

**STATUS OF MILITARY AND VA HEALTH CARE CO-
ORDINATION, INCLUDING POST-DEPLOYMENT
HEALTH CARE OF RECENTLY DISCHARGED
VETERANS**

FIELD HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED EIGHTH CONGRESS
SECOND SESSION

APRIL 13, 2004
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**STATUS OF MILITARY AND VA HEALTH CARE
COORDINATION, INCLUDING POST-DEPLOY-
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CHARGED VETERANS**

TUESDAY, APRIL 13, 2004

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The Subcommittee met, pursuant to call, at 8:43 a.m., in the City Council Chambers, City Hall Complex, Municipal Plaza Building, San Antonio, TX, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Simmons, Rodriguez and Miller.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. The Subcommittee on Health will come to order. Can you hear me now?

VOICES. Yes.

Mr. SIMMONS. Loud and clear. My name is Rob Simmons and I am a member of Congress from the State of Connecticut. I am a Vietnam veteran, proud of it, and we are here to have a hearing of the Subcommittee on Health of the Committee on Veterans' Affairs.

For opening remarks, I would like to introduce the Mayor Tempore Ron Segovia, City Councilman, District 3. Mr. Mayor.

Mr. SEGOVIA. Good morning.

Mr. SIMMONS. Good morning.

Mr. SEGOVIA. I apologize for the sunshine.

Mr. SIMMONS. I am from Connecticut and we love the sunshine. We do not have any up there. (Laughter.)

Mr. SEGOVIA. I am pleased to represent the Mayor and the City Council of San Antonio and welcome the Committee for Veterans' Affairs, the Subcommittee on Health to our city and council chambers. I would like to extend a special welcome to our hometown representative, Ciro Rodriguez. Congressman Rodriguez is a champion for our community and it is always good to have him here.

As you may know, San Antonio is known as Military City, U.S.A. San Antonio is home to four active duty military installations, plus Guard and Reserve units, representing some 48,000 active duty personnel. Even more impressive, San Antonio is home to over 153,000 veterans. I always say were it not for the veterans we would not be here today.

So your discussion related to the transition from Department of Defense Health Care Services for active duty personnel to the Department of Veterans Affairs Health Care System for separated servicemembers is very important to San Antonio. With the presence of the Audie Murphy Memorial Veterans' Hospital and the Frank M. Tejeda VA Outpatient Clinic, veterans in and around San Antonio have access to some of the best care our nation has to offer.

Today over 140,000 members of our armed forces are deployed around the world to fight terror. Many of those soldiers are from San Antonio and will come back home to transition to civilian careers, while many other may choose to retire and/or visit San Antonio because of our veterans' healthcare facilities. In any case, if recently separated servicemembers need to access the veterans' healthcare system, we must remain resolute in our commitment to provide for their health care needs in a timely fashion. We must continue to work on securing sufficient funding to provide for the veterans so justly deserved.

With assistance from this Committee on healthcare and Congress as a whole, San Antonio will continue to provide the best veterans' healthcare possible. The city looks forward in working with the Subcommittee on Health and the Congress to address the health infrastructure needs of Texas and the nation as a whole.

I hope that your stay here will be informative, productive and enjoyable. You are our guests while you are in this facility and in this city. Please let me or the city staff know if there is anything we can do to assist you.

Again, welcome on behalf of the Mayor and the City Council. We welcome you to San Antonio and hopefully maybe you can stay a few days longer and enjoy some of our fiesta. Thank you. (Applause.)

Mr. SIMMONS. I thank you, Councilman Segovia. We appreciate that invitation to stay for the fiesta. I am told that it is a very exciting event. That sounds great.

I am joined today by the Subcommittee's ranking Democratic member, my friend Ciro Rodriguez and a fellow Republican member from the great State of Florida, my colleague Jeff Miller, who represents another area of our country with substantial military and veteran populations, the 1st Congressional District of Florida, from Pensacola to Okaloosa County in the Florida Panhandle. Welcome to you here today, Jeff. Of course, this is your hometown, Mr. Rodriguez, and I am pleased to be here. And I also welcome our witnesses and all in attendance today.

I note that one individual in attendance today is Staff Sergeant Canady, a winner of the Silver Star, who has been treated for his injuries here over the last 100 days or so. Sergeant, would you mind standing and being recognized? Thank you for your service to your nation. (Applause.)

Mr. SIMMONS. The genesis of this hearing occurred in February of this year at a meeting between myself and Mr. Rodriguez when we were discussing field hearings that we wanted to hold throughout the country. We agreed that San Antonio would be a good site for a hearing because of the concentration of military and VA health resources in this area. Let me describe briefly some of these

attributes. The Audie L. Murphy Memorial Veterans Hospital, the Kerrville VA Medical Center in Kerrville and associated community clinics, a system that employs over 3,000 people with a budget of \$386 million. And 11 miles from here, the Audie L. Murphy Division, named after the nation's most highly decorated World War II veteran and native son, opened in 1973 with over 500 beds and a variety of primary and tertiary care services. The Wilford Hall Air Force Hospital at Lackland Air Force Base, about 11 miles from here, is the Air Force's largest and most extensive military treatment facility. The Brooke Army Medical Center, about eight miles from here, is the Army's most advanced tertiary care facility with its world renowned burn center serving the entire nation as a specialized source of critical care.

And speaking personally for myself, when I took my second tour in Vietnam back in 1970 to 1972 working for the CIA, a friend of mine was very seriously injured due to burns from a white phosphorus grenade. He lingered near death, was evacuated to the Philippines where they sustained him and eventually he was evacuated back to the Brooke Army Medical Center where they did an absolutely extraordinary job. They were state of the art for the nation and the world 30 years ago, they are state of the art for the nation and the world today and we should be proud as Americans that we have this wonderful facility right here in San Antonio, TX.

And then, of course, the Darnall Army Community Hospital at Fort Hood which is about 150 miles from here. Coming from Connecticut, 150 miles is a long way away, but I know for you folks here in Texas that is just a hop, skip and a jump. It is just going around the corner to the 7-Eleven.

With approximately 50,000 Army and Guard personnel returning from Iraq and Afghanistan and their family members, this is truly a center of activity for our U.S. military here in the United States of America. It is truly a center for our veterans here in San Antonio, what some people refer to as a billion dollar center for military and veterans' healthcare. What a pleasure for me to be here today.

At this point, I would like to defer to my colleague, my distinguished ranking member, Ciro Rodriguez, somebody who I have served with with great pleasure and great honor for the past 3 years. Somebody who puts partisanship aside when it comes to the healthcare and the benefits of our veterans. Somebody whose focus, in my observation, is entirely on the wellbeing of those who have served their nation and now need some of that service back from their nation. Our ranking member of the Health Subcommittee, Ciro Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. I want to personally thank you for not only your leadership back in Washington, but also for deciding to come down to San Antonio. I want to personally thank you for a relationship that we have had, as you have indicated, a very bipartisan effort in making sure that we respond to the needs of our veterans.

I also want to take this time to thank Congressman Miller for coming down. I know that we are going to be challenged right now with the construction work. I know we had some difficulty in get-

ting a location, so I do want to thank Mayor Pro Tem Ron Segovia for allowing us to utilize the beautiful City Hall facilities we have here in San Antonio.

Mr. Chairman, welcome to San Antonio. I appreciate you and Mr. Miller joining me here to hold this important hearing. I hope you enjoy our south Texas hospitality and weather. This is a little cooler than usual. This morning it was some 40 degrees, but welcome to San Antonio. We wanted to make you feel at home coming from Connecticut, so we thought we would have a little cooler weather.

Mr. SIMMONS. Where is the snow?

(Laughter.)

Mr. RODRIGUEZ. You might have to wait a good 10 years to get that.

As you know, the City of San Antonio, as indicated by the Mayor Pro Tem is referred to as Military City, U.S.A. and we are proud of that. We have a great tradition of supporting and caring for our military men and women and I cannot think of a better topic for us to explore here today than the healthcare of our veterans.

We have had several hearings in Washington which have focused on the post-deployment health of our servicemembers returning from Iraq and Afghanistan. This is clearly a topic that is in all of our hearts and minds now with such frequent reports of new casualties, particularly in Iraq, but also in Afghanistan. We want to ensure that servicemembers who are returning with their injuries, that are far more severe than the past periods of combat, are receiving the best healthcare that they can and that the nation can provide from them. We have to make sure that we are there for them.

Our military bears the chief responsibility for ensuring the healthcare of our troops, and as the Veterans' Affairs Subcommittee on Health, we also have an obligation and responsibility. While pre-deployment screening may be getting better, we still have a long way to go and there is still significant room for improvement. As you well know, Mr. Chairman, we have worked hard, and I know you have worked hard in that area in terms of reaching out to the Department of Defense in making sure we begin to do that a lot better.

Post-deployment screening also continues to be problematic. Physical examinations are often given only upon the request of the individual being discharged and then there is a waiting time for those who choose to receive them. Imagine returning home from war anxious to see loved ones and return to routine life and having to wait an amount of time to receive an examination in my view, it is highly unlikely many would choose to stay. These examinations need to happen immediately before these individuals return from deployment so that more are willing to participate.

As I stated earlier, we have held various hearings in Washington to discuss post-deployment health of our service men and women. What we have learned is the transition between the VA and the Department of Defense is effective particularly for the active duty servicemembers with severe physical wounds.

The Committee has primarily assessed the working relationship in Washington between Walter Reed Army Medical Center, Bethesda Naval Medical Center as well as the Washington VA Med-

ical Center. The VA has staff stationed at these major military treatment facilities to enroll active-duty servicemembers for VA health care and help them obtain benefits. This is also true at some of the major medical demobilization sites, such as Brooke Army Medical Center and Darnall Army Hospital in Fort Hood, as we will no doubt hear later today.

But it remains unclear how effective this system is away from these sites and how well it works if servicemembers' problems are less obvious than severe traumatic injuries—such as those that suffer from post traumatic stress disorders and other less obvious illnesses. We have to make sure that their transition occurs as smoothly as possible. For our future veterans who might have some readjustment difficulties, we have to ensure that our services will be there. We all know full well some illnesses can surface later like those veterans that served in Desert Storm who suffer from what we now refer to as Gulf War Syndrome. That surfaced later, but I know it was not recognized until much later—we have to make sure that we are there for those veterans.

What we have learned thus far is that communication between the VA and the Department of Defense must improve drastically to ensure that the active-duty members, the reservists and the National Guardsmen are not lost in the system meant to serve their healthcare needs. Ideally, there should be a shared medical record for each individual discharged showing his or her health status prior to and immediately following deployment and any service provided to that individual during that time.

Unfortunately, we have learned that the VA does not even routinely get access to the post-deployment health assessments the military is supposed to collect. This will continue to make continuity of care between the two healthcare systems problematic and will not allow the VA to adequately prepare for those it will serve.

In San Antonio, we are blessed with state-of-the-art VA and military medical treatment facilities and it is clear they are working hard to care for our soldiers returning with significant injuries. In fact, more than a thousand injured or sick servicemen and women from the Global War on Terrorism have been treated in this region alone.

I am looking forward to hearing from all of our panelists today to get a better understanding on the role of care that we are providing, and also looking in terms of the needs that we have, especially recommendations we might be getting from you to be able to address the needs in the future. As always, I also look forward to hearing directly from our service organizations and our veterans.

And again, Mr. Chairman, I want to personally thank you for coming to San Antonio and for doing what you always do in a gracious manner. And also to Congressman Miller for taking the time. I know how difficult it is to leave your district and your families during these times. So I want to personally thank both of you for being here with us. I look forward to the testimony of the panelists. Thank you very much and thank you to everyone present for being here with us.

Mr. SIMMONS. Thank you, Representative Rodriguez.

We are joined here by another colleague from the great State of Florida, representing the First Congressional District which is lo-

cated in the Florida panhandle, a district that is rich in military and veterans' facilities—my friend and colleague, Jeff Miller. Congressman Miller, do you have some remarks that you would like to make?

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you very much, Mr. Chairman. Again, I also want to echo my colleague's remarks. I think this is a very timely and appropriate place for this hearing to take place. I appreciate your service as chairman of this subcommittee. I also want to say that my colleague, Congressman Rodriguez, I do not believe anybody could serve the veterans of this district better than he has. The commitment that he has made to make sure that the care is what it needs to be and if it is not he rings the bell to make sure that folks know that it is not what it was designed to do.

I do look forward, Mr. Chairman, today to hearing the testimony from area healthcare providers and organization representatives that we see out in the audience. I think it is important that we talk about the transition as our military men and women move from active duty to veteran status, the importance of the seamlessness of how it should be when they make that transition. We know that there are some areas that need improvement without question. We also know that there are some areas where there is a lot of good work being done, and I think the DOD/VA sharing collaboration that we have seen in the south Texas area is an excellent model for us to follow.

My district has the most veterans of any congressional district in the United States. We have one community-based outpatient clinic and no VA hospital, so we are working outside the box now in northwest Florida trying to find ways that we can share. Both the Air Force and the Navy have been very helpful in doing memorandums of agreement whereby the co-sharing process can take place and the veterans in my district can receive the quality healthcare that they deserve.

I also think that it is important that we talk just for a second today—and I know that my colleagues would echo my remarks—in regards to what is going on around the world. We are in fact engaged in a war on terror. We have all had the opportunity to travel around this globe and visit with our troops, wherever they might be deployed, and witness first-hand the reconstruction efforts that are currently ongoing in Iraq. I just want to remind folks that, you know, Saddam Hussein ruled Iraq longer than Adolph Hitler ruled Germany, longer than Tojo dominated Japan. His wars scarred Iran, Kuwait, Saudi Arabia and Israel and his internal terror decimated the Kurdish minority in the northern portions of Iraq.

Less than a year after the rebirth of Iraq, our coalition forces are coming under heavy fire, literally and figuratively for its inability to fix all of the problems and to purge all the evils unleashed between July 1970 and May of 2000. Our service men and women get no salute from the media. The whole story is that the mission in Iraq is succeeding and all of Iraq is rising to live a new day. This Subcommittee and our entire Congress, if the members are reminded back home that it is the cleaning up of wounds, working to rehabilitate the injured and securing sustainable post-service

employment is just as important as searching out the hovels and the caves to push the terrorists out into the sunlight, if we will remember that, we will all be delivering on the duty that we have each been charged with.

I look forward to the testimony today. I thank the Chairman, and again, my good friend *Ciro Rodriguez* for asking that this field hearing be held in San Antonio.

Mr. SIMMONS. I thank the gentleman for his remarks.

The focus of today's field hearing is on coordination between military and VA healthcare systems, and my colleague Mr. *Rodriguez* and my colleague Mr. *Miller* have both made reference to that fact, that a military person who serves on active duty or is activated by the Guard and the Reserve is frequently confronted with a situation when—especially in the case of the Guard or the Reserve—they return back from their activation and they receive a DD 214 and they have exit health examinations. For those on active duty who are wounded, they also will be transferred out of the military. What we want to see happen, is we want to see that transition be as seamless as possible. We want to see records transferred in a seamless fashion. We want to see the physical exams coordinated, and some Members of Congress have even talked about having a single physical exam, not more than one. We want to make sure that our service men and women become veterans of this great nation in as seamless and coordinated way as possible.

We will have three panels today. The first panel will consist of Mr. *Jose Coronado*, Director of the Department of Veterans Affairs for the South Texas Veterans' Health Care System. Welcome to you, sir. He will be accompanied by *Richard Bauer*, Dr. *Bauer* who is Chief of Staff at the VA South Texas Veterans' Health Care System. We will also have Brigadier General *C. William Fox, Jr.*, Commander at Brooke Army Medical Center, accompanied by Colonel *Bernard L. DeKoning*, commander, Darnall Army Community Hospital, Fort Hood, TX; Brigadier General *Charles B. Green*, Commander of the 59th Medical Wing, Wilford Hall Medical Center.

Gentlemen, before you proceed, for those of you in the audience or watching on the television, to my left is *John Bradley*, the Subcommittee Staff Director and to my far right is *Susan Edgerton*, the Subcommittee Minority Staff Director. I thank them for their service and support.

Gentlemen, you have been announced. Please proceed.

STATEMENTS OF JOSE R. CORONADO, DIRECTOR DEPARTMENT OF VETERANS AFFAIRS, SOUTH TEXAS VETERANS' HEALTH CARE SYSTEM accompanied by RICHARD BAUER, M.D., CHIEF OF STAFF, VA SOUTH TEXAS VETERANS' HEALTH CARE SYSTEM; BRIG. GEN. CHARLES B. GREEN, COMMANDER, 59TH MEDICAL WING, WILFORD HALL MEDICAL CENTER, LACKLAND AFB, TEXAS AND LEAD AGENT, TRICARE REGION 6 and BRIG. GEN. C. WILLIAM FOX, JR., COMMANDER, BROOKE ARMY MEDICAL CENTER accompanied by COL. BERNARD DEKONING, COMMANDER, DARNALL ARMY COMMUNITY HOSPITAL, FORT HOOD, TX

STATEMENT OF JOSE R. CORONADO

Mr. CORONADO. Good morning.

Mr. SIMMONS. Good morning.

Mr. CORONADO. Mr. Chairman and members of this distinguished Subcommittee, I want to express my appreciation for the opportunity to discuss with you the South Texas Veterans' Health Care System's efforts addressing the seamless transition of returning Operation Iraqi Freedom and Operation Enduring Freedom soldiers from the Department of Defense healthcare system into the VA healthcare system.

As you are aware, the South Texas Veterans' Health Care System as a part of the Department of Veterans Affairs has four specific missions, which are to improve the health and quality of life for our patients; to facilitate graduate medical education; to foster medical research activities and lastly to support the Department of Defense. We are totally committed to achieving each of these missions, and each is critical to our success as a department. For this morning's discussion, I will concentrate on efforts to support our Department of Defense colleagues through our shared platform of partnership. In this regard, our commitment includes providing resources in support of local Department of Defense activities, ensuring a seamless transition of our military servicemembers into veterans status.

Additionally, the South Texas Veterans' Health Care System currently has 133 employees who are military reservists. Thirty-seven of these have been deployed in support of Operation Iraqi Freedom and Operation Enduring Freedom. Eight of these 37 VA employees have returned safely from active duty while 29 members of our staff still remain mobilized.

This brings me to the focus of my testimony, the South Texas Veterans' Health Care System involvement in the program for a seamless transition of active duty military to new veteran status. At the South Texas Veterans' Health Care System we take very seriously our responsibility to our servicemembers to ensure that they have timely access to the benefits they have earned through their military service. To fulfill this commitment to them we have committed resources and focused efforts with the VA's Veterans' Benefits Administration, the Texas Veterans' Commission, The Brooke Army Medical Center and Wilford Hall Air Force Medical Center. These coordinated linkages assure a smooth transition into veteran status by providing immediate enrollment or healthcare services, access to benefits information and quick determination of

eligibility for these VA benefits. This guarantees immediate priority service and allows access to all services that the South Texas Veterans' Health Care System and the Veterans' Benefit Administration have to offer. We have spared no effort to assure that not one of our heroes falls through the cracks.

In response to a VA central office directive I organized and launched a new South Texas Veterans' Health Care System task force in September of 2003 for the seamless transition of returning servicemembers into veteran status. This multi-disciplinary task force includes a full-time social worker, a program manager, a physician clinical liaison and a benefits advisor from the Veterans' Benefits Administration. The team is centered around the full-time VA social worker who is based at Brooke Army Medical Center. The social worker conducts discharge planning activities, clinical coordination services for each potential VA patient. The social worker provides prompt notification of casualty arrivals, delivers coordinated benefits briefings to all potential VA candidates and assists with the coordination of appropriate transfer to geographically distant VA facilities. Prior to discharge from the Department of Defense, our social worker enrolls all patients in the VA system to expedite their transition.

Our local team first provides timely notification and tracking of casualties. Secondly, facilitates transfer of active-duty military soldiers into veteran status prior to their separation from the Department of Defense. Thirdly, arranges care close to their homes and lastly, assists with claims processing.

Additionally, our team has identified Iraqi casualty point of contacts in each of our five satellite clinics in the Kerrville Hospital Division of the South Texas Veterans' Health Care System. These points of contacts are charged with coordinating care of any returning Iraqi conflict veterans. The team has ensured that as patients are identified appropriate measures are put in place to provide a seamless transition into veteran status.

To support communication with all returning Iraqi conflict soldiers in our area, we have initiated substantial outreach initiatives. We have produced and distributed specific brochures, scripts, role and responsibility guidance and outreach media products designed to aid in the transition of returning into veteran status. We have taken our mantra, "Treat now, ask questions later" from the words of Secretary Anthony Principi and used it as the foundation for our outreach initiatives. All guidance pertaining to the treatment of our newest veterans instructs employees to quickly facilitate care prior to determination of eligibility. Guidance on the processing of Iraqi conflict veterans has been forwarded to all front-line employees along with scripts detailing how to interact with our new patients. Furthermore, to educate our employees regarding Operation Iraqi Freedom and Operation Enduring Freedom veterans, the South Texas Veterans' Health Care System required mandatory viewing by all employees of the Our Turn to Serve video. This training video developed by our central office in Washington and the Employee Education System gives an in-depth view of the conditions faced by combat veterans as they continue down their road to recovery.

Other outreach efforts include communicating with veteran service organizations throughout South Texas during regularly scheduled meetings and by distributing flyers, posters and informative brochures through their organizations. Finally, South Texas Veterans' Health Care System publicizes and utilizes the VA Central Office website that addresses areas of interest essential to the care of this growing population. Information is readily available for employees, active duty personnel, reservists, members of the National Guard, veterans and family members.

To date, the South Texas Veterans' Health Care System has coordinated the transition of 465 service men and women who have supported our nation's defenses in Operation Iraqi Freedom and Operation Enduring Freedom. We currently care for 78 of these 465 locally and have assisted with the transfer of 128 employees—excuse me, soldiers into a VA facility geographically distant from south Texas.

Thank you for the opportunity to testify before you. I will yield to our Chief of Staff Dr. Dick Bauer.

Mr. SIMMONS. Thank you for those comments, Doctor. We will proceed with the other panelists and then save our questions until the end. I will also suggest to the panelists that we have a 5-minute clock on them. We can see a little red light here. We also have their written testimony. So if they will be mindful of the clock, I will let them know when the 5 minutes is up.

I will also note for the record that Colonel Robert Gombeski is not here accompanying Brigadier General Fox. Apparently it is Colonel DeKoning, who is Commander at Darnall Army Community Hospital. Is that correct?

Colonel DEKONING. Yes sir.

Mr. SIMMONS. I apologize for the misstatement, Colonel. It is good to have you here. Dr. Bauer.

[The prepared statement of Mr. Coronado appears on p. 51.]

STATEMENT OF RICHARD BAUER, M.D.

Dr. BAUER. Mr. Chairman and members of this distinguished committee, thank you for the opportunity to be here today and to discuss the status of VA healthcare delivery in south Texas.

The South Texas Veterans' Health Care System encompasses 63 counties in south Texas and reaches to Brownsville in the south, Victoria in the east, Sanderson in the west and San Angelo in the north, a span of 350 miles from east to west and 400 miles from north to south. Because of the distribution of population within this system, the South Texas Veterans' Health Care System operates eight VA staffed clinic sites. Three of these are in San Antonio, including the Frank Tejada Outpatient Clinic, the Southeast Bexar Clinic and clinics at the Audie Murphy VA Hospital. VA staff clinics are also located in Victoria, Corpus Christi, McAllen, Laredo and Kerrville VAMC.

Additionally South Texas has contracted for primary care services in 11 smaller communities such as Beeville and Uvalde, Alice and New Braunfels and also within San Antonio to address long waiting times and inability to provide adequate office space for primary care and mental health services within existing infrastructure.

All VA staffed clinic sites provide primary care, mental health and podiatry services. A concerted effort has been made to provide specialty services locally. In Corpus Christi, for example, an orthopedic surgeon visits the clinic bi-weekly. A sharing agreement with the Corpus Christi Naval Hospital provides optometry, audiology and general surgery services. The Corpus Christi clinic also has a radiology unit, pharmacy and physical therapy programs.

Services are also provided in local communities through contract. In the lower Rio Grande Valley, for example, the VA, through a contract with community hospitals, provides outpatient surgery such as colonoscopies, hernia repairs and cataract surgery and short-stay admissions.

Staff vacancies in several critical positions remain an ongoing problem delivering these services. Forty-eight percent of South Texas' employees are over age 50 and 75 percent of senior executives are eligible for retirement. Hard to fill positions defined as few or no qualified applicants after 6 months of recruitment include dentists, police officers, pharmacists, registered nurses, social workers, physical and occupational therapists, physicians, diagnostic radiology technicians and medical technologists.

The medical staff of the two large military treatment facilities, Wilford Hall Medical Center and Brooke Army Medical Center, have worked closely with the South Texas Veterans' Health Care System to provide services to veterans in some areas where staffing shortages exist. After deployment of one general surgeon and the resignation of the second general surgeon at the South Texas Veterans' Health Care Center, Wilford Hall assigned two general surgeons to provide inpatient surgical services at Audie L. Murphy. Neurosurgical staff from Wilford Hall has also provided on-call and emergency coverage for the neurosurgical programs. A sharing agreement has been established with Wilford Hall to improve urological care and details are being negotiated for cardiac cath and inpatient cardiothoracic services to be provided at Wilford Hall while one of our two South Texas Cardiac Cath units is being re-modeled.

Initiatives to perform joint credentialing of medical staff and for bi-directional transfer of laboratory data have also been submitted and approved for funding through a joint VA/DOD demonstration project. Additional clinical initiatives include consolidation of the bone marrow treatment facilities of Wilford Hall and South Texas to conserve resources, and staffing a vacant ICU at Wilford Hall by the South Texas Veterans' Health Care System in order to decrease ER diversions.

Thank you for the opportunity to testify before this Committee. The balance of my comments have been provided to the Committee in writing.

Mr. SIMMONS. Thank you, Dr. Bauer. Right on 5 minutes. We appreciate it very much.

Next, we will have Brigadier General Fox.

[The prepared statement of Dr. Bauer appears on p. 57.]

STATEMENT OF BRIG. GEN. C. WILLIAM FOX, JR.

General FOX. Mr. Chairman and members of the Subcommittee, as the Commanding General of the Great Plains Regional Medical

Command and Brooke Army Medical Center, I truly appreciate the opportunity to speak with you this morning on the relationship between the 10 Army hospitals that comprise the Great Plains Regional Medical Command and in particular Brooke Army Medical Center with the Veterans' Health Services Administration as it relates to the healthcare and delivery process to our beneficiaries and in particular to the service men and women that have been injured while serving this nation in the global war on terrorism. I do believe that my testimony will help this Committee to understand the various ways and means in which we are working to provide a medical process that seamlessly serves our soldiers, sailors, airmen and marines. We are ensuring that their physical and psychological needs are met with dignity and respect.

Later today Colonel Ben DeKoning, Commander of Darnall Community Hospital at Fort Hood, TX, and one of the Great Plains Regional Medical Command's subordinate commanders, will provide testimony that provides further examples of this improved coordination. He oversees the healthcare delivery at one of our Army's largest power projection platforms and he will provide to you some understanding of the extensive pre- and post-health deployment assessments that are provided and documented for each soldier as they deploy and redeploy from theater. Pre- and post-deployment health assessments, interventions, scrutiny and documentation are a critical component of our soldier and force health readiness today. This information is essential to the quality care delivery to soldiers and it is an essential historical documentation of healthcare for both immediate and long-term reference when the soldier must access the VA healthcare system.

You will also hear from Lieutenant Colonel Doctor Lee Cancio, our Chief of the Burn Center, which is a part of the Institute of Surgical Research embedded and located within Brooke Army Medical Center. Our burn center is internationally renowned and is the only DOD burn center and by agreement cares for VA patients as well.

Brooke Army Medical Center has a longstanding and productive relationship with the Veterans' Health Services Administration here in San Antonio. Prior to the conflicts in Iraq and Afghanistan, we established several joint sharing initiatives which Mr. Coronado outlined for you, and I have included in my written statements submitted to you for the record. These initiatives have resulted in more efficient use of federal resources, lowered overall healthcare costs and consistently improved our ability to deliver a more integrated healthcare benefit.

