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VETERAN'S HEALTH: ENSURING CARE FOR OUR AGING HEROES

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UNITED STATES SENATE

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VETERANS' HEALTH: ENSURING CARE FOR OUR AGING HEROES

WEDNESDAY, OCTOBER 3, 2007

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 11:48 a.m., in room 325, Russell Senate Office Building, Hon. Gordon H. Smith (ranking member of the committee) presiding.

Present: Senators Kohl, Wyden, Lincoln, Salazar, McCaskill, Whitehouse, Smith, Collins, Coleman, and Corker.

OPENING STATEMENT OF SENATOR GORDON H. SMITH, RANKING MEMBER

Senator SMITH. Good morning, ladies and gentlemen. We welcome you all to this hearing of the Senate Special Committee on Aging.

Our Chairman is the senator from Wisconsin, Herb Kohl. The way that he and I have operated is he is the boss. I was in the last Congress, but we don't, frankly, much see that distinction. Each of us are able to call hearings.

Our tradition is to work in a bipartisan way and focus on issues critical to aging Americans. Today we are going to focus on the ongoing and critical needs of our new and of our aging veterans and their physical and mental health needs.

So to that end, we will begin. I will offer an opening statement. Our Chairman will do that, as well. We will have 5-minute opening statements for others who wish to give them.

There is no greater obligation than caring for those who have served this country with their military service. We would be remiss if we did not ensure that the health care of our heroes in arms is the finest medicine has to offer.

While much of the focus in the media has been centered on the state of health care for our returning vets, it is the responsibility of this Committee to not forget those who have served in wars past.

It was exactly 3 months ago today when, in Oregon, Senator Wyden and I chaired a hearing on the topic of veterans' health. At that time, we looked at the provision of mental health services for aging veterans. While that will remain a focus of today's discussion, we will also look forward to hearing testimony on all aspects of veterans' health care.

As I made clear in July, we must ensure that our aging veterans are not left behind.

In our Nation today, we have nearly 24 million veterans, about 40 percent of whom are 65 years and older.

I think many of us have probably watched the Ken Burns series "The War." If you have, you have a fuller understanding of just how much we owe to the greatest generation. Our first witness is more emblematic of that generation than perhaps any American that I know.

The Veterans Health Administration serves about 5.5 million of them each year and employs 247,000 employees to attend to their care. I draw attention to these numbers to emphasize not only the scale of the system and, therefore, the noted difficulties in meeting all the needs at all times in such a large system, but also to reiterate that there are large numbers of veterans to whom we owe an enormous debt.

We also know that too many veterans are falling through the cracks.

Today, we will hear from the Department of Veterans Affairs Office's inspector general that wait times for outpatient care are actually longer than have been reported by the department. This report is important as we work to ensure that veterans, particularly those with time-sensitive health needs, are seen quickly.

Today, we will also hear about the numbers and needs of homeless veterans in our Nation. We know that nationally 23 percent of all homeless persons are veterans. In Portland, OR, that number could be as high as 30 percent. They suffer disproportionately from poor health, including mental health and substance abuse challenges.

We are fortunate to have wonderful community-based groups, such as the Central City Concern, in Portland working to help those who are homeless to get the help and support they need. But we must do more.

We will also hear today about the risks of suicide for our Nation's veterans.

As reported earlier this year by Dr. Kaplan from Portland State University, and subsequently in various news reports, veterans in our Nation are at twice the risk of suicide as nonveterans. With the number and needs of our veterans ever-increasing in our Nation, we must ensure that our mental health infrastructure is prepared to handle their unique needs.

I will continue to work with the Department of Veterans Affairs, the Department of Defense, the Substance Abuse and Mental Health Services Administration, and our community-based mental health network to ensure that the needs of our veterans are met.

I know that SAMHSA and the VA earlier this year worked to address the unique needs of veterans who call the National Suicide Hotline. For instance, when veterans call the hotline, they will be linked to professionals who specialize in the needs of veterans. Since the implementation in July, there have been nearly 8,000 calls made by veterans looking for a lifeline, including 177 from my home State of Oregon.

I also look forward to hearing testimony on the needs of our aging veterans as it relates to long-term care.

We know that in our Nation almost two-thirds of people receiving long-term care are over age 65, many of whom are veterans. We also know that this number is expected to double by 2030.

There are many demands and constraints on the VA system, as well as Medicare and Medicaid, to ensure that aging veterans' health needs are being met. To better understand this need, we will first hear from Senator Bob Dole after my colleagues give their opening statements.

Bob Dole is a friend of mine and a great American patriot. Senator Dole served and was injured twice in World War II while serving in Italy. For those injuries, he was hospitalized for more than 3 years.

He was a distinguished legislator in this body and in the House for many years, where he was a strong supporter of veterans' issues, including a pivotal role in the creation of the World War II Memorial on our National Mall. Most recently, he served as Co-Chair of the President's Commission on the Care for America's Returning Wounded Warriors.

I have only known Senator Dole to speak from his heart on these issues. I look forward today to hear his personal story and recommendations on how we on the Aging Committee can do a better job to facilitate in this great effort.

With that, our Chairman, Senator Kohl.

OPENING STATEMENT OF SENATOR HERB KOHL, CHAIRMAN

Senator KOHL. I thank you, Senator Smith, for holding this important hearing. Ensuring quality care for our Nation's veterans both young and old is of great importance to everybody. So we welcome our witnesses and look forward to your testimony.

In combat our veterans sacrifice their physical and mental wellbeing in order to defend our Nation and its values. In return they deserve the highest standard of care from our government.

The war in Iraq is creating a new generation of veterans, many of whom are in need of critical care. They are joining the ranks of older veterans who have survived wars of the past and are still in need of, and certainly deserving of, our attention. Unfortunately, some of them are simply not getting the care they need.

Scandals such as the deteriorating conditions at Walter Reed Army Medical Center demonstrate just part of the problem. We must also consider the broader faults in the system of veterans' health care.

Recent reports—notably, the President's Commission on Care for America's Returning Wounded Warriors and the DOD Task Force on Mental Health—have documented complex bureaucratic processes and limited communication between government agencies that have allowed too many veterans to fall through the cracks.

