State. As of March 1, I have visited 20 units. Over 1,500 additional troops are to be visited with another 14 units, not counting the ones that are still deployed. It makes no difference whether they are from the Navy, Air Force, Marines, or Army, a veteran is a veteran. We also have units who returned before my outreach position was created; so I try and make sure we get to every veteran and make them aware of Vet Centers and of any VA benefits they may need.

On other weekends we go to family readiness meetings. The Family Readiness Group is made up of families from National Guard and Reserve units whose service men and women are deployed. The Family Readiness in under National Guard Bureau, though they consist of both Guard and Reserves families. We've attended eight meetings.

When I say "we go," I'm referring to my wife and me. My wife is a Vet Center volunteer. She has been asked by the readiness groups to come along so the wives of the deployed soldiers can ask her questions. She can relate to what their dealing with. My role is to provide information about VA healthcare and benefits, be with soldiers' families, and tell them how important they are and what a great job they do caring for the homes and families of the deployed service man or woman. I find that family members write down and keep good notes on any information you have for them and they make sure the information is shared with the veterans.

In my outreach program, I also regularly speak to VFW, American Legion, and County Veterans Service Officers, as well other civic groups. I like to network with these organizations, which may have our new veterans as their members and can contact us if one should need our help. We all know that these groups and organizations include Moms, Dads, and other relatives or friends of returning veterans who can serve as resources to give those veterans the support and direction if they should need our help. I like to post Vet Center information in the communities to promote the Vet Center services and make more people aware of our support to the veteran. As you can see, I have a very active and fulfilling job, where working a weekend is not like working on a weekend, where talking to veterans is like meeting new friends, and where family readiness meetings are like family reunions.

I would like to conclude by telling you that outside of my family, this is the most gratifying thing that I have ever had the pleasure of being a part of. I thank you, Mr. Chairman, and your Committee for allowing me to talk to you about one of the greatest jobs a veteran like myself could ever have.

Chairman CRAIG. Well, David, thank you very much. I thought in that concluding moment you were going to tell us your standard joke. Is it suitable for mixed company?

[Laughter.]

Mr. HOSKING. I have three. I will give you the shortest one.

Chairman CRAIG. Give us the shortest one. You have already run over time.

Mr. HOSKING. I will give you the shortest.

Some soldiers came in from Kentucky—I love this one because I do not start off the same all the time. I go up front very seriously, and I introduce myself and I say, "Veterans, I have a very serious topic, and I would like you to be serious." Boy, they all sit up very stiff and everything. I say, "Did I tell you about the guy from Kentucky that went in the bar, and he ordered four shots of booze? The

bartender set them out, and he drank them one after the other very quickly.

"And the bartender said, 'Wow. You drank those awful fast.'

He said, "Yeah, you would, too, if you got what I got."

The bartender said, "What have you got?"

He said, "Fifty cents."

[Laughter.]

Mr. HOSKING. The next morning I was talking to a group from Minnesota, and my friends—I call them my friends now because once I meet them, they are my friends—they came walking through to go in to have their blood taken or whatever, and this great big guy looks around the corner and said, "Dave, I have only got 50 cents." We all knew what it was about. It was funny.

Chairman CRAIG. All right. Well, thank you very much. We appreciate all of your testimony.

Let us start our questioning round. We will stick to a 5-minute rule for all of us, and then we can return if necessary for a second round.

Major Duckworth, your presence and your statement are certainly inspiring to all of this panel or all of this Committee, and your outlook toward the future is also tremendously inspiring. I know you are in the Illinois National Guard, and I also know that you are recovering right here at Walter Reed Army Medical Center.

You heard my opening statement, and in that I made some probative comments that I would like to continue to pursue with you and potentially other witnesses this morning. If it were possible, would you prefer to be treated at a facility closer to your home? You might want to combine that statement or comment back. Would it make any difference to you if that facility was a VA facility? Of course, I trust you will be very honest and frank with us as we seek to find out the kinds and levels of service that are being provided. We think those are very, very necessary. In other words, if you could receive comparable rehabilitative services, and they were in a VA facility closer to your home, would that be preferable or are you satisfied, certainly, with that service and the situation at Walter Reed?

Major DUCKWORTH. Mr. Chairman, of course, being closer to home——

Chairman CRAIG. Is your microphone on? Thank you.

Major DUCKWORTH. Being closer to home is always going to be better. However, I am concerned that it is very difficult to reach the level of service and the level of care that is available for me at Walter Reed. There are several components in this.

One, I am with a group of patients that have similar experiences, and just being together and going through the rehabilitation together is an inspiration, it is comforting, it is a way to force yourself to work a little bit harder because the guy on the mat next to you is working just as hard. I always say the third floor of Walter Reed, where the occupational therapy and the physical therapy labs are, is the most inspirational place I have ever been. Once I got myself out of the hospital bed and down to that floor, I am down on the third floor with other soldiers, there was no looking back. My recovery only increased in speed from that point on.

I also wonder what the likelihood or what the effects would be of being more isolated in my hometown, even though it is at the local VA Center. I am not around the same larger population of fellow soldiers of professionals who deal on a regular basis with fellow soldiers.

One of the things that happened to me in Iraq was that I became positive with the Acinobacteria, which approximately 90 percent of the soldiers coming back from Iraq are testing positive for. If we were all to come home and then be farmed out to civilian hospitals or VA Centers across the country, you now have all of these soldiers with an infectious disease that is peculiar to that theater, something that the expertise is not there, I do not think, other than in some place like Walter Reed that deals on a regular basis with this specific population.

So, yes, sir, it would be nice to be home, but I would like to get healthy quickly, get to the point where I can stay in the Army and fly again, and to do that is to be at Walter Reed at this point.

Chairman CRAIG. I mentioned in my opening statement that oftentimes the process of review by the Physical Evaluation Board can be a long one for our service men and women, and it can sometimes be frustrating. How has that process worked for those you have rehabilitated with at Walter Reed? In a general sense, how do you feel that is working?

Major DUCKWORTH. I feel it is working well, sir. The staff at Walter Reed are very good at working with you, at setting your goals. And if your goals are to leave the service and go back to civilian life, then they help you to prepare your packet for the Board and for the evaluation for whether or not you should be retained. If, however, you would like to stay in the military then, there are counselors and people that help you prepare your case to stay in. In either case, the Board seems to be responsive to what the soldiers are trying to do, whether it is to get out or to come back in, and there is help for us as we pursue those goals.

Chairman CRAIG. Thank you very much.

The Ranking Member is not back yet, so let me turn to Senator Obama.

Senator OBAMA. Thank you very much, all of you, for your testimony. I have just got a couple of quick questions.

Major Duckworth, with respect to the process of recuperation for you, I know that you have the benefit of a caring husband who is also in the services and so has some sense, I think, of what is going on here. Are we giving sufficient training to the spouses and families of our wounded veterans in terms of helping them achieve a full recuperation, and are there areas where we could be making improvements?

Major DUCKWORTH. Yes, sir. I do benefit from having a spouse who is also a military member, and he understands the military bureaucracy and a lot of the finer points in negotiating through that bureaucracy. I think that there is room for improvement, in terms of helping the spousal member. Oftentimes, the servicemember does everything in terms of the paperwork and handles the military bureaucracy, but then when you are unable to do that and everything falls on the spousal member, it is difficult for them to do so.

We have actually talked with and tried to advise spouses of other injured soldiers who are new to the process and give them tips on what it is they should be looking at, especially if the servicemember is very young. They are very inexperienced, and they themselves do not know what some of the paperwork actually implies for them.

An example that I can think of is there was a very young servicemember—I think he is 19 years old—filling out paperwork for the VA that asked him questions about chemical agents he might have been exposed to in Iraq, whether he was exposed to industrial pollutants, those types of things. The servicemember was having his mother fill these things for him because he could not write. His arms were injured. So she asked him, "Were you exposed to industrial chemicals?" and his response was, "No," because he was not anywhere near any factories. But I knew, as a helicopter pilot flying into Baghdad every day, there is a cloud of dark smoke, pollution hanging over that city and that there were factories just outside of his perimeter that he never saw, but he was certainly exposed to the pollutants coming out of there.

Senator OBAMA. Right.

Major DUCKWORTH. And I advised him and said you need to say yes to this because, yes, indeed, you were exposed to these pollutants. And if you do not put that down, somewhere down the road, if you develop respiratory issues, this may become a problem for you in claiming your VA benefits because, on this statement, you are saying, no, you were not exposed to anything.

So there is that type of counseling, guidance that is needed for the family members who may not be as savvy to the military bureaucracy.

Senator OBAMA. Well, I think that is a terrific point. I guess what I am wondering then is whether there some sort of ombudsman or somebody who is walking our injured vets through the process as they are filling out paperwork or the families are filling out paperwork, as far as you can tell? As you said, you and the Captain have the benefit of experience. You guys look pretty young to me, but you are not 19, and so you probably have a better grasp of this stuff. Did you get a sense, and this is something I can direct to the next panel, obviously, but I am interested, from the perspective of a user of the facility, whether there is sufficient hand-holding, walking people through the process so that they can focus on recovery, as opposed to focusing on other things. My impression is, then, we need to improve that a little bit.

Major DUCKWORTH. There is definitely a presence. There was a VA rep by my hospital bed speaking with my husband while I was still just coming out, just regaining consciousness. So the VA is definitely there and dropping off booklets of the VA's services that are available.

I think there could be room for improvement in terms of, as you said, the hand-holding process or perhaps coming up with an actual road map. What happens now is you have VA representatives come through and speak with you and offer help and guidance and all of those things, but it might be easier if there were more of a checklist approach, a more systematic approach. It is wonderful. I see representatives from the VA all the time, but sometimes when

the servicemember is ill and the spouses are trying to help, it is so overwhelming. There are so many people coming through your hospital rooms that have great intentions, and want to work with you, and help you and do all of these things, and you get so many business cards that sometimes there is almost a flood of help available, and it is hard to sort through that help. Maybe some more of an organization, allowing the VA to direct how they will provide you with the support that you need.

Senator OBAMA. That is very helpful.

Thank you very much, Mr. Chairman.

Chairman CRAIG. Senator, thank you.

Let me turn back to our Ranking Member, Senator Akaka.

Danny?

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

Messrs. Hosking and Costello, let me say at the outset thank you so much for joining us today. We are looking forward to your testimony. Your being here today I know takes you away from what you so obviously love to do, and that is to help veterans, and we look forward to your returning to that.

I am curious about each of your personal experiences with your transitions from DOD to VA. Tell me how you found the process. Were you given appropriate and helpful information by VA and DOD?

Mr. HOSKING. When I first came back, as I came through, I was kind of in this want-to-get-home mode. I must say that it was a great education for me, because now when I go back up there, I learned from that, and it was like a long, drawn-out process. I must say at Fort McCoy, they are constantly trying to streamline the process. They understand the soldier wanting to get home, but, they also understand the importance of getting all of the data correct as far as their financial benefits or whatever.

So I would just say, as I came back through compared to now, I think the process is vastly improved, and I think the people, where I came through, which was Fort McCoy, have done a very good job of trying to show that feeling toward the soldier and what he is going through in that process, not being cold to them, but being very warm, but also making sure that they do everything very accurately and on a timely manner. So I would say, as they are coming through there right now, it is very much improved.

Senator AKAKA. Joseph Costello?

Mr. COSTELLO. Yes, sir, Mr. Akaka. I came back through Fort Bragg, North Carolina, and I had the benefit of being a VA employee before I went overseas and being a VA employee upon my return. Even with that experience and having had the experience of providing presentations at the various TAP presentations at military bases in San Diego, I was amused with myself because I was not listening. I really just wanted to get home. That is, generally, the case with most of the soldiers and other servicemembers. You want to get home. So, yes, VA representation was there, and I did not pay attention to a thing. I was just thinking about my wife, and my kids, and driving back to the West Coast.

So one of the issues that I try to press strongly with my global war on terrorism outreach counselor is that repetition, hitting

these folks as soon as they come back, but then going back, again, when they get back into a drill status and hitting them, again, a few months later and a constant participation because, yes, representation is there and, no, most people do not listen to a thing. They just want to go home. So you can catch bits and pieces, but I think as someone who is employed by the Department of Veterans Affairs, it is important that we continue the effort and do not just let it go with one contact.

Senator AKAKA. Thank you.

Major Duckworth, I also want to add my aloha and welcome to Captain Bryan Bowlsbey. I met him when I came in, but I want to say aloha, again.

Now, I asked for your appearance here, Major, before our Committee because I believe your experiences will be very beneficial to us as we try to address how DOD and VA can best serve you during the rest of your military career as a veteran. I understand that other injured servicemembers at Walter Reed are looking to you for guidance. Do you have a feel for how returnees perceive the care at Walter Reed and their future care at VA facilities?