With the incentives from the Congress, DOD and VA to further increase our sharing efforts, the leadership of both Department of Defense facilities here in San Antonio and the VA have participated in a new formal collaborative effort in San Antonio called the Federal Health Care Consortium which meets monthly. Collaboration from this body has resulted in further efforts which have included invasive cardiology and cardiothoracic surgery services, working out joint credentialing processes for our nurses and doctors, laboratory data sharing, a joint Northside San Antonio clinic, a joint pager system, intensive care optimization, rehabilitation and end-of-service VA physical examination coordination.

Most importantly for the global war on terrorism effort we coordinated replacing two VA medical staff members into the Brooke Army Medical Center team. It is important to detail somewhat the missions and focus of Brooke Army Medical Center before further explaining the successes that we have had with these collaborative efforts. First, Brooke is the Army's only level one trauma center and plays an absolutely vital role in the United States Army readiness and a vital role to the trauma care here in south Texas in collaboration with Wilford Hall Air Force Medical Center and the University of Texas Health Center and University Hospital.

As only one of seven medical centers in the Army—that the Army possesses, we focus on graduate and continuing medical education for Army doctors, nurses and medics and we provide the credentialed and safe platform for critical medical research. We deliver state of the art healthcare to our beneficiaries and our primary referral center for soldiers care within the Great Plains Region. These missions have proven to be essential to the Army's success in the global war on terrorism. We are inextricably linked to the healthcare delivery that occurs on the battlefield today via telemedicine, e-mail collaboration, as well as education and collaboration with providers and teams we have deployed. Many of the doctors, nurses and medics that are now assigned to deployable healthcare units on the battlefield have trained at Brooke Army Medical Center and are providing life saving care to our forces in Iraq and Afghanistan.

Since the war began Brooke Army Medical Center has continued to care for the casualties that have returned from the forward care through medical evacuation back to our Army medical center. Among the many professional accolades that our preeminent institution possesses, the most powerful credential remains the testimony of the soldiers and beneficiaries that we receive and care for in our medical system. Since January 2003, we have received 1,321 soldiers evacuated from forward theaters of operations around the world for both medical and surgical issues. Over 60 percent of these soldiers have been from the Reserve and National Guard components. Two-thirds of these soldiers have been treated and released back to active duty status or have been released from active duty or—released from active duty back to their Reserve or National Guard units. Thirty-four percent of the soldiers have progressed to needing a medical evaluation board and the majority will need to receive follow-up care in the VA system.

Within Brooke Army Medical Center there are two VA healthcare employees from the Health Benefits and Services Division who work on our Medical Center to ensure that we have a coordinated and seamless care transition. One is a clinical social worker who has consulted on more than 270 cases from OIF and OEF patients. He provides in-depth briefings on the VA benefits and he works critical coordination for referrals of intensive care patient care management with VA medical centers. Through our coordinated efforts our experience has been that the medically boarded patients receive specialty clinic care follow-up within 10 days at their receiving VA hospital or clinic through the coordinated efforts of the embedded VA staff.

Brooke Army Medical Center also has a Department of Veterans Affairs Benefits Administration liaison representative who has been at the hospital since the spring of 2003 and continues to articulate the benefits to our soldiers, more than 800 so far that have served in OIF and OEF.

Mr. SIMMONS. If you will begin to summarize, General.

General FOX. Yes, sir.

Mr. Chairman and members of the Subcommittee, I know that you have introduced Staff Sergeant Canady. I would like to just briefly cover his service because I think it is a personal testimony to the services that have been rendered to our soldiers.

Mr. SIMMONS. You do not have to be brief on that point.

General FOX. Thank you.

He is a noncommissioned officer who was severely injured in Operation Iraqi Freedom in April of 2003. He was deployed from Fort Stewart, Georgia, as part of the 3rd Infantry Division and suffered a traumatic amputation of his right arm below the elbow and shrapnel injuries to his face and right eye during the assault into Baghdad in April of last year. The battlefield heroism that he displayed that day, despite his injuries, earned him the Silver Star. Staff Sergeant Canady would be the first to tell you that he was also cared for by medics and medivac teams that were equally heroic and more importantly to his life were professional and competent in their skills, skills many of them received here at Brooke Army Medical Center.

Staff Sergeant Canady received quality immediate care followed by extensive surgical, psychological and physical therapy over this past year. Through no less than continued heroic efforts on his part to face the extent and discomfort of these injuries, coupled with our professional healthcare he has now received and can utilize a state-of-the-art right arm and hand prosthesis. Throughout his long recovery, he has continued his education towards his bachelor's degree and with our VA staff we have coordinated for medical care at the VA hospital in Wilmington, North Carolina. He plans to attend school there in Wilmington and pursue a career in public service. Staff Sergeant Canady is married and has a 6-year old daughter.

From the moment he arrived at Brooke Army Medical Center we have coordinated every step of his care in a multi-disciplinary way. Between this center and the VA, he remains assigned to the Medical Center but now is only awaiting the Physical Evaluation Board's final disposition and results from the Physical Disabilities Agency for his orders to be released from active service.

In conclusion, Mr. Chairman, in my testimony today I have shared with you some of the ways and means that Brooke Army Medical Center has cared for injured soldiers and transitioned them to the Veterans' Administration Health Care System and some of the increasing collaborations we are implementing to further improve our services to all of our beneficiaries. As partners in this most important process, we are committed to providing state of the art healthcare for America's sons and daughters injured on the battlefield.

I want to thank you again for your time and I am available for further questions.

Mr. RODRIGUEZ. Mr. Chairman, I just want to give the young man a standing ovation. (Applause.)

Mr. SIMMONS. Our next panelist is Colonel DeKoning. Welcome, Colonel. Again, we have your statement, so if you would like to summarize we would appreciate that. Thank you.

[The prepared statement of General Fox appears on p. 61.]

STATEMENT OF COL. BERNARD DEKONING

Colonel DEKONING. Thank you, Mr. Chairman.

Mr. Chairman, members of the Subcommittee and distinguished guests, as the Commander of Darnall Army Community Hospital, thank you for providing me the opportunity to discuss how we provide outstanding care to our injured soldiers and seamlessly transition them to the Veterans' Administration Health Care System when required.

Darnall is one of 10 medical treatment facilities within Great Plains Regional Medical Command. We are the largest and busiest community hospital in the Army supporting the largest power projection platform in the Army. Earlier you heard from Brigadier General Fox who is both Commanding General of Great Plains Regional Medical Command and Brooke Army Medical Center, which is our primary referral hospital.

Our current operational environment has led to soldiers being medically evacuated to Army regional and community hospitals like Darnall to provide all the necessary care these soldiers need and deserve. Since the summer of 2003, Darnall has received over 500 soldiers medically evacuated from both Operation Enduring Freedom and Iraqi Freedom.

In 2003, the Army developed the Deployment Cycle Support Program to support the successful reintegration of deployed soldiers back into their homes. One of the new programs developed to support the Deployment Cycle Support Program has been the Care Manager Program. Care Managers ensure that soldiers coping with the injuries or stress associated with combat experiences are reconnected back into a noncombat environment.

In providing these services to Darnall it became apparent to our care managers that a solid link to the VA was needed for those soldiers being medically separated from the Army. In addition, Fort Hood has Reserve Corps and National Guard soldiers who are in a medical holdover status who will transition to the VA healthcare system for which that solid link is also needed.

In response to this need, a social worker from the VA medical facility in Temple, TX began working with the Department of Social Work Service at Darnall in February of 2004 to ensure that seamless transition from Darnall to the VA. This has worked extremely well, for prior to the agreement soldiers medically separated from the Army might have known which VA facility to go to, but they had no point of contact for which they could get their medical appointments at that facility. This resulted in extreme frustration on the part of the veteran. With the VA social worker at Darnall, this process has greatly improved.

Mr. Chairman and members of the Committee, I am committed to taking care of our soldiers and providing them world class healthcare. I am also committed to ensuring a smooth transition

from the DOD healthcare system to the Veterans' Administration healthcare system for our patients.

Thank you for the opportunity to appear before you and thank you for your support of our nation's veterans. I am available for your questions.

Mr. SIMMONS. Thank you, Colonel.

Our next panelist will be Brigadier General Charles Green, Commander of the 59th Medical Wing. Welcome, General.

[The prepared statement of Colonel DeKoning appears on p. 71.]

STATEMENT OF BRIG. GEN. CHARLES B. GREEN

General GREEN. Good morning, Mr. Chairman. I am Brigadier General Charles Green, Commander of the 59th Medical Wing of Wilford Hall. I also serve as the Lead Agent of TRICARE Southwest, Region 6, which encompasses the states of Texas, Oklahoma, Louisiana and Arkansas. My comments today are taken from my written testimony to be submitted to the Subcommittee.

Mr. Chairman and members of the House Committee on Veterans' Affairs, Subcommittee on Health, thank you for allowing me to appear before you today and offer my thoughts on DOD/VA collaboration in the greater San Antonio area and how this collaboration is meeting the needs of our sailors, airmen, marines and soldiers returning from contingency operations. As Commander of Wilford Hall Medical Center, I am keenly aware of how important San Antonio is to the war fighter. During calendar year 2003 and to date in 2004, the 59th Medical Wing has provided air evacuation reception for 609 Enduring Freedom and Operation Iraqi Freedom patients. Wilford Hall Medical Center has treated 127 of those patients and arranged care for 482 with other branches of the armed services. I want to assure the Subcommittee we in San Antonio take very seriously the need to provide pre- and post-deployment surveillance for our returning military personnel.

In the Air Force, all personnel deploying and returning from deployment are required to process through their local Public Health office. Public Health ensures that post-deployment health screening was accomplished in theater prior to the airmen beginning rest and reconstitution leave. If it was not accomplished, it is accomplished here before they are allowed to take that leave. All of this is done within the first 48 hours of their return. Eight hundred and thirty-seven members processed through Wilford Hall's Public Health in 2003 and we are very proud to have 100 percent compliance with the pre- and post-deployment screening. This documentation helps Mr. Coronado and the VA ensure military members receive seamless medical care when they leave active duty.

Soon after my arrival at Wilford Hall in July of 2003 I contacted General Fox and Mr. Coronado to talk about DOD/VA cooperation and to explore ways to make it better. The San Antonio Federal Health Consortium was created with the formal charter signed by each of us in February of this year to promote sharing among the member medical facilities and monitor progress toward mutual goals and projects and we are very pleased to report many great successes.

VA and military command authorities recently notified us that three San Antonio proposals were selected to progress to the second

level of review for funding under the DOD/VA Health Care Sharing Incentive Fund. We anticipate we will receive funding for a joint DOD/VA leased clinic in north central San Antonio, that there will be additional ICU nurses at Wilford Hall to help the VA avoid expensive healthcare costs downtown and to consolidate our two bone marrow transplant units. Mr. Chairman, I am very optimistic San Antonio is leading and will continue to lead the nation in DOD/VA sharing efforts. The Air Force, Army and VA are currently building on a long history of cooperation. The projects we have proposed will strengthen our system for providing medical services and ensure our service men and women receive the very best care in the entire spectrum of the federal healthcare system.

Thank you for allowing me to speak this morning. I stand ready for your questions.

[The prepared statement of General Green appears on p. 76.]

Mr. SIMMONS. That concludes the statements by the members of the first panel, I believe. I have a couple of questions that I would like to ask. First, for any of the panelists, I think each of you in your testimony at least once mentioned the word seamless. This appears to be a term of art that we all speak. But then the question is, do we in fact have a seamless system, particularly in the case of those military personnel who are transitioning out of the active component. My question goes to the issue of does the Department of Defense and do their facilities do an exit exam, and then is that exit exam replicated by the VA or do you coordinate or cooperate in that fashion, having essentially a single exam? Feel free to stand and use the microphone if you wish.

Colonel DEKONING. Mr. Chairman, the answer is that we are constantly improving on the seamless nature. The fact that we have a social worker from the Veterans' Administration embedded within our Department of Social Work Service has greatly enhanced the seamless nature of transition to the Veterans' Administration.

Sir, to answer your second question, is there an exit exam for those that are transitioned to VA, absolutely. In fact, there are probably several exit exams all through what we call our medical evaluation board process. That is a series of very, very extensive exams, and all of those results are passed to the social worker from the Veterans' Administration to enhance that transfer to the VA healthcare system.

Mr. SIMMONS. Now as I understand it, those exit exams done by the active component are systematically and carefully done and, of course, that will affect some of the benefits that that veteran may receive and some of the services that that veteran may expect to receive. So that is—you know, those exit exams are extremely important.

You mentioned that there is a social worker from the VA. Is there a physician from the VA who sits in in those medical evaluation boards in any sense?

Dr. BAUER. We do have a physician—is this microphone on?

Mr. SIMMONS. Yes.

Dr. BAUER. We do have a physician who is identified as the team physician coordinator. He does not sit in on the exit physical exam that the military does, but coordinates all of the care transfer when

there needs to be a physician-to-physician communication and also supervises the team that actually provides ongoing primary care to those veterans who are choosing to enter the VA system. I should mention that not all people who are leaving the military—some who are not injured are choosing to—are choosing VA services.

Mr. SIMMONS. I appreciate that. So what I have heard anecdotally is that there are times when somebody participates in the exit exam from the active component and then sooner or later applies for VA services but then has to go through a separate exam. And so the question I would have is, is it truly seamless or is there a gap there? Are the military records transferred in hard copy or are they transferred electronically to VA? How does that occur?

Mr. CORONADO. I believe we are pulling together two separate activities that we have in VA/DOD. We have a physical exam that we give to determine whether a veteran is eligible for benefits—pension or compensation benefits—that they might be eligible for. The VA has a pre-discharge exam that we provide for active duty military who are on the way out. Not necessarily having anything to do with the Iraqi Freedom operation. But this is to smoothen their coming into the system and that there are no delays in arriving at the decision as to whether they are eligible for certain benefits, pension or compensation. Now what we are working at now is the fact that the military has their automated—their computerized medical record and the VA has a computerized medical record. The two systems are not connecting at this time. But some of the initiatives that we have launched is to try to get our computer systems to communicate with one another. If you would study the three projects that we have submitted for trying to get the VA and DOD to work more closely together is trying to get that communicating between the two systems so that we can move much faster in providing services to that returning veteran.

Mr. SIMMONS. Thank you for that response. I see that I have a red light, so I will now yield to my colleague, Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman. I noted during the testimony Mr. Coronado and also Doctor, you talked about—at least in the written document regarding the number of vacancies and retirements. Do we have any system in place or do you have any recommendations as to how deal with that? Because I know nationally, not only the Department of Defense but the VA and other federal agencies, almost 50 percent of our staff is scheduled to retire in the next 2 or 3 years. So what are you personally doing or would you recommend that we need to do in terms of keeping up on staff training or staff recruitment?

Mr. CORONADO. We have various initiatives depending on which career or profession you're dealing with. With nurses, for instance, we have scholarship programs that we are working with the nursing schools here in San Antonio where we will assist the nursing student pay for their tuition if they will join the VA in turn. We also have employment programs while they are in school to have them come work at the VA during the holidays or during the summer. This is again to outreach to them. The big problem that we have in the VA is that the leadership roles are thinning very fast.

You take me for instance, I have been in the VA 44 years. I have been retirement eligible for some time now.

Mr. RODRIGUEZ. I thought you were just 40 years old. (Laughter.)

Mr. CORONADO. Not quite. Thank you for that compliment, Congressman.

The thing is to try to find ways of attracting new people to come into the VA. We have many programs by which we will assist individuals. The Congress gave us the ability to pay—help an individual pay for their student loans if they join the VA and work for the VA for several years. The VA, if they fall into certain categories, will pay for their loans. And we have other mechanisms in place to try to soften that break that we are going to—that we are beginning to experience where people are beginning to leave. They are approaching retirement, they are taking advantage of retirement and we do not have the staff behind them to fill in. It is usually the management, the supervisory level people, and we are working very hard at that. The VA did sort of stop its succession program, if you will, that we had for many years and we are now reinstalling that program and trying to get all sorts of new things going to make sure that we bring in new people into the system.

Mr. RODRIGUEZ. I also wanted to ask the General, but maybe you can react. When we provide services and access to healthcare to our military personnel and the needs of the families to what extent does the VA—do we need additional authority for the VA to provide services for families? I know we are restricted in terms of the amount of service we provide for families, but I wanted some feedback from you from that perspective. And also get, if possible, the General, to make comments in terms of the services we provide to our families.

Mr. CORONADO. The VA has limited authority to take care of families. Now the widows and orphans of veterans who died of service-connected conditions do have what we call the CHAMP VA Program. We sort of ride behind the CHAMPUS Program that the military has. This provides healthcare services for the widows of individuals who died in the military service or for 100 percent service-connected can also have their families benefit and their minor children have VA benefits. This is generally done by contract. We pay for it in the private sector. But others—the system is not like the military where we take care of the beneficiaries or the dependents of the active duty military individuals as they do in the Department of Defense.

Mr. RODRIGUEZ. Thank you.

Mr. SIMMONS. Congressman Miller.

Mr. RODRIGUEZ. General Fox is getting ready to speak.

Mr. SIMMONS. Oh, excuse me.

General FOX. Did my red light come on again?

(Laughter.)

Mr. SIMMONS. Please proceed.

General FOX. I wanted to answer Congressman Rodriguez's question about how are we caring for families. Thanks to your efforts really in Congress we have been able to support families as soldiers have exited at our Reserve component and National Guard component. Their families and those soldiers are entitled to TRICARE benefits for the first 180 days from the point that they exit. So in

addition to being able to access the VA system for the soldier, the family has benefits for 180 days, which most of our soldiers are electing to utilize. That is a great benefit and it is one that I think thanks to you all we have been able to provide to those families.

Mr. SIMMONS. Thank you, General.

Anybody else want to respond to the ranking member's questions?

[No response.]

Mr. SIMMONS. Hearing none, Congressman Miller.

Mr. MILLER. Thank you, Mr. Chairman. Now that General Fox has taken a seat, I will ask you to step back up, if you would, sir. General Green, you might want to respond too. I want to shift the questioning a little bit to the VA/DOD co-sharing issue. Talk a little bit, if you would, about the federal consortium. Where does that concept come from, who serves on it? We all know the potential positives, but can you explain a little bit from DOD's side any of the negatives that may be out there that would impact the retirees and the active duty that are currently receiving care in your facilities.

General FOX. Well thank you for the question. The Federal Health Care Consortium that we designed here in San Antonio is really just a title of a collaborative effort that we had begun and sustained for a number of years. But we realized in the September/October time frame that we really had the opportunity now to leverage in a big way further efforts that could enhance our collaborative business horsepower, if you will, to get at sort of using our logistics needs, our pager system needs, our need for laundry services, a variety, a myriad of support issues that help each one of us deliver this kind of quality healthcare, but do it in a marketplace that we could go to one market vendor and lower the cost to all three services. Those efforts bind our services together better. It leaves us with an opportunity on a monthly basis to look for the ways and means to increase and improve the ability to move patients between the capabilities that we have. Vast capabilities here in these three institutions really can provide some additional intensive care nursing staff. That is one of the efforts that is being looked at seriously now for funding from this DOD/VA collaborative sharing agreement.

Another one is our work with cardiothoracic surgery patients. Instead of sending those patients from the VA system perhaps into the civilian purchase care sector, bringing them to our military healthcare centers where we have the capacity to deliver the quality care, it sustains the training and education and skills of our wartime surgeons and at the same time is a good use of the taxpayers support that they have provided us in these systems.

Mr. MILLER. Thank you.

General GREEN. Sir, if I may, the Consortium is a very simple operation. Essentially there are three voting members. We are sitting here in front of you today. We work by consensus, we do not overrule one another. It is not a voting organization. We simply look at the finances and leverage the federal health sector dollar. There are a lot of things that are making money for us today. General Fox alluded to several of those. We also are looking at equipment standardization, of buying that way. We have not joined

forces really in the pharmacy arena which may be another large dollar potential. We are looking very closely at what materials we buy and if we buy them together can we get a better price. I think most of it is driven by trying to save dollars and leverage our buying power, if that gives you some idea how it is working.

Mr. MILLER. If I could just ask you, if you would very quickly, to elaborate—and I am a very strong supporter of VA/DOD co-sharing. But what are some of the negatives that you may have come upon in this process that prevents you from doing your original intended mission?

General GREEN. There really have been none. Because it is a consensual agreement we have not run into any problems wherein we are put upon to do one thing or another. Even if we agreed to pursue the initiatives for instance that we put forward into the DOD/VA sharing initiative funds, as we go down the charter if we find that something interferes with the training program or interferes with other operations within the hospital to where it might jeopardize our mission, we come back to the table and simply talk that through to see if there is a way to make it happen. I do not believe we have run into anything—in fact, in several cases it has been very successful over many, many years. I think the most successful may be the cooperation of the VA and Wilford Hall on the blood bank operation. We provide nearly 70 percent of the Air Force's blood through the volunteerism really of our basic military trainees. We do that in cooperation with the VA who gets their blood from our center by providing about nine FTEs who have much higher skill levels than we can put into our technicians. It gives us a very extended capability that provides as much as 40 percent of the blood going to Iraq today.

Mr. MILLER. Thank you, General.

Mr. SIMMONS. Thank you. I will go to a second round of questions and I will try to keep them brief. First of all, I did have a comment to make about the testimony of General Green. I was intrigued at the cooperation that exists between you General Fox and Mr. Coronado, and in particular with regard to the shortage of ICU nurses. On the one hand, I am excited by the idea that there is cooperation and coordination, there is a protocol. You know, these resources are all federal resources, and the only difference between an active component service personnel and a veteran is the difference of the DD 214. It is the same person, the same people. So we honor them equally. So I am excited that you are working together.

I am a little concerned about the lack of ICU nurses but I will not belabor the point because I actually wanted to ask if any of our members of panel one wish to comment on the Prime Time television show that aired last Thursday featuring Diane Sawyer. I believe the program focused on the Kansas City VA Medical Center, the Brecksville and Wade Park, various other parts of the country. But there was some discussion of the Temple, Texas VA Medical Center. I just wondered if our VA panelists wished to comment on that Prime Time show at this time?

General GREEN. I would like to comment. One of the things that we found was that in many cases the VA has much more in-depth contracting mechanisms than we do. And so in cooperation with the VA, we use one of their contracting mechanisms to bring nurses

back into my facility, as we deploy nurses to the war in Iraqi Freedom. Because of that and gaining an understanding, we found that we could work much closer together using some of their mechanisms and when they started looking at their diversion rate for ICU patients—we are spending nearly a million dollars in town for veterans who are going to local intensive care units—it made good sense then for them to look at how can we bring some of that nursing into our ICUs where I can advocate the building, not the staff and then recapture that care, which is what that whole initiative is about.

Mr. SIMMONS. And am I to understand that the in-town services are contracted by VA but are privately provided?

General GREEN. That is correct, sir.

Mr. SIMMONS. So in other words, what we are saying here is that as military doctors are deployed overseas, and nurses and there is a shortage, you can use VA contracted resources to provide those services yourself to save them the cost of doing it downtown. Which is a good idea, I think it is fiscally responsible.

What do the downtown hospitals say?

General GREEN. Well, at this point in time, it will depend on whether or not we take the entire volume or not, and of course that remains to be seen. Some of these patients will present to a local hospital and make it to their intensive care unit, but it is the diversion that we are trying to stop. If they are seen at the Veterans' Hospital or at one of our hospitals and we then have to send them to a local hospital because we do not have that care, it makes only good sense to have the care and not have to divert it. So it will be interesting to see if there is any backlash. But honestly, we do not expect one. I think that we will recapture that care without too many problems in the community.

Mr. SIMMONS. Thank you.

And to my question, does anyone here from VA wish to respond to the Prime Time program of last week?

Mr. CORONADO. Before I address that, I just wanted to touch on the nursing issue with the DOD. One of the good things that has happened to us in VA is that we have been given the Title 38 authority for hiring physicians, dentists and nurses. This gives us the ability to hire nurses on a different pay scale than we would were we to stick with the Civil Service System, and therefore, we are able to recruit and retain nurses because once a year we do nurse salary surveys to make sure that the VA is not trailing too far behind, and we can adjust the salaries according to what the prevailing wage rates are. And this gives us a tremendous boost forward, if you will, in being able to attract nurses into the field.

The military still—they have the active duty military nurses which can be deployed, as they have been to Iraq and, therefore, they are left with not being able to recruit unless they hire nurses using the Civil Service System, which does not put them in a very competitive position.

So General Green and General Fox and I have talked about the fact that we could use Title 38 authority and we would be better able to recruit these nurses.

But switching over to your second question, and that has to do with the Diane Sawyer program that took place last Thursday. And

at the risk of sounding defensive, I would like to tell you that I did watch the program. I noted at the beginning of the program, Ms. Sawyer said that she did not want the audience to feel that what was being presented was the usual thing that happened in the VA because they had met a lot of dedicated people and that excellent care was being provided and it was about a one or two minute statement that she made.

Being an old timer in the healthcare business, it would seem to me that presenting a balanced picture would be a little bit more convincing in presenting such a show, in that I think equal time should have been given to presenting someone that is doing an outstanding job, and we have many outstanding staff in the VA system who are delivering excellent care. And I think it is a discredit to the system and also probably worries our veterans greatly to hear that their system is flawed majorly, as it was presented in this program.

I personally do not feel that is true. I think things do happen in healthcare. As someone has pointed out, we are human, mistakes are being made. One thing that I have always found to be amazing in the healthcare system in general is that people are very honest. When a mistake is made, they admit that a mistake has been made and we work with the patient and the family to try to correct the situation. The VA has now adopted a system by which we track all errors and mistakes, misadventures if you will, that have happened and we do root cause analyses to see what caused these problems, because we want to avoid them happening again. So we need to learn from mistakes.

The things that were pointed out about the system in Temple, because that is our neighbor, were things of neglect, probably the building needed attention, the staff probably lacked direction. These things were taken care of even before the program was aired, corrective action was initiated by the VA.

There were five different review teams that went through Temple. I know because South Texas lent a lot of our staff to that effort, as well as providing as much support as we could to make sure that they got their system back together.

I can assure you, from having talked to the staff at Temple and to my boss, Mr. Stranovo, that the healthcare delivery system in Temple is now well up to the task that is being asked of them. It is a quality program and it is moving very aggressively and I can assure you that knowing people as I do that those mistakes will not happen again.

Mr. SIMMONS. I thank you for that response. I would ask if my colleague, Mr. Rodriguez or Mr. Miller have additional questions for panel one?

Mr. RODRIGUEZ. Just on the same issue, Mr. Coronado—and let me just qualify my statement by saying that I know from the Congress, and I want to congratulate our Chairman because I know the Committee is pushing forward to try to get additional resources and I know that part of the problem is the fact that we just do not have sufficient resources that are needed.

But back to the Primetime program, based on one of the responses that we got was that they sent a team immediately down there, but I was concerned with one of the recommendations that

they had. It says action taken since then includes revising facility care protocol, reorganizing the supervision structure and it goes on and on. But it also says suspending admissions while recruitment for additional staff is taking place. So if we stop additional recruitment of veterans that are in need of service, I was just wanting you to react to that. Do you know what the situation is down there? To what extent that has occurred and if we are back providing the services. And I just got this piece of paper here. I know we have got some Vietnam veterans in America here that are concerned about us not going out there and educating our veterans about the types of services that we have. And so I hope that because of the program, that we do not do that because I know instead of telling them you cannot come in because we do not have the staff, you cannot come in because we cannot provide the service, yet they are entitled to that.

So I was wondering—

Mr. CORONADO. I have not actually seen that document, but I think that refers to their extended care unit.

Mr. RODRIGUEZ. A little louder, please?

Mr. CORONADO. I believe that that document refers to their extended care unit. They do have capability—

Mr. RODRIGUEZ. You are right, by the way.