These problems have been around for a long time. They will not yield to easy fixes.

While we work to improve treatment and health care for our veterans' bodies, we have also learned that it is just as important to treat their minds. Too many of our bravest men and women are suffering silently from mental health problems which can lead to personal struggles, homelessness, and even suicide.

We have heard a great deal about how these problems affect the veterans returning now from Iraq and Afghanistan. But we certainly should not forget that for many of our older veterans time has not erased their mental battle scars. Our hope is that it is certainly not too late to help them.

We are very pleased that our former Senate colleague, Senator Bob Dole, is here to share his thoughts on these issues.

We welcome you back, Senator Dole. I have the fondest recollections of the time that we spent together. As I told you, I have the greatest respect for your service. We are very pleased that you could join us.

We thank also of our witnesses for participating.

I would like to remain for the entire hearing, Senator Smith, but I am Chairman of the Antitrust Subcommittee, which is having a hearing as we speak. So I am going to have to——

Senator SMITH. We will carry on in a bipartisan fashion. In that spirit and with your permission, we will go in this order: Senator Wyden, Senator Collins, Senator Corker, Senator McCaskill, Senator Coleman, Senator Salazar. I think that is the order of arrival.

Senator Wyden.

OPENING STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Senator Smith. I want to commend you for this follow up on the very important hearing we held at home. I especially appreciate the bipartisan cooperation we have always had on this Committee with Senator Kohl.

In our home state, from the woods of central Oregon to the streets of downtown Portland, older veterans are needlessly suffering because the veterans' health system has let them down.

In the woods in our state, the veterans have had to establish camps trying to find a way in the woods to get by. I don't see how anyone can argue that having veterans try to get these kinds of services through camps in rural Oregon is acceptable in 2007.

In the city, my state has worked with a number of older veterans who have drug problems. They have been able to get clean. But then they go into these extraordinarily long waiting lines for housing, which is representative of the bureaucratic water torture that our veterans are submitted to.

Senator Dole is with us here today. He has really been a role model for a lot of us because he has shown on these key kinds of health issues that it is possible to bring together your head and your heart and to think sensibly about how to tackle the issues.

Senator Dole, your report, as is always the case with your work, is chock full of useful recommendations. But I am especially pleased that you and Secretary Shalala have come up with this idea of a care coordinator. I think that is going to be especially helpful for the older veteran because, as Gordon and I got about the state and listened to veterans, we especially found the older veteran getting lost in this health care system.

So your suggestion about the idea of a care coordinator, where somebody would actually be held accountable and the veteran wouldn't just be jostled from one place to another, is especially sensible.

So we thank you, once again, for your contributions, something you have done again and again throughout your time in public service. I am just glad to have you here.

I am an Oregonian now, but you and I will always have our Kansas roots. I thank you.

Senator SMITH. Thank you, Senator Wyden.

Senator Collins.

OPENING STATEMENT OF SENATOR SUSAN COLLINS

Senator COLLINS. Thank you, Mr. Chairman. First, let me thank you for calling this hearing to examine the many challenges facing our Nation's older veterans and to consider possible policy changes that are necessary to ensure that veterans receive high-quality health care.

Like the rest of my colleagues, I am absolutely delighted that Senator Dole is our leadoff witness today. He not only knows from personal experience the challenges that our veterans face, but I can't think of someone who has a greater knowledge of how the Congress works, plus how the veterans' health care system works, than Senator Dole.

So he is indeed the ideal leadoff witness for this hearing. He is a person for whom all of us have the greatest admiration.

So it is great to welcome you back, Senator Dole.

My work on the Senate Armed Services Committee has only served to heighten my personal admiration for the men and women who wear the uniform of this country.

Throughout our history, our Nation's veterans have done their duty with honor and with great dedication. For their sacrifices, we can never fully repay that debt that we owe them.

But I also have a very deep personal connection to our veterans.

My father is a member of the greatest generation. He is a World War II veteran who fought in the Battle of the Bulge. He was wounded twice and has a Purple Heart, Bronze Star, and Oak Leaf Cluster.

Like so many veterans of his generation, he never talked much about the service that he rendered to our country. It was only now, as he has gotten older, that he has begun to share those stories with us and with his fellow veterans. But he was always very proud of that service.

As I have gotten older I have appreciated even more his sacrifice and patriotism, so typical of those of that generation, so typical of those like Senator Dole.

In the State of Maine, which is a large, rural state, we face two particular challenges in providing health care to our veterans. They both really have to do with access to health care.

The first is transportation so that our elderly veterans are able to get to the one veterans' hospital that we have in our state. It is the Togus Hospital in Augusta. It is an excellent facility. But for some of our veterans, it is as far as 5 hours away.

The second challenge has been funding, funding not only for Togus to ensure that it has the specialists that many of our veterans need so that they don't have to travel even further to the Boston area to get the care they need, but also funding for community-based outpatient clinics. These clinics are enormously success-

ful because they provide much closer access to health care for our veterans.

The ones that have been established work very well. But there are many that have been on the drawing board for a long time, delayed from opening due to funding constraints.

I noticed Senator Salazar is here today. I was very pleased to cosponsor last year a Veterans' Ride Bill that he developed to establish a grants program to help veterans travel to appointments at our VA clinics and our VA hospital.

But I think transportation and funding are the two biggest challenges that I see for providing this care.

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

Senator Dole, what an honor it is to have you here today.

Senator SMITH. Thank you, Senator Collins.

Senator Corker.

OPENING STATEMENT OF SENATOR BOB CORKER

Senator CORKER. Mr. Chairman, thank you for holding this hearing.

We are honored to have Senator Dole, who can help us with this issue, help introduce it, help us be focused on it the right way.

He also, I think, can help us with civility in the Senate in general. We were talking a little bit about that before we began.

But in order to be able to hear him today, I am going to withhold any comments and questions until after the testimony, but thank you.

Senator SMITH. Thank you, Senator Corker.

Senator McCaskill.