Major DUCKWORTH. Senator Akaka, I do. I think that, as Mr. Costello was saying, repetition is necessary. The hospital staff, as well as the VA staff and volunteers who also work for the VA, come through and are always there to talk with the soldiers, at this point, I do not know if some of the younger servicemembers really understand all of the benefits that are available to them and all of the resources that are available to them. We get the little book with the VA services, and that has been a great resource to have to go through and read through that. But I still think that there is still some lack of understanding, especially younger servicemembers or those that are not as familiar with the military system, lack of understanding of what benefits are available to them and what they can access and when can they access those things.

It would be nice to have a counselor or a checklist or something that you could go back to and use as a reference to guide you through the process later on, because right now you have personal contact, but then you have all of the information that is available to you, but you do not have a road map, per se, as to how you transition from one status to the next and what services are available to you. It would almost be nice to have a counselor assigned to you to sort of review your case as you are still going through the rehabilitation process.

Senator AKAKA. Have you had any contact with VA, direct contact with VA personnel, during your recovery?

Major DUCKWORTH. Oh, yes, sir, definitely. They were there even just as I was coming out of anesthesia within the first weeks.

Senator AKAKA. Thank you.

Chairman CRAIG. Danny, thank you very much.

Now, let us turn to Senator Salazar.

Ken?

Senator SALAZAR. Thank you, Mr. Chairman.

Let me ask this question of Mr. Hosking. You, obviously, visit with thousands of veterans returning from Iraq and from Afghanistan, and you probably hear a lot of their stories about what hap-

pens when they return back here to this country. So, if you were king for the year, and somebody were to ask you what is it that you would do, if anything, to improve the transition from being an active member of the military to being a veteran, what would you do to improve it? What recommendations would you give to this panel?

Mr. HOSKING. Well, I can really only speak on the outreach part because that is what I do. But what I see in the outreach part is this—they constantly look to upgrade, and we get that appraisal from those soldiers I told you about, which really is very, very helpful in the transitional period.

I find out that the soldiers coming through right now are telling me that, wow, this is going rather quickly. When we talk about their benefits, I list their benefits. I tell them who to contact about their benefits, County Veterans Service Office. "Do me a favor, if I have helped you at all today, do me the favor of taking your DD214, go down and meet your County Veterans Service Officer, and get it registered. That is your ticket to your benefits and not only Federal benefits, there are State benefits."

So that is where you start. I try to tell them where to start and how to go through that process of talking to the specialists who will deal with the benefit they need. As far as outreach goes, all I would ask is just please let me keep doing my job.

Senator SALAZAR. Let me ask a question with respect to those who come back from the war more seriously injured. I think some of my colleagues on the panel mentioned we are talking about young lives with many, many years ahead of them. I look at Major Duckworth, and I am inspired not only by her history before her combat injuries in Iraq, but also with respect to her future.

For those men and women who are coming back from Iraq or from Afghanistan who have the kind of serious injuries that will stay with them for an entire lifetime, can you comment on what you think we might be doing to make sure that that transition from the life that they used to know to the life that they are going to be facing in the future, how that is going and whether there are things we might be able to do to improve that future for them.

Mr. HOSKING. From the earlier question talking about where they would get their care at, I think it would be nice if they had a choice. I think there are some of us who like to stay with our Guard, with our unit. I am a helicopter crew chief. Going with my unit, I have that support from my friends within my unit, which I never had when I came home from Vietnam. I feel like I had that support.

I think maybe having a choice on where they have their care—maybe there are some who would rather be closer to home, where they feel that support from their wife and family, and others who would rather do as the Major said, maybe stay right here where that top-quality care is and be with other soldiers who, naturally, we get support from our comrades. So maybe choices like that would make it easier for them to make that adjustment.

Senator SALAZAR. Just one more question. In terms of making that initial choice about where they go I understand is something that could be helpful for many families that come in, the kinds of worries, though, that you hear anecdotally in terms of long term,

whether it will be 10, 20, 30, 40 years from now, is that something that is commonplace, and do you think that we as a national Government are doing enough to make sure that veterans with serious injuries are going to be taken care of in the way that they ought to be taken care of?

Mr. HOSKING. It is a difficult question, sir, because a lot of these young people are focusing on tomorrow, what is going to happen tomorrow, but I do see concern as to whether I can stay in the military. There are a lot of young people who love that military, and they want to stay with that military, and they want to stay with their comrades, if they can, maybe not in their unit, but maybe a different unit. I think that is one thing I do hear: "Why can't I stay in the military, maybe in another position?" So that is maybe something we would like you to look at.

Senator SALAZAR. Thank you, Mr. Hosking.

Chairman CRAIG. Ken, thank you very much.

We have been joined by Senator Patty Murphy, of Washington. Patty, welcome. You did not make an opening statement. If you want to extend your time a bit longer, with any additional comments and, of course, questions of the panelists, please proceed.

Senator MURRAY. Thank you very much, Mr. Chairman. I really appreciate you having your hearing and having us get a chance to talk with you about this really critical issue. Major, thank you especially for your courage and willingness to be here today to help us understand how we can do a better job.

Following up on the question that was just asked, I hear, as you do, from our military who are coming out, that they feel like they are being discharged too fast. They really do want to remain part of the military. They want to be part of the service, particularly those that I have talked to who are amputees or who have serious brain injuries that they are recovering from. In particular, I am hearing from them that they believe that they are being discharged too soon simply to save DOD money and to be sent to the Veterans for care. Is that anything any of you have been hearing as well?

Mr. COSTELLO. No, ma'am. I would not be able to speak for DOD on those issues. I could speak for VA, but I have not been hearing much of that, not from the veterans that come to our center.

Chairman CRAIG. Mr. Hosking?

Mr. HOSKING. As I said before, I have heard from a couple of soldiers who would have liked to have kept their career going maybe in a different field. I think if you have a soldier who has knowledge, I would like to retain that knowledge as long as I can, especially this could be someone in finance who knows everything about finance, and do we want to let that resource get away if he wants to be in there, if he wants to be a good soldier? I would like to see us look at that closely.

Senator MURRAY. Major, have you felt any pressure to leave the service?

Major DUCKWORTH. No, ma'am. Actually, I have had the absolute opposite experience. When people sat down with me to talk to me about what I wanted to do and set my goals for my recovery, I told them that I wanted to stay in the service, and I wanted to fly helicopters for the Army once again. Nobody laughed at me. Nobody

looked at me like I was insane. They all just said, "Well, let us sit down and see what we need to do to help you fight that fight."

There have been a few other soldiers ahead of me who have fought the fight to stay in and have been allowed to stay in. I am learning from them and their blueprints for how they were able to accomplish that goal. There is not really anybody who can be my counselor and tell me, "OK, if you want to stay in, these are the steps you have to take." It is something that I have to take my own initiative and go talk to the other soldiers and then find out what that road map is.

I can see if somebody were unsure of themselves and not quite sure whether or not they wanted to stay in that they might end up out of the service by nature of not having mounted an effort to stay in. That is really what you need to do is you really have to mount an effort when you go before the Board, and you will be rejected the first time, and then you will have to be ready to appeal. It is only on appeal do you then win the fight to stay in.

Senator MURRAY. So it takes tremendous effort to stay in.

Major DUCKWORTH. Yes, ma'am.

Senator MURRAY. Major, you were at Walter Reed, correct?

Major DUCKWORTH. I still am.

Senator MURRAY. You still are. I understand that everyone is assigned an Army counselor to help them get through the process, but some of the VSOs are telling us that they are having trouble getting access to patients at Walter Reed. Has that been your experience?

Major DUCKWORTH. I have not had any problems with accessing any help that I have needed, and I do not know of any other soldiers who have said that they have had that experience. Most of us actually have so many people talking to us that it can become a little bit bewildering.

Senator MURRAY. They might not know who they are talking to as well.

Major DUCKWORTH. Right.

Senator MURRAY. Have either of you heard of VSOs having difficulty accessing patients at Walter Reed to help them?

Mr. HOSKING. No, I have not, not in my area.

Mr. COSTELLO. Nor have I. I am in California, so I really would not be able to answer that.

Senator MURRAY. One other question, and it is a difficult one. Major, I will ask you, and I know it is a tough one. But I am hearing from some of our soldiers who are coming back and being discharged, particularly from Guard and Reserve, that they have deep concerns about the issue of being asked about sexual assault while they have been deployed, coming back and not feeling comfortable answering questions regarding that, being put into situations where they do not feel comfortable answering those questions, being discharged.

The reason I am concerned about that is because if they are discharged without having talked about it beforehand, and then they get out in their community and there is either mental problems associated with it, which is often, or physical problems associated, which is often as well, because they were not asked correctly, in

a comfortable situation, that they may not get the services they need, and we are not treating them fairly.

I just wonder if you have heard any of that or have any concerns about women, in particular, being discharged without having the proper ability to be asked about sexual assault while being deployed.

Major DUCKWORTH. I have not had that experience, ma'am, and I have not heard of that. If anything, at Walter Reed, the counseling teams that come through are of varied mixture of gender types, ethnic groups coming through, so that if I were uncomfortable with talking, for example, with a male psychologists, there were female psychologists and counselors that also came through that I could have spoken with.

Senator MURRAY. I understand Walter Reed may be different, unlike some of the discharges that occur out across the country.

Have either one of you heard this concern expressed at all?

Mr. COSTELLO. My personal opinion is it continues to be an under-reported issue and an under treated issue. One of the things that the Vet Center—and I am very proud of the Vet Center for providing military sexual trauma counselors specifically. That is their only role in our center is to provide care for those who have been sexually traumatized. It is a big issue because I think with this new theater of operations we have many people who have combat trauma and military sexual trauma, so it is quite an issue, and it is challenging.

We have a female licensed psychologist who is also a Naval Reserve officer, and it seems to be more comfortable for both men and women—and men are, clearly, underreported, even more so than women—but both genders feel more comfortable with a female, I think, because the perpetrators are usually male. We work very, very hard to address that issue. I will say it is challenging. It is challenging, even in the most sensitive manner, it is very challenging to ask that question and to also receive an answer the first time. So we try to leave the door open. When they are ready to talk, we are there for them.

Senator MURRAY. Mr. Hosking?

Mr. HOSKING. I also speak about that when I do my demobilization. I also point out the fact that we have female and male counselors, whether it be for them or their children or whatever. So we try to do our best to make them aware of that and make them aware that we are in a community setting where they can come in and talk to us. So I guess we work at it, but you are right, it is a very sensitive area, and we need to keep working at it.

Senator MURRAY. I appreciate that response. It is a difficult one, Mr. Chairman, but I am concerned, particularly for Guard and Reserve who just want to answer the questions and get home, that if we do not provide the correct counseling, the correct atmosphere, that we are causing some severe damage to women and men who have served us, and we have to be very sensitive to how we do this.

Thank you.

Chairman CRAIG. Well, I thank you for those questions, and I think that was a most appropriate one to be asked. Thank you very much.

Now, let me turn to Senator Rockefeller. Jay, welcome before the Committee. You are a long-time senior Member of this Committee. I have been on it a while, but you have been here a while longer, and we appreciate always your presence and your questions.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
U.S. SENATOR FROM WEST VIRGINIA

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

Last Saturday, I went to Keyser, West Virginia, which is kind of a rural area, to welcome a Guard group returning home. That region covers Pennsylvania, Maryland, and West Virginia. It was the 101st Battalion. The whole crowd was about 400, but there were about 45 veterans who were returning that day. The whole town—it is not a big community—they all turned out. There was an enormous amount of celebration, and then they were introduced one-by-one, the returning soldiers as they came in.

It was very interesting to me. I looked at it in two ways. One is that, although two of them had been wounded, they had not been wounded severely. I was glad about that. The second thing is that all of these strapping young folks that came back who looked so healthy, there are two kinds of ways of measuring health, and that is if you get an injury that is physical, and the other is if you get an injury internal to you which nobody sees. Patty made reference, obviously, to one of those.

I try to go back to the first Persian Gulf War and the difficulty we had on this Committee trying to prove that the DOD was literally withholding information on the Persian Gulf War Syndrome, and Pyridostigmine bromide, and DEET, and all of that kind of stuff. The doctor who was in charge of stonewalling us then is still there now, and I do not know that he stonewalled us on anything, but he sure did on that. I had hundreds and hundreds in West Virginia, soldiers, men and women whose lives just sort of collapsed, and the old pattern was to tell them to take an aspirin and get a good rest.

Now, I would like to ask each of you, from a wounded soldier's perspective and a counselor's perspective, what are the kinds of effects upon those young men and women who came in, in a line, all robust, young, glowing, families running toward them, did we not see—injuries that were there, but we did not see?