Mr. CORONADO. They do have capabilities for extended care services beyond that actual in-patient unit. They have another facility that has extended care services and they are also under contract for extended care services in the community.

So while I cannot speak to actually how they manage individual cases, they do have alternative sites for providing those services.

Mr. SIMMONS. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

Since you brought it up, I just want to make a statement and I think everybody on the full Committee would say that those issues that were highlighted in the Prime Time program, none of those are acceptable. So that I think should go without saying.

That being said, I do not think the veterans were well-served at all. In fact, I am rather appalled by the way that the program was put together. My degree happens to be in journalism, but I do not think ambush journalism serves anybody well. The fact of the matter remains if in fact ABC's intention was to assist in any way with improving the healthcare of veterans in this country, they would not have gone in, shot video and waited 5 months before that video was exposed. They would not have done a program 14 years ago and then waited for 14 years to go back and check and see how things had changed.

You know, we have a lot of political issues that we deal with in Congress back and forth. But one of the committees that very few—when you get down to the discussions, there are very few differences and that happens to be the Committee on Veterans' Affairs, because there are no Democrats, Republicans, Independents when it comes to taking care of the veterans of this country. And I think that, you know, unfortunately during this year, this campaign season, we are going to be seeing more and more issues like this arise and I am not casting aspersion on either party because both sides are going to be trying to make their point.

I think the most important thing for the veterans of this country to know is that the members that serve on this Committee and the vast majority of members in Congress understand the plight that the veterans are faced with today. They know that the veterans understand the plight that the VA is under today. There are, in certain instances, limited resources and that is why VA/DOD sharing is so important, to be able to take the limited dollars that are out there today and make the best use and achieve the best outcome.

But I cannot let the opportunity pass without saying that, you know, what we all witnessed—and I watched it too last week—was really a disservice to the veteran community in the way that it was portrayed and I would hope that any media outlet that chooses to do something to highlight potential negatives to veteran healthcare would bring it to attention as quickly as possible so that a solution can be found and a problem can be fixed, so that the veterans will not continue to be under-served.

Mr. SIMMONS. I thank the gentleman for his comments. We have taken a good long piece of time this morning on panel one and I thank them for their testimony. They have really helped us get kicked off in this process very nicely.

Now I would like to welcome the members of panel two to come forward. We have Dr. Stephen L. Holliday, President of the Association of VA Psychologist Leaders; we have Lieutenant Colonel Brian Masterson of the Wilford Hall Medical Center; we have got Lieutenant Colonel Lee Cancio, Chief of the Burn Center, Brooke Army Medical Center; we have got Ms. Janeth DelToro, a nurse practitioner from the VA South Texas Veterans' Health Care System; and we have Raul Aguilar, M.D., Chief Medical Officer of McAllen Outpatient Clinic, VA South Texas Veterans' Health Care System.

Having read them off in sequence, I will now read them off again in the sequence that this note says that they are going to speak. We will begin with Ms. DelToro and then we will do Dr. Aguilar and then we will do Dr. Holliday, then we will do Lieutenant Colonel Cancio and we will conclude with Lieutenant Colonel Masterson.

We do have you statements which we read as you speak. So feel free to highlight your statement in a form that will fit within 5 minutes. Ms. DelToro, thank you and please proceed.

STATEMENTS OF JANETH DELTORO, NP, VA SOUTH TEXAS VETERANS' HEALTH CARE SYSTEM; RAUL AGUILAR, M.D., CHIEF MEDICAL OFFICER, MCALLEN OUTPATIENT CLINIC, VA SOUTH TEXAS VETERANS' HEALTH CARE SYSTEM; STEPHEN L. HOLLIDAY, PH.D., ABPP, PRESIDENT, ASSOCIATION OF VA PSYCHOLOGIST LEADERS; LT. COL. LEE CANCIO, M.D., CHIEF, BURN CENTER, BROOKE ARMY MEDICAL CENTER and LT. COL. BRIAN J. MASTERSON, M.D., CHIEF INFORMATION OFFICER, WILFORD HALL MEDICAL CENTER, LACKLAND AFB, TEXAS

STATEMENT OF JANETH DELTORO

Ms. DELTORO. I wanted to let you know I am not a physician, I am a nurse practitioner.

Texas, with 84,000 women veterans, has the third largest population of women veterans. In the South Texas Veterans' Health Care System, we have approximately 10,000 women enrolled. Throughout the system, there are women health programs at each facility. Women are eligible to receive women's healthcare through their primary care clinic or through a specialty women's clinic. At the Frank Tejada Outpatient Clinic, we have the Women's Place and at the Kerrville Division we have the Women's Health Clinic. At each hospital, there are nurse practitioners employed as Women Veteran Program Managers, who are responsible administratively and clinically for the provision of comprehensive women's healthcare. I am the Women Veterans' Program Manager from the Kerrville Division. Each of the five satellite clinics also provide women's healthcare. At each outpatient clinic, there is a Woman Veteran Liaison to ensure that to women veterans' needs are met.

The women veteran population has unique issues. Among the issues that the VA is faced with in the women veteran population includes screening and treatment for military sexual trauma and clear access to women's healthcare. Women in the military have not seen the VA as a system willing and able to care for women veterans. In talking with women veterans, I have been surprised to hear that in many cases, women do not consider themselves veterans, and in those cases they certainly do not consider themselves eligible for healthcare at the VA. They are surprised and pleased to find that the VA has services that equal or surpass women's healthcare offered in the private sector.

Another priority issue in the women veteran population is the screening and treatment of women with military sexual trauma. As you know, victims of sexual abuse often do not report this crime. Women delay disclosure of sexual abuse until after departure from active duty, perhaps in fear of retaliation or rejection or the fear of the negative consequences the accusation will have on her career.

Non-randomized surveys of women veterans indicate rape or attempted rape while in the service are at rates of 23 to 43 percent. This represents a challenge to us in the delivery of care and availability of services. Many victims of sexual trauma are not eligible for services other than sexual trauma counseling. In this system, we have been able to coordinate and collaborate military sexual trauma services within the VA and the Vet Center. For many years, this system has worked collaboratively with the Vet Center to provide counseling. For those veterans who live in remote areas, we work with private counselors to provide this.

Women veterans are seen in our Mental Health Clinic, the PTSD Care Team, within the Women's Clinic and through the Vet Center for military sexual trauma counseling. For the past 9 years, the Kerrville Division has collaborated with the San Antonio Vet Center to bring these services locally. We have also collaborated to offer a retreat to women veterans involved in military sexual trauma group therapy. This has been a tremendous success with women veterans expressing that this has been the most successful therapeutic experience that they have received.

The VA is eager and able to provide women's healthcare; however, getting that information to them has been a challenge. We

have met this challenge in a number of ways. For the past 13 years, we have offered the Salute to Women Veterans in Kerrville. The purpose of this program has been to honor the role of women veterans and to increase community awareness of the role of women in the military. The Salute has reached women throughout the entire system and has heightened awareness of women veteran issues and healthcare services.

The Women's Place has held women's health fairs at a local San Antonio community college and a representative from the Women's Health Program presents weekly at the local military base's TAPS briefing to apprise military women of services that they are entitled to.

In November 2002, we collaborated with a local theater group to produce the play *A Piece of My Heart* to women throughout the system. This play is a moving depiction of women veterans in the Vietnam War. Regularly, the Women Veterans' Program Managers meet with the media in television, radio and newspaper regarding women veterans' issues and stories of interest.

At the Frank Tejada Outpatient Clinic, we have two primary care physicians, two nurse practitioners and a gynecologist and at the Kerrville Division, we have one nurse practitioner providing women's healthcare. At the Audie L. Murphy Division, women can choose to receive their healthcare in the primary care team or be referred to the Women's Place. At the satellite clinics, patients receive women's healthcare with either a nurse practitioner or a physician. Throughout the system, for complex women's healthcare issues, patients are referred to the Women's Place to be seen by the gynecologist. We have a collaborative relationship with University Health Systems for gynecological surgical procedures and these are done at University Hospital. For obstetrical care, we have contracted with local private providers as well as with Wilford Hall Air Force Medical Center. These collaborative program have been well received. Since the VA began providing obstetrical care, we have delivered 63 babies for women veterans and we anticipate 16 additional babies this year.

I was also asked to discuss the role of the nurse practitioner in this system. Nurse practitioners have been instrumental in providing care to all veterans but have been especially effective with women veterans. Women veterans generally expect holistic care, including meeting not only their physical needs, but evaluating their emotional, spiritual and psychological needs. Women in America tend to be the primary person in the family responsible for healthcare. Women expect detailed information prior to making healthcare decisions and nurse practitioners are uniquely able to meet this with training in both medical and nursing science. There are 24 nurse practitioners in our system where they are utilized in the hospitals and within the outpatient clinics. Nurse practitioners can be found in long term care, primary care, in triage and in specialty clinics.

As a nurse practitioner who has worked in both the private sector and within the VA, I am in a unique position to evaluate the best of both private and public healthcare. And I feel that our system has met the challenges of women veterans well. In this environment, the women receive care that surpasses the services that

I am able to receive in the private sector as a non-veteran. In 2002, we received the Clinical Program of Excellence in Women's Health award, one of six VA facilities to receive this award. I am honored to serve in the capacity of the Women Veterans' Program Manager and I feel that I have learned as much from my patients as I have imparted to them.

And I thank you for this opportunity.

Mr. SIMMONS. Thank you. The next person to testify will be Dr. Raul Aguilar, VA South Texas Veterans Health Care System. Thank you for being here and feel free to summarize.

[The prepared statement of Ms. DelToro appears on p. 82.]

STATEMENT OF RAUL AGUILAR, M.D.

Dr. AGUILAR. Good morning. I am honored to be requested to testify before this U.S. House of Representatives Veterans' Affairs Health Subcommittee on veteran healthcare in the Rio Grande Valley. I have been associated with the Veterans' Administration as a healthcare provider since 1981 and it has been my goal to provide veterans with the best healthcare that the system can deliver. We also have a team of VA healthcare professionals in the Valley that are providing daily healthcare delivery to a veteran population that has proudly served their country in the Armed Forces.

The VA Clinic in McAllen, TX was established in 1972 as an outpatient facility and housed in a trailer located near the now demolished and relocated McAllen Methodist Hospital. Originally, the clinic was under the auspices of the director of the San Antonio Outpatient Clinic. In June 1977, however, the outpatient clinics were merged and became satellite facilities of the Audie L. Murphy Memorial Veterans' Hospital under the auspices of the hospital director. In 1978, the clinic relocated from the trailer to a structure of 5,000 square feet. And in August 1991, the clinic relocated to its present facility of 27,000 square feet. This facility is located 250 miles south of the parent facility here in San Antonio, TX. The catchment area that we have is comprised of approximately 47,000 veterans, of which we have a market share of 23 percent of the veteran population. This figure does not include the large number of winter visitors that significantly swells the veteran population in the Valley.

Services provided in our clinic include medical and psychiatric treatment, mental hygiene classes, Aid and Attendance and Housebound exams. We have special clinics for flexible sigmoidoscopy, geriatric assessment, gynecology, minor ambulatory surgery, endocrinology and podiatry. Other services in the clinic are psychological evaluation and testing, pharmacy, physical therapy, laboratory, radiology, social service, smoking cessation, marital counseling and dietary therapy. Furthermore, the clinic participates with the South Texas Family Practice Residency in McAllen in teaching 20 family practice residents in geriatric medicine and internal medicine, flexible sigmoidoscopy and minor surgery. We have four Board certified family practice physicians, of which one is certified in geriatric medicine, three board certified internal medicine physicians which have specialties in pulmonology, endocrinology and geriatric medicine and we have a psychiatrist and a psychologist assigned to the mental health unit. Five of these seven

physicians have faculty appointments as clinical assistant professors in the University of Texas Health Science Center here in San Antonio. The clinic recently received accreditation from the Joint Commission for Accreditation of Healthcare Organizations from 2002 to 2005. There are six primary care teams delivering primary care and one mental health team composed of a psychiatrist, psychologist, mental health nurse and social worker. The Lower Rio Grande Valley Surgical Contract that has been mentioned before has provided day surgery on a local basis for Valley veterans for the past 5 years or so.

There are 24 Iraqi-Afghanistan war veterans that have enrolled in the McAllen VA Outpatient Clinic, of which four were female veterans. Ten of these veterans declined treatment but wanted their enrollment documented in the system. Initial screening for post traumatic stress disorder, infectious diseases, depression and alcohol abuse are conducted on all these veterans as well.

We anticipate that we will have a Harlingen VA Outpatient Clinic that will be operational as early as July 2004. We will start initially with two primary care teams that will eventually expand to eight teams by the year 2006. This expansion of primary care delivery to the veteran population will decompress the McAllen VA Outpatient Clinic, which is operating at full capacity, and accommodate the continued growth of the veteran demand for medical services in the Rio Grande Valley. The Harlingen Outpatient Clinic will be situated in the Regional Academic Health Center affiliated with the University of Texas Health Science Center in San Antonio and will have approximately 30,000 square feet of clinic space. The facility will mirror the clinic in McAllen with the exception of providing additional services in optometry and dental care.

I would just like to say that my family has proudly served in the United States Armed Forces. My father Eulalio Aguilar, Sr. served in the Army during World War II, my brother Eulalio Aguilar, Jr. served two tours in Vietnam as a Marine receiving a bronze star and two purple hearts; and my older brother Alfredo Aguilar also served in the Air Force as a medic. I have been associated with the United States Air Force Reserve for 15 years and it has been a privilege serving with the other men and women serving in the Armed Forces.

Thank you for your attention.

Mr. SIMMONS. Thank you for your testimony and thank you for your family's service.

Next we will hear from Dr. Holliday, President of the Association of VA Psychologist Leaders.

[The prepared statement of Dr. Aguilar appears on p. 85.]

STATEMENT OF STEPHEN L. HOLLIDAY

Dr. HOLLIDAY. Mr. Chairman, I apologize that you did not get my statement in advance. I will see that you get a copy.

Mr. SIMMONS. Thank you, I appreciate it.

Dr. HOLLIDAY. My name is Stephen Holliday and I am a clinical psychologist and Board certified in clinical neuropsychology. For more than 18 years, I have been actively involved in providing psychological services for veterans in the South Texas Health Care System. I have also served as a psychology training director for the

past 10 years and this past January was named Chief of the Psychology Service. As such, I have administrative and clinical responsibility for all psychological services provided at South Texas, including our outpatient clinics.

In addition, as you noted, I am President of the Association of VA Psychologist Leaders, representing 200 VA psychology, chief psychologists and program leaders throughout the country. I will preside at our annual meeting in Washington later this month and I am pleased to say your senior staffers will be participating at that meeting. A major focus of our meeting in Washington will be on preparations for veterans returning from Iraq and Afghanistan.

We at South Texas have a long and fruitful history of collaboration with DOD in psychology training. Many of our trainees serve at BAMC and do training in neuropsychology there. In addition, we collaborated on research projects and educational seminars with our colleagues at both Wilford Hall and BAMC for the past 15 years.

Our staff members at South Texas, both in triage, medical administration service and primary care as well as mental health have been trained to expedite services for returning veterans from Iraq and Afghanistan. Mental health program leaders have specifically been instructed to ensure that these priority veterans receive all needed services in a timely fashion.

Recent military actions in Afghanistan and Iraq have already increased our caseload of PTSD patients, not so much from returning veterans themselves, but from veterans of former wars whose PTSD symptoms have been exacerbated by the news coverage of the current conflicts.

Our PTSD program recently received authority to expand their staff to accommodate PTSD treatment. They have expanded a half time social worker position to full time and we have been authorized to recruit for an additional psychologist and psychiatrist to help with this caseload. The new psychiatrist has already been selected and the new psychologist should be selected within a few weeks.

Dr. Abney, our PTSD clinical director, is currently planning for new groups, especially for these new PTSD cases. Indeed, Dr. Abney has already treated several active troops who were disturbed by nightmares from their service in Iraq. I might add that these were adult children of Vietnam veterans that Dr. Abney has treated over the years.

In conjunction with our education service, we are also planning for an extensive workshop at South Texas on the treatment of acute stress disorder by staff from the VA's PTSD Center of Excellence.

In addition, other mental health resources have been increased this year and we are currently recruiting additional psychiatrists, two mental health nurses, an additional psychologist for our outpatients clinics in both San Antonio and Kerrville.

Although it is difficult to accurately predict the number of returning veterans who will require mental health services, we suspect that it will be substantial. Unlike the relatively brief and low casualty first Gulf War, the current conflict in Iraq and Afghanistan are likely to be more protracted and difficult. The mental

health toll taken by extended tours in such stressful conditions is well known to us. The question is not if many returning veterans will need VA mental health services, but only when they will seek it. We know how to effectively treat acute stress disorder and to prevent it from becoming severe chronic PTSD. However, we will need the resources to do this. Our budgets are cutting currently.

As the first of the returning veterans begin to enter the system over the next several months and seek mental health care, we should have a better estimate of the number needing additional mental health services and resources. We know that the Committee will closely monitor this need and adequately fund the VA services accordingly.

Thank you for your time.

Mr. SIMMONS. Thank you very much, Doctor.

Next, we will hear from Lieutenant Colonel Lee Cancio, Medical Doctor, Chief of the Burn Center, Brooke Army Medical Center and we do have your testimony. We look forward to hearing your summary.

[The prepared statement of Dr. Holliday appears on p. 87.]

STATEMENT OF LTC LEOPOLDO C. CANCIO, M.D.

LTC CANCIO. Good morning.

Since 1949, we have been the burn center for the Department of Defense for VA cases from across the nation and for civilians from south Texas.

Burn care is time, manpower and resource intensive and requires a multi-disciplinary team effort at specialized centers. I will give you an overview of our experience during the war and of our care for the servicemen as they return to duty or civilian life.

This Burn Center's mission in this war has been to receive all burn casualties up to our maximum capacity and not to close to civilian burns here in south Texas unless absolutely necessary.

As we prepared for the war, we developed plans for expanding our burn center up to a 60-bed capacity, we created a national response for burn care in the event of a mass casualty situation. We conducted burn training for hundreds of military medical personnel and we put into place a rapid response aeromedical evacuation plan.

With respect to the national response for burn care, our worst-case-scenario prediction was that this conflict could generate approximately 1,000 burn patients, clearly no one burn center could provide intensive care for this many patients. Therefore, we collaborated with the American Burn Association, the U.S. Air Force and the National Disaster Medical System.

We e-mailed a daily request for open bed status to 60 participating burn centers across the country and collated the responses and sent a report to our Liaison Officer in Germany. In the event of a mass casualty situation, this would have allowed him to regulate burn patients coming out of Iraq to available beds in the U.S. This unprecedented nationwide system was in continuous operation between March and May of 2003.

We also spoke with the National Disaster Medical System concerning the possibility of activating the Burn Disaster Medical As-

sistance Teams to support the Army Burn Center, but this was not required.

With respect to training, most military providers have little hands-on burn experience, so we trained approximately 1,100 personnel on site at the Army Burn Center, on the ground in Kuwait and aboard the Hospital Ship Comfort.

With respect to aeromedical evacuation, this center's burn flight teams have pioneered the aeromedical transport of seriously ill burn patients since 1951. Today, they are the only Army teams whose members are also trained and certified by the U.S. Air Force as Critical Care Aeromedical Transport Teams.

During this conflict, the Army Burn Flight Teams have performed 18 flights to Germany in order to transport burn patients without complications. Fortunately, we have been able to care for all of the burn casualties from this conflict at our burn center.

Between March of 2003 and April of 2004, our burn center has admitted a total of 91 combat casualties with burns and after discharge, we have followed these patients in our outpatient clinic for up to one year.

These burned servicemen have been supported by a variety of services that are unique to this burn center, to include family lodging at the Fisher House, close liaison with the servicemen's units, Purple Heart ceremonies and visits by General Officers, Members of Congress and the Secretary of Defense.

Having these soldiers at one burn center versus scattered across the nation has facilitated this type of support and has allowed us to collect data on long-term outcome after injury.

About 25 percent of our combat casualties with burns have ongoing psychological problems and have been referred to mental health services for long-term follow-up. About 25 percent have deep burns of the hands or of the face, requiring the services of specialized hand therapists and reconstructive surgeons. Fifteen have not been capable of returning to duty and have undergone a medical evaluation board or are undergoing one now.

All of the burn patients at Brooke Army Medical Center have received assistance from two VA employees, one a clinical social worker and the other a benefits expert, and their hard work has been absolutely essential.

In conclusion, it has been a real honor to care for the burned servicemen who have been injured in this conflict. We look forward to working with the Veterans' Administration system to facilitate the long-term care they will need. And thank you for the opportunity to testify.

Mr. SIMMONS. Thank you, Colonel.

The last panelist for panel two will be Lieutenant Colonel Brian J. Masterson, Chief Information Officer, Staff Position Psychiatry and Internal Medicine at Lackland Air Force Base, Texas. Colonel, welcome.

[The prepared statement of LTC Cancio appears on p. 91.]

STATEMENT OF LTC BRIAN J. MASTERSON, M.D.

LTC MASTERSON. Good morning. I am Brian J. Masterson, I practice internal medicine and psychiatry at Wilford Hall. I previously served as Commander for the Critical Care Squadron which

has all the ICUs at Wilford Hall Medical Center. Mr. Chairman and members of this House Committee on Veterans' Affairs Subcommittee on Health, thank you for allowing me to present before you today and offer you my thoughts on the medical military healthcare in the Department of Defense and the Veterans' Affairs cooperation and initiatives in San Antonio.

Prior to coming to San Antonio, I spent 5 years at the VA Medical Center in Iowa City, Iowa and worked extensively with post traumatic stress victims from both World War II and Vietnam. For the last 11 years, I have served as staff psychiatrist and physician here in San Antonio and have come to appreciate the unique and ideal community that we have here practicing and teaching medicine while delivering health care in a cost-effective and efficient manner.

These world class facilities and research here allow us the opportunity to share resources and to improve the quality of care for our military and civilian community. In addition to the unparalleled opportunity to share resources, San Antonio Veterans' Affairs Hospital and the military medical facility play a key role in preparing our troops as well as treating the casualties when they return home.

Prior to deployment, our readiness squadron prepares personnel that are deployed to all contingencies, whether they be Operation Enduring Freedom or Operation Iraqi Freedom. Requirements for deployment are validated by the squadron and matched against the personnel available with their unit type codes and their skills. The individuals are screened against 43 indicators for deployment on administrative requirements, training, medical and dental fitness. To date, there have been no errors and no need to remove Lackland personnel from the theaters of operation. The lowest disease, non-battle injury in history is four percent in Operation Iraqi Freedom, which is much lower than the six percent that was seen in Operation Desert Storm, clearly demonstrating the success of screening and aggressive public health and safety initiatives within the theater.

Personnel returning from deployment are required to process through the Air Force Public Health before they can have their rest and reconstitution leave. Approximately 840 personnel returned in 2003. To ensure that this screening is conducted, all tasks must be completed before they present to the finance department to receive their TDY pay. This has ensured compliance and 100 percent completion of these requirements. Additionally, the medical members have medical records screening to ensure that the post-deployment health assessment survey is done. That is the DD Form 2796, which must be completed in theater. However, there have been a few cases that have not. During their processing, they have made arrangements with their primary care manager at Lackland. This accounts for the 100 percent capture rate that we have had with getting the information.

As I said, the survey is completed and they are seen face-to-face with a healthcare provider. If follow-up with the individual is needed, that is addressed and the member is scheduled for appointments. The PCM also schedules any follow-up appointments needed after they have reviewed the screening.

This survey analyzes the location, psycho-social health, special medications and occupational exposures that they have had during deployment. A post-deployment blood sample is also drawn and forwarded to the DOD serum repository.

Post-deployment care regarding reserve personnel is coordinated through their unit and the VA facilities close by. The members that require immediate and extensive evaluation are received on active duty until they have a disposition. During calendar year 2003 and 2004, the 59th Medical Wing had received over 609 OEF and OIF patients, Wilford Hall treated 127 and 482 were sent to other facilities.

We work closely with our VA points of contact to ensure that the patients are fully aware of their VA benefits. For those patients who may be transitioning from DOD healthcare to the VA healthcare, we are committed to ensuring their access to the VA. One example is a U.S. Marine Corps corporal who basically came in having had a cervical spine fracture. He was treated at Wilford Hall and is now receiving pain management and coordinated care with the Dallas VA system which was facilitated by our VA here in San Antonio. In 3 months, he will be re-evaluated and hopefully will be returned back to duty.

The second unfortunate case is a senior airman who jumped off a tracked vehicle in Afghanistan and received a foot injury that led to reflex sympathetic dystrophy, which is a chronic pain syndrome. This is a debilitating issue and we are waiting to do the medical board after we get input from the local community. Here again, this was facilitated by the DOD/VA.

In summary, I have been involved with post-Desert Storm surveillance as program director of primary care at Wilford Hall Medical Center and later provided oversight as the Chief of Clinical Medicine for Headquarter Air Education and Training Command. I can attest to the lessons learned from the comprehensive clinical evaluation program, a retrospective analysis of post-Gulf War syndrome, that we have successfully implemented lessons learned. This is demonstrated by the effectiveness of both pre-and post-deployment survey completions as well as aggressive public health and safety initiatives, both before they go to theater and in theater.

Mr. Chairman, I am convinced that continued asset sharing between the U.S. Air Force, Army and VA will strengthen our system and provide medical services and ensure our service men and women will receive the best care in the entire spectrum of the federal health system.

Thank you for allowing me to testify today.

[The prepared statement of LTC Masterson appears on p. 96.]

Mr. SIMMONS. Thank you, Colonel Masterson.

We have completed the testimony of panel two. I have a question for Dr. Cancio, LTC Cancio, representing the burn center.

In your testimony, you made a statement on page 3 that with regard to the aeromedical evacuation of burned servicemen and the Army burn flight teams that were prepositioned in Saudi Arabia, your experience was that they were under-utilized. At the same time, on page 1 of your testimony, we have a worst-case-scenario prediction that the conflict and the global war on terrorism could generate approximately 1,000 burn patients.

I just want to share with you an anecdote. On September 11—and you know I am from Connecticut—the State of Connecticut mobilized all of its doctors to deal with what we anticipated to be the injured, the burned, the broken and the injured. And in the southwestern part of our state, all surgeries were canceled and all doctors were called in to deal with the injuries. But in fact, there were very few. When the World Trade Center collapsed, most people were killed. Those who suffered burns died of their injuries or were crushed in the building.

And so the point I am getting at here is that it is very hard I think to anticipate what your caseload is going to be in a particular situation. As you say, you anticipated certain types of burns in the war in the Gulf and that did not occur. You say that a lot of the burns are due to accidents, not actually through combat. Maybe that is because flame throwers are not used any more, napalm is not used. I am not sure.

How do we, as a nation, anticipate what those burns may be? I mean if there is a nuclear explosion of some sort delivered by a terrorist group, I would expect those burns would be very substantial. How do we do that? What confidence do you have that you are maintaining the right capacity for the nation at this point in time?

LTC CANCIO. The question of burn bed capacity I think is an important one when you examine, for example, a scenario in which the World Trade Towers would not have collapsed. Under those circumstances, we do not know the answer, but it is possible that there may have been hundreds of seriously injured casualties that would have had to be transferred out of New York City across the United States.

What we found from our experience during Operation Iraqi Freedom was that the daily burn bed capacity was approximately 400 beds, of about which were intensive care beds and half were ward beds in the 60 participating burn centers. 400 burn beds on any one day, an average of nine and a half beds per burn center, is not a large excess capacity and thus, what we learned from that experience was that the burn capacity is not unlimited.

When one considers certain more severe scenarios, as you mentioned a nuclear terrorist attack in which we would anticipate many thousands of burn casualties, then those casualties would certainly potentially overwhelm the burn bed capacity and we would have to fall back on non-burn bed to take up the slack.

Mr. SIMMONS. So the bottom line is we have to maintain the capacity in anticipation of an incident that could occur, but to date we have not actually experienced that.

LTC CANCIO. I absolutely agree.