OPENING STATEMENT OF SENATOR CLAIRE MCCASKILL

Senator MCCASKILL. Thank you, Mr. Chairman.

I am always self-conscious when we all talk before a witness testifies, but somehow I have a feeling you understand, Senator Dole, about the need of all of us to say a few words before we begin. I want to welcome you and thank you for all you have done for our country.

As you well know, I am your neighbor. I will tell you one thing.

When I was being brought up in Columbia, MO—both of my parents being graduates of Mizzou—my father told me, without a smile on his face, that I could go to college anywhere I wanted to go, but if I went to KU I had to pay for it myself. [Laughter.]

So with the one exception of the rivalry between the Jayhawks and the Tigers, I am a big fan of yours and welcome you here today.

When I did my veterans tour back on the week after Memorial Day, I traveled all over the state. I was blessed to have the opportunity to visit with hundreds and hundreds and hundreds of Missouri veterans of all ages. I was struck by that when I went to Iraq about a month later because in every unit I visited, I saw some variation of the theme leave no fallen comrade behind.

I reflected on the ethic that imbues our military about taking care of one another; taking care of your unit. I realized what an incredible lonely and solitary journey it must be, particularly for those men and women who come home with mental health issues.

After you have been surrounded by this all-enveloping culture that it is about taking care of one another, you all of a sudden are facing an incredibly lonely time. The stigma associated with it can be almost as paralyzing, I think, as a physical paralyzation.

I think it is so important as we move forward that we be very aggressive reaching out in giving these men and women the kind of moral support and the kind of bureaucratic support within this bureaucracy that removes the loneliness from that journey and works very hard on the stigma. I think so much of your work on the commission will go toward that end.

I am also anxious to hear from the other witnesses today, particularly the IGs, about some of the internal problems we have within Veterans Affairs in terms of the bureaucracy. I am particularly offended by this game they are playing with waiting lists.

You know, we owe our veterans a lot, but we sure owe them a straight shot in being truthful with them about how long they are going to have to wait to see a doctor. This idea that we are playing games with waiting lists to try to make us look better is so offensive, I think, to the military and what they mean to our country.

So I thank you for being here today. I look forward to your testimony and the testimony of the other witnesses.

Senator SMITH. Thank you, Senator McCaskill.

Senator Coleman.

OPENING STATEMENT OF SENATOR NORM COLEMAN

Senator COLEMAN. Thank you, Mr. Chairman.

Mr. Chairman, I would like my full statement to be entered into the record and——

Senator SMITH. Without objection.

Senator COLEMAN. Let me just say one brief comment, because I look forward to hearing Senator Dole's testimony.

I recently buried my dad in Arlington Cemetery just less than a couple of months ago. He was a veteran of World War II, on the beach in the early morning hours of D-day at Normandy; like Senator Collins' dad, was at the Battle of the Bulge, wounded, received his Purple Heart there.

My dad and his generation—and, Senator Dole, your generation—experienced the Depression, world war, holocaust, defeated two isms—fascism and communism—and came back with this unbridled optimism that has given us the opportunity to have all that we have.

For that, we say, "Thanks." For that, we owe you and those who have served a debt of gratitude. We owe you and those who you speak for a system in which there aren't waiting lines, in which there is adequate mental health facilities.

I just want to thank you for being a voice for so many whose voices have been stilled by time and circumstance.

Senator Dole is a patriot. He is a great American.

Senator, I thank you for your service. I look forward to your testimony.

Senator SMITH. Senator Salazar.

OPENING STATEMENT OF SENATOR KEN SALAZAR

Senator SALAZAR. Thank you very much, Senator Smith. I just want to thank Chairman Kohl for also holding this hearing on veterans' issues.

I will just change chairs. [Laughter.]

Let me just begin first by thanking both Senator Kohl and Senator Smith for holding this hearing. It is truly an example of bipartisanship here in the Senate that I am very proud of.

Second, to you, Senator Dole, we are all very, very proud of you. I think, when we look at you, most of us are in that generation where we know that we have stood on your shoulders and the shoulders of our parents. In the same way that Senator Coleman and Senator Collins were talking about their parents, I, too, could talk about both my father and my mother and their efforts in World War II. So we appreciate your service to our country.

The issues of veterans for us are very important. It is not a Democratic or a Republican issue. It is an American issue.

For me and my service on the Veterans' Committee for the first 2 years that I was in the Senate, there were a number of issues that I was very concerned about. Hopefully, during your testimony you might address a few of those issues.

The first of those had to do with rural veterans and the disparity of health treatment and health care availability to veterans in rural areas in comparison to those in urban areas. Then-Undersecretary Perlin had done a very comprehensive study that demonstrated the huge disparity that existed in terms of health care treatment for veterans in far-away places in rural areas and those in urban areas.

In my state, we have tried to address some of those issues over the last several years with community-based outreach clinics and have had some success there. But I continue to believe that that disparity still exists.

Second, there is an issue of long-term care. In my view, I do not believe that the VA has done an adequate job in terms of putting together a long-term care plan for our veterans, for our Nation. It is something that I have legislation which has been passed which has directed the VA to develop a plan with respect to long-term care.

Then third, an issue which has been very hot here in Washington, DC, but it is a very real issue that some of my colleagues have addressed, and that is the issue of mental health. Especially now with the bulge of veterans that we will see from Operation Iraqi Freedom and Operation Enduring Freedom, it is going to be important for us to make sure that we are doing what we have to do with mental health care.

Finally, let me just once again echo my thanks to you and the pride that we have in people like you who have really shown us the way here in America. Thank you.

Senator SMITH. Thank you, Senator Salazar.

Senator Dole, I have been given a long introduction, but I don't think you want to hear it. We all are here in part as a reflection of the esteem in which we hold you. We thank you for being here and for being patient to hear us out, as well. We are anxious to receive your testimony.

STATEMENT OF FORMER SENATOR ROBERT DOLE, WASHINGTON, DC

Senator DOLE. Well, thank you very much. Herb had to leave. Mr. Chairman had to leave, but I appreciate all your statements.

I know all of you. You are all doing a great job. This is one Committee where you can come in and have a bipartisan meeting and agreement and everybody leaves thinking, you know, we have done the right thing.