Major DUCKWORTH. Senator Rockefeller, well, of course, soldiers over the long term, especially those that were in high-combat stress positions, on foot patrols, soldiers who conducted daily convoys were exposed to tremendous amounts of stress that may not appear or begin to affect them long term until after they have left the service. I am not in the health care profession, so I will leave the concerns on how that develops to medical professionals.

I do know, though, that when I came home on R&R leave, prior to being hit, the first 3 or 4 days I had a very difficult time slipping back into my old life and being with my husband. Just driving on the Interstate was very nerve-wracking for me because as cars cut in and out in front of me, my instinct was to just run them over because if that happened—which, if you know Chicago traffic, it is like DC traffic, it is probably a good instinct——

[Laughter.]

Major DUCKWORTH. But in Iraq that means that somebody with an IED or a car bomb is trying to get into your convoy, and every bit of training that we received and how we drove over there taught us to be very aggressive. So I think you might see more aggression.

I was very skittish. I came from a world where the world was shaded in different colors of sand, and tan and brown, and I came here and everybody was in bright colors, and there were men and women in different—and I was just very nervous for quite a few days, and it was hard to settle back in.

For soldiers that face stress on a regular, daily basis, I can see how that, long term, could be come an issue.

Senator ROCKEFELLER. I am, obviously, thinking of matters like post-traumatic stress disorder and a variety of other things. I talked to several of the soldiers afterwards, and they said that they were really having a hard time just getting back into their family, which you have indicated, which is an injury of sorts, or can be. Maybe the transition works and maybe it does not. But I think I am right in saying that 50 percent—and tell me if I am wrong—that 50 percent of our soldiers who are in Iraq for a period of 2 years that they will go through or consider the process of divorce during the course of those 2 years. That has to have an enormous effect.

So PTSD, stress, readjustment, and I am putting this in the context of, I would say to you, that we have about 5,800 returning troops so far, with many more to come, in West Virginia, and we have one outreach counselor. So that will be a second question. But what would you see as the unseen injuries—psychological, physical, whatever?

Mr. COSTELLO. Well, probably the greatest unseen injury would be referring to post-traumatic stress disorder. From a psychological perspective, I think that every veteran—and I may be wrong—but just as Major Duckworth said, when I redeploy—because I am still in the Reserves—I am not taking R&R, because you come back and you are all of those things—skittish, uncomfortable, it is not OK to not have your weapon, and you lose a bit of an edge when you return.

When people finally return from theater, that can last for quite a bit of time. Discomfort with not having your weapon is what I hear most commonly, not feeling that they fit in, and things are different, and it is difficult to sleep, and all of those things, difficult to readjust to the family. People change in a year, and situations change in a year, and even under the best of circumstances, if you were going on a year with some private company and you returned, there would be readjustment issues.

So my belief is that everybody has readjustment issues. Some of those are more pervasive and chronic, and that is what the Vet Centers are there for, is to provide that long-term care. We do not have a time limit. We have been doing this since 1979 and continue to see those Vietnam veterans who need readjustment counseling and treatment for more chronic issues, such as post-traumatic stress disorder or other diagnosed mental illnesses. But that is what we are there for. We are there for the duration.

But, yes, you are right. Those issues will continue, and we hope to be there to continue to address them.

Senator ROCKEFELLER. Mr. Chairman, I have another question, but I will defer.

Thank you very much.

Chairman CRAIG. Senator Rockefeller, thank you very much.

Now, let me turn to Senator Thune.

John, any questions?

STATEMENT OF HON. JOHN THUNE,
U.S. SENATOR FROM SOUTH DAKOTA

Senator THUNE. Thank you, Mr. Chairman.

I also want to thank our panel and thank the Major for your service to your country. That is powerful, powerful testimony to the courage of our young men and women. Thank you for being here, and thank you, gentlemen, for the work that you do to support our veterans across this country.

A couple of questions. If I might, Mr. Chairman, I would like to submit for the record a statement or a letter from a lady in my home State of South Dakota, who, incidentally, I just met with in the hallway, whose father recently died of Agent Orange. I think it pertains, in some measure, to what we are talking about here today—people who come back and the service that they get from the VA and some of the issues that they deal with subsequent to that service. I would like to include that in the record.

Chairman CRAIG. Without objection, that will be a part of the record.

[The letter referred to follows:]

March 14, 2005

Hon. Senator JOHN THUNE,
United States Senate,
Washington, DC 20515

DEAR SENATOR THUNE: General William T. Sherman said, "War is hell." This takes on an additional meaning for my family and I'm sure, for thousands of other families across the country. My father was diagnosed with multiple mylomia in September 1995. He and our entire family went through the steps of being diagnosed with a terminal cancer and later, with the realization that this cancer was a direct result of Agent Orange and his military service in Viet Nam.

Several years after diagnosis, my parents bought a fifth wheel camper and headed to California to visit my brothers. My father's health took a turn for the worse while there, and I arranged for an emergency flight home. When my father left South Dakota, he was driving a forty-foot fifth wheel and when I picked him up at the airport, he was in a wheel chair.

In a matter of weeks, my father's condition worsened and we had to put my father in a nursing home, as the Veterans Administration Hospital had no facilities for patients suffering from dementia. In a very short time, I watched my father go from a 200 pound independent man to a 90 pound can't-sit-up, roll-over, do-anything-for-himself man. I watched him be physically and mentally abused in the nursing home. I watched him fall, writhing in pain and I watched my father die with no dignity.

My father ate, drank, and breathed the Navy. He always gave 200 percent to the military and served for 20 years. Several months before my father passed away, I had asked Governor Rounds to check into his service record and see if he were eligible for benefits because his medical condition was related to Agent Orange. The Veterans Administration (VA) then informed us that my father was indeed eligible and was awarded $2,300 per month. Unfortunately, within days of this ruling, my father died and this money was never awarded to his "survivor," my mother.

On September 1, 2003, my father died and I stood over him, crying and looking at his narrow, sunken face. As I slowly pulled the sheet up over his body, I thought to myself that his sharp, protruding bones could still be seen through the sheet. I watched a movie clip play through my mind, remembering playing hide and seek

with my father, tagging along with him to Moffet Field Air Base, opening presents on Christmas day, teaching me how to drive stick shift, and holding me when something or someone made me cry. I remembered how he and my son were inseparable. I grieved thinking how my father would never see me graduate from college or his grandson graduate from high school. He would never see his grandson get married or see any great-grandchildren.

My father's mother had to bury her son. I have been deprived of my father. My son has been deprived of his grandfather and my mother deprived of her friend and husband. Most of all, my father has been deprived of his life.

Since my father's death, I have been contacting my congress people to reinstate my mother's claim to the money promised my father through his Agent Orange-related illness. Although the Veteran's Administration provides my mother with a small pension, she does not receive the survivor's benefits as the full amount of what was promised my father before his death. The response from Congress to this request is that because my mother did not "live the war," she is not entitled to this monthly benefit.

Yes, it is true that my father "lived the war"; he served in the Korean War and in Viet Nam. But so did my mother—she "lived the war" when Internet and satellite communications were nonexistent. She "lived the war" by moving to whichever base the United States Navy asked her to move to. She "lived the war" when my brother was born in Africa, another brother in Tennessee and I was born in Florida. My mother "lived the war" as she watched the ill effects of Agent Orange take the life of her husband. What part of this can you say, my mother did not live?

Just as the military has support units back at the bases to help the soldier accomplish the mission, so too was my mother a support unit to my father and the Navy, helping ensure that all was taken care of at home, including all financial business, moving the family to different bases without the help of her husband, and with little or no support from the Navy. Is her contribution any less than that of the military's support units?

Besides the mental anguish, the pain and suffering, which our family has suffered, there has been a monetary impact as well. My mother has had to sell the truck, the van and other personal possessions to help meet monthly bills. After two strokes, the doctors have told her she needs to alleviate as much stress from her life as she can. But how can she do that when the monthly cost of living bills are far greater than her pension each month?

At the very least, the Veterans Administration should pay my mother the back pay due the family for the time of illness my father endured. This would be from September of 1995 to the time of his death in September 2003. This alone would make a real difference in the quality of my mother's life. It wasn't until my father's dementia and he began to relive his Viet Nam days that we realized Agent Orange was the cause of his illness. A dedicated Navy man to the end, he had honored his vow of secrecy given to the Navy about his involvement in the war.

Our country is generous in its gifts to others throughout the world who are suffering. But, what about our own soldiers and their families—those who are willing to lay down their lives for the freedoms we enjoy? The United States asks people to join the military and fight for our country, but when they are wounded, or killed, then what? What about the families of those who serve? Veterans and their families are often pushed aside and forgotten. When my father died, we received a letter with a stamped signature from President Bush. We received word that my mother would receive a small pension, but was not entitled to the $2,300 survivor's benefits. And we continue to hear throughout each and every legislative session how money is being cut from veteran programs and how families of veterans are often unable to meet the costs of living.

I remember so well how my father looked up at me while he was suffering in the nursing home and with tears in his eyes, he said, "The military promised me they would always take care of me medically and financially for the rest of my life if I re-enlisted." These words came back to haunt me this week as I was talking with an Army vet. He told me that for re-enlistment, he too, had been told that the Army would take care of him for the rest of his life. These promises were made to soldiers willing to serve their country in times of need and they require a commitment from the American people to honor these promises.

I ask you to support legislation that would add dignity to the lives of survivors of soldiers who faithfully served our nation. We can do this by providing financial compensation to the widows of military personnel in a manner commensurate with their great sacrifice. This comes with the full recognition that no monetary gift can

ever replace a person's life, yet financial compensation can provide a token of respect and honor for our veterans and their families.

Sincerely,

PAULA HATZENBUHLER

Senator THUNE. Thank you, Mr. Chairman.

I guess I am interested, in particular, and we have a lot of National Guard people in South Dakota who have been deployed—in fact, 74 percent of the members of the South Dakota National Guard have been deployed to Iraq or Afghanistan or are involved in some aspect of those operations, and I also have a number of active duty personnel in South Dakota as well—and we want to make sure that as they return that they are able to transition, and those who have been injured in either of those theaters, that we are doing everything we can to address the health care needs that they have, both in the military setting and then also later in the VA.

Just one question with respect to that, and it kind of goes back to the question that Senator Rockefeller was asking, because I think, in many cases, there are these issues that crop up that may be theater-specific, that may be related to particular aspects of these conflicts, that when they come back, are there things that we could be doing to better anticipate those types of things, illnesses that might be created as a result of things that they are exposed to areas. I am thinking, of course, in the Vietnam era to the conversation I just had with my constituent about Agent Orange.

But are there things that our VA facilities could be doing better here to anticipate some of the issues that we are going to be dealing with as a result of people coming back? That is sort of a follow-up I think to the question Senator Rockefeller was asking. I direct that I guess to you, Major, first, and then perhaps maybe the other panelists.

Major DUCKWORTH. Not having to access the VA services thus far, I am just doing the rehabilitative process at Walter Reed, I cannot say what the experience would be through my local VA center. I do think it is important to make the distinction. I have come up with a good definition of what health is. Being healthy is not the absence of disease. I am healthy. I was very healthy before I was injured, and I did not contract an illness or catch any disease. I lost my limbs, and now as I am recovering, I am becoming healthy again, but I will still need the VA to help me access my environment and especially with the youth of the injured soldiers today, a quality of life, a healthy life will mean sports and those types of things and the adaptive equipment they will need for that.

Just because somebody does not have a particular disease does not mean that they are healthy. They can develop PTSD or those types of things later on. We need to understand that there are other needs beyond the immediate sickness that you may undergo.

Senator THUNE. It kind of ties into the question that you were referring to with PTSD, Mr. Chairman, but I guess I am just, as sort of a preemptive measure, thinking ahead of things that we need to be doing to be prepared for folks as they are coming back in. I realize you are not accessing the VA yet.

We have, in my State, benefited—I am a rural State, a lot of geography—from the community-based outpatient clinics has given some of our veterans access to facilities, but just in terms of the

treatments, and the therapies and all of the things that are going to be necessary when people return home, and because of some of the unique things that I think they are exposed to in each of these different operations, that was I guess my line of thinking with respect to that question.

I have got one other quick question if I might ask, and that has to do with is health care, and benefits, and those types of things. Is it a deterrent to young people today, when it comes to signing up, either recruiting for the first time or getting them to re-up and stay in? Do you hear that when you talk with people who come back and are considering or contemplating whether or not they want to stay in the National Guard, for example? Are there things that, as a political body here, we ought to be doing differently to continue to provide the incentives for people to stay in the services? A very open-ended question.