Mr. SIMMONS. Thank you, Colonel. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much. I have three questions, if it is okay, Mr. Chairman.

Ms. DelToro, let me ask you, I just introduced legislation to permanently extend the military sexual trauma counseling and treatment and I wanted to know how we are doing there and how we are progressing and some feedback in terms of are we making any gains into the future in that area.

Ms. DELTORO. That is one of our priority programs in the women's healthcare program, to provide for military sexual trauma.

And it is a significant need. I would say more than 50 percent of my patients have a history of sexual trauma.

Mr. RODRIGUEZ. What percentage? I am sorry.

Ms. DEL TORO. It is a guesstimate, I would say at least half of my patients that I care for have a history of sexual trauma. Very few request counseling services.

We collaborate with the Vet Center to provide counseling services throughout our whole system.¹

I feel like we have good collaborative programs, but I think we need more. We need more counselors available.

Mr. RODRIGUEZ. Thank you. And Dr. Aguilar, I know that we had, through the last legislation we also included some language in there with the help of Congressman Ortiz to look at the Valley, both from Corpus all the way to Brownsville as well as the McAllen area that are represented by Congressman Ortiz, Congressman Hinojosa, myself and now of course Congressman Doggett and I know that there is a great deal of disparity there. There were some plans—I know the McAllen Clinic, there is a plan there to expand. Where are we at on that expansion and any other comments you want to make as it relates to, especially Brownsville and that area down there where we do not have sufficient services for our veterans.

Dr. AGUILAR. Well, first of all, the vast majority of our patient population is made up of two counties and that is Cameron County and Hidalgo County. Right now in McAllen, TX, we are serving both counties, so we are having to take on almost essentially 40,000 veterans, potential veterans, of which we serve about maybe 23 percent of them right now.

What is going to happen is that that the Harlingen Outpatient Clinic will decompress to McAllen VA Outpatient Clinic. In anticipation of that, we are going to move over two physicians from our clinic in McAllen over to Harlingen. In the meantime, we have been granted over-hire authority to go ahead and bring in two new physicians to replace those.

As that happens, we are going to be transferring the care of the patients that are coming in from Cameron County, the adjoining county, all the way to McAllen. Those veterans will be asked to see if they want to transfer over to the Harlingen Clinic and I think most of them probably will accept moving closer to that facility. In the case of those that want to stay, of course they will be allowed to stay in McAllen.

So that decompression right now, which is slated to occur as early as July 2004, will tremendously help McAllen right now, with further plans for expansion in the future. Of course, this is going to go on and expand into 2006 with that 30,000 square foot facility, with the Regional Academic Health Center that will certainly mirror what we have in McAllen, and I think that both of those facilities will probably be able to handle that patient load.

Mr. RODRIGUEZ. And hopefully we can move on that as quickly as possible. But let me also indicate that one of the arguments that I get in Washington is that I get told that the demographics show

¹Patients are also seen for counseling in the mental health clinics in San Antonio, at the Kerrville Division and in the satellite clinics.

a large number of veterans in the Valley, both in Cameron, Hildago and Nueces and all those areas, yet the numbers are not reflective of what the VA has and usually there are serious discussions and arguments and they have those specific numbers. And I was wondering, you know, what we might be doing to try to correct that, because we actually need help. I know the veterans are there, but the demographics does not show that, for some reason or other and they are not registered. And there are a lot of veterans that do not even have—I guess they are not reporting or not coming forward.

Are you guys involved at all in that in terms of trying to get that corrected?

Dr. AGUILAR. I know that the veteran population that they have given I think will pretty much mirror I think what we have anticipated is the population down there, which is about 47,000 veterans. That does not include, of course, the winter visitor population that will visit every winter down in the Valley area. But I feel that number is about as accurate I think as I can anticipate.

Mr. RODRIGUEZ. Thank you very much. And Mr. Chairman, last question, if I can ask, I wanted to get on the post-traumatic stress disorder, this is a real serious dilemma in the military especially in people that serve in combat. I just have been going to Wilford Hall and Walter Reed, we visited several months ago and we talked to the soldiers and of course, they are still gung hearing officer, they are real proud and I understand that. But I also understand how post-traumatic stress disorder operates and they go through this process and I know they go through a process of personal guilt that they could have done something to prevent whatever, and then they go to displacement and then blame until they are re-assessed.

Is there something that we could be doing now? Because the typical person in active duty will come back and tell you oh, there is nothing wrong with me, I am okay. It does not happen until later, sometimes it can be 20, 30 years later. So I was wondering if we have come up with some kind of response that we could really address some of these needs on the long-term and I wanted to get some feedback from you.

LTC MASTERSON. Yes, sir. Actually there are a number of studies that are ongoing right now to include the use of virtual reality to treat patients. A recent article published Science date April 2, 2004, beta blockers to treat individuals exposed to a traumatic incident.

One of the things that we have been doing at Wilford Hall is individual and teams receive a briefing before they go and after they return. Before, so they understand what they might expect to see, so we tailor it to their area of operation for the pre-brief. When they come back, they get a post-brief to say these are some of the things that you may experience. We also have a number of pamphlets and booklets that we give to the family members as well as the deploying member on how do you deal with these type of things. And then we have some cards and pamphlets—I actually have them with me—that actually give them a number to call, because a lot of times the person has to be ready to talk about it.

But here again, one of the initiatives that we started back in 1996–1997 was basically a commander community effort on looking

at suicide in particular. It also applies to post-traumatic stress. Looking for signs and symptoms and therefore letting people know, you know, what kind of questions do you need to ask of your co-workers, of your husband, of your wife. And then knowing what resources are available in the integrated delivery system we have in place which are chaplains, social workers, psychiatrists, psychologists and the family support centers that are all on line. And that is new since the Persian Gulf War.

Mr. RODRIGUEZ. Let me just share one thing with you that—most people do not agree with me on this issue, but we have a large number of people in our prison system and 80 percent of our prison system has to do with drug-related, and a lot of it might be self-medication because of the problems. We have got a large number of our veterans that are in our prison system for self-medication and involving illegal activities regarding drugs. But a lot of it is the issue of trying to self-medicate.

Somehow, I would hope that at some point, and I am just throwing this out, that we do something about those veterans, not only our veterans but especially our veterans that are in our prison systems that are there for non-violent crimes because of use of drugs and in some case might be a result of self-medication trying to cope with the situation.

So I just thought I would throw that out there. And I am wondering if anyone is doing anything in that area.

LTC MASTERSON. Yes, sir, there are ongoing efforts in those areas and there are probably many people out there that would agree with you.

Dr. HOLLIDAY. If I could just respond, Congressman, with two points. One is, as you know, the computerized medical record in VA has something called clinical reminders where certain healthcare information, clinical information, comes up periodically and prompts the provider to ask key questions, to make key diagnoses that further care. We are already asking about substance abuse and depression on an annual basis with every veteran who is seen in our clinics. Shortly we will be adding screening questions for PTSD. So every veteran who comes into our system will be queried annually by their providers, are you having these symptoms, are you having these problems. And if you are, then we can help you get some care for that.

In addition, through the use of social workers in almost all of the primary care clinics and now increasingly psychologists and psychiatrists assigned to some of these clinics, we are trying to move some of our mental health resources into the primary care setting with less stigma against approaching a mental health provider, because we are part of the regular healthcare team.

So those two initiatives are ways we are trying to be ready and proactive in identifying these folks that need help.

Mr. SIMMONS. Mr. Miller.

Mr. MILLER. Mr. Chairman, if I might, in view of time since we have another panel, I will waive my questions.

Mr. SIMMONS. Most certainly. Mr. Rodriguez, do you have additional questions?

[No response.]

Mr. SIMMONS. Hearing none, I want to thank panel two very much for their testimony. We appreciate their being here and we appreciate what they do every day of their lives. Thank you very much.

Panel three is made up of Ignacio Leija of the American GI Forum, National Veterans Outreach Program; Jose Diaz, former District 20 Commander, Post 20, Veterans of Foreign Wars; Douglas Herrle of the Disabled American Veterans and Richard Holloway of The American Legion.

Gentlemen, welcome, thank you for being here today, and we look forward to hearing your testimony. We are limiting our testimony to 5 minutes for sake of time. So if you want to summarize your comments, we do have your written statements in our package to review. First, Mr. Leija of the American GI Forum. Welcome, sir.

STATEMENTS OF IGNACIO LEIJA, AMERICAN GI FORUM, NATIONAL VETERANS OUTREACH PROGRAM; DOUGLAS HERRLE, DISABLED AMERICAN VETERANS accompanied by WILLIAM MORIN; RICHARD HOLLOWAY, THE AMERICAN LEGION

STATEMENT OF IGNACIO LEIJA

Mr. LEIJA. Thank you, Mr. Chairman and members of this Committee. Good morning, and thank you for inviting me before this Committee and for allowing me to participate in this important hearing. My name is Ignacio Leija and I am the Vice President of Service Operations for the American GI Forum, National Veterans Outreach Program based in San Antonio, TX.

It is my understanding that today's session focuses on transition and access between the Department of Defense and the VA medical facilities. This is truly a timely subject due to the thousands of troops that are returning within 90 days. Obviously due to the current situation within Iraq, things may change. Eventually however, this transition will occur.

The American GI Forum constituency is made up of many Hispanic veterans. Many of our veterans reside in areas without reasonable access to VA medical centers. For that reason, I would like to take the opportunity to voice our support for the continuing addition of VA community based outpatient clinics in areas lacking VA medical centers.

Our nation is faced with the homecoming of many more new veterans who will be returning soon, some of which may require long-term medical care for illnesses or injuries suffered during this Iraqi war. For this reason, we support the recent introduction of collaboration between the Department of Defense and Department of Veterans Affairs. The result is that military medical evaluation findings can be accepted by the VA for ratings of medical conditions of newly discharged veterans without burdening them with further duplicating evaluations.

The American GI Forum also supports the initiative by the Department of Defense's personnel evaluation boards that will consider the cases of disabled veterans who want to continue their military career. We encourage the continued sensitivity on the part

of the Department of Defense to expand that opportunity for those veterans to cross-train to other fields and remain productive in the military in spite of a disability.

A great concern that the American GI Forum constituency has is that of releasing veterans immediately after returning state side. The participation in a war zone can have a long-term detrimental effect. It is our understanding that the Department of Defense plans to rotate reservists back from Iraq and discharge them within 48 to 72 hours. The Vietnam experience, as supported by vet centers, should have taught us that combat veterans must have time to defuse and adjust among their peers with similar experiences. We encourage the Department of Defense to further investigate and possibly consider a 30 to 45 day adjustment period before discharge during which time the Department of Defense and the vet centers could collaborate and offer appropriate counseling and other supportive services. If not, we fear that another cycle of post traumatic stress disorders will follow this new generation of veterans.

Our organization and other VSOs are prepared to assist our returning veterans by joining transition teams that will facilitate the return and re-entry of new veterans into civilian life.

The American GI Forum is proud to serve the needs of all veterans through its National Veterans Outreach Program. With offices in six of the largest cities in Texas, we currently provide services in employment and training for recently separated veterans, disabled veterans and veterans that served in theaters of war. The staff assigned to these offices are prepared to assist veterans by providing them with job search skills and other skills that they need for job search placement.

In closing, I would like to thank Congressman Ciro Rodriguez for his continued effort in helping us. We are very fortunate to have him in this state. Thank you very much.

Mr. SIMMONS. I thank you very much for that testimony.

Next is Douglas Herrle, Chapter 61 Commander of the DAV. I understand he is accompanied by William Morin.

[The prepared statement of Mr. Leija appears on p. 101.]

STATEMENT OF DOUGLAS HERRLE

Mr. HERRLE. My name is Douglas Herrle. Mr. Chairman and members of the Subcommittee, we thank you for the opportunity to present the views of Disabled American Veterans, DAV, Department of Texas, an organization of more than 73,000 wartime disabled veterans, on the status of military and Department of Veterans Affairs healthcare coordination, including post-deployment healthcare of recently discharged veterans.

I have primarily two issues, Mr. Chairman. One of them is the funding for the VA healthcare. As we know, at this time VA healthcare is underfunded. The numerous veterans' organizations have put out an independent budget and we have seen that budget be cut by our Congressmen and Senators because they do not feel that VA healthcare is important. Now that may not be the message you want to send, but I will guarantee you that is the message that the people out here in the world are getting. You do not care about the veterans.

The other thing is the time it takes to get an appointment at the VA. I am 100 percent service-connected disabled. Actually numerically a little over 300 percent. For me to get an appointment at the VA—to call and get a scheduled appointment will take me anywhere from three to 6 months, period. There is no—they will send me to triage. I can go sit in triage and I can sit there anywhere from three to 18 hours before being seen. It makes no difference what I come in for, whether it is heart, chest pains, whatever. I am having a bad day because I do have PTSD and they are going to send me to triage and let me sit there for 3 or 4 hours. When a veteran has PTSD and he is reaching out for help, the last thing you want to do is put him in a crowd and tell him he has got to sit until he is called which may be 3 or 4 hours. I am lucky. If I had not have been retired, I would probably be dead if I had to rely on the VA, because when my episodes hit, a lot of times I may come home, sit down in the easy chair to watch television and suddenly I am hitting on the nitroglycerin and trying to get my air which I cannot do. To go to the VA and sit in triage with chest pains, we have had disabled veterans ask department commanders for the DAV that have gone there with chest pains and sat for over 8 hours waiting to see a doctor.

Our doctors, most of them are limited in their English language or they are a part-time doctor available one day a week and then maybe only for half a day.

I see I just got the red light, so I want to thank the Chairman.

In closing, the DAV of Texas sincerely appreciates the Subcommittee for holding this hearing and for its interest in approving benefits and services for our nation's veterans. The DAV deeply values the advocacy this Subcommittee has always demonstrated on behalf of America's service-connected disabled veterans and their families.

Thank you for the opportunity to present our views on these important measures. Again, I would like to extend my very much thankful that we have Congressman Rodriguez there to help the veterans. Thank you.

Mr. SIMMONS. Thank you very much.

The third panelist is Richard Holloway, Vice Chairman of the Americanism Commission of the American Legion. Welcome, and we look forward to your statement, sir.

[The prepared statement of Mr. Herrle appears on p. 105.]

STATEMENT OF RICHARD HOLLOWAY

Mr. HOLLOWAY. Thank you, sir.

Good morning, Mr. Chairman and members of the Subcommittee. I appreciate the opportunity to present views of the 2.8 million members of the American Legion worldwide and those here in San Antonio on the status of military and VA healthcare coordination, including post-deployment healthcare of recently discharged veterans. The American Legion commends the Subcommittee for the holding of this hearing on this timely and important subject.

With the global war on terrorism and the ongoing military action in Iraq and Afghanistan it is clear that DOD and VA must coordinate healthcare delivery to our veterans of this conflict. The young men and women returning to Fort Sam Houston, Lackland and

Randolph cannot and should not slip through the cracks between these massive agencies due to the lack of information sharing or outreach coordination. Our knowledge of the efforts of war on both the mind and body has uniformly increased with each succeeding military conflict involving our nation. This knowledge obligates our government to follow the health status of our veterans who return from war.

The most recent analysis of VA healthcare utilization show that 127,970 veterans have returned from Operation Iraqi Freedom. Fourteen percent, 17,800, have sought healthcare from VA. Other than dental or unspecified musculoskeletal conditions the most frequent diagnosis were deafness, 1,212 veterans; infectious and parasitic diseases, 1,103; essential hypertension, 996; and adjustment reaction, 970, including 626 diagnoses of PTSD. So far, coordination between the DOD and VA systems with regard to OIF and Operation Enduring Freedom, OEF, appears to be working well at the operational level. Pre- and post-deployment health screening has improved since the initial programs noted in various reports by GAO.

The American Legion is heartened by the Army's new Disabled Soldier Support System, DS3, an initiative to deliver services to the veterans with a minimum of delay and red tape. In previous conflicts, veterans presented themselves to the VA and were required to prove their own eligibility. DS3 now facilitates referral to VA and provides disabled soldiers with a system of advocacy, including representation by VSOs such as the American Legion. The American Legion appreciates DOD's inclusion of VSOs in this process. Hopefully this will evolve into the same relationship that VSOs now enjoy with the VA.

In March of last year VA announced that any veteran returning from a combat zone is entitled to 2 years of free VA healthcare. This applies to active duty, Reserve and National Guard personnel. In the announcement, VA noted the progress made in partnership with Department of Defense, notably standardized post-deployment physical examinations and clinical practice guidelines. Two joint post-deployment VA/DOD clinical practice guidelines address general post-development issues and unexplained fatigue and pain have been released and a new CPG is soon to be released on the management of traumatic stress with the aim of preventing PTSD.

In an unusual move the Surgeon Generals of the Army, Navy and Air Force have approved the detailing of VA benefits counselors and clinical social workers to MTFs receiving casualties from OIF and OEF.

Mr. Chairman, these efforts by VA and DOD to avert the problems encountered after Operation Desert Shield and Desert Storm have been innovative and laudable. Never before have the VA, DOD and the VSO community come together so effectively to ensure that those who shall have borne the battle receive the care and benefits they have earned and deserve because of their service.

More challenges lie ahead in institutionalizing these reforms for the future. Described as seamless transition, attempts to bring together the DOD and VA healthcare are nothing new. The DOD/VA Health Resource Sharing Operation Act of 1982 paved the way for cooperation in the sharing of resources during national emer-

agencies. Since then a plethora of legislation has mandated and encouraged further VA/DOD cooperation. The most recent and significant of these laws is the National Defense Authorization Act of 2003, Subtitle C. DOD/VA Health Resource Sharing required VA and DOD to develop and publish a joint vision statement and a joint strategic plan on sharing efforts among two departments.

Major resources are being applied by both departments to comply with this law. A few current projects include the Joint VA/DOD Electronic Health Records Plan will result in a virtual health record accessible by authorized users within the DOD and VA. The VA and DOD Health Executive Council is providing oversights of these activities.

The Clinical Resource Repository/Health Data Repository seeks to develop the software components to ensure the interoperability of the DOD and VA Clinical Data Repository.

The Lab Data Sharing and Interoperability projects facilitate electronic order entry and results retrieval between DOD, VA and commercial medical labs to maximize resources and reduce costs.

In closing, U.S. field commanders are aware that their responsibilities include Force Health Protection and this has become a major theme in military operations. Congress had widely seen to it that these themes extend to the highest reaches of the Pentagon and the VA. The American Legion is cognizant that DOD and VA face many challenges to achieve these goals. The administrative and management cultures are unique in both agencies and information sharing in the past has been slow in coming. The American Legion however is confident that the goal of seamless transition will be achieved as the requisite technologies are developed and implemented.

Mr. Chairman, I again thank the Subcommittee for the opportunity to present the views of the American Legion on this subject of today's hearing. I will be happy to answer your questions if you have any. Thank you.

[The prepared statement of Mr. Holloway appears on p. 107.]

Mr. SIMMONS. Thank you, Mr. Holloway, for that testimony.

I have a question for the record.

Mr. Leija, I was very interested in your testimony. I am from New England and we do not have a chapter of the GI Forum in New England or in Connecticut that I am aware of. I am very interested in the fact that you have stated on page 3 of your testimony that you focus on vet centers and outreach centers. I am assuming you are a Vietnam veteran or members of your organization are Vietnam veterans?

Mr. LEIJA. Vietnam era veterans.

Mr. SIMMONS. Vietnam era veterans. How do you find—20 years ago when I returned back from Vietnam, I worked very hard with Senator Chafee of Rhode Island to extend the vet centers. That would be in the late 1970s or early 1980s. I gather that you find that this is still a very useful program for our returning veterans. How do you cooperate or intersect with the more traditional VSOs and with the VA and the other healthcare providers? Do you have protocols for that? Is it an informal relationship? How does that work?

Mr. LEIJA. Congressman, a lot of those are informal relationships that we have established. The American GI Forum is a membership organization and as such has established a services organization, the National Veterans Outreach Program. The National Veterans Outreach Program in turn has been able to establish relationships with other VSOs and with vet centers and with the VA as we collaborate and try to assist veterans that are getting out of the military or have been out of the military for quite some time and are in need of employment. That is basically the area that we are specializing in, employment and training. Consequently we get a lot of the VSOs that refer individuals to us in addition to vet centers. Once veterans have gone through their treatment services they are then referred to our organization in order to obtain employment or training to further enhance their skills so that they can lead productive lives.

Mr. SIMMONS. Thank you very much for that response. That was very informative to me.

Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you, Mr. Chairman.

I also want to take this opportunity to thank the American Legion, the GI Forum, the DAV and all the other organizations that have come forward. I know that the service that you personally provide and extend to our veterans, you are the ones that reach out to a large number of our veterans, to help us in educating them in terms of what the needs are. So I want to personally thank you for what you do, not only here but also throughout, and let you know that I know the Chairman recognizes the national organizations also provide testimony on an annual basis to us. We want to thank you for what you do in that area.

I want to specifically kind of talk a little bit about where we are at right now, especially as it deals with job training and development. I know that GI Forum—do any of you want to react to that in terms of resources that you get and where we are at in terms of employment situations for our veterans, especially since we have been—you know, here in Bexar County we have done I think pretty well economically. We have picked up. I know nationwide we have had some difficulty with the unemployment rate increasing and see how that impacts the veterans directly.

Mr. LEIJA. That is a good question, especially right now with, as you say, the economy, although it is picking up. We have experienced a considerable amount of unemployment across the board and obviously this does affect veterans. Many of the veterans that are coming out right now especially are in a situation where they have been specialized in their field in the military, but the crossover to the civilian sector sometimes is difficult. And one of the things that we have looked at, and the Department of Labor I think has also reviewed, and that is utilizing or being able to utilize some of the certifications and licensures that the military get in the—or that the veterans get in the military are not transferrable to civilian life; therefore, they are required to take tests. They are required to go through a recertification process, et cetera. One of the things that we would like to see is maybe a situation that will allow that transition a little bit more easily.

The idea also of working with the VA as far as allowing individuals to—that come out and continue to be in the military, if in fact there is a disability, I think is something that I mentioned in my testimony, because some of them do not want to come out. Some of them would like to stay in the military. Consequently that is something that maybe the Committee should investigate a little further.

Mr. RODRIGUEZ. Thank you very much.

Mr. SIMMONS. Mr. Miller. Oh, excuse me. Yes, please, go ahead.

Mr. Herrle. Congressman, I would like to address the question regarding employment. Having been a Texas veterans' representative, employment, local employment representative for almost 10 years, there are several avenues that a veteran can take when he is coming out of the service, especially here in Texas. He can go to the Texas Work Force, contact the local veterans' representative there, get job referrals, get assistance with planning, training, with the work—the WIA program here in Texas which helps fund a lot of their programs. Also he can go on monster.com and find jobs in his local area. He can contact a DAV service officer and they can help him. Our DAV NSOs here in San Antonio, Houston are all willing to step up and help the department service officers the same way.

There is such a thing here in Texas called the Hazlewood Act. I call it the best kept secret in the world. It went into effect in January of 1947 and it allows a veteran 150 semester hours of tuition-free school at any state-supported school. That is after he runs out of his VA benefits, GI bill, vocational rehab. He can still continue in school under Hazlewood for 150 additional hours. Thank you.

Mr. RODRIGUEZ. Thank you, Mr. Herrle.

Mr. SIMMONS. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

I just wanted to talk a little bit—ask a question about the Veterans' Outreach Program, if I could. Then you talk about staff being assigned to assist vets in providing them with job search skills, resume writing, enrollment, short-term vocational class training, on-the-job training. How do you coordinate with VA? How does your organization coordinate?

Mr. LEIJA. Well as far as not only San Antonio but in those areas that I have mentioned, many of the veterans that we work with are not only recently discharged veterans but also some of the veterans that have been out for a while and are experiencing problems let us say in the area of substance abuse. So consequently what we do is we coordinate our efforts so that an individual can go through the substance abuse program and receive treatment from the VA. We attend their staffings so that we are in touch with the veteran that we have referred over there. Once the veteran is released, we know about it and they are ready to come back to our office where we can continue the development as far as any skills training that they may need, coordinate that with vocational schools in the area or on-the-job training. If a school is not available, we will work with employers that are willing to train the individual in a particular skill and thus become employed once the training has been concluded. But the relevancy as far as the coordination takes place as individuals go through their system. There has to be coordina-

tion and communication between our organization and VA representatives.

Mr. MILLER. Is part of that duplication of services?

Mr. LEIJA. Is it duplication of services? I do not believe so. In what manner, Congressman? I am sorry.

Mr. MILLER. Well vocational training that the VA provides.

Mr. LEIJA. Oh, I see, that the VA provides. I do not see that because we are actually looking at individuals that heretofore have not been able to access the VA system maybe and either had difficulty or did not want to, and through coaxing from our staff then went into the system and were ready to come back out to us.

Mr. MILLER. Thank you.

A final question, Commander Herrle. You can do it from right there if you want, sir. Has DAV had any success with being able to visit with those returning military men and women who are disabled and will be discharged as such in the hospital? Have you been able to get in to them to be able to tell them about the services or are you being prevented from doing that?

Mr. HERRLE. I will defer to Mr. Morin on that one.

Mr. MILLER. If you would, identify—

Mr. SIMMONS. Mr. William Morin.

Mr. MORIN. Yes, I am DAV National Service Officer for this area, south Texas. We do have an active transition assistance program that is alive and healthy. I might add, in conjunction with the veterans' benefits program the VA has provided a full staff of VA contact facilitators. In conjunction with that, I have a single person that works a transition assistance program at BAMC, at Wilford Hall, and Randolph Air Force Base. So it is alive and well. The DAV specifically—we are working about 100 to 125 claims per month transitioning servicemembers that are also provided a medical and physical evaluation representation. So yes, the program is there and it is alive and well, and in my professional opinion is really providing excellent service to those veterans that are coming off of active military duty and making that transition into civilian life.

Mr. MILLER. We had received some testimony in Washington that DAV was having some trouble accessing some of the patients. Has that been corrected?

Mr. MORIN. Yes, it has been corrected. I believe a lot of it was the media. I think a lot of it was protecting the privacy of the individuals, especially those that were catastrophically disabled. But from the standpoint of us being able to go in and make the transition, the contacts we expect to serve as members that were injured, that has improved, at least in the San Antonio area. We are not having any problems at the present time getting onto the base and seeing those veterans that are making the transition.

In the DAV system, we provide counsel on the physical evaluation boards and that is when a servicemember is being found physically unfit for active military duty. At that point, he will need, from a medical evaluation board side, he will go over to the administrative side, the physical evaluation board side which determines whether or not he is reasonably capable of performing his duties within limitations of his disability. At that point, we are very successful in that. We are conducting approximately 30 to 35 formal

hearings before the physical evaluation board in both the Army and the Air Force system here in San Antonio.

Mr. MILLER. Thank you.

Mr. SIMMONS. Thank you. As we bring this hearing to a conclusion, I would like to thank all of the panelists who appeared here today and I will remark that something very unusual happened, something that does not happen that frequently in Washington, DC, but all of the panelists arrived at the beginning of the hearing and then they all stayed. You know, that is really exciting for me, because so often in Washington, DC, if it's panel two or three, they will come in halfway through the hearing, boom, testify, gone and show no interest in what others have to say. And this conveys to me an important message, a message that this community of military officers and NCOs, this community of Veterans' Administration healthcare providers, this community of VSOs actually care about each other, they know about each other, they care about each, they care about what they have to say and that leads me to believe that they probably care very much about the active component soldiers and the veterans that they serve. I am really excited to see that.

Let me make a couple of housekeeping announcements and then I will ask Mr. Miller and Mr. Rodriguez if they have closing statements that they would like to make, and I have a short closing statement that I would like to make.

First of all, I understand that personal circumstances prevented Mr. Diaz from appearing today. If he provides a statement within 5 days, we will include it as part of the official record of this hearing.

Secondly, all members at the dias and all panelists have the opportunity to revise and extend remarks that they have made if they have additional revisions or extension of remarks that they would like to put into the record, I ask unanimous consent that they be allowed to do that.