I think before I—I don't have a very long statement, which I read to Elizabeth last evening. She is a member of the Committee, and she approved it. I said, "Well, you don't have to come then," so——[Laughter.]

Senator DOLE [continuing]. I gave her an excuse.

But the one thing that I think—there are a lot of problems. Secretary Shalala, I must say, is the original Energizer bunny. I mean, she is doing something every second.

We work very well together and never got into any political differences. We didn't even know the politics of the other seven of members.

Of the other 7 members, 2 were Iraq veterans—1 who lost an arm, 1 who had a badly damaged leg—another was the wife of a husband who had burns on 70 percent of his body, and then the other was Ed Eckenhoff, who directs the National Rehabilitation Center, who has a very difficult problem.

So there are 5 out of the 9 with disabilities. So we understood a little about what we were supposed to do. We relied a lot on these younger veterans.

But the point I want to make right up front—I mean, there are so many negative stories about DOD and Walter Reed and the VA. The one thing that we found almost without exception is that these patients—young, old, men, or women—would brag about their doctors, brag about their nurses, brag about their therapists. The care was good or excellent. It was after you get into the outpatient category, when you start trying to make appointments and things of that kind, that we found difficulties.

Now, Walter Reed is a great hospital. I have been going there for 30-some years as a patient and to visit other patients.

Building 18 was a facilities problem, but it was a disaster. The Washington Post story kind of was a wakeup call. Certainly everybody is focusing on veterans and veterans' health care, which is a good thing.

But I think the morale sometimes of these hardworking people in the VA hospitals—I know at Walter Reed because I have talked to some of the professionals—is sort of down because they read the stories and they watch television. The inference is that, "I am not taking care of this young man or this older man or this older woman or young woman." That is certainly not the case. I know none of you—I think you all agree that it is not the case.

The individuals, for the most part, in the Veterans Administration and all the DOD facilities are just good, hardworking men and women doing a job, trying to help our veterans.

That doesn't mean there aren't some mistakes or bureaucracies.

You go out to Walter Reed or you go to a VA hospital for a better example and you see people lined up for hours waiting for their

drugs. They like the program. The formulary is not really—could be bigger—but it is a great program.

So we traveled all over the country. We only had 4 months. We went to the different VA and DOD facilities and talked to the patients away from the doctors so there wouldn't be any intimidation—perceived intimidation. I want to report to this group that there may be some—obviously there are some—but very few would say anything but good things about their treatment.

We wanted to make certain that Walter Reed was in A–1 condition until somebody finally turned off the lights 3 or 4 years from now. So one thing we did is to urge Congress to offer incentives to contract doctors or other staff, military or whatever, to keep them there until Walter Reed finally closes, because 27 percent or 28 percent of those who come from Iraq or Afghanistan, their first stop is Walter Reed. So it has got to be kept an A–1 facility. We can't let it diminish to any extent at all.

Well, anyway, I feel at home here before the Aging Committee. I know I am the oldest one here. Every day I feel more qualified to be here.

But I am reminded this morning of the words of General George Marshall who, during World War II, was asked if America had a secret weapon that would ensure a victory. "Yes," he said, "America does have a secret weapon. It is the best darn kids in the world." What was true in World War II has been true ever since in places like Korea and Vietnam and Afghanistan and Iraq and the Gulf crisis.

So we remain free and we remain strong because there are always the young men and women out there willing to make sacrifices for the rest of us. Today, most of us the only sacrifice you make is getting on an airplane and that is about it. But the families make sacrifices and obviously the young men and women who are injured or wounded make sacrifices.

I think whatever you think of President Bush and whatever you think of war—we didn't get into that in our Committee—but the President told us—told me and Secretary Shalala—he said, "Do whatever it takes." We never had raised any question about the cost.

Now, I don't think our recommendations are perfect. We have only had 4 months. We are already getting a little push back in certain areas from certain veterans' groups, and that is to be expected. But we think overall, you know, it is a good, balanced program.

One thing that Ron mentioned—excuse me, Senator Wyden mentioned—was the care coordinator.

Now, you know, we were limited to Iraq and Afghanistan in our charter. But I think it is a good idea to expand it to the older veterans. That program is already started.

They already started training these care coordinators on October 1. So the Administration is moving quickly in the areas where they should move quickly.

I met a young man on our commission, Jose Ramos, who lost an arm above the elbow. He did a lot of work in the disability area. He had so many caseworkers he couldn't remember their names.

That is where, you know, if somebody meets you at the door at Walter Reed when you come here, whether you are wounded, sick, whatever, and if you are in serious condition and a care coordinator meets you at the door and follows you all the way through—they may have two or three others, too—but they follow you all the way through to the time you go back to your unit or the time you go back to the farm or back over to the VA or wherever it may be. That will make a big, big difference when it comes to efficiency.

Most of our complaints were people waiting for appointments and then having them delayed.

Another thing that Ken mentioned, the fact that—the rural areas—I think it is very important. One thing we stress in this—and you have, I think Norm mentioned, too—rural areas.

You know, it is a long way to a VA hospital in states like Colorado, Minnesota, even my State of Kansas, Missouri, wherever. We stress that there should be available to this person private-sector care.

If there is someone, you know, in a city, not Denver, but some smaller place closer to this person's home that can provide adequate high-quality care, then they ought to have it. They shouldn't have to travel 300 or 400 miles to go to a VA hospital.

You know, there may be some in the VA who think, "Well, that may mean we will have fewer patients." But we had a patient-centered commission.

We were only concerned about the patient. We were concerned about the DOD facilities and the VA facilities. But our primary responsibility was what can we do for the patient?

The care coordinator is a little thing, but it is a very, very important thing. I think you have a great idea, if Congress will expand it, because there are some older people—and I said before this hearing started, I visit a lot of VA hospitals. I have been to the Portland VA hospital, for example, and I have been to a lot of hospitals.

But you got to think of these men in their 1980's—and we are down to about 4.5 million out of 16.5 million—and if they are hospitalized, you know, maybe their family's a couple hundred miles away. They probably see the person who mops the floor and brings in their food and that is about it.