Mr. COSTELLO. Yes, it is, but I appreciate the question, Senator. I will speak as a soldier in that regard.

As a soldier, certainly I would love to see medical benefits increased via DOD. I think that would be great. As a Reservist, any greater access would be a wonderful thing. It is not the thing that keeps us in. In fact, I have never heard anybody talking about, you know, I would reenlist if they gave me more medical benefits. Bonuses are nice, but it is not what keeps people in.

You get something in military service that you just cannot get elsewhere, and you are either committed or you are not and particularly as a Reservist. Reservists stay in because of the brother- and sisterhood, and commitment to mission and the team. That is why we stay in. But, sure, that would be nice.

[Laughter.]

Mr. HOSKING. I guess, on behalf of my brothers and sisters in the National Guard, I concur totally. But Joe is exactly right. I took what is called a Try–1 that turned into Try–28. I always said the National Guard is kind of a trap. I never missed the National Guard until the day after I retired. It is a very close group of people, and that is why they stay because it is hard to walk away. When you have got friends by the name of Zeke, and Bear, and Treehugger and things like that, you just do not walk away from them.

But as far as taking care of them and doing more for them in the Guard and Reserve, yes, by all means.

Senator THUNE. Thank you, Mr. Chairman. It is a discussion that I hear a lot about when it comes to our efforts to recruit and retain people who are serving and making sure. And we had the discussion about Tricare access for National Guard members and that sort of thing, and it is something that we are debating again here in the context of the DOD authorization bill this year. So I appreciate your comments.

Thank you for your testimony.

Chairman CRAIG. I wish we could assume another round. I am going to ask our colleagues to be tolerant so we can get to our second panel, but there may be some questions we would submit to you all in writing. You have been an extremely valuable panel to us as we build what I think is an increasingly important record.

Certainly, Major, to you, you are an example of a great generation of young Americans who are currently serving. You are also an example of a generation of veterans coming that we recognize, we recognize we must serve, and will serve and be prepared to serve, and I think you have made extremely valuable points this morning. One of them, obviously, is your youth and the youth of those young men and women who are serving who are coming home not physically whole and yet are anticipating a full life. So it is certainly our commitment to assure that that happens. It is part of the reason we are holding these kinds of hearings and will continue to pursue it, attempting to get it as right as we possibly can.

Gentlemen, your service is, obviously, extremely valuable. That transition, we are developing a phrase here that has been used, but I am not sure is yet perfected, and that is called "seamlessness." So we are going to study that a long while to make sure that it is a seamless transition from military to civilian life, and the roles you are playing in it are extremely valuable.

Thank you all very much. We appreciate it.

Now, we would ask our second panel to come forward, please.

To our second panel, welcome. We thank you for your patience, but I trust, I watched, you were all listening very intently, and I appreciate that. I think we all have a lot to learn in all of these experiences, and so we appreciate you being here.

Let me, first, turn to Major General Kenneth Farmer, Commanding General, Walter Reed Army Medical Center and North Atlantic Regional Command.

General, thank you very much for being with us today. You are a very important person to a lot of active military and soon-to-be veterans.

Please proceed.

STATEMENT OF MAJOR GENERAL KENNETH L. FARMER, JR., M.D., COMMANDING GENERAL, NORTH ATLANTIC REGIONAL MEDICAL COMMAND AND WALTER REED ARMY MEDICAL CENTER

General FARMER. Thank you, Mr. Chairman and distinguished Members of the Committee, for this opportunity to come before you today to discuss the care of our wounded servicemembers and especially those from Operations Iraqi Freedom and Enduring Freedom and our efforts to facilitate the transition between military and Veterans Affairs health facilities and between military and Veterans Status. Our efforts have been extraordinary in this area.

The VA-DOD partnership has made generational advances over the past efforts to synchronize military health care treatment and transitions between DOD and VA and has sought to ensure that the process of moving patients from one health care system to the other is as seamless as possible. As part of the VA's seamless transition program, the Veterans Health Administration has assigned several full-time employees to DOD casualty treatment facilities, including two social workers at Walter Reed Army Medical Center, to serve as liaisons between our hospital and VA facilities.

Each VA facility has also selected a specific point of contact who works closely with these liaisons to assure a seamless transition to

the most appropriate plan and place for care. They work closely with the treatment teams at Walter Reed to provide ongoing consultation regarding complex discharge planning issues as well as to identify and access health care benefits and resources.

Once our discharge planning staff refers a servicemember for VA care, the liaisons meet with a servicemember and family to orient them to the VA system, to provide an overview of the veteran's health care benefits, to address current medical issues identified as part of the servicemember's treatment plan, and in collaboration with our Walter Reed staff, they also coordinate referral information, enrollment, identify treatment needs and transfer of medical records with a receiving VA facility to assure that the health care delivery remains uninterrupted during a transition.

The success of this collaborative effort is evident in the case of Specialist Lance Geiselman, a soldier from Fort Hood, Texas, who sustained severe injuries when his M1A2 tank detonated an improved explosive device or IED. Specialist Geiselman's injuries consisted of a left above-the-knee amputation and a lower spine fracture, and that spine fracture left him with significant neurologic deficits in both legs. Because of the cooperation between VA and the DOD, two synchronized treatment teams were able to efficiently and effectively coordinate the transfer of Specialist Geiselman from Walter Reed to the Memphis VA Hospital to begin his neurological rehabilitation for his spinal injury.

After several months in the Memphis VA, Specialist Geiselman was able to walk, with some assistance, and he then was transferred back to Walter Reed to complete his prosthetic fitting for his amputation, with aggressive rehabilitation at our amputee center. With his family and our staff cheering him on, he was able then to walk with minimal assistance. I think this shared responsibility for care was a textbook case of excellent teamwork with an optimal outcome.

But this type of collaboration with the VA is not a new phenomenon for Walter Reed. In fact, the Defense and Veterans Brain Injury Center, which integrates clinical care, clinical follow-up with applied research, treatment and training, stands as another shining example of the benefit of our partnership.

This program was created after the first Gulf War to address the need for a systematic program for the provision of care and rehabilitation within DOD and VA facilities specific to brain injuries. The Brain Injury Center is headquartered at Walter Reed, but operates through the cooperation of seven military and VA hospitals across the United States. These sites work collaboratively to provide evaluations and expert case management to help active duty military veterans and other eligible beneficiaries with traumatic brain injury to return to work, duty and their community.

Our goal is to ensure individualized evidence-based treatment for each patient as well as to provide educational programs for patients, their families and the community. In fact, the Director of the Defense Veterans Brain Injury Center, Dr. Deborah Warden, is participating in the Congressional Brain Injury Task Force Brain Injury Awareness Month lecture series today here on Capitol Hill.

The center is uniquely situated for seamless transition due to its 12-year history of DOD-VA collaboration. An example of this col-

laborative work is with Warrant Officer John Simms, who was injured in a Blackhawk helicopter crash in Iraq 15 months ago. Initially, not expected to live, he was treated on the *USNS Comfort* and was transferred to Walter Reed for intensive care. He was then sent to the Richmond VA Hospital, one of four VA centers for treatment of traumatic brain injuries and difficulty of speech. From Richmond, Simms was sent to Virginia Neuro Care, the Brain Injury Center's civilian partner, for community reentry. He is no longer piloting an aircraft, but he is able to fully care for himself and live independently in the community.

In the attempt to interview early and reduce the emotional stress associated with a transition between DOD and veteran status, the Veterans Benefit Administration has also assigned benefits counselors to Walter Reed full time to provide comprehensive education and assistance to these seriously injured combat veterans.

We also provide full-time vocational rehabilitation and employment counseling services onsite. They make initial assessments of the servicemember's abilities, interests, and aptitudes and forward them to a counselor in the home State or area. The counselors use this information to help the servicemember prepare resumes and arrange interviews for those planning to go into the workforce and enable some servicemembers to volunteer in various VA jobs while awaiting discharge.

In closing, I have only mentioned a few of the things that we are doing together on behalf of our injured, wounded and ill servicemembers and their families. I want to again thank the members of this great institution for providing us with the funding and resources to execute our mission, which is to take care of some of the finest men and women of this Nation who have committed their lives to our well-being and defense.

Finally, I would like to point out that the Army Medical Department at Walter Reed and elsewhere is providing world-class health care to our injured and ill members of all services and will continue to do so. We have established a strong partnership with the Department of Veterans Affairs, facilitated by an unwavering spirit of cooperation in our efforts to provide a holistic approach to taking care of the needs of our servicemembers and families.

I look forward to your questions and, Mr. Chairman, I would especially be happy at that time or now, if you prefer, to respond to your question about the ways that we are getting casualties close to their home for care.

[The prepared statement of General Farmer follows:]

PREPARED STATEMENT OF MAJOR GENERAL KENNETH L. FARMER., JR., M.D., COMMANDING GENERAL, NORTH ATLANTIC REGIONAL MEDICAL COMMAND AND WALTER REED ARMY MEDICAL CENTER

Mr. Chairman and distinguished Members of the Committee, thank you for the opportunity to come before you today to discuss the care of wounded servicemembers injured in Operations Enduring (OEF) and Iraqi Freedom (OIF) and our efforts to facilitate the transition between the Military and Veterans Affairs (VA) Health Care Facilities and between military and veteran status. The efforts of my regional medical facilities and the VA have been extraordinary in this arena.

Let me begin by addressing the VA and Department of Defense (DOD) partnership that assists military servicemembers who have served in the Global War on Terrorism (GWOT) in obtaining health care and other services from the VA. The VA/DOD partnership has made generational advances over past efforts to syn-

chronize health care treatment and transitions between DOD Medical Treatment Facilities (MTFs) and the VA health care facilities. This partnership has sought to ensure the process of moving patients from one health care system to the other is as seamless as possible. Prime examples of this are the exchanges of experienced clinical and administrative staff members to serve as liaisons between the MTFs and VA facilities. The VA has provided dedicated social workers and nurse case managers that serve as the VA representative that can assist with the multi-disciplinary coordination required to ensure the most effective treatment regimen for patients is harmonized prior to Servicemembers being transferred from the MTF to the VA. Furthermore, these case managers collaborate with TRICARE in order to synchronize medical issues between the patient, their family members and the TRICARE benefit counselor. The results of these moves have been notable improvements in obtaining TRICARE authorized benefits for both the Servicemember and their family. In addition, the WRAMC staff is coordinating with VA on the separation of traumatically injured Servicemembers, to ensure VA disability benefits can be awarded days after separation. The VA has stationed several VA/DOD liaisons at the major DOD health care facilities, along with the creation of the VA Office of Seamless Transition (which provides policy guidance on improving the clinical and administrative processes between our two agencies). In collaboration with these initiatives, the Army Medical Department (AMEDD) has assigned dedicated social work and nurse case managers to coordinate patient transfers between the MTF and the VA. Furthermore, the AMEDD is assigning active duty liaisons to support all four of the VA's Poly Trauma Centers on a trial basis. The goal of this initiative is to maintain the lines of communication between the agencies to ensure priority placement and access to VA health care services. These moves provide for clear, comprehensive and early intervention and overview of VA health care services and benefits for Servicemembers and their families. Because of this relationship between our two organizations and by virtue of early assistance intervention, the transition from the MTF to the VA has been much improved.

Since last summer, NARMC has transitioned over 54 Servicemembers from our MTFs to the VA. This process replicates itself throughout the AMEDD and the VA. But I also want to expand on the benefits of this partnership to include more than just the seamless transition of Servicemembers from one health care system to another. Our reengineered relationship is energized at the grass root level between the major MTFs and the VA health care centers. These programs allow VA benefit counselors to access Servicemembers and their families before they are transferred to the VA. The VA has stationed seasoned rehab, benefits and vocational counselors at Walter Reed Army Medical Center (WRAMC) and other major MTFs within DOD to assist Servicemembers and their families. These counselors provide crucial information and education related to the network of VA benefit program available to Servicemembers and their families. They work with the MTF, VA case managers and the other various DOD/MTF patient initiatives to arrange for the full breadth of patient care and family assistance. This care and benefits coordination has proven to be instrumental to the success of the Defense and Veterans Brain Injury Center as servicemembers transition between Walter Reed Army Medical Center and the four Poly Trauma Centers located in Richmond, VA, Tampa Bay, FL, Minneapolis, MN and Palo Alto, CA. But the partnership is more than this; it also focuses on the needs of the Servicemember and their families beyond the boundaries of immediate, direct health care. It takes on a more holistic approach by expanding the scope of assistance to Servicemembers and their families once integrated into those communities. The VA intercedes at the earliest point possible to discuss the many benefits they can offer. One snapshot of these initiatives is the pastoral care services of the Tampa VA under Chaplain David Lefavor, a Chaplain in the Traumatic Brain Injury Center. He works very closely with WRAMC's social work service center by coming to WRAMC and visiting Servicemembers and their families prior to their transition to the Tampa VA.