Thirdly, I would like to note for the record the presence of Thomas Strenovo, Director of the Veterans' Integrated Service Network or VISN, for this region. I appreciate his attendance and his attention to these issues. Mr. Strenovo, would you stand please?

[Mr. Strenovo rises.]

Mr. SIMMONS. Thank you very much for being here, we appreciate that very much.

I would like to thank the City Council of San Antonio, Mayor Ed Garza and his staff and Chief of Police Albert Ortiz, who I hope allowed us to park on the street and did not tow our car. (Laughter.)

Mr. SIMMONS. For their courtesies in arranging our use of this facility, and I also am very pleased with the hospitality of the City of San Antonio today.

I want to thank Councilman Segovia for doing the introductions this morning. That was extremely helpful to have that assistance. And I also want to thank my friend and my colleague Mr. Rodriguez and his excellent staff for their help and support in setting up this hearing. I am told by my own staff that they did a great job and we really appreciate that very much.

At this point, I would ask Mr. Miller if he has any closing statement he would like to make.

Mr. MILLER. Again, thank you, Mr. Chairman and my colleague Ciro Rodriguez for holding this hearing. I think the testimony that was taken for the record was good, our colleagues will be able to peruse it and review it as staff will as well.

A couple of things if I can add, we talked about veterans' funding and I think it is important for the record that we do talk about it. We all know that more can be done, the fact remains that in the last 3 years, Congress has added over \$3 billion above the administration request for veterans' issues and in 5 years, in the past 5 years, there has been a 47 percent increase in benefits and services. And I would say that right here in San Antonio, it is my understanding that in the last 6 years, there has been about \$100 million more that has been put into the medical center in San Antonio.

Is it all we can do? Probably not. Are we trying hard? Yes, we are. We owe it to those men and women who have served this country, we appreciate and honor them every day and more will be joining your ranks in the future.

But thank you for allowing us to serve in Congress and be able to represent you on this subject.

Mr. SIMMONS. Thank you, Representative Miller, for your presence, for making the trip here from Florida, for our insightful questions and for your comments.

Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you, Mr. Chairman. I want to personally thank you for coming to San Antonio. I know you are also going to have an opportunity to visit some of the sites here in both the VA and other sites and I know the staff is going to have an opportunity to visit. I know that you will be going to visit our nursing home in Wilson County, one of the few veterans' nursing homes that we have in Texas, I am very proud to say that that was in my original district, then was changed, and now it is back in my district, so we will see what happens.

But I do want to thank you for being here. And also Congressman Miller, thank you. I know how difficult it is once again to come across the country to go to another member's district, but I want to personally thank you for coming over.

And Mr. Chairman, like always, you have been real gracious and I do want to thank the staff. We get a lot of credit but our staff does a lot of work. On my staff we have Patricia, Janet, Hector, Rudy, J.M.—can you all raise your hands?

(Applause.)

Mr. RODRIGUEZ. Thank you very much. And to all the presenters and the panelists, thank you for also coming forward. You know, in hearing the testimony, it is always good and we have got to continue to dialogue about how do we make that match between the Department of Defense as our soldiers get released and the VA, and how do we continue to improve in making sure that those soldiers do not fall through the cracks. So I want to personally thank you for being here and for especially the organizations, veterans' organizations that are here, thank you for being here and thank you for what you do.

And once again, Sergeant Canady, thank you for your service and thank you for joining us.

Mr. SIMMONS. Thank you, Mr. Rodriguez.

I would like to conclude a little bit on a personal note. As some of my colleagues know, I retired from the U.S. Army after 4 years of active duty and over 30 years of Reserve duty, a total of 37 years, 7 months and 24 days of service and I am a Vietnam veteran, I served for 20 months in the military and 2 years in Vietnam as a civilian with the CIA.

One of the things that has affected my life and motivated my life in many respects is the fact that when I returned back from Vietnam, I did not feel that America appreciated the veterans, I did not feel that the nation was grateful for the service and sacrifice of Vietnam veterans. And whenever I go to the mall and I see the names, the 58,229 men and women, on the wall, I get choked up because I think of what they gave to this great country of ours.

Never in my life did I ever expect to be a member of Congress or to chair the Veterans' Health Subcommittee in Congress, and it is a great honor for me to do that. But it is also exciting for me to work with my colleagues on both sides of the aisle to try to bring about better funding, better coordination, better cooperation, better services to our veterans. And at a time when my colleague, Mr. Rodriguez, who has done so much for his state and so much for the nation and so much for the veterans that he serves in Congress every day, at a time when he could probably be focusing on other issues, it also makes me feel very good to know that he is taking this day off for his constituents and for America's veterans. That to me again is a testament of what this community is all about and so I thank you, Ciro, for your service, for your dedication to our veterans, not just here in Texas, but throughout the nation, and I look forward to working with you in the future.

Thank you very much.

Thank you, Jeff, for your service and for coming all the way from Florida. And at this point, this hearing is adjourned.

[Whereupon, at 11:36 a.m., the Subcommittee was adjourned.]

A P P E N D I X

JOSE R. CORONADO, FACHE
Director, South Texas Veterans Health Care System

on behalf of the
DEPARTMENT OF VETERAN AFFAIRS
before the
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

APRIL 13, 2004

WRITTEN TESTIMONY

SOUTH TEXAS VETERANS HEALTH CARE SYSTEM

The Department of Veterans Affairs STVHCS was created on March 17, 1995 with the integration of the Audie L. Murphy Memorial Veterans Hospital, San Antonio, and the Kerrville VA Medical Center, Kerrville. STVHCS is comprised of three divisions referred to as the Audie L. Murphy Division, the Kerrville Division and the Satellite Clinic Division and has a FY04 operating budget of \$375 million. The STVHCS serves one of the largest primary service areas in the nation, 63 counties, and is part of the VA Heart of Texas Veterans Integrated Service Network (VISN 17), located in Arlington, TX.

The Audie L. Murphy Division (ALMD), named after the nation's most decorated World War II hero, began operations and initiated its affiliation with the University of Texas Health Science Center at San Antonio in October 1973. Acute medical, surgical, psychiatric, geriatric, and primary care services are offered for veterans residing locally, regionally, and nationally. The ALMD is comprised of 500 authorized hospital beds (included is a 30-bed state-of-the-art Spinal Cord Injury Center). In addition, a 90-bed Extended Care Therapy Center is located on the facility grounds. ALMD provides tertiary services including bone marrow transplantation, open-heart surgery, magnetic resonance imaging and positron emission tomography. The ALMD supports the eighth largest research facility in the VA with a total FY 04 budget of approximately \$8.2 million. The ALMD hosts nearly 32 principal investigators who conduct research on aging, cardiac surgery, cancer, and diabetes. The facility houses the only inpatient National Institute of Health sponsored clinical research center in VA; the Geriatric Research, Education & Clinical Centers (GRECC) is a "Center of Excellence". Additionally, "Centers of Excellence" designations have been awarded to our nationally prominent HIV Program as well as our women's health program.

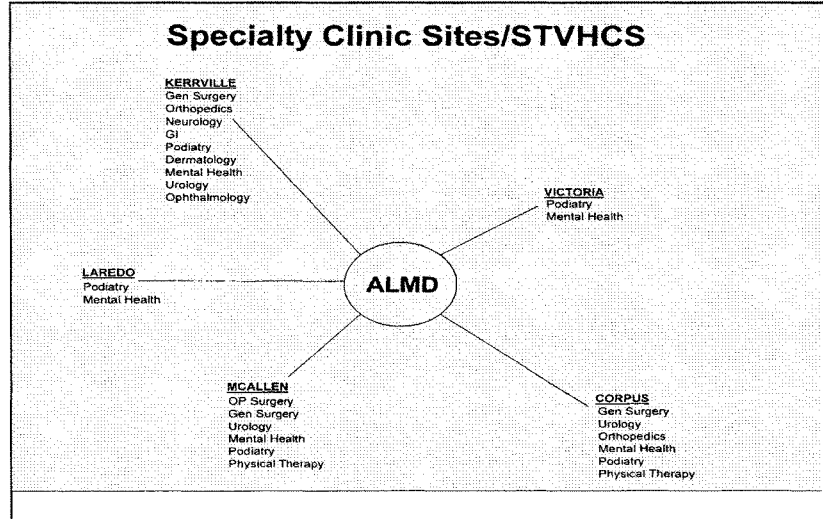
The Kerrville Division (KD), located 65 miles northwest of San Antonio, provides acute medical, primary care and long-term care services for an estimated 16,000 veterans residing in the "Texas Hill Country." Comprised of 25 operating hospital beds and a 154-bed Transitional Care Center, the Division delivers primary care, geriatric evaluation and management, hospice care, and a variety of specialty clinics. The KD has developed an extensive primary care delivery system and was the recipient of the 1995 VA Deputy Secretary's Scissors Award for its accomplishments. Along with its primary care program, KD's focus is long-term care and reflects the needs of the local retirement community.

The Satellite Clinic Division act is the first point of entry for many veterans and offers primary care and some specialty services. When required, veterans are referred to ALMD and KD for specialty care. The satellite clinic divisions is comprised of VA-staffed and contract Community-Based Outpatient Clinics (CBOCs). Staff clinics are located in San Antonio (1995), Corpus Christi (1972), McAllen (1972), Victoria (1989) and Laredo (1990). Contract clinics are located in Brownsville (1996), Alice (1998), Beeville (1998), Kingsville (1998), Uvalde (1998), San Antonio (2000) and New Braunfels (2000). The STVHCS also supports the clinics by providing ophthalmology, general surgery, mental health, orthopedic, podiatry and urology teams on-site (offerings vary by site). These actions provide services closer to patients' homes. In 1997, STVHCS initiated a contract with medical facilities in the Lower Rio Grande Valley (LRGV) to provide outpatient surgery and short inpatient stays to local residents. Annually, over 1,852 procedures (e.g. colonoscopies, endoscopies, hernia repairs and cataract surgeries) are performed locally in the LRGV.

COMPENSATION AND PENSION: The Frank M. Tejada Outpatient Clinic (FTOPC) is responsible for executing the Compensation and Pension (C&P) Exam Program. Currently over 500 veterans are evaluated monthly in the C&P Program. The FTOPC also houses a division office of the VBA's Houston Regional Office. The C&P Program received over 6,923 requests in FY 2003.

LOCAL ISSUES: The STVHCS continues to expand its accessibility while increasing the number of unique veterans served and is the epicenter of health care for over 300,000 U.S. veterans residing in south Texas and Mexico. Socioeconomic conditions of the area range from relative affluence in the immediate San Antonio and Kerrville areas to widespread poverty and unemployment in the largely Hispanic Rio Grande Valley. The number of unique veterans served is steadily increasing, with particularly rapid growth in the Lower Rio Grande Valley. Wait times and long travel distances remain a continuing challenge. In general, costs have been controlled and actually decreased relative to national cost per patient. Quality measures have also improved or stayed stable despite the increased patient population.

San Antonio is home to the National Defense Medical Services Area Manager, the Fort Sam Houston VA National Cemetery and the Alamo Federal Executive Board. The STVHCS sponsors a host of sharing agreements, joint procurements and collaborative arrangements with San Antonio's large Department of Defense contingent. For example, all blood products used at Wilford Hall and the South Texas Veterans Health Care System are collected and processed in a jointly operated blood bank. As a result, cost savings of over \$150,000 annually are realized for both VA and the medical treatment facility. Other sharing agreements with DoD include outpatient surgery, audiology, and optometry at the Corpus Christi Naval hospital; maternity care with Wilford Hall USAF Medical Center (WHMC); lab tests with Brooke Army Medical Center (BAMC); Lithotripsy with WHMC; and hyperbarics with Brooks Air Force Base.



AREA OF SPECIAL INTEREST: VA/DoD Collaborations

The South Texas Veterans Health Care System (STVHCS), Wilford Hall Medical Center, Brooke Army Medical Center, and other Department of Defense (DoD) facilities in San Antonio and South Texas are actively pursuing multiple strategies for sharing resources to better serve veterans and DoD beneficiaries. The goal is to identify opportunities to better utilize federal resources to provide care for beneficiaries and to achieve cost savings through resource sharing.

The VA/DoD Health Executive Council (HEC) has recently approved five initiatives in the San Antonio federal health care market to proceed to the second round of review for funding through two programs: the DoD/VA Health Care Sharing Incentive Fund and the Health Care Resources Sharing and Coordination Project.

Incentive Fund Proposals (DoD/VA Health Care Sharing Incentive Fund)

The FY 2003 National Defense Authorization Act (NDAA), Public Law 107-314 directed the Department of Defense and the Department of Veterans Affairs to establish a program to provide incentive funding in support of creative DoD-VA sharing initiatives. Each Department has contributed \$15 million to the fund for FY 2004. The STVHCS and Wilford Hall Medical Center (WHMC) submitted four Incentive Funding Concept Proposals on January 9, 2004.

Demonstration Projects (Health Care Resources Sharing and Coordination Project)

The FY 2003 NDAA also established the second funding program. Subtitle C, Section 722 requires that

VA and DoD establish a health care resources sharing and coordination project to serve as a test for evaluating the feasibility, advantages, and disadvantages of measures for programs designed to improve the sharing and coordination of health care and health care resources between the VA and the DoD. One of the following three elements must be included in the projects: (a) budget and financial management system, (b) coordinated personnel staffing and assignment system, or (c) medical information and information technology system. The demonstration period is to begin in October 2004 and end in fiscal year 2007. Funding will be provided to carry out this project. Each Department is to provide \$3,000,000 in FY 2003, \$6,000,000 in FY 2004, and \$9,000,000 for each subsequent year in FY 2005, 2006, and 2007. The STVHCS, Brooke Army Medical Center (BAMC), and WHMC submitted proposals in August 2003 and received approval on October 24, 2003 to move to the second level of review for two projects:

1. Lab Data Sharing Interoperability - STVHCS, BAMC, WHMC
2. Joint Credentialing Project – STVHCS, BAMC, WHMC

Both projects are classified as medical information and information technology management systems under this funding program. The next step is to submit business and implementation plans by April 30, 2004 to obtain approval for funding. Implementation of the demonstration projects will occur on or before October 2004.

1. Lab Data Sharing Interoperability (LDSI)

- The purpose of the project is to test LDSI in the San Antonio federal health care market. Specifically, the STVHCS would evaluate the feasibility of electronically transmitting test results from BAMC directly into VISTA under the current sharing agreement between BAMC and STVHCS for send-out lab tests.
- STVHCS has been utilizing the reference lab at BAMC for more than five years.
- Having the test results electronically submitted would reduce the chance for human error during manual entry, as is the current procedure.
- Following successful implementation of LDSI, STVHCS would review all individual lab test volumes with the intent to transfer those send-out tests to BAMC.
- LDSI is a VA developed methodology, currently being tested at VAMC Hawaii with Tripler AFB.
- Goals for LDSI include:
 - Share and coordinate resources in order to reduce costs and redundancies and increase efficiencies within the two agencies
 - Facilitate the electronic exchange of patient information between DoD and the STVHCS to enhance delivery of patient care
- In subsequent stages of this project, LDSI would be expanded to include other DoD facilities plus testing of a two-way interface. (Currently, the LDSI interface only allows transfer of information from DoD to VA.)

2. Joint Credentialing

- The STVHCS, WHMC, and BAMC propose to pilot joint credentialing of VA and DoD licensed providers based on an interface between the Department of Defense (DoD) Centralized Credentials Quality Assurance System (CCQAS) and the Department of Veterans Affairs (VA) VetPro.
- The project would be divided into three phases:
 - Phase I – Implement the current CCQAS/VetPro interface (CCQAS 2.7.6) and identify needed changes/enhancements based on a local operational user perspective.

- Phase II – Integrate functionality of CCQAS 2.7.6 into CCQAS 2.8 in the fall when it is released and implement CCQAS 2.8, moving BAMC and WHMC from a paper-based to a web-based application process with capabilities to scan primary source verification documents. Identify needed changes/enhancements based on a local operational user perspective. Identify a means to provide the capability to view credentialing files and scanned primary source verification documentation in either system by VA or DoD staff.
- Phase III - Explore the need for and feasibility of a local centralized site for primary source verification in San Antonio.
- Phase IV - Expand the use of credentialing in VetPro at STVHCS and CCQAS at WHMC to include nurses and other licensed professionals as currently done at BAMC
- The goal of the joint credentialing project is to eliminate duplication of efforts due to each VA/DoD facility independently verifying the credentials of the same licensed practitioners.
- Tangible benefits include cost savings achieved through operational efficiencies gained by sharing staff and consideration of one site for primary source verification.
- Sharing of data would result in time savings during the credentialing process. Standards for quality and quantity of work performed by the credentialing staff would be developed and implemented at all locations.
- The ability to identify and deploy providers appropriately in the case of a local or national emergency would be enhanced.
- Accuracy and consistency of data entry and data validation would be maximized. Electronic data validation would improve data quality. The use of shared data should reduce mistakes through dual entries of information.
- Communications would also be improved between the staff at each facility. Each medical treatment facility would be able to access the verification data through CCQAS or VetPro.
- Job satisfaction for credentialers should be improved due to process improvement initiatives, time savings, and standardized work processes. An effective credentialing system will enhance the ability of VA/DoD facilities to maintain provider skills and better serve the beneficiaries.

AREA OF SPECIAL INTEREST: Seamless Transition Task Force

In response to a VA Central Office directive, the STVHCS organized and launched a taskforce in September 2003 for the Seamless Transition of returning service members into veteran status. This multi-disciplinary taskforce includes a full-time social worker, a program manager, a physician clinical liaison, and a benefits advisor from the Veterans Benefits Administration. The team is centered around the full-time VA social worker who is based at Brooke Army Medical Center. The social worker conducts discharge planning activities and clinical coordination services for each potential VA patient. The social worker provides prompt notification of casualty arrivals, delivers coordinated benefits briefings to all potential VA patients, and assists with the coordination appropriate transfer to geographically distant VA facilities. Prior to discharge from Department of Defense, VA's social worker enrolls all patients into the VA system to expedite their transitions.

VA's local team:

- Provides timely notification and tracking of casualties;
- Facilitates transfer of active-duty soldiers into veteran status prior to their separations from Department of Defense;
- Arranges care close to veterans' homes; and
- Assists with claims processing

Additionally, VA's team has identified Iraqi casualty point-of-contacts in each of the 5 satellite clinics and in the Kerrville Hospital Division of the South Texas Veterans Health Care System. These point-of-contacts are charged with coordinating care of any returning Iraqi conflict veterans. The team has insured that as patients are identified, and appropriate measures are put in place to provide a seamless transition into veteran status.

To support communication with all returning Iraqi conflict soldiers in this area, we have initiated substantial outreach initiatives. We have produced and distributed specific brochures, scripts, roles & responsibility guidance, and outreach media products designed to aid in the transition of returning into veteran status. We've taken our mantra, "Treat now, ask questions later" from the words of Secretary Anthony Principi and used it as the foundation of our outreach initiatives. All guidance pertaining to the treatment of our newest veterans instructs employees to quickly facilitate care prior to determination of eligibility. Guidance on the processing of Iraqi conflict veterans has been forwarded to all front-line employees along with scripts detailing how to interact with our new patients. Furthermore, to educate our employees regarding Operation Iraqi Freedom & Operation Enduring Freedom veterans, the South Texas Veterans Health Care System required all employees to view the "Our Turn to Serve" video. This training video, developed by VA Central Office and the Employee Education System, gives an in-depth view of the conditions faced by combat veterans as they continue down their roads to recovery.

Other outreach efforts include communicating with veteran service organizations throughout South Texas during regularly scheduled meetings and by distributing flyers, posters and informative brochures through VSOs. Finally, South Texas Veterans Health Care System publicizes and utilizes the VA Central Office website that addresses areas of interest essential to the care of this growing population. Information is readily available for employees, active duty personnel, Reservists, members of the National Guard, veterans, and family members.

To date, the South Texas Veterans Health Care System has coordinated the transition of 465 service men and women who have supported our nation's defenses in Operation Iraqi Freedom and Operation Enduring Freedom. We currently care for 78 of those 465 locally, and have assisted with the transfer of 128 soldiers into a VA facility geographically distant from South Texas. Our sons and daughters have risen to the challenges of Operation Iraqi Freedom & Operation Enduring Freedom with distinction and honor. They have fulfilled their promises to our country with a diligence and determination of the highest honor. Our responsibility and obligation is to immediately make good on this nation's promise to take care of its veterans with an equal level of diligence and determination. We are applying the lessons learned from previous conflicts to ensure that no veteran experiences delays in receiving the benefits and care they have earned. Our collaborative efforts have strengthened the vital relationship between the VA and the Department of Defense. Secretary Principi stated recently that, "We will have failed to meet our very reason to exist as a Department if a veteran is poorly served." I share this belief, and assure you that through our collaborative efforts that all veterans are receiving benefit services and medical treatment of the highest honor.

**Statement of
Richard Bauer, M.D.
Chief of Staff
Department of Veterans Affairs
Before the Field Hearing of the Subcommittee on Health
House Committee on Veterans' Affairs**

April 13, 2004

Mr. Chairman and members of this distinguished committee, thank you for the opportunity to be here today to discuss the status of VA and military health care delivery and coordination including post-deployment health care of recently discharged veterans.

The South Texas Veterans Health Care System (STVHCS) encompasses over 40 counties and reaches to Brownsville in the South, Victoria in the East, Sanderson in the West and San Angelo in the North – a span of 350 miles from east to west and 400 miles from North to South.

The veteran population of South Texas was estimated at 243,000 in Fiscal Year 2001 with about 60% of that population located here in Bexar County and 75% located in the San Antonio metropolitan area. There is, however a large population of veterans of about 50,000 residing in the area extending from the Corpus Christi area south and west to encompass the lower Rio Grande Valley. Additional large populations of about 7,000 veterans reside within Kerr County, Webb County and Victoria County.

The STVHCS operates two (2) hospitals – a large tertiary care facility in San Antonio (Audie L. Murphy) with 106 medical beds, 56 surgical beds, 50 psychiatric beds, 30 SCI beds, 26 substance abuse treatment beds and 90 long term care beds and Kerrville a smaller facility with 25 medical beds and 154 long term care beds.

Because of the distribution of population within the system, STVHCS operates eight (8) VA staffed clinic sites; three of these are in San Antonio including the Frank Tejada Clinic and SE Bexar Clinic. Additional clinics are located in Victoria, Corpus Christi, McAllen, Laredo and at the Kerrville VAMC.

Additionally, STVHCS has contracted for primary care services at eleven (11) additional sites in smaller populated communities such as Beeville and Uvalde and also within San Antonio to address long waiting times and inability to provide adequate office space for this care within existing infrastructure.

All VA staffed clinic sites provide primary care, mental health, and podiatry services. In addition a concentrated effort has been made to provide specialty services locally. In Corpus Christi, an orthopedic surgeon visits the clinic bi-weekly. A sharing agreement with the Corpus Christi Naval Hospital provides optometry, audiology, and general surgery clinical services. The Corpus Christi clinic also has a radiology unit, pharmacy and physical therapy program.

A transportation system operated jointly by the Veterans Services Organizations and the VA makes regular trips between outlining clinics and Audie Murphy. A lodging program at a local hotel provides overnight stays and meals for veterans with appointments in San Antonio.

Services are also provided in local communities through contract. In the Lower Rio Grande Valley, the VA through a contract with community hospitals provides outpatient surgery and short stay admissions. Emergency medical services are provided through the Mill Bill and fee services with annual FY03 costs of \$28 million, a 54% increase of previous fiscal year.

The Kerrville VA Medical Center provides inpatient services for veterans for the northern and western regions of the STVHCS service area. The 25 medical beds also serve as a back up for general medical and substance abuse detoxification admissions when the Audie L Murphy facility exceeds its capacity. One hundred and fifty-four long-term care beds are also located at Kerrville.

Audie Murphy is the tertiary care facility for STVHCS. The STVHCS provides comprehensive medical, surgical, psychiatric, rehabilitation and spinal cord injury care. STVHCS also provides referral care for other systems in the VISN and for patients from west Texas and serves as a national referral center for bone marrow transplant patients. Care is also provided through contracts with community providers. Over \$19 million is projected for extended care services for FY05. This is a 34% increase over last fiscal year.

The STVHCS is closely affiliated with the University of Texas Health Science Center at San Antonio (UTHSCSA) and is located immediately adjacent to that institution.

STVHCS has one of the largest VA post graduate medical programs in the country with 156 paid residents and training programs for over 35 disciplines including psychology, podiatry, dentistry, pharmacy, and physics.

The STVHCS also operates one of the largest medical research programs among VA hospitals with 154 active investigators, \$33.7 million in annual federal (VA and NIH) research income, and 459 approved research projects.

Staffing Issues.

Forty-eight percent of STVHCS employees are over age 50 and 75% of senior executives are eligible for retirement.

Hard to fill positions defined as few or no qualified applicants after six months of recruitment include dentists, police officers, pharmacists, registered nurses, social workers, physical and occupational therapists, physicians, diagnostic radiology technicians, medical technologists and computer specialists.

STVHCS has 133 employees in reserve units with a high proportion of these in nursing. Thirty-seven (37) reservists have been activated for periods of up to 18 months. Eight (8) of these 37 have returned safely while 29 remain mobilized. Nursing Service has utilized agencies to fill short-term vacancies and the VA Nursing Education for Employees Program, scholarships for nursing students with subsequent commitment for employment and a summer jobs program to address long term staffing problems. Sign on bonuses, pay step increases for work in critical shortage areas, and joint programs with local nursing schools to provide in hospital training programs have been the most successful recruitment strategies. It would be desirable to have legislation allowing a salary stipend with a pay back period for selected specialty nursing providers; e.g. nurse practitioners.

In general the STVHCS has attempted to increase clinical productivity by leveraging the work of physician providers by reorganizing clinic space and adding mid level providers and clerical support to clinical teams. Most specialty care is provided through part-time physicians, with academic appointments at the UTHSCSA or with contracts for professional services with medical school departments.

Shortages in several medical school departments have led to significant increases in STVHCS costs. Rising incomes for physicians working in community settings have led to staff vacancies in neurosurgery, anesthesiology, general surgery, vascular surgery, radiology, urology and thoracic surgery. Income for physicians working in the community exceeds \$300,000 for all of the disciplines cited above. Although academic physicians within these disciplines generally earn a third less, salaries for all exceed the current pay cap under local control. In neurosurgery, a small division, all physician staff left over a six month time span and STVHCS resorted to locum tenens providers with a \$300,000 increase in costs over a six month period to provide neurosurgical services to veteran patients.

VA/DOD Cooperation on Provision of Medical Services.

The medical staff of the two large military treatment facilities, Wilford Hall USAF Medical Center (WHMC) and Brooke Army Medical Center (BAMC), has worked closely with the STVHCS to provide services to veterans in some areas where staffing shortages exist.

After deployment of one general surgeon and resignation of the second general surgeon at the STVHCS, WHMC assigned three general surgeons to provide inpatient surgical services at Audie L. Murphy. Neurosurgical staff from WHMC has also provided on-call and emergency coverage for the neurosurgical program. A sharing agreement has been established with WHMC to improve urological care. Details are being negotiated for cardiac cath and inpatient cardiothoracic services to be provided at WHMC while one of our two STVHCS cardiac cath units are being remodeled.

Initiatives to perform joint credentialing of medical staff and for bi-directional transfer of laboratory information have been submitted and approved for funding through a joint

VA/DOD Demonstration Project. Additional clinical initiatives include consolidating the Bone Marrow Treatment facilities of WHMC and STVHCS to conserve resources, and staffing a vacant ICU at WHMC by the STVHCS in order to decrease ER diversions from both STVHCS and WHMC. Planning is on going for a joint primary care clinic in North San Antonio.

Operation Iraqi Freedom Casualties.