You know, it is a pretty lonely life. I know there are a lot of activities and a lot of people come, but it is still a pretty lonely life.

Anything you can do in those areas to sort of give them a life—and there is a little program going on right now that I think some of your states are participating in. But it is something each of you could start. It is called Honor Flight.

They would go to Portland, ME, for example, and raise say $50,000, charter an airplane, put people like your father on this airplane early in the morning. They would fly to Washington, visit the memorials, have a boxed lunch at the World War II Memorial, and just spend a couple or 3 hours there.

Let us see, I think we have had a group from Missouri. I don't think any other—maybe a group from Minnesota. Right. We had a group from Minnesota.

But anyway, it is a great program.

You ought to see the faces of these 80-, 85-, 90-year-old men when they get off that bus or somebody pushes their wheelchair and they get into that memorial. Suddenly they are thinking about what? I don't know. When they were young, where they were in the service?

You know, it is just a great thing. It doesn't cost them one cent. Many could never make the trip because of the cost or because of their disability. They can't get on a plane, if, you know, they are in bad shape and in a wheelchair.

So get it on the Web site. It is Honor Flight. Look into it. It is a great program.

It is now in about 18 States. Some fellow who ran a laundromat—well, he had several—in North Carolina came up with this idea because of his father.

You know, you talk about making the day for this World War II vet, it makes his whole life in some cases.

Well, I didn't mean to get off on that.

But we are going to testify before our—Secretary Shalala and I—before the Senate Veterans' Committee on the 17th of this month. I think the purview of this Committee—I know it deals with people what, a little older than the Iraq and Afghan veterans? But I think it is important because a lot of these things that we recommend will also affect older veterans.

One thing we do that I think is very important, that applies to the Iraq and Afghan veterans, for the first time we have a quality of life payment. You know, when you get your VA rating somebody may say, "Well, the quality of life may be different," but it has never been explicit.

So there is going to be—when they add up your total check, there is going to be a little box there: quality of life. Now, if you lose your sight, your quality of life has gone from a 10 to what, 1, 2, 3? Or any loss of limb or whatever, burns, whatever the injury might be.

We also think it is important when some person leaves the service that they have a transition payment, maybe 3 months paid, to get back home and get settled and get back to work and, you know, get the kids in school; little things.

We also believe that where you have got a seriously injured spouse, the other spouse should have educational benefits, aid and attendant care, and respite care so they can take a break.

These are all things that we didn't apply to Vietnam or World War II or Korean veterans or Gulf veterans but, you know, they are available.

The toughest part is in the benefits section. That will be the area that I think we need to work out with Congress and the veterans' groups.

But you have got to keep in mind that you are dealing with a group that probably hasn't had a uniform on in 60 years. That is a long time.

Now, a few of these guys that come on these Honor Flights still can wear their original uniform. They are very proud of it, that they haven't changed that much.

But we just can't diminish our commitment to our veterans, whether 24 million, 25 million. Not all of them have a problem.

I still get a lot of mail from veterans. I spend, I think, about 2 hours—I think I can say maybe an hour-and-a-half a day answering emails from veterans across the country. Some because they have read about the commission or the World War II Memorial or they think I am still here. [Laughter.]

So, you know, we try to send it on to whoever we can, probably one of you.

But there is no doubt about it. The VA can be bureaucratic. I am sure that has always been the case.

We went way back to a commission chaired by General Omar Bradley in 19—what, what, 50—I don't know—early 1950's. We haven't really changed the system since then. We just believe—and, again, it is a little beyond the purview of this Committee—that it is time to simplify and update this system.

The young men and women today are going to be the seniors of tomorrow. They want to be compensated, don't misunderstand me. But they want a life. They want an education. They want an opportunity.

So we sprinkled the educational part with incentives to keep people in the program. If you stayed a second year, you get a 10 percent increase; a third year, 10 percent more; a fourth year, 10 percent more, plus a stipend. So they would be able to, you know, really make a contribution.

But I know you have got some great panels coming up to deal with long-term care and homeless veterans and paralyzed veterans.

The PVA does a great job for paralyzed veterans. I do a lot of work with the PVA. They are just a great group, as are the other VSOs. But obviously they are going to tell you things that we didn't get into.

But the thing we don't want to forget, that somebody—I think, Gordon, you said or Herb—just because we are getting old, don't forget us. You know, we are still here. We are still breathing. We are still watching "Law and Order"—I know I do, or whatever—and things like that. We are still making contributions.

You see some of these fellows at the World War II Memorial who are in a wheelchair, and they are in their nineties. The fellow yesterday I met from Findlay, OH, 92 years old. I said, "Well, you just stay in the chair, and I will get—" "Oh, no, I am going to stand up." He stood up straight as a string. He said, "I am the smartest guy in this group." He probably was. He had been around longer.

So that is sort of where we come from.

We had a good commission. We worked hard. We know it is not perfect. We didn't try to overhaul the whole system.

But we do understand the importance of this Committee hearing and what it may mean to, you know, senior veterans, because you have got these baby boomers coming along, and we are going to have to get ready for them. I think we have got a lot of good people on this Committee who put the patient ahead of anything else. That is what it is all about.

If anybody has any questions, I will be——

Senator SMITH. Thank you, Senator Dole.

To your last point, obviously the focus of this Committee is on our older veterans.

Clearly, we are doing a lot to take care of those coming home from Afghanistan and Iraq. We need to do more. But is it your view that we will, by taking care of them, the older ones will automatically be included, or do we need to put a special focus and emphasis that they not be forgotten?

Senator DOLE. I think what you may want to do, if I were up here, is go through this recommendation, maybe do a little cherry picking, and say, "Oh, that would be great for, you know, World War II veterans." It is going to cost money, but that is—I have a view that if we spend billions to get them there in harm's way, we ought to spend whatever it takes to, you know, get them back to as normal as possible.

But I think there are some of the recommendations, even though they are now limited to, I think, people who entered the service after 2001, the others can stay in the old system so we don't touch the old system. But I think you may find some things in there that you might want to apply to World War II, Korea, certainly Vietnam.