Let me take a few minutes to relate some of the many other initiatives and programs that the MTF, in conjunction with DOD and other players, have brought into existence to assist and serve our Servicemembers and their families. WRAMC recognized at the outset of the war that it was not fully equipped to handle the many needs of the family members of Servicemembers injured or wounded in Afghanistan and Iraq. Thus the Medical Family Assistance Center (MEDFAC) was created to address the needs of family members and Servicemembers. The MEDFAC's primary objective is to provide for comprehensive support to those family members and next-of-kin who would travel from across the country to be with their loved ones injured in support of operations in Iraq. The MEDFAC was activated on 4 April 2003 and since its inception, the MEDFAC has provided services to over 4,000 patients and their family members/next-of-kin. The MEDFAC operates on a 24 hour basis and

a representative from this cell meets every Servicemember evacuated to WRAMC upon their arrival. They assist Servicemembers and family with a barrage of issues or concerns ranging from family and Servicemember travel, reception of both family members and Servicemembers, arrangements for lodging, and financial assistance for those in need.

Between April 2003 and March 2005, the MEDFAC arranged over 1,200 invitational travel orders (ITOs) for family members of sick, wounded or injured Servicemembers. They coordinated and arranged for an assortment of referral services for Servicemembers and their families (such as grief/mental health support, legal consultation, crisis counseling, etc). They have established a network of lodging facilities that include the WRAMC Mologne House, the Fisher House and various hotels in the local community that have accounted for over 20,000 room nights for OIF/OEF patients and family members. In support of this, the MEDFAC has arranged for over $400,000 in grants for lodging and food assistance. They have arranged for the disbursement of over 400 airline tickets for family members at no cost to the family member. The MEDFAC serves as the focal point for family assistance with the myriad of organizations that are friends and supporters of the military community (American Red Cross, United Services Organizations (USO), Fisher House Foundation, Fallen Patriot Fund, Soldiers' Angel Foundation, Walter Reed Society, VA, Disabled Soldiers Support System just to name a few). The MEDFAC can and will continue to broaden its role into peacetime family support operations with the goal of maintaining a ready, responsive organization with available resources for immediate response and activation in crisis situations.

I want to personally thank the Members of Congress for working to amend statutes that restricted our ability to provide appropriate, time sensitive support to our GWOT Servicemembers and their families. The authority granted by this body for injured or wounded GWOT Servicemembers to receive up to $250 for the procurement of civilian attire has had positive effects on soldiers and their families. In addition to seeking statutory changes from Congress, the military is also revising its own regulation to make certain that we have the tools and procedures in place to expeditiously address and assist military personnel and their families during time of uncertainty and bereavement at the injury or loss of a loved one. In late 2003, WRAMC's Staff Judge Advocate established an Expedited Personnel Claims Program (under the Military and Civilian Personnel Claims Act). Soldiers returning from Operation Iraqi Freedom/Operation Enduring Freedom who are combat causalities, or who have otherwise suffered from an in-theater injury or illness, sometimes have had personal property destroyed, or are forced to leave their personal property behind in the care of their units. The expedited personnel claims program simplifies the process by minimizing documentation which allows the majority of claims to be settled in one working day. Reimbursement is speeded by treating the claims as "emergencies" and arranging for electronic funds transfer. Well over 600 claims have been filed, settled and paid under these procedures, with disbursements in the past 15 months in excess of $1M.

In order to facilitate the medical and non-medical needs of our Servicemembers and family members, WRAMC has teamed up with a combination of Federal and State agencies, private sector employers, service-providers, veteran service organizations and DOD support staffs to address four core objectives; (1) identify challenges and solutions to transitioning servicemembers and their families; (2) identify special services that organizations and agencies will provide; (3) identify ways to effectively implement services; (4) insure integration and collaboration. As a result, DOD liaison offices are being established at WRAMC to coordinate the delivery of services to our Servicemembers and their families. Two of the primary HQDA/DOD agencies that have or will have liaison offices at WRAMC are the Disabled Soldier Support System (DS3) and the Military Severely Injured Joint Support Operations Center. The Army's DS3 program is on the cutting edge of providing assistance to soldiers and their families. In April of 2004, the Army introduced DS3, providing severely disabled soldiers and their families with an advocate to support America's sons and daughters as they transition from military service back into their civilian communities.

DS3 provides soldiers and their families with a personal DS3 advocate, called a soldier/family management specialist. This specialist ensures soldiers understand the numerous support programs available to them and provides the soldier with assistance in completing administrative requirements to receive support that is so well deserved. DS3 maintains contact with the Department of Veterans Affairs, Department of Labor and other organizations that assist veterans. Additionally, private sector employers have agreed to routinely sponsor career events at WRAMC; and for the first time at WRAMC, both Department of Labor and the VA will work along with Army Career and Alumni Program Counselors (ACAP) to facilitate Transition

Assistance Program workshops. The intent is to better integrate existing programs to provide holistic support services for our severely disabled soldiers and their families from initial casualty notification to the soldiers' return to his or her home station and final career position. DS3 will also use a system to track and monitor severely disabled soldiers for a period up to 5 years beyond their medical retirements to provide appropriate assistance through an array of existing service providers.

Each of the Services has initiated similar efforts to ensure that our seriously wounded Servicemembers are not forgotten—medically, administratively, or in any other way. To facilitate a coordinated response, DOD has established the Military Severely Injured Joint Support Operations Center. The Joint Operations center is collaborating, not only with the military Services, but also with other departments of the Federal Government, non-profit organizations, and corporate America to assist these deserving men and women and their families. Twenty-four hours a day, 365 days a year, the Joint Support Operations center is a toll-free phone call away.

In closing I have pointed out only a few of the things that we are doing together on behalf of our injured, wounded or ill Servicemembers and their families. I want to again thank members of this great institution for providing us with the funding and resources to execute our mission which is to take care of some of the finest citizens of this Nation. These are the men and women in uniform who have committed their lives and well being to the defense and protection of this great Nation. Finally, I would like to point out that the AMEDD, with WRAMC on the cutting edge, has provided world class health care to injured and wounded members of all the Services and will continue to do so. We have established a strong partnership with the Department of Veterans Affairs facilitated by an unwavering spirit of cooperation in our efforts to provide a holistic approach to taking care of the needs of our Servicemembers and their families.

Thank you.

Chairman CRAIG. Thank you, General. I will be back to you, and you can anticipate that question.

Thank you very much.

Now, let me turn to Dr. Jonathan Perlin, Acting Under Secretary of Health, U.S. Department of Veterans Affairs. As I mentioned earlier, he is accompanied by Robert Epley, Deputy Under Secretary for Policy and Program Management, Veterans Benefits Administration.

Doctor, welcome, again, before the Committee. Please proceed.

STATEMENT OF JONATHAN B. PERLIN, M.D., PH.D., MSHA, FACP, ACTING UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT EPLEY, DEPUTY UNDER SECRETARY FOR POLICY AND PROGRAM MANAGEMENT, VETERANS BENEFITS ADMINISTRATION

Dr. PERLIN. Good morning, Mr. Chairman and Ranking Member Akaka. Thank you, both, very much for the opportunity to appear today and for the privilege of submitting a written statement for the record.

I would also like to introduce our own example of seamless transition. I am accompanied as well by Dr. Michael Kussman, Major General, Retired, but former Commander of Walter Reed Army Medical Center.

Let me begin by telling you how humbled my colleagues and I are by the heroism of Major Tammy Duckworth. She personifies the point of VA's commitment, our mission to care for those who have borne the battle and our pledge to constantly improve and do our best for America's newest heroes.

Mr. Chairman, the Veterans Health Administration has no higher calling, no more important mission, than to provide exemplary health care to our Nation's combat disabled veterans. Providing

true care means more than providing health services that are technically sufficient. True care means that we must honor these heroes and their families by providing them with compassion and dignity and by coordinating every possible service and support activity that may help improve their functioning and restore them to their rightful place in our society.

VHA, the Veterans Benefits Administration and the entire department are reaching out to all new combat veterans in unprecedented ways. Since fiscal year 2002, we have spoken to more than 700,000 active duty servicemembers, members of the Reserves and National Guard in discharge planning and orientation sessions. Secretary Nicholson and Secretary Principi have sent more than 230,000 thank you letters, with information brochures, to each OIF and OEF veteran identified by DOD as having left active duty. We have prepared videos, wallet cards and websites to assure that they are aware of their eligibility for VA health care and benefits.

Each VA medical center has identified a point of contact to coordinate activities locally and to assure the transition from military to veterans health care not only provides clinical data, but also conveys a full picture of the person we care for. To assure this, VA has also assigned full-time social workers and benefits counselors to seven military treatment facilities to facilitate immediate, comprehensive and compassionate care and family support. They have coordinated more than 1,900 transfers of OIF and OEF servicemembers and veterans to VA medical centers.

Forty-eight thousand seven hundred and thirty-three veterans, out of approximately two hundred and forty-five thousand separating servicemembers, have sought VA care as of December 2004. In general, the medical issues that we see are those we might expect to see in a young, active military population—musculoskeletal, dental and psychological. However, one of the harshest realities of modern warfare is the number of servicemembers returning with major and multiple trauma, including amputation, spinal cord injuries, traumatic brain injuries or combinations of all of these.

We are expanding the scope of VA's four regional Traumatic Brain Injury Centers and creating true Polytrauma Centers, with additional clinical expertise to address the special problems that multi-trauma, combat-injured patients face. Our goal is to coordinate these services across traditional disciplinary lines and, to the extent possible, meet all rehabilitative needs simultaneously, not sequentially.

Another reality is that some of those who serve in combat will return home with mental health issues requiring treatment. Veterans and their families, as well as Members of Congress and GAO, may be concerned about the potential for high incidence of post-traumatic stress disorder or PTSD among returning OIF and OEF veterans. They may also be concerned with VA's ability to properly care for veterans with PTSD. While some adjustment problems are normal and can be treated successfully at VA's Vet Centers, PTSD differs from other adjustment disorders in that it is not necessarily time-limited.

This fiscal year, we have allocated $100 million more to implement initiatives contained in the Department's Mental Health Strategic Plan. The President's fiscal year 2006 budget proposes to

supplement this with an additional $100 million. These initiatives will benefit not only veterans with PTSD, but all veterans receiving mental health care from VHA.

As of December 2004, 6,386 OIF and OEF veterans—only about 2 percent of VA's total number of PTSD patients—have been referred for evaluation or diagnosed with potential PTSD at VA facilities. I am confident that the President's budget contains sufficient funding to allow us to provide world-class care for veterans with PTSD and to meet all of the health care needs of OIF and OEF veterans.

In conclusion, Mr. Chairman, VA has embraced the opportunity to serve this newest generation of returning war heroes by reinventing existing programs, enthusiastically creating outreach initiatives, enhancing specialized clinical services and collaborating with our DOD partners to share access to health records.

I have had the privilege of meeting many of these heroes and discussing their needs with them and their families. Although I am very proud of what VA has done before and already, I know that we can never do enough. We have an opportunity to heal their wounds and restore them to their rightful place in our society. I promise you, and I promise them, that we will make the very most of that opportunity.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Perlin follows:]

PREPARED STATEMENT JONATHAN B. PERLIN M.D., PH.D., MSHA, FACP, ACTING UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

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 servicemembers 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 servicemembers 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 vet-

erans 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 fiscal year 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 servicemembers and new veterans, including producing numerous pamphlets, brochures, and videos to more than 209,000 returning servicemembers. VA has increased the overall briefings on VA benefits to returning servicemembers, including Reserves and National Guard members, from 5,300 briefings with 197,000 attendees in fiscal year 2003 to 7,200 briefings to over 261,000 attendees in fiscal year 2004. In January 2005, we have already provided 2,260 briefings to 79,000 returning servicemembers.

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, cochaired 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 servicemembers is enhanced to the extent that we can obtain accurate health care information from DOD in the shortest timeframe 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 servicemembers 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 records; 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 fiscal year 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 Servicemembers. 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 servicemembers. 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 servicemembers and veterans. Throughout the process, we have greatly improved dialog and collaboration between VA and DOD.