Transfer of care between BAMC and STVHCS for Operation Iraqi Freedom Casualties is facilitated by a VA social worker located at BAMC. A primary care team located at the Frank Tejada Outpatient Clinic coordinates medical care for military returnees. We have provided either information or care for 465 service men and women. We currently care for 78 of those 465 and have assisted with the inpatient transfer of 16 soldiers into a VA facility close to their home communities. Eight (8) individuals have been referred for dental, audiology and mental health outpatient services at the STVHCS. Training of all staff regarding the eligibility for benefits for these new veterans has been accomplished through a mandatory education program.

**STATEMENT OF
BRIGADIER GENERAL C. WILLIAM FOX, JR.
COMMANDER
GREAT PLAINS REGIONAL MEDICAL COMMAND
AND
BROOKE ARMY MEDICAL CENTER
APRIL 13, 2004**

Mr. Chairman and members of the subcommittee, as the Commanding General of the Great Plains Regional Medical Command and Brooke Army Medical Command, I appreciate the opportunity to speak with you on the relationship between the 10 Army Hospitals in the Great Plains Regional Medical Center and the Veterans Health Administration as it relates to patients injured while serving this great nation in the Global War on Terrorism (GWOT). I believe my testimony will help this committee to understand the various ways and means in which we are working to optimally serve our Soldiers.

I can assure you that Medical Treatment Facilities within the Great Plains Regional Medical Command have continued to improve upon preexisting relationships with the Department of Veterans Affairs (VA) to provide compassionate, quality health care to restore the physical and psychological health of wounded Soldiers with dignity and respect. Our organizations have improved upon the ability to coordinate and synchronize to provide the military members and veterans with superb, seamless care. Later today, Colonel Bernard DeKoning, Commander of the Darnall Army Community Hospital at Fort Hood, Texas will provide testimony that provides further examples of this improved coordination which provides our Soldiers the optimal post deployment health care.

Brooke Army Medical Center has a long standing and productive relationship with the Veterans Health Administration in San Antonio. Prior to the conflicts in Iraq and Afghanistan, Brooke Army Medical Center and the VA began several joint sharing initiatives. These include the following: laboratory support, hearing aides, nursing training, radiology services, bio-medical equipment and devices, nuclear medicine studies, gynecology services, burn care, teledermatology, ethylene oxide (ETO), sterilization services, sleep lab studies and laundry support. These initiatives have resulted in more efficient use of federal resources, lower overall health care costs and consistently improved our ability to deliver integrated health care.

In addition, the leadership of both Department of Defense (DoD) facilities in San Antonio and the VA have created a new formal collaborative effort in San Antonio called the Federal Healthcare Consortium that meets monthly. Collaboration from this body has resulted

in new initiatives including: invasive cardiology and cardiothoracic surgery services, joint credentialing, laboratory data sharing, a joint Northside San Antonio clinic, a joint pager system, intensive care optimization, rehabilitation, and physical examination coordination from the DoD health care system to care provided in the VA.

In the arena of patient care, we have had a long history of caring for "dual" eligible beneficiaries, as well as transferring Soldiers from ongoing DoD care into the VA system following their discharge from military service.

Brooke Army Medical Center plays a vital role in United States Army readiness by providing patient care to our Soldiers and other military beneficiaries, Graduate and continuing Medical Education for Army doctors, nurses, and medics, and also through medical research. These missions have proven to be critical to the Army success on the Global War on Terrorism. We are inextricably linked to health care delivery that occurs on the battlefield today. Doctors, nurses, and medics that are assigned or have trained at Brooke Army Medical Center are delivering care to our forces in Iraq. Since the war began, Brooke Army Medical Center continues to care for casualties that have returned from forward care, through medical evacuation, back to our medical center. Among the many professional accolades that our preeminent institution possesses, the most powerful credential remains the testimony of the Soldiers and beneficiaries that receive medical care at our institution.

The advent of the Global War on Terrorism demanded increasing collaborative efforts between the DoD and VA health systems. Since January 2003, we have received at Brooke Army Medical Center 1,321 Soldiers evacuated from the forward theatres of operation around the world for both medical and surgical issues.

1,112 patients were evacuated from Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), or Operation Noble Eagle (ONE). The remaining Soldiers came from other areas where the U.S. Army has deployed Soldiers such as Bosnia and Kosovo. Over 60% of the OIF/OEF/ONE Soldiers that we have received are Reserve or National Guard Soldiers.

Most of the Soldiers (66%) have been treated and released back to active duty status or have been released from active duty back to their Reserve or National Guard units. Thirty-four percent (34%) of the Soldiers have progressed to needing a Medical Evaluation Board (MEB). The MEB is initiated when a physician believes the Soldier has reached a maximum therapeutic state and yet, is still unable to meet regulatory retention standards or can not meet a full fitness for duty status. The MEB includes

a due process system of ensuring that Soldiers have a fair and equitable opportunity to represent themselves prior to separation due to a medical condition. This includes an opportunity to challenge the findings and ask for other opinions from military and civilian physicians.

Of the 1,321 Soldiers treated at Brooke Army Medical Center, 452 Soldiers have entered the MEB process. Approximately 30 percent of the Soldiers have completed the process. We anticipate the majority of these Soldiers will receive ongoing care at VA facilities.

The care that the Soldiers will need after completing the MEB process and transitioning into the VA system are characterized by the following:

- 1) 20 Soldiers (4.4%) burn care
- 2) 20 Soldiers (4.4%) mental health
- 3) 24 Soldiers (5.3%) cardiology
- 4) 34 Soldiers (7.5%) neurology
- 5) 51 Soldiers (11.2%) neurosurgery
- 6) 92 Soldiers (20.4%) general medical care
- 7) 95 Soldiers (21%) orthopedics
- 8) The remainder of the care needed (25.8%) is dispersed across all the other medical and surgical services.

Some specifics on the type of care we have provided illustrate the kind of world class health care our Soldiers are receiving. Incorporated into Brooke Army Medical Center is the Army's Institute for Surgical Research which commonly referred to as the Burn Center. This is the only DoD Burn Center. The 40 intensive care beds and staff provide care to all DoD, VA, San Antonio and SW Texas Civilian patients, and State Department approved patients from throughout the world. The Burn Special Medical Augmentation Team (SMART Team) has made 18 flights to pick up seriously burned Soldiers from the Global War on Terrorism. Later in this hearing, you will receive testimony from LTC (Dr) Lee Cancio, our current chief of the Burn Center. He will outline the state-of-the-art burn care provided for Global War on Terrorism patients, to civilians from South Texas, and other military members injured all around the world.

Twenty severely burned Soldiers have been hospitalized and extensively treated at the Burn Center. In addition, there have been 67 other Soldiers treated for burns as inpatients. Some of these Soldiers will have significant health care needs for reconstructive plastic and hand surgery. Brooke Army Medical Center also houses one of the two DoD Amputee Centers of Excellence and has treated 83 inpatient and over 300 outpatients. These patients include 40 mine blast trauma patients and 17 amputees.

Staff from the local Veterans Affairs, including representatives from the Audie L. Murphy Veterans Hospital in San Antonio, provide support and information to those Soldiers leaving the Army due to physical disability.

Within Brooke Army Medical Center, there are two Department of Veterans Affairs employees from the Health, Benefits and Services Division, who work in our medical center to ensure we have a coordinated and seamless health care transition for these Soldiers.

One of these employees is a clinical social worker who has consulted on more than 270 cases of OIF/OEF patients. He provides in-depth briefings on VA health benefits to include the two years of medical care available after separation at any VA facility for disease or health issues relating to active duty performance.

In addition to the consultations, the VA social worker has coordinated 128 referrals requiring intensive case management with the gaining VA medical centers across the United States.

Brooke Army Medical Center is credited with providing the second greatest number of referrals to the Department Veterans Affairs. Walter Reed Army Medical Center provides the greatest number of referrals. Our medical center case managers and the VA social work staff member assess patients and determine the appropriate course of treatment with our physicians to include follow-up appointments and referral. Our medical center experience has been that the medically boarded patients receive specialty clinic follow-up within ten days at their receiving VA hospital or clinic with the coordinated efforts through the presence of imbedded VA staff.

Brooke Army Medical Center also has a VA liaison representative who started at the hospital in the Spring of 2003. To date the benefits liaison has provided consultation to more than 800 OIF/OEF patients.

The liaison reviews benefits and coordinates for those benefits that may be provided to medically discharged Soldiers. To date, the representative has processed 85 claims from Soldiers deployed for the Global War on Terrorism. Soldiers in the process of separation from the Army file claims to obtain VA benefits. Examples of these special VA benefits include several OIF Soldiers who have applied for the \$9,000 allowance known as the Automobile Grant to use towards the purchase of a specially equipped vehicle. In addition, the VA pays costs to specially adapt the car and train the individual driver. In addition, several veterans have been processed for the Special Adapted Housing Allowance of up to

\$50,000 to modify homes for veterans who have lost the use of extremities and need modifications to hallways, bathrooms, doorways, and such.

I would like to provide the stories of two specific Soldiers which provide living testimony to the outstanding quality of the health care system that is provided to our Soldiers. It begins on the battlefield, the Air Force evacuates them to our Army hospitals, like Brooke Army Medical Center, and seamlessly coordinates their follow on care with the VA.

Corporal Robert E. Jackson Jr., is 22 years old and was injured in OIF in February 2003. He was deployed with the 186th Military Police out of Fort McCoy, Wisconsin, as a member of the Iowa National Guard. He suffered bilateral below the knee amputations, with 6 percent body surface burned, vocal cord paralysis and permanent damage to his right hand. He has received bilateral prosthesis in addition to his other care. He has completed extensive care that includes four major operations, multiple revisions along with rehabilitation. He has now completed his care with the medical board process, receiving a 100 percent disability. His follow on care has been professionally and fully coordinated with the Des Moines VA hospital. He plans to attend college and become a physician, specifically a radiologist. He is a Purple Heart recipient, married with two young daughters ages 2 and 4. Corporal Jackson could not be here today because he is has achieved his goal of returning with his unit to the state of Iowa as they come home from their deployment to Iraq today.

Now let me introduce to you Staff Sergeant Rashaan Canady, age 26, who was injured near Bagdad in Operation Iraqi Freedom, in April 2003. He was deployed out of Fort Stewart, Georgia, as part of the 3rd Infantry Division. He suffered a traumatic amputation of the right arm below the elbow and shrapnel injuries to his face and right eye. Staff Sergeant Canady has received extensive surgical, psychological, and physical therapy. Through no less than heroic efforts on his part coupled with our professional health care he has now received and can utilize a state-of-the-art right arm and hand prosthesis. Throughout his long recovery, he has continued his education towards his bachelor degree and we have, together, coordinated for his follow on rehabilitation and medical at VA hospital Wilmington, North Carolina. He is both a Purple Heart and Silver Star recipient. He plans to attend school in Wilmington, North Carolina, and pursue a career in public service. Staff Sergeant Canady is married and has a six-year old daughter.

These men are just two examples of America's most precious asset, the young men and women who wear our nation's uniform and defend our nation's freedoms. They have both been an inspiration to their fellow Soldiers, to our medical staff, to those Soldiers who are still in the process

of recovering from their injuries, and I would submit, to their fellow Americans.

Conclusion:

Mr. Chairman, in my testimony today I have shared with you some of the ways and means that Brooke Army Medical Center has cared for the injured Soldiers and transitioned them to the Department of Veterans Affairs health care system.

As partners in this most important process, we are committed to providing state-of-the-art health care for America's sons and daughters injured on the battlefield. We will ensure that our Soldiers and America's veterans never forget that we were there for them and provided them with optimal and seamless care in both the DoD and VA health care systems. We believe that our efforts to date are clear examples of the kind of efforts that should serve as a role model for how the DoD and VA health care systems can be optimally integrated. However, we are continuing our efforts to further identify and refine ways and means to enhance our coordination and integration.

I want to thank you again for your time and I am available for your questions.

Information on BAMC:

Brooke Army Medical Center is a tertiary care regional referral center for a 16 state area encompassing 10 Military Treatment Facilities and 22 outlying clinics. It operates as a Center of Excellence for orthopedics, burn, trauma, and amputee care. The hospital is also noted for cardiology and cardiothoracic surgery, and offers advanced oncology, and ophthalmology care.

The hospital staff provides inpatient care in a 219-bed facility, 1.5 million square foot, state-of-the-art facility that has the expansion capability of 368 beds.

Forty beds are devoted to the Army Institute of Surgical Research, which operates the renowned "Army Burn Center" – the only Department of Defense Burn Center.

As the Army's only certified Level 1 trauma center, Brooke Army Medical Center receives more than 1,800 emergency room visits each month. Many trauma patients are civilians treated under a local military-civilian trauma consortium agreement.

Brooke Army Medical Center further provides specialty care within the disciplines of Internal Medicine, Surgery, Pediatrics and OB/GYN. Other clinics available at Brooke Army Medical Center include:

Allergy and Immunology	Hematology/Oncology
Audiology Clinic	Pathology
Behavioral Medicine	Pharmacy
Cardiothoracic Surgery Clinic	Physical Medicine and
Dental / Oral and Maxillofacial	Rehabilitation
Surgery	Social Work
Family Medicine Services	Women's Imaging Center
Geropsychology Services	

Brooke Army Medical Center's 58-outpatient specialty clinics record a million patient visits each year. The hospital sustains over 60 accredited educational programs that include 25 Graduate Medical Education Programs, eight nursing programs, 18 enlisted allied health and medic phase II training along with additional programs in administration and allied health specialties. GME programs include 270 Army and 250 Air Force residents and interns.

Brooke Army Medical Center's staff of almost 3,000 includes 1,500 military and 1,500 civilians who are augmented by contractors and volunteers.

Brooke Army Medical Center's annual operating budget is \$200M. The hospital has a total workforce of over 3,200 personnel to include military and DA civilian employees, plus over 500 volunteers.

An "Average Day at Brooke Army Medical Center" includes a census of 128; 24 admissions, 3 for civilian emergencies; 2,900 clinic visits; 3,000 laboratory procedures and 7,000 prescriptions filled.

In cooperation with the Air Force's nearby Wilford Hall Medical Center at Lackland AFB (the regional TRICARE lead agent), Brooke Army Medical Center serves 185,000 local beneficiaries.

Joint agreements:

Brooke Army Medical Center currently has 13 VA-DoD Resource Sharing Agreements with another 5 agreements under development.

13 Current Agreements:

Laundry support – provided to Brooke Army Medical Center from the Kerrville VA. Brooke Army Medical Center pays 47.5 cents per pound as opposed to a market rate of 55 cents per pound paid by Methodist Hospital or 51 cents per pound by WHMC

Laboratory Support – Provided by Brooke Army Medical Center to Audie Murphy Medical Center. Brooke Army Medical Center provides approximately 14 different lab tests for the VA, at CMAC minus 10% or approximately 80% of commercial lab test rates. This provides Brooke Army Medical Center with approximately \$12K in reimbursements from the VA annually.

MOA for VA Contract for Hearing Aides – Provides discounted rates to Brooke Army Medical Center for the purchase of hearing aides and hearing aide batteries to Brooke Army Medical Center beneficiaries. Discounts obtained through piggybacking on the VA's nation-wide contract.

Nursing, MOA for Training – Training affiliation between Brooke Army Medical Center and VA. Brooke Army Medical Center sends their nurses to the VA for training and case mix diversity. This is a gratis arrangement.

Radiology Services – Currently under review due to a reduction in Brooke Army Medical Center radiology capacity.

Bio-Medical Equipment and Devices – Brooke Army Medical Center piggybacks on a VA centralized contract. Brooke Army Medical Center Medical Maintenance estimates savings of approximately \$500K annually.

Nuclear Medicine – Brooke Army Medical Center provides scans to Audie Murphy Medical Center. Under review and negotiation on reimbursement rate (90% of CMAC).

GYN Services – Brooke Army Medical Center provides both Oncology and D&Cs to Audie Murphy. Currently under revision, not due to price, but a refinement of process. Reimbursement based on 90% of CMAC.

Burn Care – Brooke Army Medical Center provides burn care to all VA patients nation-wide. Under revision on reimbursement rates, since burn rates are so unique from normal CMAC charges.

WHMC / AUDIE I. MURPHY MED CEN – Alternate site agreement which shifts medical care to one of our three Federal partners, in case one of the three facilities is taken out of service for emergency or contingency reasons.

Teledermatology – Brooke Army Medical Center provision of tele-dermatology services (consultation) to Temple VA. Now finalized and signed by both parties. Reimbursement based upon 90% of CMAC.

ETO Sterilization Services – Brooke Army Medical Center gave Audie Murphy our sterilizers, in exchange for VA providing ETO sterilization services to Brooke Army Medical Center until 2007. Brooke Army Medical Center wanted to get out of the ETO sterilization because it is a somewhat out-dated technology. Reimbursement based on bartered agreement – equipment for services.

Sleep Lab – Services provided by Brooke Army Medical Center to Audie Murphy VA. Agreement has been in effect since 2002. Reimbursement based upon 90% of CMAC.

Five Developing Agreements:

Invasive Cardiology and Cardio Thoracic Surgery Services – Provided by Brooke Army Medical Center to the Temple VA at 90% of CMAC. Provides the VA with quality services at a discounted rate, while augmenting the hospital's GME programs.

Joint Pager Services – A tri-party arrangement between BAMC, WHMC, and Audie Murphy to gain economies of scale discounts through pooling of lease requirements. All parties pay a fair share of their respective bills.

Joint Credentialing – Another tri-party arrangement with BAMC, WHMC, and Audie Murphy to gain economies of scale discounts. Business plan is still in development.

Laboratory Data Sharing & Interoperability (LDSI) - An agreement between Brooke Army Medical Center and Audie Murphy to evaluate the feasibility of sending-out lab tests with the intent to have test results electronically transmitted from Brooke Army Medical Center directly into VISTA. STVHCS has been utilizing the reference lab at Brooke Army Medical Center for more than five years. Having the test results electronically submitted would reduce the chance for human error during manual entry (current practice). LDSI is a VA developed methodology currently being tested at VAMC Hawaii with Tripler AMC. Business plan is still in development.

Operation Enduring Freedom / Iraqi Freedom – Places VA representatives at Brooke Army Medical Center to assist Soldiers undergoing medical retirements to make a seamless transition from the DoD to VA system. Awaiting final signature by VA. Also a gratis arrangement.

STATEMENT BY
COLONEL BERNARD DEKONING
COMMANDER, DARNALL ARMY COMMUNITY HOSPITAL

Mr. Chairman, members of the subcommittee, and distinguished guests, as the Commander of the Darnall Army Community Hospital at Fort Hood, Texas, I want to thank you for the opportunity to discuss how we provide outstanding, quality health care to injured Soldiers at our hospital and seamlessly transition them to the Department of Veterans Affairs (VA) health care system when required.

BACKGROUND

Darnall Army Community Hospital is one of 10 medical facilities within the Great Plains Regional Medical Command. Earlier, you heard from Brigadier General Fox who is both the Commanding General of the regional medical command and Brooke Army Medical Center, which is our primary medical referral hospital.

The medical, psychological, social, and toll of war on Soldiers was most recently seen by the Army during our last major engagement, Desert Shield/Storm or Gulf War. I. The current operational climate with Operation Noble Eagle (ONE), Operation Enduring Freedom (OEF), and Operation Iraqi Freedom (OIF) has led to Soldiers once again being medically evacuated to DoD medical facilities, such as Darnall Army Community Hospital, to provide the necessary health care these Soldiers need and deserve.

In early 2003, the Army developed the Deployment Cycle Support (DCS) program to support the successful reintegration of deployed Soldiers back into their homes. One of the new programs developed by the AMEDD to support this DCS initiative was the development of the Care Manager Program. The mission of this program is to insure that Soldiers coping with injuries, physical symptoms, or stress associated with war zone experiences are reconnected and reintegrated into the non-

combat environment. Services provided by the care managers include:

Needs assessment

Education

Assistance with marital/family issues

Support for family members before, during, and after deployments

Support groups (Combat injuries group)

Individual counseling

Advocacy

Help accessing health care

In providing these services, it became readily apparent to us that our care managers must interface with the VA. This is a vital component in providing direct services to Soldiers pending a medical separation from the Army and their families. Since implementation of the Care Manager Program in December 2003, the five Fort Hood Care Managers have assisted more than 1300 of 10,000 redeployed or demobilized Reserve Component (RC), National Guard (NG), and Active Duty Soldiers.

Since January 2003, Fort Hood has mobilized more than 12,000 RC/NG Soldiers in support of OIF. Approximately 4-5% of these Soldiers experienced injuries, manifestations of pre-existing medical conditions or aggravation of pre-existing medical conditions during their training phase at Fort Hood or at other state-side training centers. These RC/NG Soldiers then became Medical Holdovers (MHO) and did not deploy with their units. They are retained at Fort Hood, pending final determination of their fitness for duty. Our hospital has closely managed the MHOs through Case Managers who insure these Soldiers receive the appropriate medical appointment as determined by their physician. In our experience, approximately 45-50% of the MHO Soldiers have been medically separated from the Army and transitioned to the VA health care system. 7 April, 2004, Ft Hood has 89 MHOs undergoing medical separation from the Army.

In January 2004, we became aware that Walter Reed Army Medical Center (WRAMC) in Washington, D.C., had formed an integrated relationship with their local VA. This relationship led an improved, coordinated transition of the medical care for Soldiers from DoD to the VA health care system. Darnall Army Community Hospital immediately began coordination with the central Texas region Veterans Integrated System Network (VISN) to establish a similar effort embedding a VA liaison/counselor in our facility beginning in February 2004.

Concurrently, while Darnall Army Community Hospital was formalizing the relationship with the VA hospital in Temple, Texas, the Vet Center in Austin, Texas expressed an interest in establishing an early connection with Soldiers experiencing combat stress symptoms or post traumatic stress disorder. They requested to co-facilitate combat stress groups with mental health providers from Darnall Army Community Hospital and/or interview Soldiers who met the description described previously.

STATUS OF DARNALL ARMY COMMUNITY HOSPITAL/VA COORDINATION

A Social Worker from the VA medical facility in Temple, Texas, began work in the Department of Social Work at Darnall Army Community Hospital on the 17th of February 2004. The social worker provides bimonthly VA benefits briefings for the Soldiers' Processing Center on Fort Hood for departing military Soldiers. Additionally he meets with rear detachment reserve unit commanders assigned to Fort Hood to insure they are fully aware of the services he can provide their Soldiers.

The VA Social Worker is in routine contact with our MHO Case Managers to insure that appropriate VA referrals for Soldiers undergoing medical separation from the Army are completed. He coordinates with the VA medical personnel employed at the Thomas Moore Clinic on Fort Hood to receive these referrals from Soldiers seeking

enrollment in the VA health care system and to answer their questions.

The VA social worker works closely with the office conducting medical separations to schedule Soldiers for appointments for enrollment in the VA, provide information, and to ensure a seamless transition of medical services to the VA health care system is coordinated. This includes contacting the VA facility closest to the Soldier's home of record and making all initial appointments. The Soldier is also provided an individual point of contact to call if he/she has questions or needs an advocate to facilitate services in the VA system.

Since being assigned to Fort Hood on 18 Feb 04, the VA Social Worker has received 44 referrals from Darnall Army Community Hospital staff and our Care Managers. Many of these patients were severely injured and have complex medical and mental health problems. It is extremely vital to ensure follow-on needs are identified and coordinated with the VA before these Soldiers are released from active duty. Each VA facility has selected a POC to receive and expedite referrals and transfers to the VA for combat veterans needing clinical follow-up services. We coordinate with the VA staff to ensure a Case Manager is assigned to the veteran and their family to further coordinate the transition of care.

This process has addressed and greatly eliminated a shortfall we identified after Gulf War I. It ensures the Soldiers being discharged from the military for combat related injuries know exactly which VA facility will provide their follow on care and who their point of contact will be to call.

A Memorandum of Agreement has been drafted between Darnall Army Community Hospital and the Austin Veterans Center describing the conditions and responsibilities of both agencies in allowing a mental health counselor from the VA to co-facilitate groups and/or see individual patients at Darnall Army Community Hospital. This agreement is pending a signature from the VA. Once the MOA has been approved and the counselor from the Austin Veterans Center is credentialed to provide services within Darnall Army Community Hospital the coordinated counseling services will begin immediately.

CLOSING

Mr. Chairman and members of the committee, I am committed to taking care of our Soldiers and providing them world class health care. I am also committed to ensuring there is a smooth transition from the DoD health care system to the VA health care system for our patients. Thank you for this opportunity to appear before you and thank you for your support of our Nations' veterans. I am available for your questions.

Department of the Air Force

**Presentation to the Committee on Veterans' Affairs
Subcommittee on Health
United States House of Representatives**

Subject: Status of Military and VA Healthcare

**Statement of: Brigadier General Charles B. Green
Commander, 59th Medical Wing
and Lead Agent, TRICARE Region Six
Lackland AFB, Texas**

**Field Hearing
San Antonio, Texas
April 13, 2004**

**Not for publication until released by the
Subcommittee on Health
Committee on Veterans' Affairs
United States House of Representatives**

Good afternoon. I am Brigadier General Charles B. Green, Commander of the 59th Medical Wing, Wilford Hall Medical Center. I also serve as the Lead Agent of TRICARE Southwest, Region 6, which encompasses the states of Texas, Oklahoma, Louisiana, and Arkansas. Mr. Chairman and Members of the House Committee on Veterans' Affairs, Subcommittee on Health and distinguished visitors, thank you for allowing me to appear before you today and offer my thoughts on military healthcare and Department of Defense (DoD)/Department of Veterans Affairs (VA) collaborative efforts in the greater San Antonio area. I hope you will see today how this federal collaboration is meeting the needs of our Sailors, Airmen, Marines and Soldiers returning from contingency operations.

Over the first year of my command, I have truly come to appreciate San Antonio as one of the most ideal communities in the nation for delivering medical care in a cost effective and efficient manner. World-class medical centers and research facilities combine to offer a unique opportunity to share resources and improve the quality of health care for our community. In addition to this unparalleled opportunity to share resources, San Antonio VA and military medical facilities play a key role in the support of casualties and returning troops from overseas.

As Commander of Wilford Hall Medical Center, I am keenly aware of how important San Antonio is to the war fighter. Wilford Hall operates the largest graduate medical education program and the only Level I trauma center in the Air Force. Wilford Hall is also home to a very active Aeromedical Staging Flight that receives military patients for treatment or transfers them to other military medical facilities. During calendar year 2003, and to date in 2004, the 59th MDW provided Aerovac reception for 609 OEF and OIF patients. WHMC treated 127 patients and arranged care for 482 with other branches of the Armed Services. Many have been transferred to Brooke Army Medical Center's world-renowned burn unit.

I am very proud of my staff's commitment to our nation's men and women serving in harm's way. We have some of the best trauma surgeons in the world. Recently, our surgeons put their skills to use to help a critically wounded soldier who suffered a bullet wound to the face. His wound required significant facial reconstruction. Our surgeons have also provided hand surgery for several wounded soldiers. This world-class care is possible because of the excellent trauma programs maintained at both Wilford Hall and Brooke Army Medical Centers.

I also want to assure the committee we in San Antonio take very seriously the need to provide pre- and post-deployment surveillance for our military personnel. In the Air Force, all personnel deploying and returning from deployment are required to process through the local Air Force Public Health Office. Public Health ensures a post deployment health assessment was conducted in theater when Airmen return, even prior to their beginning rest and reconstitution leave. Eight hundred and thirty-seven members processed through Wilford Hall Public Health in 2003. This documentation helps Mr. Coronado and the VA ensure military members receive seamless medical care when they leave active duty. As most casualties returning to San Antonio are provided definitive care at Brooke Army Medical Center, the VA has placed a full-time social worker at the Army facility to ensure this flawless transition.

This history of DoD/VA cooperation in San Antonio goes back to the Spring of 1991 when the San Antonio Health Care Coordinating Council was established to maximize cooperation and coordination within the military medical community and the other Federal, State, local government, and civilian providers of health care. Soon after my arrival at Wilford Hall, I contacted Brigadier General Fox and Mr. Coronado to talk about this history of cooperation and to explore opportunities to take it to the next level. The San Antonio Federal Health Consortium was created in February of this year to promote sharing among the member

medical facilities and monitor progress toward mutual goals and projects. We are pleased to report many great successes.