Senator SMITH. Senator, I have never been in battle. I can only imagine its horrors from watching documentaries like many Americans have just finished watching about the second world war.

But as a student of history, I am aware that there have been many ways to describe post-traumatic stress syndrome. It has been called soldier's heart, soldier blues, shell shock, battle fatigue. All of these relate to mental health issues.

Now, we know that, you know, General Patton used to go through and slap a soldier occasionally. Clearly, we have come a long way since then.

But I wonder if you can speak to at least your impressions as to how we are dealing with battle fatigue now. Are we doing it adequately? Does it enjoy——

Senator DOLE. Oh, we spent a lot of time on PTSD and TBI.

They are different stages of traumatic brain injury. Right now, we have four VA polytrauma centers in Richmond and Tampa and Minneapolis and Palo Alto, CA, where they sort of specialize in TBI treatment.

They are about 250 severe TBI cases from the present conflict. The rate of PTSD claims is probably going to reach 15, 20 percent.

I would always ask the question, when we had these people in front of the mental health experts, "If I brought somebody in who had PTSD symptoms, would you all reach the same conclusion?" They always told me yes. But I don't know how they do that because they are—there may be guidelines that I am not aware of you can follow.

But another thing we recommend is that every 3 years this person ought to have a checkup by the VA. That anybody who has PTSD symptoms, the VA is obligated to take them whenever it happens, if it is 3 years from now, 5 years from now, whatever. We think a 3-year review is good because you might find some other things the veteran needs help for.

But we did spend a lot of time on that. It is a big, big problem.

In our generation, it was battle fatigue or see your chaplain or whatever. But now it is real. It is out there. People have, you know, nightmares and all kinds of experiences.

Senator SMITH. Do you believe that enjoys an equal legitimacy with physical wounds?

Senator DOLE. Oh, yes, in the VA.

Senator SMITH. OK.

Senator DOLE. I think our commission was not properly named. It was called Wounded Warriors. But you don't have to be shot, you know, to be the line of duty, combat-related, whatever-injured.

Senator SMITH. Yes.

Senator DOLE. You don't have to get shot. So I thought the name of our commission was a little too narrow. But we didn't really worry about the title.

Yes. It is equivalent.

Senator SMITH. OK. That is a very important answer for me.

Senator DOLE. Oh, I mean, what is the difference? I mean——

Senator SMITH. Yes.

Senator DOLE [continuing]. If somebody, you know, well, you know what—if somebody experiences that, it ought to be treated just the same as if it was combat-related, line of duty. It ought to be compensable.

Senator SMITH. Nobody says to them, "Look, you buck it up. Get over it."

Senator DOLE. Yes. Well, that might have been—I think there are some who might game the system. Let us be very honest about it. You need to caution it. But that is a very small number.

Senator SMITH. Yes.

Senator DOLE. It is hard—I am not an expert so I couldn't detect it, but the experts can detect it. You may have members on the other panels who are experts in that area.

It is out there. We need to deal with it. The people who suffer from it need to be compensated and entitled to all the benefits the same as anybody who may have lost an arm or been burned or whatever.

Senator SMITH. I just have one other question.

You mentioned that there are some veterans' groups that are disagreeing with some of the recommendations. I wonder if one of the disagreements would be the idea of a care coordinator that would coordinate——

Senator DOLE. They like that——

Senator SMITH [continuing]. Care in the private sector. They like that?

Senator DOLE. Well, they didn't like—initially, we were going to have the Public Health Service—Secretary Shalala had done a lot of work with Public Health Service, and she thought, instead of the VA or DOD doing it, let us get some third party that doesn't have any bias. I think VSOs thought that wasn't a good idea, thought it would be another layer of bureaucracy. They may be right.

So we decided the PHS would help train the coordinator, but it would be a VA person.

Senator SMITH. OK.

Senator DOLE. But you have got to give that person some authority, otherwise some colonel's going to come along and say, "You know, get out of here." They have got to have authority to cut through the——

Senator SMITH. The bureaucracy.

Senator Wyden.

Senator WYDEN. Let me pick up there, Senator Dole, and as always, when we listen to you, you always get the sense Senator Dole's being too logical for Washington—— [Laughter.]

—just coming in here and offering unvarnished common sense.

One of the reasons that I came up with this thought about having a care coordinator for older people is that I thought that you logically said it is useful for the Iraq and Afghanistan veterans. What we have seen in Oregon is that it is usually the older veteran who is least equipped to kind of navigate all these various, bureaucracies and systems.

I wanted to get your sense on one point with respect to the idea of a care coordinator for older veterans.

I don't get the sense that this is primarily going to be a big ticket financial item. It is primarily an organizational challenge, because right now the veteran is supposed to have a case manager and, as we heard, various other people to help. But it seems so often that one of these systems doesn't communicate with the other and then the veteran ends up being sort of lost somewhere in the bureaucracy.

So my thought was, if we could take your idea as it relates to Iraq and Afghanistan veterans, apply it to the older, person, make sure that there would be one person accountable, one person to be the care coordinator, all you would be talking about is reorganizing most of what is going on today so that somebody would be accountable.

I think it would be helpful to have your sense about whether this is going to be a big expense item because I don't get the sense it will be.

Senator DOLE. You know, I hadn't thought of this. But, you know, some of these senior men and women have maybe Alzheimer's. They really need help.

I certainly do not denigrate the case workers. I think in most cases they do—.

Senator WYDEN. Right.

Senator DOLE. But they get transferred or they——

Senator WYDEN. Right.

Senator DOLE [continuing]. Leave or something, so somebody has to pick it up.

We are not talking about—we think 50 care coordinators is what we need right now, 50. I mean, that is not a lot of people.

You can extend that to certain VA cases. You know, most of these people they don't need it. They are only hospitalized for a while.

But some are there for 1 year, 2 years, 3 years, 6 months. They need help; the families who are there, the spouse or the mother. Then you also work with them.

So, yes, I think it just makes sense that when I go to the hospital that somebody is going to watch out for me, not 10 somebodies, but one person. That doesn't mean that there might be cases where they have to move on or something, but rarely.