Many servicemembers 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 servicemembers receive information and counseling about VA benefits and programs. They also coordinate the transfer of active duty servicemembers 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 servicemembers who have sustained serious injuries or illnesses while serving our country. VHA staff have coordinated more than 1,900 transfers of OIF/OEF servicemembers and veterans from an MTF to a VA medical facility. VBA benefits counselors are also stationed at MTFs 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 servicemembers 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 servicemember is still on active duty. For the most seriously injured, the military services now work with VA to determine the discharge date (usually 3 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 MTFs, 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 servicemembers 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 servicemembers 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 servicemembers 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 servicemembers who served in OIF/OEF, it is intended to become an enduring process that will support all servicemembers 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 servicemembers, 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 servicemembers, and we have expanded our collaboration with DOD to enhance outreach to returning members of the Reserves and National Guard. Since fiscal year 2002 through the 1st quarter of the fiscal year 2005, VBA military services coordinators have conducted more than 19,000 briefings, reaching a total of more than 700,000 active duty servicemembers. These briefings include 1,795 pre- and post-deployment briefings attended by over 88,000 activated Reserve and National Guard servicemembers. During fiscal year 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 USOs. 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 servicemembers 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 offsite functions such as health fairs.

As servicemembers 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 servicemembers, 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 websites 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 servicemembers 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 2-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 2-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 1 percent of our total veteran patients (4.7 million in fiscal year 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

servicemember 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 fiscal year 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 2 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 fiscal year 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 President's fiscal year 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 servicemembers 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 servicemembers 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 servicemembers 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 data base 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 data base 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 servicemembers 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 fiscal year 2005 and fiscal year 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 servicemember 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 providers 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.

Chairman CRAIG. Doctor, thank you very much. We do appreciate that statement.

Now, let me turn to Cynthia Bascetta, Director of Veterans' Health and Benefits at the Government Accountability Office.

Welcome.

STATEMENT OF CYNTHIA A. BASCETTA, DIRECTOR OF VETERANS HEALTH AND BENEFITS, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. BASCETTA. Thank you. I apologize for this gravelly voice. I hope you can hear me.

Mr. Chairman, Senator Akaka and Senator Rockefeller, I am very pleased to be here to provide GAO's perspective today on these important issues. As you know, Major Duckworth's experience and the continuing deployment of our military forces compel us to reaffirm our commitment to ensuring effective and efficient management of the VA programs on which many of them will come to rely.

My testimony is based on three reports; one on vocational rehabilitation and employment services for the seriously injured; and, two, on post-traumatic stress disorder. We conducted our work at major MTFs, where most seriously injured servicemembers are initially treated, including Walter Reed, as well as several VA medical

facilities. I would like to highlight the steps VA has taken and the challenges we believe it faces in providing services to the seriously injured, especially those servicemembers transitioning to veteran status.

I would like to emphasize, first, that VA has placed the highest priority on serving the seriously injured. Through collaboration with DOD, servicemembers in some locations are even receiving services while they are still on active duty. For example, VA has expedited vocational rehabilitation services by taking steps such as assigning social workers and benefits counselors to MTFs in certain locations. Walter Reed is the model for this approach.

Similarly, VA requires that every returning OEF/OIF servicemember receive priority consideration for health care appointments. Notably, in contrast to previous wars, both VA and DOD are taking steps to screen and provide treatment for combat-related psychological injuries, particularly PTSD. While we commend these steps, our work so far indicates that VA may face significant challenges in achieving its goals.

One inherent challenge is the difficulty VA providers face in determining when a seriously injured individual may be receptive to assistance. The uncertainty of the recovery process is just one of many complicating factors. To ameliorate this, we recommended that VA establish a policy for maintaining contact with servicemembers who initially decline vocational rehabilitation. In the absence of such a policy, some regional offices reported that they do not stay in contact, while others reported a variety of methods and timeframes for routine follow-up. As a result, some who could benefit from services may be overlooked.

Another challenge is that VA has been unable to obtain systematic data about seriously injured servicemembers from DOD. VA requested lists of servicemembers being evaluated for medical separation who might be likely to turn to the VA. VA and DOD have been working on a Memorandum of Agreement but, in the meantime, VA has had to rely on ad hoc regional office relationships to identify those who might need vocational rehabilitation. This is particularly troublesome because early intervention is critical for the most successful outcomes.

DOD officials reported concerns about the potential adverse effect on retention if servicemembers were informed of their entitlement to VA benefits. They also cited potential privacy issues as impediments to sharing health information. Such information, particularly about psychological injuries, would, of course, be especially sensitive but, at the same time, VA would be better-positioned to plan for the projected influx of at-risk and newly diagnosed veterans with PTSD and other psychological injuries if it had better data from DOD.

Mr. Chairman, the dilemma is that issues like these, if not resolved, constitute challenges for the seamless transition overall, as well as for the health and welfare of individual servicemembers and veterans. Overcoming these challenges will require VA and DOD to continue and improve on their efforts to work closely so that seriously injured servicemembers and veterans receive the care they need.

In our ongoing work on PTSD, mandated by the National Defense Authorization Act of 2006, we are assessing the methods DOD and VA have established to identify and treat those returning from the OEF/OIF conflicts with or at risk of developing PTSD.

A critical component of our work will be our continuing review of the efforts of the two departments to build on the collaborative efforts they have engaged in so far for the benefit of the active duty forces as well as veterans.

I would be happy to answer any questions that you might have.

[The prepared statement of Ms. Bascetta follows:]

PREPARED STATEMENT OF CYNTHIA A. BASCETTA, DIRECTOR, HEALTH CARE, VETERANS HEALTH AND BENEFITS ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

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.

Chairman CRAIG. Cynthia, thank you very much for that testimony. Let me start right with you and go forward.

We keep hearing, and I mentioned, certainly, in some of my comments, an effort to create a seamless transition and you, I believe by your testimony, are suggesting that if the seams are there, the threads are not joined in all instances. Informational flow is critical. Understanding the conditions, situation, but more importantly the individuals involved.

In your opinion, how has the lack of data, as you have stated it, sharing agreement or I should say impeded VA's ability to assist severely injured servicemen or servicemembers?

Ms. BASCETTA. Well, first of all, let me say that there is total buy-in on the seamless transition. I have not detected an unwillingness or a lack of commitment.

Chairman CRAIG. I do not dispute that either.

Ms. BASCETTA. It is a work in progress. I would just want to make that clear from the onset. But I think the risk in not continuing to make sure that it truly is seamless is that servicemembers and veterans, as they transition to veteran status, may be overlooked, may not be able to avail themselves of all of the benefits, and that is health benefits as well as vocational rehabilitation to which they are entitled. This is why we are so interested in following up and looking at not only the policies for the seamless transition, but the actual implementation of those policies.

Chairman CRAIG. Well, thank you. We will follow up, too, and continue to do so as we proceed through this.

Dr. Perlin, we are going to make it a part of the record.

[The letter referred to follows:]

THE SECRETARY OF VETERANS AFFAIRS,
Washington, DC, March 8, 2005.

Name of Veteran
Street Address
City, ST, 00000–0000

DEAR VETERAN: We at the Department of Veterans Affairs (VA) thank you for your service to our country. We are grateful to all the men and women who risked their lives to fight terrorism in Afghanistan, Iraq, and many other places around the world. America is more secure because of your participation in these hazardous operations.

You received this letter because the Department of Defense notified VA that you have been released from active duty although you may still be a member of the Reserves or National Guard. If this is not the case the information which follows will not apply to you until you are released from active duty. If you are still a member of the Reserves or National Guard the following information does apply to you.

VA can offer you a wide range of health care benefits and assistance to aid in your transition to civilian life. VA can provide combat veterans with 2 years of free health care for any health problem that is possibly related to service in a designated area of military conflict. It can also pay compensation for service-connected disabilities and provide other benefits.

Information about health care and benefits is provided in the enclosed brochures:
A Summary of VA Benefits
A Summary of VA Benefits for National Guard and Reserve Personnel

Our benefits offices and medical centers will assist you. If you have questions about benefits or health care you can contact VA toll-free by dialing 1–800–827–1000 for benefits information and by dialing 1–877–222–8387 for information on health care eligibility. You may also visit the VA website at *www.va.gov*. The VA home page links to the Iraqi Freedom/Enduring Freedom website that describes benefits for returning veterans.

If you need help with personal and family concerns following your return from military service, or with other community readjustment issues such as finding a job, please contact a Vet Center which you can locate by calling the toll-free numbers above or by visiting *www.va.gov/rcs*.

On behalf of President George W. Bush and a grateful Nation, thank you for your service.

Sincerely yours,

R. JAMES NICHOLSON

Chairman CRAIG. We have a copy of the letter that the Secretary sends out to veterans that certainly I think has some valuable information in it as part of that transitional environment that we are talking about. At the same time, we want to make sure he is sending them out to all veterans and that those nameless are complete and that DOD and VA are appropriately working together to make sure that happens.

Are you confident at this time that you are getting all of the necessary information, the necessary individuals who are transitioning out and that you are gaining access to them in the way you expect to and should?

Dr. PERLIN. Well, first, Mr. Chairman, thank you very much for the opportunity to describe the ongoing process of seamless transition. This is, as Ms. Bascetta said, a work in progress, and I am very confident about the work that has been done. I am extremely appreciative for the 245,000 names that have been provided to us, but there is work to be done and, under the aegis of our Joint Executive Council chaired by our Deputy Secretary and the Under Secretary of Defense for Manpower and Readiness, we are building toward a joint electronic record, an interoperable health record, and we believe that will be the final culmination of seamless information.

We expect initial operation of that in October of 2005. In the interim, we appreciate any and all efforts from the Department of Defense to provide information about any separating servicemembers, particularly those individuals who are going through the physical evaluation board, so that we can best anticipate and meet their needs both in terms of benefits and health services and so we have a plan we have great confidence in.

We have an appreciation for what has been done. We recognize that there is additional work that needs to be done.

Chairman CRAIG. Doctor, there are some in Congress that suggest we should extend the period from 2 to 5 years during which a veteran from Operation Enduring Freedom or Operation Iraqi Freedom may enroll in VA's health care system and be exempt from copays. We have also heard in the panel just before you this rush to get home, not all are listening, reality is not setting in. Do you feel or does VA support such an extension of time?

Dr. PERLIN. Mr. Chairman, thank you for that question. You recognized absolutely correctly that the servicemember has a choice between two lines, one that says "go home" and the other that says "more boxes to check." Understandably, they go for the "go home."

This is why it is so important that we give them materials that are durable, these cards that identify that 2-year eligibility, which is tremendously important.

The Department does not have an official position on this yet. I think it is important to note that the individuals who do present during that 2-year period can continue on for any care that they might need. If they have service-connected conditions, certainly, they remain eligible to receive care for those. Should a veteran ever present to VA, say, 10 years out with a service-connected condition or a condition that they feel might be service connected, including something such as symptoms of PTSD, they certainly can be evaluated for that condition and could be service connected in perpetuity for the care that is required.

Unfortunately, we have no Department position. We welcome those veterans and appreciate your encouragement for veterans to come seek us out in that 2-year window.

Chairman CRAIG. I am running out of time. I am going to ask one more question. I am not confident we will have time for another round, so, General, I must get to you, and I want you to answer the question that you have asked or you have anticipated.

General FARMER. Yes, sir.

Chairman CRAIG. I think that is most important, and I also in doing so would ask has DOE considered——DOD considered—see, I wear another hat, and it is the Energy Committee, so I am DOD'ing, I suspect sometimes.

[Laughter.]

Chairman CRAIG. Has DOD considered partnering with VA and sending severely injured servicemembers to a local VA facility in their community with friends and family while the PEB decision is pending rather than keeping them at a military treatment facility? If you would speak in those parameters, please.

General FARMER. Yes, Mr. Chairman. I am happy to respond to that.

First, I would tell you that when we keep a casualty at Walter Reed or any other military treatment facility, it is generally because of their wishes or the family's wishes or for continuity and completion of care.

Second, through invitational travel orders and other means of assistance to include financial assistance for families, when we cannot get the soldier there, we are usually getting the family here. Our Malogne House Hotel on the Walter Reed campus, the three Fisher Houses and a substantial number of rooms in other local hotels have turned into that family away from home, to have the family here with the soldier when it is not appropriate or possible to get the soldier home.

Third, we do get many servicemembers, and it is our general approach and policy to get the servicemember to the medical treatment facility that is closest to their home or to their duty station, that is appropriate and capable of delivering their care.

Fourth, as noted in my testimony and in direct response to the final part of your question, we do get many others to VA medical centers, even while the medical evaluation board and physical evaluation board are in progress and while they are still on active duty and particularly for things where the VA has a specialty center—

I mentioned the spinal cord injury, traumatic brain injury and a number of other specific niches.

Finally, the Community-Based Health Care Organizations—CBHCOs—that have been created in response to these casualties returning from Iraq and Afghanistan, under the oversight of the National Guard Bureau, offer an opportunity to get many soldiers back living at home, under a command and control organization under the National Guard Bureau of State, with duty at or near their home and getting their care in the local community and often with the VA. These were established last year, initially, in Massachusetts, Florida, Wisconsin, Arkansas and California, and we have recently added Virginia, Alabama and Utah. And those eight States cover soldiers from all of the 48 contiguous continental States.