VA and military command authorities recently notified us that three San Antonio proposals were selected to progress to the second level of review for funding under the DoD/VA Health Care Sharing Incentive Fund. Of 57 proposals submitted nationwide, 28 were selected for further consideration.

~~Several sharing activities that we are moving towards include. One project selected for further review, a proposed a potential northside DoD/VA clinic that could -would make primary medical care more convenient for beneficiaries. As part of the effort to move primary care to locations convenient to patients. I have directed my staff to partner with Brooke Army Medical Center to move some primary care capability to an existing clinic at Camp Bullis. I anticipate having staff at the Camp Bullis Clinic this month.~~

At Wilford Hall, I currently have a shortage of Intensive Care Unit (ICU) nurses that causes my emergency room to divert trauma patients due to lack of adequately staffed beds. This impacts Wilford Hall's trauma program from both a currency and training standpoint. The diversion affects Mr. Coronado and the VA when their patients cannot be seen in my emergency room. To address this issue, we are exploring having the VA staff these ICU nurse positions in return for a commensurate commitment by Wilford Hall to see the VA's patients. We feel very confident we can recapture approximately \$1 million annually spent by the VA downtown for this same care.

We also have been approved as joint demonstration sites for the sharing of lab and credentialing information. Our staffs are working on a joint purchasing contract for pagers and exploring the possibility of bringing certain lab tests in house to save dollars. These initiatives

are just a few examples of how we are assisting each other to leverage our individual institutional strengths to benefit our beneficiaries and maintain a strong system for caring for military personnel.

Activities are built on an impressive base of already existing agreements. Currently Wilford Hall and Brooke Army Medical Center have 21 sharing agreements with the South Texas Veterans Health Care System. One of these agreements is a blood services arrangement between South Texas Veterans Health Care System and Wilford Hall Medical Center. The VA provides half of the personnel (9 Full Time Equivalents) for the Blood Donor Center at Lackland AFB in exchange for a one-third share of packed cells, plasma and platelets. Wilford Hall also provides complete maternity care, and on a space available basis, endoscopic ultrasound, strabismus and lithotripsy services.

Brooke Army Medical Center provides burn unit support and pathology lab tests for VA patients. In the event of a backlog at the VA, standing agreements exist for Brooke Army Medical Center to provide nuclear medicine scans and GYN services. The VA reciprocates and provides laundry and sterilization services for the Army. There are also agreements for Brooke Army Medical Center to utilize VA contracts for bio-medical equipment repair and hearing aids.

The sharing relationship can alleviate manpower crises and improve graduate medical education. For instance, Wilford Hall Medical Center currently has a general surgeon at the VA full-time. Obviously, the VA benefits from the addition of a surgeon and Wilford Hall Medical Center benefits from an additional training and currency opportunity. We continue to explore these types of mutually beneficial arrangements.

The Tri-Service Regional Business Office (TRBO) carries sharing to an even higher level by bringing together the National Acquisition Office of the Veteran's Administration and the

VHA Standardization Office, as well as the Tricare Southwest and Central Regions (6, 7, and 8), creating a consortium of 163 VA hospitals and 46 DoD facilities. At this time, we forecast a DoD cost-avoidance of \$6.5 million over a period of 5 years and look forward to even more savings as we further develop other initiatives currently being explored. The TRBO office recently sponsored a tri-service and VA surgical equipment standardization conference in San Antonio.

Mr. Chairman, I am very optimistic San Antonio is leading and will continue to lead the nation in DoD/VA sharing efforts. The Air Force, Army and VA are currently building on a long history of cooperation. The projects we have proposed will strengthen our system for providing medical services and ensuring our service men and women receive the best care in the entire spectrum of the federal health care system. Thank you for allowing me to appear before your Subcommittee.

JANETH DEL TORO, NP
South Texas Veterans Health Care System

on behalf of the
DEPARTMENT OF VETERANS AFFAIRS

before the
HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

APRIL 13, 2004

Texas, with 84,000 women veterans has the 3rd largest population of women veterans. The South Texas Veterans' Health Care System (STVHCS) has approximately 10,000 women enrolled. Throughout this system there are Women's Health Programs at each facility. Women are eligible to receive women's health care through their primary care provider or through a specialty Women's Clinic. The Frank M. Tejada Outpatient Clinic (FTOPC) has the Woman's Place and the Kerrville Division has the Women's Health Program. At each hospital, there are nurse practitioners employed as Women Veteran Program Managers who are responsible administratively and clinically for the provision of comprehensive women's health care. I am the Women Veterans' Program Manager for the Kerrville Division. Each of the 5 satellite clinics has provided women's health care services. Each Outpatient Clinic (OPC) has a Woman Veteran Liaison to ensure women veterans' needs are met.

The women veteran population has unique issues that we have identified and addressed. Among the unique issues that VA is faced with in the women veteran population includes screening and treatment for military sexual trauma and clear access to women's health care. Women in the military have not seen VA as a system willing and able to care for women patients. In talking with women veterans, I have been surprised to hear that in too many cases, women do not consider themselves veterans and in those cases they certainly do not consider themselves eligible for health care at VA. They are surprised and pleased to find that the VA has services that equal or surpass the women's health care offered in the private sector.

Another priority issue in the women veteran population that we have faced is the screening and treatment of women with military sexual trauma. As you know, victims of sexual abuse often do not report this crime. Women delay disclosure of sexual abuse until after departure from active duty perhaps in fear of retaliation or rejection or the fear of the negative consequences the accusation will have on her career.

This reluctance presents challenges to VA in the delivery of care and availability of services. Many victims of sexual trauma are not eligible for services other than sexual trauma counseling. In this system, we have been able to coordinate and collaborate military sexual trauma services within VA and the Vet Center. For many years this system has worked collaboratively with the Vet Center to provide counseling services to women veterans. For those veterans who live in remote areas, we have worked with private counselors to provide needed counseling. Women veterans are seen in the Mental Health Clinic, The PTSD Care Team, within the Women's Clinic, and through the Vet Center for military sexual trauma counseling. For the past three years, the Kerrville Division Women's Health Clinic has collaborated with the San Antonio Vet Center to offer military sexual trauma counseling locally. We have also collaborated to offer a retreat to women veterans involved in military sexual trauma group therapy. This has been a tremendous success with women veterans expressing that this has been the most successful therapeutic experience they have received.

VA is eager and able to provide care to women veterans; however, getting that information to them has been a challenge. We have met this challenge in many ways. For the past 13 years we have offered the Salute to Women Veterans in Kerrville. The purpose of this program has been to honor the role of women veterans and to increase community awareness of the role that women have served while in the military. The Salute to Women Veterans has reached women throughout the entire system and has heightened awareness of women veteran issues and healthcare services. In addition it has heightened public awareness. The Women's Place has held women's health fairs at a local San Antonio community college. A representative from the Women's Health Program presents weekly at the local military bases TAPS briefing to apprise military women of services that they are entitled to. In November 2002, the Kerrville Division collaborated with a local theater group to produce the play A Piece of My Heart to women throughout the system. This play is a moving depiction of the role of women veterans in the Vietnam War. This served the purpose of increasing awareness of the issues of women veterans and to honor women veterans. Regularly, the Women Veterans Program Managers meet with the media in television, radio and newspaper regarding women veterans' issues and stories of interest.

The FTOPC has two primary care physicians, two nurse practitioners and a gynecologist providing women's health care. The Kerrville Division has one nurse practitioner providing women's health care. At the Audie L. Murphy Division (ALMD) women can choose to receive their care in their primary care team or they can choose to be referred to the Women's Place at FTOPC. At the satellite clinics, patients receive women's health care with either a nurse practitioner or a physician. Throughout the system, for complex women's health care issues, patients are referred to the Women's Place to be seen by the gynecologist. We have a collaborative relationship with University Health Systems for gynecological surgical procedures. These are done at the University

Hospital. For obstetrical care, we have contracted with local private providers as well as with Wilford Hall. Both have been well received. Since the VA began providing obstetrical care in 2001, we have delivered 63 VA babies. Sixteen additional babies are expected this year.

I was also asked to discuss the role of Nurse Practitioners in the STVHCS. Nurse practitioners have been instrumental in providing care to all veterans but have been especially effective with women veterans. Women veterans generally expect holistic care, which means care for their emotional and spiritual needs, as well as their physical needs. Women in America tend to be the primary person in the family responsible for health care needs. Women expect detailed information prior to making health care decisions. Nurse practitioners are uniquely able to meet this need with training in both medical science and nursing science. Nurse practitioners are trained to assess from a holistic perspective in a caring manner. There are 24 Nurse practitioners in our system where they are utilized in the hospitals and within the outpatient clinics. Nurse practitioners can be found throughout the system in long term care, in primary care clinics, in triage and in specialty clinics.

As a nurse practitioner, who has practiced in both the private sector and within the VA, I am in a unique position to evaluate the best of both private and public health care. I feel that the STVHCS has met the challenges of caring for women veterans well. In this environment, the health care that women veterans receive surpasses the services that I am able to receive as a non-veteran in the private sector. In 2002 the STVHCS received the Clinical Program of Excellence in Women's Health award. We were one of six VA facilities to receive this award. I am honored to serve in the capacity of the Women Veterans Program Manager. I feel that I have learned as much from veterans I care for both women and men as that I have imparted to them.

RAUL A. AGUILAR, M.D.
Chief Medical Officer McAllen Veterans Outpatient Clinic
McAllen, Texas
Department of Veterans Affairs
South Texas Veterans Healthcare System

April 8, 2004

I am honored to testify before this US House of Representatives' Veterans' Affairs Health Subcommittee on veteran healthcare in the Rio Grande Valley. I have been associated with the Department of Veterans Affairs as a healthcare provider since 1981. It has been my goal to provide veterans with the best healthcare that the system can provide. We have a team of VA healthcare professionals in the Valley that are providing daily healthcare delivery to a veteran population that has proudly served their country in the Armed Forces.

The VA clinic in McAllen, Texas was established in 1972 as an outpatient facility and housed in a trailer located near the now demolished and relocated McAllen Methodist Hospital. Originally, the clinic was under the director of the San Antonio Outpatient Clinic. In June 1977, the outpatient clinics were merged and became satellite facilities of the Audie L. Murphy Memorial Veteran's Hospital under the auspices of the hospital director. In 1978, the clinic relocated from the trailer to a structure of 5000 square feet. In August 1991, the clinic relocated to its present facility of 27, 000 square feet. This facility is located 250 miles from the parent facility in San Antonio, Texas. The McAllen Clinic serves seven counties in South Texas: Starr, Hidalgo, Cameron, Brooks, Jim Hogg, Kennedy and Willacy. The catchment area is comprised of approximately 47,000 veterans, of which the market share is 23%. This figure does not include the large number of winter visitors that significantly swells the veteran population in the Valley.

Services provided at the clinic include: medical and psychiatric treatment; mental hygiene classes; Registry examinations (Agent Orange, ionizing radiation exposure, Gulf War Service); and other examinations (e.g. former POWs, Aid and Attendance and Housebound). Additionally, special clinics include flexible sigmoidoscopy, geriatric assessment, gynecology, minor ambulatory surgery, endocrinology and podiatry. Other services in the clinic are psychological evaluation and testing, pharmacy, physical therapy, laboratory, radiology, social service, smoking cessation, marital counseling and dietary therapy. Furthermore, the clinic participates with the South Texas Family Practice Residency in McAllen and the University of Texas Health Science Center at San Antonio in teaching 20 family practice residents ambulatory internal medicine, geriatric medicine, flexible sigmoidoscopy and minor surgery. There are four

board certified family practice physicians of which one is certified in geriatric medicine, three board certified internal medicine physicians of which two have subspecialties in pulmonology, endocrinology, and geriatric medicine and a psychiatrist and psychologist assigned to mental health. Five of the seven have faculty appointments as clinical assistant professors to the University of Texas Health Science Center at San Antonio. The clinic received accreditation through the Joint Commission for the Accreditation of Healthcare Organizations from 2002 to 2005. There are 6 primary care teams delivering primary care and one mental health team composed of a psychiatrist, psychologist, mental health nurse and social worker. The Lower Rio Grande Valley Surgical contract has provided day surgery on a local basis for Valley veterans for the past 5 years.

There are 24 Iraqi-Afghanistan war veterans who have enrolled in the McAllen VA outpatient clinic of which 4 were female veterans. Ten veterans declined treatment but wanted their enrollment documented in the system. Initial screening for Post-traumatic Stress Disorder, Infectious Diseases, Depression and Alcohol Abuse is offered to all these veterans.

The Harlingen VA Outpatient Clinic will be operational as early as July 2004 and will start initially with two primary care teams that will eventually expand to 8 teams by 2006. This expansion of primary care delivery to the veteran population will decompress the McAllen VA Outpatient Clinic, which is operating at full capacity, and accommodate the continued growth of the veteran demand for medical services in the Rio Grande Valley. The Harlingen VA Outpatient Clinic will be situated in the Regional Academic Health Center affiliated with the University of Texas Health Science Center at San Antonio and will have 30,000 square feet of clinic space. The facility will mirror the clinic in McAllen with the exception of providing additional services such as optometry and dental care.

The Veterans Health Initiative Independent Study Courses provided by VA for healthcare personnel has been a substantial help in the recognition of medical problems unique to the veteran population. Examples of these courses include: Endemic Infectious Diseases of Southwest Asia; Caring for War Wounded; Preservation-Amputation Care; and Treatment and Traumatic Brain Injury. There are a total of 15 on-line courses that are available to healthcare personnel that encompass other aspects of VA medicine. I have found these to be excellent resources and have encouraged the medical staff in McAllen to participate in these on-line courses.

My family has served proudly in the U.S. Armed Forces. My father Eulalio Aguilar Sr. served in the Army during World War II, my brother Eulalio Aguilar Jr. served two tours in Vietnam as a Marine receiving a bronze star and two purple hearts; and, my older brother Alfredo B. Aguilar who served in the Air Force as a medic. I have been in the US Air Force Reserve for 15 years, and it has been a privilege serving with the other men and women serving in all branches of the Armed Services. Thank you for your attention.

Testimony of Stephen L. Holliday, Ph.D.
Chief, Psychology Service
South Texas Veterans Health Care System
&
Associate Clinical Professor of Medicine (Neurology)
University of Texas Health Science Center - San Antonio

INTRODUCTION:

My name is Stephen L. Holliday. I am a clinical psychologist and am board-certified in Clinical Neuropsychology by the American Board of Professional Psychology. For more than 18 years I have been actively involved in providing psychological care for veterans at the South Texas Veterans Health Care System (STVHCS), including those with posttraumatic stress disorder (PTSD). I previously served as the Psychology Service Training Director here for the past 10 years. This past January, I was named Chief of the STVHCS Psychology Service. As such, I have administrative and clinical responsibility for all psychological services at the STVHCS, including outpatient clinics. I also have responsibility for the educational and training programs in psychology. As Chief Psychologist, I also serve as STVHCS's liaison to the local Vet Centers, which serve veterans with PTSD from all conflicts. I also serve on the STVHCS Mental Health Council and assist in the coordination of care and planning for mental health care in our system.

In addition, I currently have the honor of serving as President of the Association for VA Psychologist Leaders (AVAPL), an independent organization that represents about 200 VA psychologists who serve as Chiefs and program leaders throughout the nation. As AVAPL President, I will preside at our annual meeting later this month in Washington. A major focus of this meeting will be preparing for new veterans returning from Iraq and Afghanistan.

I would like to discuss our history of close collaboration with the Department of Defense (DOD) and current planning efforts in preparing for providing psychological and mental health needs of our veterans, especially those new veterans returning from the conflicts in Iraq and Afghanistan.

COLLABORATION WITH DOD:

STVHCS has a long history of close and mutually beneficial training collaborations with DOD health care institutions in the San Antonio Area. The Psychology Service here has conducted joint neuropsychology training activities on a monthly basis for our respective interns/residents for over 15 years. Staff neuropsychologists at Brooke Army Medical Center (BAMC) and Wilford Hall Medical Center (WHMC) have also collaborated with our staff psychologists on research projects and difficult clinical cases frequently over the years. In addition the psychology departments at BAMC and WHMC frequently invite our staff and trainees to attend special conferences and workshops by nationally known Visiting Distinguished Professors (of Psychology) funded through DOD. Our neuropsychology trainees have frequently done off-site training rotations with Dr. Pamela Clement at BAMC. Two staff neuropsychologists from WHMC also attend and help teach our weekly

Neuropsychology Readings Conference/Journal Club. Similar arrangements have been made over the years for our resident physicians in Psychiatry and Medicine.

With respect to returning Iraqi veterans, a VA staff social worker (along with several other VA administrative/clinical staff) has been detailed to DOD to assist with seamless referral of DOD personnel for VA services. To my knowledge, all of these referrals to date have been for medical and rehabilitation services. However, the social worker is also knowledgeable about STVHCS mental health resources and will assist in making those referrals as needed. We suspect that many DOD personnel may be reluctant to seek mental health services while on active duty for fear of adversely affecting their military careers. We anticipate that many returning Iraqi veterans will seek VA mental health and Vet Center services after they are demobilized/separated from DOD. When that happens, additional VA mental health resources will likely be required.

STVHCS front line personnel in Triage, Medical Administration Service, and Primary Care have been trained to expedite services for returning veterans from Iraq and Afghanistan. Our mental health program leaders have been specifically instructed to ensure that these priority veterans receive all needed services in a timely fashion.

STVHCS is currently planning several collaborate initiatives with DOD to jointly provide clinical services for both veterans and DOD personnel/dependents. We anticipate opening two new outpatient primary care clinics in San Antonio: one with the Air Force on Brooks City Base in the underserved south side of town and another with the Army in the rapidly-growing north central area. We are also exploring expanding the VA Corpus Christi Outpatient Clinic by co-locating it with the underutilized DOD hospital facility at the Naval Air Station in Corpus Christi. We will ensure that each of these facilities has substantial mental health capability.

RECENT CHANGES & FUTURE PLANS:

For many years, our Post Traumatic Stress Disorder Clinical Team (PCT) here had 1.5 FTE psychologists, a psychiatrist, a social worker, and program specialist to provide specialty mental health care for STVHCS veterans with PTSD. Recent military actions in Afghanistan and Iraq have already increased their caseload with PTSD patients from previous conflicts, likely due to exacerbation of their symptoms from news coverage. They currently have a backlog of PTSD patients referred for their services. For this reason, they recently received authority to expand the social worker position to full time and to recruit for an additional psychologist and psychiatrist to help with this backlog. The new psychiatrist has already been selected and the new psychologist should be selected within a few weeks. In addition, the PCT recently held a staff retreat to plan better, more cost-effective methods to assess and treat these patients. For example, the additional social worker will create a new "drop-in" center/low intensity treatment program for patients currently followed for chronic PTSD, freeing up other staff and group therapy resources to clear the backlog and make room for new PTSD cases returning from Iraq.

Dr. Abney, the PCT clinical director, is currently planning for new therapy groups, especially for these new PTSD cases. Indeed, Dr. Abney has already treated several

active duty troops who were disturbed by nightmares from their service in Iraq. These were the adult children of Viet Nam veterans he saw through the PCT in past years. Dr. Abney is a nationally-recognized authority in the treatment of PTSD and offered one of the first group therapy interventions for Viet Nam veterans at the Temple VAMC in 1978. The PCT staff regularly visits and consults with the local Vet Center, which also provide extensive individual and group treatment for PTSD patients. In conjunction with our Education Service, we are also planning to schedule an extensive workshop at STVHCS on treatment of acute stress disorder by staff from the VA's PTSD Center of Excellence in Boston. VA Central office recently developed extensive new treatment guidelines for evidence-based treatment of acute stress reactions and PTSD. These were distributed to the staff at the PCT and Psychology Service earlier this year and will be incorporated into their program.

VA Central Office has also added annual mandatory screening for PTSD (along with current screening questions for depression, substance/tobacco abuse, etc.) for all veterans served. This process is automated through our state of the art computerized medical record system, ensuring that all veterans receiving medical care will be annually screened for these major mental health conditions. When identified, they will be either treated in the primary care setting or referred for more specialized mental health programs. This should ensure that all veterans with these problems are identified and appropriately treated, even if they do not specifically request these services. We are determined not to repeat the mistakes from Viet Nam, when delayed identification and the lack of effective early treatment for PTSD may have contributed to lifelong disability for so many veterans. We now understand that early identification and community-based treatment/case management are key to this effort. Our new psychosocial rehabilitation program located at Villa Serena near Audie Murphy Hospital should be especially helpful in this regard. This is a residential program that focuses on psychiatric, psychological, and vocational interventions aimed at providing patients with the skills needed to return to the community and gainful employment.

Other mental health resources have been increased this year at STVHCS. We have recently authorized and are recruiting two additional psychiatrists, two mental health nurses, and one psychologist for our outpatient clinics in San Antonio and Kerrville. We are also developing telemedicine initiatives to extend specialized mental health care to our remote outpatient clinics and to ensure all clinicians in these settings have access to consultants and continuing educational opportunities. Psychology Service is continuing our efforts to offer mental health services within primary care medicine settings. For the past seven years, each of our five psychology interns were assigned to half-day Internal Medicine Clinics at Audie Murphy Hospital throughout their training year. In this way, veterans have easy/quick access to psychological services without the delays or stigma associated with referrals to psychiatry clinics/programs. We are now planning to expand these services to the primary care clinic at the Frank Tejada Outpatient Clinic in San Antonio. In addition, our staff recently received training in DIGMA groups which pair a mental health professional with a primary care provider to provide integrated medical/psychological care in a cost-effective group setting. The VERDICT, our center of excellence for evidence-based medicine, is currently working on a 3-year program implementation grant which would resource, train staff, and expand mental health services within primary care across VISN 17.

PROJECTED NEEDS:

Although it is difficult to accurately predict the number of returning veterans who will require mental health resources, we suspect it will be substantial. Unlike the relatively brief and low-causality first Gulf War, the current conflicts in Iraq and Afghanistan are likely to be protracted and difficult. Like Viet Nam, our forces in Iraq and Afghanistan have great difficulty differentiating friend from foe and there are no truly safe (rear echelon) areas. The mental health toll taken by extended tours in such stressful conditions is well known to us. The question is not IF many returning Iraq/Afghanistan War veterans will need VA mental health services, but only WHEN they will seek it.

We know how to effectively treat acute stress reaction and to prevent it from becoming severe, chronic PTSD; however, our budgets are now barely keeping up with our current demand. We are now implementing workload and staffing guidelines for mental health clinics. We need to ensure that VA mental health providers are both productive and adequate in number to meet this need. We will equip our staff with the knowledge and facilities to do the job. We will also monitor their productivity, caseloads, and clinical outcomes to ensure fiscal accountability and quality care. As the first of the returning veterans begin to enter the VA system over the next several months, we should have a better estimate of the number needing additional mental health services and resources.

We would encourage the Committee to closely monitor this need and to fund VA mental health services accordingly. The cost of failing to provide timely/effective mental health services for these veterans would be much higher in terms of lost wages/taxes and the costs of chronic psychiatric care for another generation. Our country cannot afford another lost generation of chronic PTSD patients... financially, ethically, or morally. We know that the House Committee understands our debt and sacred obligation to our veterans and will continue to help us to provide quality mental health care for all who have served.

SUMMARY OF KEY POINTS:

1. We have a solid track record of effective collaboration with DOD facilities.
2. New sharing agreements are planned for joint care with DOD.
3. PTSD treatment resources are strong and we are actively preparing for returning veterans.
4. New methods are in place to identify and provide effective treatment for PTSD and other mental health problem in returning veterans.
5. Additional funding will likely be needed to provide care for returning veterans, but will be much less expensive than failure to identify/treat PTSD in a timely fashion.

Thank you for this opportunity to present to you this morning.

Leopoldo C. Cancio, M.D., F.A.C.S
Lieutenant Colonel, Medical Corps, United States Army
Director, Burn Center
U.S. Army Institute of Surgical Research (USAISR)
Brooke Army Medical Center (BAMC)
Fort Sam Houston, TX 78234-6315

Statement for the House Committee on Veteran's Affairs, Subcommittee on Health

Good afternoon,

My name is Lieutenant Colonel (Dr.) Lee Cancio. I am the Director of the U.S. Army Burn Center, which is part of the Institute of Surgical Research located within Brooke Army Medical Center, Fort Sam Houston, Texas. Since 1949, we have been the only Burn Center serving the Department of Defense. We also serve the acute burn care needs of Veterans Administration patients from across the nation. Finally, we are the only burn center for civilians in this South Texas region.

Our center has cared for all of the seriously burned casualties from Operations Iraqi Freedom and Enduring Freedom, and the Global War on Terrorism. The majority of these casualties have come to us from Operation Iraqi Freedom. I will give you an overview of our preparations for war in Iraq, our experience during the war, and our care for these servicemen as they return to duty or civilian life.

Historically, burns have constituted 5 to 10 percent of conventional warfare casualties. Burn care is time-, manpower- and resource-intensive, requires a multidisciplinary team effort in specialized centers, and can result in lifelong disability.

From the onset, we prepared to care for burned servicemen from the Global War on Terrorism. This Burn Center's mission was to receive all burn casualties up to our maximum capacity, to receive any mustard agent casualties, and not to close to civilian burns here in South Texas unless absolutely necessary. We developed plans for the expansion of this Burn Center up to 60 beds. In addition, we created a National Response for Burn Care in the event of a mass casualty situation. We also developed a plan for mustard agent casualties; we conducted burn training for military medical personnel; and we put into place an aeromedical evacuation plan.

The National Response for Burn Care

Our worst-case-scenario prediction was that conflict in the Global War on Terrorism could generate approximately 1,000 burn patients, of whom 200 had life-threatening burns of greater than 20 percent of the body surface area. Clearly, no one burn center could provide intensive care for 200 critically ill burn patients.

Therefore we, in collaboration with the American Burn Association, the U.S. Air Force, and the National Disaster Medical System, put into place a method of directing burn casualties to those civilian burn centers within the Continental United States with open beds—in the event of an overwhelming number of casualties.

A daily request for open bed status was e-mailed from the Army Burn Center to 60 participating burn centers across the country. This information was collated here, and then was sent to the Army Burn Center Liaison Officer at Landstuhl Regional Medical Center in Germany. It was also sent to the Federal Coordinating Centers (FCCs) and to military coordinators across the U.S. In the event of a mass casualty situation, this would have allowed the Liaison Officer in Germany to advise the Air Force and to regulate burn patients coming out of Iraq to available open beds in the U.S.

This unprecedented nationwide system was in continuous operation between 17 March and 9 May 2003, and has been periodically tested since then. The availability of burn beds across the nation among the 60 participating burn centers was 407, for an average of 9.5 beds per burn center. Clearly, there is no large surplus of burn beds in the United States at any one time.

We also engaged in discussion with the National Disaster Medical System concerning possibility of activating the Burn Disaster Medical Assistance Teams (DMATs) to support the Army Burn Center, but this was not required.

Combat Burn Training

Because burn care is specialized and centralized in burn centers, most military medical providers, to include surgeons and nurses, have little hands-on burn experience. Also, civilian courses in emergency burn care, which emphasize rapid transfer to a burn center, do not fully prepare personnel for battlefield scenarios such as prolonged care.

Accordingly, we created burn training modules specific for military situations, to include the management of mustard agent and white phosphorus injuries, care after the first 24 hours postburn, wound care and infection, and aeromedical evacuation. We trained approximately 1,100 personnel on-site at the Army Burn Center, on the ground in Kuwait before the conflict, and aboard the hospital ship USNS Comfort in the Persian Gulf. In addition, we provided burn care information on the Army Knowledge Web site. This was one of the top-10 Army Web sites during the war.

Mustard Agent Plan

Recognizing the similarities between burns and mustard injuries, we developed a protocol for the care of mustard casualties in conjunction with the U.S. Army Medical Research Institute of Chemical Defense. This plan included sending all mustard casualties to the Army Burn Center.