Senator WYDEN. If I have a——

Senator DOLE. That was Secretary Shalala's thought. She just thought it would be a good move, and she was right.

Senator WYDEN. If I am in trouble on the floor of the Senate, I am going to bring you and Secretary Shalala out so we get this done.

Senator DOLE. Well, we think they need a coordinator for the Senate, too. [Laughter.]

Senator WYDEN. Well, there, again, getting logical. [Laughter.]

Thank you for all you have done, Senator Dole.

Senator SMITH. Senator Collins.

Senator DOLE. I don't mean that. You know, I am only kidding. [Laughter.]

Senator COLLINS. Actually, Mr. Chairman, when Senator Dole made that comment, I thought it would take way more than one coordinator for the Senate, probably per senator, in order to coordinate things.

Senator Dole, I mentioned in my opening statement my concern about access to care in a large rural state like mine.

I realize that your commission was looking more at the problems of the recently returned younger veterans from Iraq and Afghanistan. But are there any lessons that you learned from looking at that population on how we could improve access to care for elderly veterans or senior veterans for whom transportation may be much more of an issue?

Senator DOLE. You are exactly right. I mean, when you are 80, 85 years old, you are not driving. You may not have a spouse. Your children may be somewhere. You know, how do I get to the VA hospital? We didn't deal with that because we are dealing with this younger generation.

But the thing we did deal with, which should apply to any veteran, that if you have a facility say much, much closer to you than the VA hospital, that you ought to be able to use it. There ought to be authority to use it. That is happened in some cases in Afghan and Iraqi veterans.

The National Rehabilitation Hospital here in Washington, DC, is one of the finest in America. They have treated, I think, about a dozen Iraq-Afghanistan veterans.

The Rehab Institute of Chicago, they have had veterans who—because they get really excellent care.

So, yes, the answer is that ought to be available to—you know, we don't want to forget these people just because they are getting older and say, "Well, we don't really care about them. Let them figure it out." If we have to send a taxi, I guess that would be all right with me, too; maybe a limo. Why not a limo? Yes.

Senator COLLINS. Thank you. Thank you for your excellent service and your testimony.

Senator DOLE. Thanks a lot.

Senator SMITH. Senator Dole, I just wanted to follow up.

What are the veterans' groups objecting to so far in your commission's recommendations?

Senator DOLE. Well, I am hoping we are going to be able to work it out. But one group said we didn't go far enough. We didn't go back over the whole system.

We only had 4 months. So we did limit it to Iraq and Afghanistan because that seemed to be where the focus was, based on, you know, different stories.

There is a benefits commission going to report—I thought last week; maybe this week—but they pretty much agree with ours.

I think it is when you start dealing with benefits and somebody thinks they are going to get a dollar less, that is not a good program. Our view was, we don't want anybody to get any less, but we also want to stress that we are dealing with outcomes where people can be prepared. We had these two young men on our commission, both Iraqi-wounded veterans, who worked on the benefits section.

But hopefully we can work it out. We are meeting with all the different groups and——

Senator SMITH. So it is nothing we need to be alarmed about or——

Senator DOLE. No. But before you introduce a bill, I think I would——

Senator SMITH. OK.

Senator DOLE [continuing]. Read it carefully, so—— [Laughter.]

Senator SMITH. I apologize, Senator Lincoln. I didn't see you come back in. Do you have questions for Senator Dole?

OPENING STATEMENT OF SENATOR BLANCHE LINCOLN

Senator LINCOLN. A special thanks to you, Chairman Smith, for having this discussion today. We do think it is so important.

I am the daughter of an infantryman from the Korean War and was taught certainly at a young age how important it was to have the respect and appreciation for our servicemen and women.

I want to thank you, Senator Dole, for coming to speak to Arkansans that were in town. What a treat that was when our World War II veterans were here and you came down and spoke. They had a wonderful——

Senator DOLE. Well, I was just bragging about that program. You have been there. You know how the veterans feel after they have been here.

Senator LINCOLN. Oh, they are just—it is incredible for them to be with one another and to be with fellow servicemen like you. It is a wonderful thing.

Arkansans, and certainly brave men and women all across our country, they continue to make these tremendous sacrifices today. In my State, thousands, both active duty and reserve, have served honorably in Iraq and Afghanistan. Tragically, 74 have given their lives. I received word of our latest fatality just 2 days ago.

So it is ongoing, and it is heavy on the hearts of the families, and in States like Arkansas and all across this Nation. My heart grows heavier by the day as nearly 3,200 Arkansans from our Guard and Reserve will deploy to Iraq probably December or right after the first of the year.

So providing for our men and women in uniform is essential when they are in harm's way. But undoubtedly, when they return home, it is absolutely our responsibility to provide for them.

So we thank the Chairman for having this hearing, and, Senator Dole, to you for your incredible service, not only serving our Nation honorably in uniform, but here in the U.S. Senate and yet again your work here with Secretary Shalala.

My one question to you, sir, would be one of your recommendations was to shift more responsibility for awarding benefits from DOD to the VA. I share your belief in this that it would help streamline the process that has become so cumbersome in terms of the bureaucracy for our veterans who are applying for disability benefits.

We are trying to do the same thing here in shifting that responsibility for the educational benefits of our Guard and Reservists because we are finding that when they come home they don't have the time to access.

I noticed you mentioned that looking for benefits for spouse for educational purposes was another recommendation. But just making sure that they can get those benefits and having them delivered through the VA, as opposed to DOD, particularly I would think these disability benefits, but also the educational benefits, which we are.

But as you also well know, in this place and in this city the battle for jurisdiction is a great one.

Have you experienced any pushback on this recommendation? Do you have any advice for those of us that are trying to kind of circumvent some of that territorial bureaucracy?

Senator DOLE. What we do is get the DOD out of the disability business, and they do what they should do. They decide whether Gordon Smith is fit for duty.

But we want to make certain whoever makes that examination also—because you can have certain things wrong with you and still be fit for duty, which might be compensable under a VA rating. So whoever examines Mr. Smith, once he finds he is unfit, we are going to have a little checklist to make sure that all those things he finds wrong is given to the VA so when they make the rating it is based on, you know, accurate information.