So, in summary, I think we are providing a number of options or choices, when and where appropriate, to get the casualty to the most appropriate place and a place closest to their home or duty station.

Thank you, sir.

Chairman CRAIG. General, thank you very much.

Let me turn to Senator Akaka.

Danny?

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

Dr. Perlin, I understand that VA has created a temporary database to list the servicemembers treated at each military treatment facility. I do not see how you can ensure seamless transition without knowing what patients are in the system. I was surprised to learn that VA did not already have this, and maybe you can correct me on that. How did you track servicemembers at MTFs prior to the establishment of this database?

Dr. PERLIN. Thank you, Senator Akaka for the question.

First, let me state that VA, for the first time, actually has VA personnel located at Walter Reed Army Medical Center, National Naval Medical Center, Madigan, Eisenhower, Brooke, Fort Hood, and Fort Carson. And so we actually are very much aware of those individuals who will be coming from one of the military treatment facilities into VA.

Our Seamless Transition Task Force, now operationalized as a full seamless transition office, is the owner of this database. That office was established, formally, on January 3rd of this year, but the actual program has been operational now for 18 months.

So we track each and every individual who is going to come for VA service, be it a new veteran who has separated from active duty, Reserve and Guards included, or an active duty person who is seeking specialized care anywhere within VA under a Tricare arrangement. So we know each and every individual who has come into VA. With the advent of the office, we provided some additional reporting and are pleased to provide to your office and to the majority side a monthly report, so you really do see the physical manifestation of that seamlessness of transition.

Senator AKAKA. Well, I was glad to see the letter that the Chairman shared with me, dated March 8th, that the Secretary is making this effort directly to veterans as they separate from active duty.

Major Farmer, I commend you for the many collaborative efforts and holistic approach utilized by the North Atlantic Regional Medical Command and also VA. I am pleased to learn more about the initiatives in place to assist the injured servicemembers and their families.

Can you tell me what is being done to assist servicemembers who have what we have been talking about: "invisible" wounds, such as post-traumatic stress disorder? How do they fit into programs such as DS–3?

General FARMER. Yes, sir. Thank you, Senator Akaka.

There are a myriad of ways in which we have responded to and started new initiatives to help those with mental and stress-related concerns. As you are aware, we last year sent in a Mental Health Advisory Team into theater with psychiatrists, psychologists, social workers, chaplains, counselors in to talk with soldiers, to talk with commanders, to talk with others and to assess the care and the availability of those with concerns in theater. We have sent that team back recently to do a relook, and we have actually responded to those concerns.

As you know, we have Combat Stress Control Teams in theater that are there to practice early intervention before one really becomes ill with a mental illness and to advise commanders, as well as having Mental Health Treatment Teams also associated with our hospitals, and health care organizations, and embedded in the divisions in the theater.

Back here on this side, a number of things. Our Deployment Health Clinical Center that was set up at Walter Reed after the Gulf War, which, in its early days, focused especially on those with physical symptoms without explanations. That population which we often refer to as "Gulf War illnesses," has, over the past year, formed a new track or program called Track 2 to focus specifically on those with psychiatric, psychologic trauma concerns and post-traumatic stress disorder, and they have set up a referral center and a program where we can bring those in to deal with that.

Finally, I would tell you that the post-deployment health survey that every soldier coming out of the theater fills out, either as they exit the theater or as they redeploy here, was amended last year. The length of that survey was doubled. What was specifically added were two pieces—one to get more at the stress-related and mental concerns and, second, to get at the occupational and environmental exposures.

So, Senator, we have much left to do, but I think we are doing many new initiatives to get at and respond to those kinds of concerns.

Senator AKAKA. Thank you very much, Mr. Chairman. My time has expired. I will submit my questions for the record.

POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA, U.S. SENATOR FROM HAWAII TO DEPARTMENT OF VETERANS AFFAIRS

Question 1: I am pleased that VA will be spending $100 million on the Mental Health Strategic Plan. How exactly will this money will be spent and on which programs?

Response: The Veterans Health Administration has established priorities for additional funding of programs based on the recommendations of the Secretary's Mental Health Task Force as well as the initiatives contained in the Mental Health Stra-

tegic Plan. Areas identified for priority funding are expansion of PTSD services, OIF/OEF post deployment mental health services, expansion of Substance Abuse programs, expansion of mental health services in CBOCs, creation of new Mental Health Intensive Care Management teams and programs for the SMI (Seriously Mentally III) veteran, new Homeless Domiciliaries, and creation of case manager positions for the Grant and per diem program.

New CARES projections for mental health services were completed in Fall 2004 and provided to the field in January 2005. This data is broken down by mental health program and is specific to the CARES markets. These data are available to the VISNs who will now be able to identify where there may be gaps in services within their markets. The $100 million will be used to correct service gaps once the Networks provide specific strategic plans on how these gaps need to be addressed. Priority for funding will be based on service need as identified by the Networks. The Under Secretary for Health has agreed to establish a team of mental health experts to continue to work with the actuarial data to develop a model that attempts to identify the gap.

VA plans to spend an additional $100 million in fiscal year 2006, in addition to the $100 million in fiscal year 2005, on mental health initiatives as outlined in the strategic plan as follows:

1. $29 million for continued expansion of Post Traumatic Stress Disorder (PTSD) services and Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) mental health services;
2. $10 million for Homeless Domiciliaries;
3. $20 million for continued expansion of substance abuse services;
4. $20 million for continued expansion of mental health in Community-Based Outpatient Clinics (CBOCs);
5. $4.5 million for Mental Health Intensive Case Management (MHICM) teams and Serious Mental Illness Services' expansion;
6. $4.5 million for Homeless Initiatives, which includes an additional $500,000 to be taken from the $35 million set aside in FY06 for non-recurring residential treatment infrastructure funding;
7. $9 million for Telemental Health (addresses rural mental health initiatives contained in the Mental Health Strategic Plan);
8. $2.4 million to fund an Inpatient Psychiatry Unit at the Lexington, Kentucky VA Medical Center (Network 9); and
9. $600,000 for education programs developed by the VHA Employee Education Service (EES).

Question 2: At both the VA and DOD Committees I have heard that a joint computerized patient record is on its way any day now. Please explain what the delay is and what can be done to break the logjam?

Response: VA and DOD are committed to development of interoperable electronic health record systems. VA and DOD have achieved interoperability on multiple levels including the Federal Health Information Exchange (FHIE), the Bi-Directional Health Information Exchange (BHIE), and the Joint Electronic Health Records Interoperability Plan—HealthePeople (Federal) Plan (JEHRI), each of which is described in more detail below. Significant and steady progress toward this goal is evidenced by having successfully implemented one-way and bi-directional data exchanges.

FHIE: In June 2002, VA and DOD began implementation of the first phase of the Plan, the (FHIE), enabling DOD to transmit laboratory, pharmacy (outpatient and retail), radiology, admission, disposition and transfer (ADT), consult, discharge summary, allergy and coding data on separated servicemembers from DOD's Composite Health Care System (CHCS) to a data repository for use and viewing by VA clinicians in VA's Vista Computerized Patient Record System (CPRS).

FHIE is fully deployed across all VA medical centers and usage is monitored closely by the Departments. Since implementation, DOD has transferred over 10 million clinical records associated with 2.9 million unique patients. Of this number, over 1 million have presented to the VA for care and treatment. Every month, DOD continues to send updates that include approximately 10,000 unique DOD patients to the shared FHIE repository on separating and retiring servicemembers.

BHIE: Having successfully implemented a one-way transfer of electronic health data, the Departments identified an additional opportunity to leverage the work and lessons learned as part of FHIE. In October 2004, the Departments implemented Cycle I of the DOD/VA BHIE at the Madigan Army Medical Center (Tacoma, Washington) and the VA Puget Sound Healthcare System. BHIE Cycle I was next implemented between the William Beaumont Army Medical Center and the EI Paso Texas VA Healthcare System. BHIE Cycle I permits these facilities to share in real-time patient demographic, allergy, and pharmacy data. The Departments are now

testing Cycle II of BHIE and preparing for a third quarter fiscal year 2005 release. Cycle II will add the capability to exchange in real-time laboratory result data and radiology report text data.

JEHRI: In addition to BHIE, in 2002 VA and DOD sought and obtained approval from the Office of Management and Budget to implement the VA/DOD JEHRI Plan. VA and DOD are implementing Phase II of the JEHRI Plan. Pursuant to Phase II, VA and DOD will achieve interoperability of next-generation health information systems, CHCS II and HealthVet-VistA, through the DOD Clinical Data Repository (COR) and the VA Health Data Repository (HDR) by October 2005. This interface, which is known as "CHDR" will support the bidirectional exchange of computable data. In October 2004, VA completed a successful CHDR demonstration using a pharmacy prototype in a lab environment. The Departments are presently on target to complete the CHDR interface by October 2005. The initial domains of data that will be shared include pharmacy, allergy, laboratory, and demographic data. CHDR will also permit the Departments to perform drug/drug and drug/allergy interaction checking in one another's health information systems and to implement standards approved by the interagency Consolidated Health Informatics initiative.

Question 3: In your statement you report the number of veterans with PTSD utilizing facilities, making the point that this is a relatively small group. What projections do you have about delayed PTSD in these returning troops?

Response: VA anticipates that the great majority of OEF/OIF veterans will not suffer long-term consequences of their war zone experience, although many will have some short-term reactions to the horrors of war. Of those who do develop mental/emotional problems, PTSD will not be the only issue. Major depression and substance abuse are two issues that can be anticipated. In his July 2004 *New England Journal of Medicine* article, Col. Charles Hoge cites an incidence of 17 percent positive screens for PTSD, depression, and anxiety disorders 4 months post-return from combat in an anonymous survey of Army and Marine troops from the Iraq and Afghanistan theaters.

Studies of Veterans of the Vietnam War, which bears many similarities to the current conflict especially in Iraq, indicated an incidence of 15 percent PTSD 5–20 years after the war. Considering the outstanding efforts of in-theater DOD Combat Stress Control Teams, and combined DOD/VA efforts at early identification and management of problems before they deteriorate into established mental disorders, it is reasonable to anticipate an incidence of 10–15 percent of war zone troops with mental disorders.

Question 4: GAO argues that VA may not be able to meet an increase in demand for post-traumatic stress disorder care. Early numbers indicate that you are going to have major increases in demand for care. What assurances can you give the Committee that you will be ready for new veterans and will continue to care for those already in the system?

Response: VA Mental Health is fully prepared and poised to treat the mental health needs of any of our newest veterans who are returning from OIF/OEF.

Number of Veterans Served: 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. To put this number in the context of our capacity, in fiscal year 2004, we saw approximately 279,000 patients at VA health care facilities for PTSD alone and 63,000 in Vet Centers. Thus OIF and OEF veterans account for only about 2 percent of VA's PTSD patients.

VA has created a number of tools to assist staff in meeting returning veterans' needs. A "pop-up" screening tool prompts clinicians to ask a series of questions to assess the possibility of PTSD, depression and alcohol abuse. VA's National Center for PTSD (NCPTSD) in collaboration with colleagues at Walter Reed Army Medical Center created and recently revised an Iraq Clinician War Guide available as a CD-ROM and on the NCPTSD website. VA has placed skilled staff in each VA Medical Center and has instituted outreach to demobilization centers by Readjustment Counseling (Vet Center) and VBA staff.

For those who have mental disorders, VA's orientation involves the concepts of rehabilitation that address a patient's strengths as well as deficits. It embodies a belief in recovery of function to the greatest degree possible for each patient. For veterans suffering from PTSD, VA provides state-of-the-art psychotherapy and psychopharmacology treatments.

VA/DOD Efforts: The joint VA/DOD Clinical Practice Guidelines direct evidence based care for PTSD and other disorders that may be associated with PTSD and

the stress of war such as major depression and substance use disorders. VA provides this care through 144 specialized PTSD programs across the Nation.

There are PTSD programs in all States. The PTSD programs include specialized inpatient PTSD units, residential treatment units, and outpatient PTSD clinical teams. VA's ongoing PTSD program evaluation indicates improvements in PTSD symptoms and functioning in patients treated by VA for PTSD. In FY04, VA spent more than $3 billion on the provision of treatment services (medical and psychiatric) to veterans with a mental illness.

Readjustment Counseling Service (RCS): RCS takes the lead in providing outreach services through the 207 community based Readjustment Counseling Centers (RCS), often called Vet Centers, throughout the United States. Fifty additional Global War on Terrorism Counselors have been added to these centers to meet this need. In addition, the Secretary has expanded authority for RCS to deliver bereavement counseling to those in need.