Aeromedical Evacuation of Burned Servicemen

This Center's Army Burn Flight Teams have been in operation since 1951, and pioneered the aeromedical transport of seriously ill burn patients. In addition, these are the only Army teams whose members are trained and certified by the U.S. Air Force as Critical Care Aeromedical Transport Teams, or CCATTs.

During Desert Storm, three Army Burn Flight Teams were pre-positioned in Saudi Arabia. Our experience was that they were underutilized. Therefore, in preparation for the Global War on Terrorism, we placed one Liaison Officer in Kuwait and one in Landstuhl, and deployed Burn Flight Teams to Landstuhl as needed, in order to bring back critically ill patients to the Army Burn Center.

In support of Operations Iraqi Freedom and the Global War on Terrorism, the Army Burn Flight Teams have performed 18 flights to Germany in order to transport burn patients. There were no flight-related complications.

Care for Burned Servicemen at the Burn Center

Between March 2003 and April 2004, the Army Burn Center admitted a total of 91 patients with burns sustained during Operations Iraqi Freedom and the Global War on Terrorism. Four of these patients were from Operation Enduring Freedom in Afghanistan and two were from Djibouti. Eight-five patients sustained their injuries while involved in Operation Iraqi Freedom. This figure included one Department of Defense civilian employee and four patients from the Republic of Georgia.

Nineteen percent had life-threatening burns of greater than 20 percent of the body surface area, and five also had smoke inhalation injury. There have been two deaths.

Accidents have been the single most common cause of injury. These accidents have included the burning of human waste, the handling of ordnance or gunpowder, the handling of fuel, chemical injuries, motor vehicle accidents, and scalds. Non-preventable burns have included rocket propelled grenade attacks, land mines, and other explosives.

We communicated our findings on accident related burns as the leading cause of injury to the troop leadership in the theater of operations in the Fall of 2003, following which we have seen a decrease in this type of injury. In addition, we are intensifying our educational efforts to the commanders and key line medical staff.

These burned servicemen have been supported by a variety of services that are unique to this Burn Center. The Fisher Houses have frequently provided families with a place to stay near the hospital. Soldiers have been supported by events such as Purple Heart ceremonies and visits by General Officers, Members of Congress, and the Secretary of

Defense. Some of them have undergone Medical Evaluation Boards and others have been returned to their units.

Having these soldiers at one burn center versus scattered across the nation has facilitated this type of support, and has allowed us to collect data on long-term functional outcome after injury.

All of the burn patients at Brooke Army Medical Center have received assistance from two Veterans Administration employees – one a clinical social work and the other a benefits expert.

Psychological problems are a frequent component of the response to burn injury. Recognizing this, the Psychiatric Clinical Nurse Specialist for the Burn Center screens every burn casualty upon admission, and provides treatment and followup as needed. 55 percent of burn casualties from Operation Iraqi Freedom have had acute symptoms of anxiety or depression during their hospital stay. Anxiety is more common, occurring in about 45 percent, than is depression, which occurs in 26 percent. Other common findings are body image disturbance, delirium, and anger. Thirty-two percent of hospitalized OIF patients have received medications to treat symptoms of anxiety and/or depression. Long-term followup has revealed that approximately 25 percent have ongoing psychological problems.

Our process for handling patients with psychological symptoms after discharge includes referral to mental health services at the patient's home base, including the Veterans Administration facilities.

In addition, we follow our burn patients in our outpatient clinic, for up to one year after discharge. These outpatients are also screened for psychological problems at this time. The true incidence of post-traumatic stress disorder following combat injury, and how best to prevent or treat it, remains an important, and as yet unresolved, clinical question.

Many burn patients, particularly with burns of the hands and burns of the face, also have significant long-term rehabilitation and reconstructive surgery needs. Burns of the hand often require a burn-center-experienced Occupational Therapist, or at least a Certified Hand Therapist.

Second, patients with burn of the hands and face develop scars which frequently require reconstruction by plastic or hand surgeons experienced with the long-term treatment of burn patients. Furthermore, patients with deep burns of the face require special face masks during the first year postburn in order to reduce scar formation. These are best constructed using laser scanning technology; only a few centers across the nation have this state-of-the-art technology.

All in all, approximately 20-25 percent of our Operation Iraqi Freedom burn patients have significant burns of the hand or of the face, which require these specialized types of therapy and reconstructive surgeries.

Some of our Operation Iraqi Freedom soldiers have not been capable of returning to duty. A total of seven burned servicemen have undergone medical evaluation boards (MEBs), or are in the process of undergoing one at this Center. Two other servicemen have undergone MEBs at other facilities. Six more of our Operation Iraqi Freedom burn patients are likely to require MEBs, and there are 14 patients who have long-term problems that could result in an MEB and a separation from the service at some point in the future. This assessment does not include the possibility of more servicemen in the future requiring separation because of post-traumatic stress disorder or other psychological complications of their injury.

Conclusion

In conclusion, it has been a real honor to care for American service men and women who have suffered significant burns during this conflict.

Burn care is a complex, multidisciplinary team process requiring the coordinated services of nurses, surgeons, occupational, physical, and respiratory therapists, social workers, dieticians, and specialists in psychiatry.

The needs of the burn patient do not end with the hospital discharge, but are in many cases lifelong in nature. Adequate care of these Global War on Terrorism patients will require long-term follow-up.

We have initiated this process here at the Army Burn Center as part of our core mission of taking care of soldiers during the acute phase of illness. Many of the soldiers, however, will require lifetime follow-up by specialized personnel with burn experience. We look forward to working with the Veterans Administration system to facilitate and assist in this process even after we have medically discharged them from active service.

Thank you for the opportunity to testify. I would be happy to answer any questions.

Department of the Air Force

**Presentation to the Committee on Veterans' Affairs
Subcommittee on Health
United States House of Representatives**

Subject: Status of Military and VA Healthcare

**Statement of: Colonel (sel) Brian J. Masterson
Chief Information Officer and
Staff Physician, Psychiatry and Internal Medicine at
Wilford Hall Medical Center, Lackland AFB, Texas**

**Field Hearing
San Antonio, Texas
April 13, 2004**

**Not for publication until released by the
Subcommittee on Health
Committee on Veterans' Affairs
United States House of Representatives**

Good morning. I am Lieutenant Colonel Brian J. Masterson, Chief Information Officer and Staff Physician for Internal Medicine and Psychiatry at Wilford Hall Medical Center (WHMC). I previously served as Commander, Critical Care Squadron at WHMC. Mr. Chairman and Members of the House Committee on Veterans' Affairs, Subcommittee on Health, thank you for allowing me to appear before you today and offer my thoughts on military healthcare and Department of Defense (DOD)\Department of Veterans Affairs (VA) cooperation in the greater San Antonio area.

For nearly 11 years I have served as a staff physician and psychiatrist in the San Antonio area and have come to appreciate this as an ideal community for practicing and teaching medicine while delivering medical care in a cost effective and efficient manner. These world-class medical centers and research facilities combine efforts to offer a unique opportunity to share resources and improve the quality of health care for our military and civilian community. In addition to this unparalleled opportunity to share resources, San Antonio VA and military medical facilities play a key role in the preparation for deployment of troops as well as treatment of casualties returning from overseas.

Prior to deployment, our readiness squadron processes personnel deploying to any contingency, including Operations IRAQI FREEDOM (OIF) and ENDURING FREEDOM (OEF). Requirements for deployment are validated and matched against personnel assigned to a specific unit type code for skills. The individuals are screened for the 43 readiness indicators for deployment in the areas of administrative requirements,

training, medical and dental fitness. To date, there have been no errors and no need to remove a Lackland AFB member from the theaters of operations. The lowest Disease Non-Battle Injury rate in history, four percent during OIF, as compared to six percent in Operation DESERT STORM, clearly demonstrates the success of screening, aggressive public health and safety initiatives in theater.

Personnel returning from a deployment are required to process through Air Force Public Health before they begin their rest and reconstitution leave. Approximately 840 personnel have been processed during 2003. To ensure the screening is conducted on all personnel, the local Finance Department will not process travel vouchers for leave until this requirement has been met. Additionally, the military members' medical records are reviewed to ensure a Post Deployment Health Assessment Survey (PDHAS), (DD Form 2796), was completed in theater. If not, one is completed during processing and the member is scheduled for an appointment with their Primary Care Manager (PCM). This accounts for a 100 percent capture of required information. The PDHAS requires the member to be seen by a health care provider. If follow-up or individual concerns need to be addressed, the member is scheduled for an appointment prior to leaving the Public Health processing site. The PCM will address the individuals' responses on the PDHAS; information collected includes medical, mental or psychosocial health, special medications taken, environmental or occupational exposures occurring during the deployment. A post deployment blood sample is drawn and forwarded to the DoD Serum Repository.

Post-deployment follow-up care for Guard and Reserve personnel released from active duty is coordinated through their units' and/or a VA medical facility. Members

requiring immediate or extensive evaluation are retained on active duty, with the members' consent, pending resolution of the medical condition.

During calendar year 2003, and to date in 2004, the 59th MDW provided Aerovac reception for 609 OEF and OIF patients. WHMC treated 127 patients and arranged care for 482 with other branches of the Armed Services. We are working closely with our VA points of contact to ensure the patients are fully aware of all their VA benefits. For those patients who may be transitioning from DoD health care to VA health care, we're committed to ensuring they'll have access to all their VA benefits and services. One example is a USMC Corporal who experienced a cervical spine facet fracture and is undergoing pain management and convalescence at home. He is awaiting a 3-month follow up evaluation to see if he will return to duty. A second example is a Senior Airman, an activated reservist, who has developed a chronic pain syndrome and Reflex Sympathetic Dystrophy from a foot injury in Afghanistan. Due to the debilitating nature of the pain, he will have a medical board to determine the return to duty status. We are awaiting the medical documentation from private local providers in the Dallas area.

In summary, I have been involved with the post DESERT STORM surveillance program as Clinical Director at WHMC and later provided oversight as Chief of Clinical Medicine at Headquarters Air Force Education and Training Command (AETC). I can attest that the lessons learned from the comprehensive clinical evaluation program, a retrospective analysis of post gulf war syndrome, have been successfully implemented. This is demonstrated by the effectiveness of pre- and post-deployment surveys and screenings as well as aggressive public health and safety initiatives in theater.

Mr. Chairman, I am convinced the continuation of asset and knowledge sharing between the United States Air Force, Army and VA in San Antonio, Texas will strengthen our system for providing medical services and ensure our service men and women receive the best care in the entire spectrum of the Federal health care system. Thank you for allowing me to appear before your subcommittee.

PRESENTATION
Before the
**House Committee on Veterans' Affairs,
Subcommittee on Health**

San Antonio, Texas
April 13, 2004

By **Ignacio Leija**
Vice President of Service Operations
American GI Forum National
Veterans Outreach Program

Good morning. Thank you for inviting me to come before this committee and for allowing me to participate in this important hearing. My name is Ignacio Leija and I am the Vice President of Service Operations for the American GI Forum National Veterans Outreach Program based in San Antonio, Texas.

It is my understanding that today's session focuses on transition and access between the Department of Defense and the VA medical facilities. This is truly a timely subject due to the 100,000 troops that are returning within 90 days. Obviously, due to the current situation within Iraq, things may change. Eventually, however, this transition will occur.

The American GI Forum constituency is made up of many Hispanic veterans. Many of our veterans reside in areas without reasonable access to VA medical centers. For that reason, I would like to take the opportunity to

voice our support for the continuing addition of VA Community Based Outpatient Clinics in areas lacking VA Medical Centers.

Our nation is faced with the homecoming of many more new veterans who will be returning soon, some of which may require long term medical care for illnesses or injuries suffered during this Iraqi war. For this reason, we support the recent introduction of collaboration between the Department of Defense and the Department of Veterans Affairs. The result is that military medical evaluation findings can be accepted by the VA for ratings of medical conditions of newly discharged veterans without burdening them with other duplicating evaluations.

The American GI Forum also supports the initiative by the Department of Defense's Personnel Evaluation Boards that will consider the cases of disabled veterans who want to continue their military career. We encourage the continued sensitivity on the part of the Department of Defense to expand that opportunity for those veterans to cross-train to other fields and remain productive in the military in spite of a disability.

A great concern that the American GI Forum constituency has is that of releasing veterans immediately after returning stateside. The participation in a war zone can have long-term detrimental effects. It is our understanding that the Department of Defense plans to rotate reservists back from Iraq and

discharge them within 48 to 72 hours. The Vietnam experience, as supported by Vet Centers, should have taught us that combat participants must have time to defuse and adjust among their peers with similar experiences. We encourage the Department of Defense to further investigate and possibly consider a 30 to 45 day adjustment period before discharge during which time the Department of Defense and the Vet Centers could collaborate and offer appropriate counseling and other supportive services. If not, we fear that another cycle of posttraumatic stress disorders will follow this new generation of veterans.

Our organization and other VSOs are prepared to assist our returning veterans by joining transition teams that will facilitate the return and re-entry of new veterans into civilian life.

The American GI Forum is proud to serve the needs of all veterans through its National Veterans Outreach Program. With offices in six (6) of the larger cities in Texas, we currently provide services in employment and training for recently separated veterans, disabled veterans, and veterans that served in theaters of war. The staff assigned to these offices are prepared to assist veterans by providing them with job search skills, resume writing assistance, enrollment into short-term vocational classroom training, and on-the-job training with businesses that are ready to employ them.

In closing, I would like to thank Mr. Jose Coronado from the Audie Murphy Hospital here in San Antonio. We certainly feel very fortunate to have his leadership. I would personally like to thank him for his willingness to collaborate services with our newly formed Homeless Veterans Residential Center.

Finally, I would like to thank Congressman Ciro Rodriguez for inviting us to this very important session. The American GI Forum expects to continue to work with him for many years to come. Thank you.

**STATEMENT OF
DOUGLAS HERRLE
CHAPTER 61 COMMANDER
OF THE
DEPARTMENT OF TEXAS
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
APRIL 13, 2004**

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to present the views of the Disabled American Veterans (DAV) Department of Texas, an organization of more than 73,000 wartime disabled veterans, on the status of military and Department of Veterans Affairs (VA) health care coordination, including post-deployment health care of recently discharged veterans.

Mr. Chairman, I have two issues I wish to discuss. The first issue is the lack of adequate funding for veterans health care. I am aware that our Government has many commitments throughout the world. However, I feel that the Government, when creating the budget, should consider veterans' health care as a high priority, as a continuation of the cost of war.

Timely access to quality health care for service-connected disabled veterans is a top priority for DAV. We have often stated that through their extraordinary sacrifices and contributions, veterans have *earned* the right to free health care as a continuing cost of national defense. The Health Care Eligibility Reform Act of 1996 authorized eligible veterans access to VA health care and brought us closer to meeting our moral obligation as a nation to care for veterans and generously provide them the benefits and health care they rightfully deserve.

Since Operation Iraqi Freedom started, we have watched our sons, daughters, fathers and mothers put on the uniform of our armed services and go to foreign lands to risk life and limb, believing that the government which sent them into harm's way would take care of them. The fiscal year 2005 budget is again inadequate. The state of Texas has over 73,000 disabled veterans residing within its borders, and every one of them wants VA health care adequately funded.

We believe it is disingenuous for our government to promise health care to veterans and then to make it unattainable because of inadequate funding. Rationed health care is no way to honor America's obligation to the brave men and women who have so honorably served our nation. DAV will continue to work to increase awareness and support for veterans issues and to seek sufficient federal funding for VA by shifting VA health care from a discretionary to a mandatory funding method to ensure the viability of programs for our wartime disabled veterans.

I also wish to discuss the excessive time it takes for veterans to receive health care. At the present time, the waiting period for getting appointments to see even a physician's assistant takes anywhere from 3 to 6 months, if you are lucky. If you require an appointment with a doctor, this will take much longer. The last three doctors I have had in the VA Medical System of South Texas have been available only one day a week and then usually only part of the day. One of the other doctors

had poor command of the English language, which made it very difficult to understand his instructions to me. He also had problems understanding me. There is a definite need for additional doctors and nurses in the VA health care system. I am aware that the medical providers are in short supply and the few that are available are able to find employment at other facilities, at higher pay.

Many of the veterans I am in contact with do not desire to have the program privatized, since it results in the loss of services. Many veterans feel that a temporary fix for improving health care for veterans, requiring overnight stay or longer would be to contract with the hospitals in the area. It is not feasible to contract with the military hospitals in the area, since they are just as overburdened as the VA medical system. The problem that arises from having to wait for excessively long periods of time for appointments is that prior to the appointment an illness that could have been treated as something minor becomes a major illness.

There is another problem with not having sufficient staff to schedule and treat veterans. Many veterans from the Vietnam and the Iraq wars suffer from post traumatic stress disorder and when they need to see a doctor, they have frequently already delayed to the point that they are becoming a danger to themselves or others. It is recommended to them that they go to the Audie Murphy VA Medical Center Emergency Triage and ask to see a doctor. It is a bad idea to send a veteran who is already on a short fuse into a crowded waiting room and ask him to wait anywhere from 3 to 18 hours for treatment. The triage is usually short on staff and the doctor on duty may be on call for emergencies only. Patients with chest pains and difficulty breathing have been known to wait in excess of 8 hours to see a doctor or nurse practitioner.

There are returning Operation Iraqi Freedom veterans who are in need of treatment but are unable to get an appointment in a timely manner. Even with VA's new directive to provide health care for two years for veterans returning from a combat theater, this situation is aggravated by time constraints such as a 90-day limit for dental care and a one-year limit for other health care problems that arise from their time serving their country with regard to filing a claim through the Veterans Benefits Administration.

The patient count is down because veterans are unable to get appointments. As a result, VA has been closing wards. I am a 100% service-connected disabled veteran, and due to my medical problems I am not able to be treated at the VA satellite clinics. I am lucky that I retired from the military and have Tricare to fall back on. If I had only the VA to rely on for my treatment, there is a likelihood that I would not have survived to stand before this panel today. Similarly, many returning injured Iraqi Freedom veterans, some of whom will be medically retired, and dually eligible, like myself, will have an easier time receiving care. However, thousands of other returning veterans—those without dual eligibility—will be left to navigate the complex VA health care system, with no other choices.

In closing, DAV Department of Texas sincerely appreciates the Subcommittee for holding this hearing and for its interest in improving benefits and services for our Nation's veterans. The DAV deeply values the advocacy this Subcommittee has always demonstrated on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important measures.

STATEMENT OF
RICHARD C. HOLLOWAY, VICE CHAIRMAN
AMERICANISM COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE STATUS OF MILITARY AND DEPARTMENT OF VETERANS AFFAIRS
HEALTH CARE COORDINATION
INCLUDING
POST-DEPLOYMENT HEALTH CARE OF RECENTLY DISCHARGED VETERANS

San Antonio, Texas - April 13, 2004

Mr. Chairman and Members of the Subcommittee:

On behalf of the 2.8 million members of The American Legion, I thank you for this opportunity to present our organizational views on the status of military and VA health care coordination including post-deployment health care of recently discharged veterans. We commend the Subcommittee for holding this hearing on this timely and important subject.

With the continuing global war on terrorism and the events in Iraq and Afghanistan, it is critically important that the Department of Defense and the VA coordinate healthcare delivery to our returning troops and new veterans of these conflicts. No veteran should be allowed to slip through the cracks between these massive agencies for lack of information or outreach.

Perhaps it was easier in President Lincoln's day "*to care for him who shall have borne the battle and for his widow and his orphan.*" The Government then was limited in what it knew or could do about caring for survivors of the Civil War. The physical wounds of war were no less horrific than today, however, nearly nothing was then known of the delayed effects of participation in the brutal business of war. Veterans went home, or not, to the farms and cities with pensions for disfigurement, missing limbs or organs of sense and little else. The residuals of diseases such as cholera and scurvy endemic in garrisons and prisoner of war camps generally were not recognized as war-related and veterans were usually left to fend for themselves. Veterans whom we would now diagnose with Post-Traumatic Stress Disorder died from exposure and alcoholism in the streets or were warehoused in proliferating insane asylums and prisons. Those veterans who were totally disabled were, if they were lucky, allowed to live out their lives in veterans' homes run by the States. The first of these was Rocky Hill State Veterans Home and Hospital in Connecticut that is still serving veterans today.

The point here is that with each succeeding war, we have learned more and more about what war does to the human body and psyche, both immediately and later in life. Our knowledge of these

effects is now so extensive that the government that called them to sacrifice must objectively follow our veterans who return from war; from the very moment they shed the uniforms in which they fought. For example, it is now known that almost every individual who is exposed to prolonged periods of combat exposure will exhibit symptoms of Acute Stress Disorder. Once removed from the stressors, most troops readjust within a month or two and those that do not are considered for a diagnosis of PTSD. For this reason, returning troops may be kept in garrison for a short period of observation so that those troops who do not readjust well may be counseled and referred to VA on release from active duty. Lessons learned from the experience of veterans of the Vietnam War and extensive research into combat-related stress reactions by the VA's exemplary National Center for Post-Traumatic Stress Disorder have led to these protocols.

According to the most recent Analysis of VA Health Care Utilization (Report 5, dated March 29, 2004), 127,970 veterans have returned from Operation Iraqi Freedom. Fourteen percent (17,800) have sought healthcare from VA. Of those veterans, 15.1% (2,691) were diagnosed with mental disorders. The most frequently diagnosed (970 veterans) mental disorder was ICD-9 Code 309 Adjustment Reaction including 626 diagnoses of Post-Traumatic Stress Disorder (PTSD). The only discrete non-dental diagnoses with higher rates were infectious and parasitic diseases (1103), essential hypertension (996) and deafness (1212). So far, coordination between the DoD and VA systems with regard to OIF and Operation Enduring Freedom (OEF) appears to be working well at the operational level. Pre- and post-deployment health screenings of troops has improved since the initial problems noted in various reports by the General Accounting Office (GAO).

On the DoD end, The American Legion is heartened by the implementation of the Army's new Disabled Soldier Support System (DS3). In previous conflicts no program to transition disabled soldiers into the VA system existed. Veterans presented themselves to VA and were required to prove their own eligibility. As noted above, the new knowledge of the front-end sequelae of combat indicates a requirement for follow-up. The deployment cycle support feature of DS3 facilitates referrals to VA. DS3 provides its severely disabled soldiers and their families with a system of advocacy, including representation by Veteran Service Organizations (VSOs) such as The American Legion. VSOs are involved at the Physical/Medical Evaluation Board (PEB/MEB) level at major Military Treatment Facilities (MTFs) and follow the veteran to his or her initial contact with VA healthcare. If the soldier is medically retired, the VSO conducts a Needs Assessment and tailors specific assistance to the soldier and family. On release from DoD, the veteran is handed off to a "hometown" VSO for enrollment in VA medical care and application for VA disability compensation. Periodic telephonic follow-up by DoD then ensues for a minimum of five years. This is a commendable initiative, designed to deliver services to the veteran with a minimum of delay and red tape and The American Legion appreciates DoD's precedential involvement of VSOs at the level of the MTF. Hopefully, this will evolve into the same symbiotic relationship that VSOs now enjoy with VA. Time will tell.

At the VA end, on March 19, 2003 Secretary of Veterans Affairs Anthony Principi announced that, under authority granted by Pub. L. 105-368, any veteran returning from a combat zone will be entitled to two years of free VA healthcare starting from date of discharge from Federal service. This benefit applies to active duty, Reserve and National Guard personnel, irrespective of any service-connected disability status, and will not affect the veterans continuing eligibility

for care of service-connected conditions after the two-year period expires. VA is currently conducting aggressive outreach to Reserve and National Guard troops who may not be aware of the benefit. VA is also working to overcome well-publicized unacceptable veteran interactions with individual VA healthcare facilities related to wait-times for initial appointments. A number of long-term strategies, policies and procedures have been implemented to assure that timely, appropriate care is provided to returning service members.

In the announcement, the Secretary noted the progress made in VA's ongoing partnership with DoD, specifically standardized post-deployment physical examination guidelines and establishment of the War-Related Illness Centers in Washington, DC and East Orange, New Jersey. Two joint post-deployment VA/DoD clinical practice guidelines (CPGs) have been released to educate physicians and other providers in deployment and exposure related health concerns. The current CPGs address general post-deployment issues and unexplained fatigue and pain. A new CPG is soon to be released on the management of traumatic stress with the aim of preventing acute and chronic PTSD. In another unprecedented move, the Surgeons General of the Services have enthusiastically approved the detailing of Veterans Benefits Administration (VBA) benefits counselors and Veterans Health Administration (VHA) clinical social workers to MTFs receiving casualties from OIF/OEF.

Mr. Chairman, the outstanding efforts of the VA and DoD to avert the problems encountered after Operations Desert Shield and Desert Storm have been innovative and laudable. Never before have the VA, DoD and the VSO community come together so effectively to ensure that those *who shall have borne the battle* receive the care and benefits they have earned and deserve because of their service.

More daunting challenges lie ahead in institutionalizing this progress for availability in this and future conflicts. Now described under the rubric of "seamless transition", attempts to bring together the DoD and VA healthcare are nothing new. Pub.L. 97-174, the Department of Veterans Affairs/Department of Defense Health Resource Sharing Operations Act of 1982, paved the way for VA/DoD cooperation in the sharing of resources during national emergencies. Since then a plethora of legislation has mandated and encouraged further VA/DoD cooperation. The most recent and significant of these new laws is Pub.L. 107-314, the National Defense Authorization Act of 2003—Subtitle C: DoD-VA Health Resources Sharing which requires VA and DoD to develop and publish a joint strategic vision statement and a joint strategic plan to shape, focus, and prioritize the coordination and sharing efforts among appropriate elements of the two Departments and incorporate the goals and requirements of the joint sharing plan into the strategic and performance plan of each Department.

Major resources are being applied by both Departments to comply with this law. A few current projects include:

The Joint VA/DoD Electronic Health Records Plan-HealthPeople. This overarching initiative guides activities and deliverables of VA and DoD sharing and will result in a "virtual" health record accessible by authorized users within DoD and VA. It will be comprised of a family of systems or converged applications between DoD and VA. The VA/DoD Health Executive Council (HEC), co-chaired by the VA Under Secretary for Health and the DoD Assistant Secretary of Defense for Health Affairs, is providing senior level executive oversight and

management of the Departments' activities related to health systems interoperability. The HEC meets routinely to review and/or approve, when timely and appropriate, new and on-going initiatives or health IT sharing projects for coordination between VA and DoD.

The *Clinical Data Repository/Health Data Repository (CHDR)*. This project seeks to ensure the interoperability of the DoD Clinical Data Repository (CDR) with the VA Health Data Repository (HDR) by FY 2005. CHDR is the effort to develop the software component services that will be used by the Composite Health Care System (CHCS II) CDR and the HealthVet HDR to exchange clinical data in order to provide services in a seamless fashion to both TRICARE and HealthVet beneficiaries. The Departments formed an active working group to lead this effort and are making significant progress toward building a prototype.

Lab Data Sharing & Interoperability (LDSI). This project will facilitate electronic order entry and results retrieval between DoD, VA, and commercial reference labs to maximize label resources and reduce costs. Phase One was successfully completed with the release of software that supports the ability of VA to initiate lab requests for filling at DoD labs. Development of software permitting DoD to initiate the request for filling at VA labs began December 1, 2003.

U.S. field commanders are aware that their responsibilities include Force Health Protection and this has become a major theme in military operations. The Congress has wisely seen to it that this theme extends to the highest reaches of the Pentagon and Department of Veterans Affairs. The American Legion is confident that the goal of seamless transition will be achieved as the requisite technologies are developed and adapted. We also believe that this will serve to enhance the professionalism, prestige and pride-of-service of those men and women currently serving in the 21st Century All-Volunteer Military of this Nation and will encourage others to serve.

Mr. Chairman I conclude my remarks with a quotation from our first Commander-in Chief :

“The willingness with which our young people are able to serve in any war, no matter how justified, shall be directly proportional to how they perceive the veterans of earlier wars were treated by the nation.”

I again thank the Subcommittee for this opportunity to present the views of The American Legion on the subject of today's hearing. I will be happy to answer any questions you may have.