Mental Health Strategic Plan: To position VA for future needs, as noted in the reply to Question 1, $100 million in fiscal year 2005 was allocated to implement initiatives contained in the Department's Mental Health Strategic Plan. The President's fiscal year 2006 budget submission proposes an additional $100 million for mental health initiatives. These initiatives will benefit all veterans receiving mental health care from VA and include OEF/OIF outreach programs designed to provide preventive health services that should, in many instances, identify issues and address them before they require more extensive clinical intervention.

These enhancements will also address increased clinical needs of returning veterans and existing veterans who come to VA for PTSD care and provide funding for substance abuse disorder programs.

As part of VA's overall outreach effort, letters are sent from the Secretary of Veterans Affairs to all returning troops informing them of the availability of VA to meet their healthcare and readjustment needs, including the 2-year eligibility for care provided under Directive 2002–049.

POST-HEARING QUESTIONS SUBMITTED BY HON. JOHN ENSIGN, U.S. SENATOR FROM NEVADA, TO JONATHAN B. PERLIN, M.D., PH.D., ACTING UNDER SECRETARY OF HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Question 1: Secretary Perlin: I understand that there were some comments by Members of the House of Representatives regarding the status of the future Las Vegas Veterans Hospital. Those comments alluded to the fact that that hospital was not a "done deal" and caused much concern amongst the Veterans community in Nevada.

Please elaborate on your understanding of the status of the Las Vegas Veterans Administration Hospital?

Response: The Department of Veterans Affairs (VA) plans to construct a comprehensive medical center in Las Vegas, as included in VA's budget request for fiscal year (FY) 2006. Funding for a 120 bed VA nursing home will be considered for the FY 2007 budget, and the facility is currently scheduled to open in FY 2010. The total cost of the comprehensive medical center and long term care facility is $286 million. Construction of the project will begin in 2007.

A parcel of approximately 152 acres, formerly under the control of the Bureau of Land Management, has been legislatively transferred to VA. The environmental assessment, a site utility study, as well as geotechnical and topographic surveys are ongoing.

A project architectural design contract has been awarded to a joint venture between RTKL Associates, Inc., a national architectural and engineering firm in Washington, DC, and JMA Architectural Studios in Las Vegas, NV. Each has significant expertise in health care design. The schematic design is progressing and a preferred conceptual design option has been selected. Meetings with medical center staff to develop department layouts are ongoing. The negotiation for schematics design development, and construction documents have been completed and a contract award is being processed.

The first construction contract will be awarded in August 2006 to include road construction, site grading, off and on-site utility infrastructure development and construction of a central energy plant. Additional contracts will be awarded as appropriate.

VA is also planning to lease a minimum of four Community Based Outpatient Clinics throughout the Las Vegas Metropolitan Area to meet approximately 50 per-

cent of primary care needs of Las Vegas area veterans. This will allow many veterans the opportunity to continue to receive their primary care close to their home.

The Las Vegas Metropolitan Area is one of the fastest growing in the nation. VA is committed to meeting the growing healthcare demands of Nevada's veterans.

Question 2: Secretary Perlin: Rural healthcare is of vital importance to the veterans of northern Nevada. Those who live in Elko must travel to Salt Lake City, a drive of more than 5 hours to get some of their healthcare needs met. I know that Elko failed to meet the CARES Commission population standard of 7,000, but isn't there something that the VA can do to address this situation?

Response: Elko did not meet the population threshold of 7,000 required to establish a community based outpatient clinic (CBOC) at the time of the May 2004 Capital Asset Realignment for Enhanced Services (CARES) Decision. However, the Veterans Integrated Service Network (VISN) 19 can propose a new CBOCs independent of the CARES Decision. In addition to veteran population, factors such as veterans' demands, travel time to VA facilities, and the inherent obstacles that rural areas face are taken into consideration when submitting their CBOC priority list to Central Office for review. A CBOC at Elko, Nevada will likely be a high priority based upon the fact that it is the largest population area in VISN 19 without a CBOC.

Question 3: Secretary Perlin: John Bright is currently the Acting Director of the VA Southern Nevada Healthcare System. Every Veterans organization in my state is anxious to change the "acting" to "permanent."

What is the status of this appointment?

Response: As of May 1, 2005, John Bright was appointed as the Director of the VA Southern Nevada Healthcare System.

Chairman CRAIG. Danny. Thank you very much.

Now, let me turn to Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. Mr. Chairman and Senator Akaka, I hope you will forgive me if I reflect a little bit on 21 years of history on this Committee with respect to some of the issues that we are talking about.

I can remember very shortly after I got here that we had sitting back there in a wheelchair an atomic radiation veteran who was a victim of the testing that was done in the Pacific in the 1940s and 1950s, and there were thousands and thousands of those people. He described what it was like to die, to be in the process of dying, knowing that his Government was not there for him and that he could not prove to the Government's satisfaction that there was a cause between his cancer and his service, but he knew. That brings up the whole argument of presumption.

The Government did not really have any interest in what I had to say at the time, and it was not until years later that we got some legislation passed that got some help for those folks back in the 1940s and 1950s. He had long since died, of course.

Second, I am thinking back to the Agent Orange crisis. I do not remember the DOD or the Veterans Administration being anywhere particularly on that issue, and I do not remember the Congress being anywhere on that issue. I remember the people who were affected by Agent Orange being somewhere on that issue, and that was in great pain and great suffering.

In fact, it is ironic and tragic, but thank heavens, it happened, it really was not, as I remember it until Admiral Zumwalt came before a committee and pointed out that his son was dying from cancer from Agent Orange, and then years later the Congress did something about that. I do not remember advocacy from the military or the VA community.

I go back later to the Persian Gulf War Syndrome. I mentioned that, and I will mention it again because I was angry about it 10 years ago, and I am angry about it today, that the Defense Depart-

ment absolutely denied it, fought it. We had experts on this Committee. I was Chairman at the time. We did a full investigation of it. They pooh-poohed it, and there was no recognition. It was kind of, again, you are maybe a little stressed, get a good sleep, take some aspirin. That made me very angry then. It makes me very angry now. We may be doing better on that.

So this has not been what I would call a distinguished history of automatic sympathy and people reaching out to help each other. I am going to say something else. I apologize to the Chairman, but I am speaking from my heart.

Mr. Perlin was asked whether he supported Senator Akaka's bill to extend care from 2 to 5 years for veterans returning now from Iraq and Afghanistan. I certainly do, and I think it is a great piece of legislation. You said you did not have a position.

That leads me to another thing about, Mr. Chairman, this whole business of hearings. I do not think that any of the men and women who have testified—except I suspect you [Cynthia Bascetta] can say whatever you want. The deal is, when you have a hearing in Congress, if you are a Senator, do not for a moment think that people are just talking off the top of their heads, they sat down the night before and wrote out some testimony. That testimony has all been vetted by OMB or the Administration. So that if you do not have a position—Mr. Perlin, you do have a position, and you are for that legislation, but you cannot say that. You cannot say that because you are not allowed to say that because of OMB, because of the budget crisis, but I think you have a duty to say that. I do not want you to be fired.

But we cannot accept that he does not have a position, Mr. Chairman, when there is that kind of—and that is true in all committees, all Cabinet Secretaries, Assistant Secretaries, Deputy Secretaries, whenever they come up, every one of their testimony is vetted and has to be approved by OMB, and if it does not fit into the President's budget plan or his plans, it will not be sent. So that brings into question the whole what is a hearing? What really is a hearing?

So I come at it a little bit with that. I want, profoundly, to be helpful to Major Duckworth and to the folks that I saw coming back last Saturday, to the Vietnam vets that I meet when I go into a Vet Center in West Virginia. You see people that are sort of dressed like I am, and you think, well, they must be some group of accountants in to audit the Vet Center. No, I am sorry. They are Vietnam vets who are there for PTSD treatment. They just do not happen to look like that is what they are looking for, but they are. Just like the unemployed people will often carry a copy of the *New York Times* under their arm so that they will not look like they are unemployed.

So this question of what you say, what we can do, I think says, fundamentally, Mr. Chairman, we need to really have an expert staff, as I did years ago as Chairman in hiring Diane Zuckerman, she was fabulous—and we closed that case, as far as I was concerned, on Pyridostigmine bromide. At that time, everybody had to take a pill every day. But the pill had never been approved by the FDA for use in human beings during the first Persian Gulf War—it had never been approved and yet people had to take it every day.

The military kept no records, kept no records. I am not going to ask you now about your position because I have sort of given a speech. But these are things I think that need to be said. I think it is very, very important that when we hear testimony saying about how wonderfully the VA and the DOD are getting along, I am not sure that is what Cynthia said. You said there were some areas that you were not getting information. I know from sitting on the Intelligence Committee that we do not use the word "share" information any more because you have 15 different intelligence agencies. They all have their own information. They all want it to be theirs. In some cases, it may be necessary, but the word is "access" to. If you say "share information," that means you own it, and you can share it with somebody else. If you have access, it is a right. Anybody else in that business has a right to have that information.

If we are dealing with the health care of people, and we call them heroes, and we do all of these wonderful things because they absolutely are, but when they come back, do they get the treatment that they should? I have never been convinced of that, and I have never been convinced that the budget was there. You indicated you felt the budget was there for PTSD. That comes as a surprise to me, and we will see. But I think it would be very useful for this Committee to take a very aggressive posture on pursuing the various aspects of returning men and women from these theaters of war.

Thank you, Mr. Chairman.

Chairman CRAIG. Senator Rockefeller, thank you.

I suspect I have developed a few reputations over the years I have been here, but one of them is persistence, and we will be persistent in pursuing all of the information we think necessary to allow you—meaning, Senator Akaka and others—to make the appropriate judgments as it relates to the care that our veterans and our active military deserve. So we will be persistent.

Let me close with a couple more questions, if I can, and maybe one of those is part of that persistence and I ask this of you, General. Have you or your staff placed any limitations on VA access to injured servicemembers in an effort to prevent the loss of military personnel?

General FARMER. No, sir.

Chairman CRAIG. Do you think this is a little legitimate concern for the military, considering that these injured men and women have already given so much?

General FARMER. Sir, I am not aware of that being a concern because I am not aware that we are doing it in any way. I will tell you that getting to the genesis of the questions, I think it goes, in part, back to I think it was Senator Murray's question earlier about are we pushing people out too early? We have some, of course, who think we are pushing out, and there are others who think, "Hey, look, get me out. You are not getting me out quickly enough." Those are all individual cases, and what guides us is doing the right thing for the soldier, sailor, airman, Marine, Coast Guardsman and for their care not what their status is, and we are certainly not trying to push anybody out of the VA system for what was asked earlier, for monetary reasons or otherwise.

Chairman CRAIG. Well, I will tell you Major Duckworth, and her condition and her desires challenge us all, but in the appropriate way. One of my frustrations has been, and I have shared this I think with Dr. Perlin, we have not adjusted some of our military standards of service for service, physical standards, to modern medicine. You have to be perfect in all ways to be able to do certain things, and modern medicine today allows people to be as functional, in many respects, as they are as a whole person, from a physical standpoint.

One of those challenges I think we will all have—because there is great desire on the part of our military men and women and the professionalism of them today—to retain them. We talked of costs, of experience, and all of that and how valuable it is.

I have heard reference, and it is a frustration, that DOD, in part, still operates in a bit of a cold war mentality. Cold war mentality juxtapose a now career military, a professional military that was not there during the cold war. It is obvious to me, at least in my effort, and I think the effort of this Committee and the effort of all of you, that the term or the phraseology we are using today, and therefore the action you are taking, "seamlessness," would suggest there is, in no way, a barrier between DOD and VA.

I am extremely pleased to hear the positioning of VA people inside military facilities. The Secretary and I will be visiting one of those soon in Germany. But our men and women deserve nothing but that. If we are, in fact, honoring them as career and professional people, that is extremely important I think not only that we treat them with that kind of respect, and therefore that kind of organization and system, but certainly for value of retention and sustaining that over the years, it is going to be increasingly important that we do that.

So let me thank you all again for your presence here this morning. We will stay with you on this. I am one who believes in persistence and doggedness where necessary.

Cynthia, we appreciate your presence here this morning and your testimony, and we will continue to make sure that in that process of crafting a seamlessness environment that the threads are tightly woven, and consistent and thorough.

Thank you all very much for your presence here this morning.

Again, Major Duckworth, we thank you. We hope this has not been too inconvenient for you, and we will look forward to watching your future and anticipate that you will be able to do exactly what you want to do.

Thank you so much.

The hearing will stand adjourned.

[Whereupon, at 12:31 p.m., the hearing was adjourned.]

○