There is not much pushback there. I think most veterans, I think, feel the VA is a little more generous in their rating system. Of course, you have the right of appeal and all the other things. But I don't think that is a difficult point.

But you made another thing that made me realize, which probably doesn't come within the purview of this Committee. But the hardest thing for the younger generation, the seriously injured—and there are about 3,000 in that category, seriously injured—is when they leave the hospital and go back to Russell, KS, or wherever it is and there are no nurses around or doctors or somebody to do this.

You know, it takes a while for, you know, to really understand what you are going to have the rest of your life. You can't compensate for that. But we have to do everything we can to make, you know, to make it as normal as possible.

Senator LINCOLN. Well, the rural centers that we are setting up with the VA are doing a good job at helping in that outreach. We just need a few more of them.

But you are right. That transition is critical. When you are going back to rural America, it is hard. You have got to have somebody there to help you.

Thank you.

Senator DOLE. Well, we do a lot more for the—when I was wounded and in the hospital, my mother came and nobody—we didn't have any money. But somehow she was able to stay there and take care of me day after day and even held cigarettes, which I shouldn't have been doing and she didn't think was a good idea, but I couldn't use my arm, so—but now we make certain that person gets there—the spouse or the mother—and we relocate them and we take care of them.

You know, we really do a lot of good things. It is just those cases that fall through the cracks. I guess when 25 million people are involved, that is going to happen. It just happens.

I always tell people who send me emails, if everything else fails, and I say this very seriously, you need to contact your senator or your Member of Congress because they can sometimes work these things out. So——

Senator LINCOLN. Thank you.

Senator SMITH. Thank you, Senator Lincoln.

Senator DOLE. Thank you very much. I appreciate it.

Senator SMITH. Senator Whitehouse has rejoined us.

Senator DOLE. Oh, excuse me.

Senator SMITH. Do you have a question? Or do you have a statement you want us to put in the record?

OPENING STATEMENT OF SENATOR SHELDON WHITEHOUSE

Senator WHITEHOUSE. One of the things that is notable about the Veterans Administration and that it often gets great credit for is the extent to which it has adopted modern technologies: electronic health records, internal electronic physician order entry, and other such technologies. Throughout the American health care system, we are way, way, way, way, way behind on the adoption of those technologies.

Not too long ago, The Economist magazine reported that the American health care system is second only to the American mining industry in being at the bottom of adoption of these information technologies.

It is a little bit peculiar because if you look at the diagnostic side, we have the best equipment in the world. We have the most astonishing radiology, MRI, other devices. Yet when you go to the information management side, we fall to the very bottom of all American industries.

I am wondering if you have any comment on, first of all, how effective this investment has been for the Veterans Administration, and second, why you think the Veterans Administration has shown such leadership in this area and what we, as senators, might take from that experience in terms of trying to improve the adoption of health information technology in other areas.

Senator DOLE. Well, we recognize that IT electronic recordkeeping was—the VA probably has the best system in the country. I mean, it is the envy of all the private hospitals.

We had a Dr. Harris in the Cleveland clinic who that is his sole responsibility. He came back there and met with Members of Congress, with the VA, with the DOD.

So you can get these—at my age, I don't understand all the stuff like you do—but you can get these computers talking to each other.

If you leave Walter Reed, you leave with a half a bushel of paper. If you leave the VA hospital, you have got a little tape, I guess.

But the DOD is doing better. There is improvement. That is one of our 6 strong recommendations that we improve electronic record-keeping because we are behind. It means so much if I am out in Phoenix somewhere and I get sick and somebody can just push a button and they have got everything.

Yes. We have got a provision. We don't know what it costs. But that, again, that wasn't—we didn't have any restraints, so that, we think, will bring us up into this century.

Senator WHITEHOUSE. I thank you, Senator.

I just want you to know, as a new Senator it is an honor to be with somebody who served this institution so proudly and so long as yourself.

Thank you.

Senator DOLE. Thank you. I appreciate it.

Senator SMITH. Senator Dole, before we let you go, for my colleagues' benefit and for the record, I'd like to read a couple of statements, a couple of paragraphs, from your book, "One Soldier's Story."

Senator DOLE. Oh, yes.

Senator SMITH. Senator Dole wrote:

I once said that I was the most optimistic man in America. It was a phrase reminiscent of Franklin D. Roosevelt, who undoubtedly was the most optimistic man in America during his lifetime. Deprived of the use of his legs, he had been brought through his own personal hell yet continued to hope for the best. I could relate to that.

Today, I am still an optimist. I believe that the greatest generation is today's generation. My optimism is based on the belief that anyone in America, whatever your race, age or status, whatever your strengths, weaknesses or disabilities, deserves an equal opportunity to succeed. You can find that opportunity in America.

That is what we fought for in World War II. That is why I charged uphill 9–13. That is what some of my friends bled and died for. That is what I lived for ever since.

Thank you, Senator Dole.

Senator DOLE. Thank you. Good luck.

[The prepared statement of Senator Dole follows:]

Senator Bob Dole

United States Senate Special Aging Committee

October 3, 2007

Thank you, Senator Smith. It's a pleasure to be back on the Hill, and I appreciate the opportunity to appear before the Senate Special Committee on Aging. In fact, each day I feel more and more qualified as an expert witness to talk about aging.

I am reminded this morning of the words of General George Marshall, who, during World War II, was once asked if America had a secret weapon that would ensure victory. "Yes," he said, "America does have a secret weapon. It is the best darned kids in the world." What was true in World War II has been true ever since in places like Korea, Vietnam, Afghanistan and Iraq. America has remained free and strong precisely because we have kids who have always been willing to risk their life for their country. And it should go without saying that when these kids return home, America owes them more than our gratitude, we owe them the best medical care possible.

As you may know, former HHS Secretary Donna Shalala and I have recently finished serving as Co-Chairs of the President's Commission on America's Returning Wounded Warriors. Later this month, we will be testifying before the Senate Committee on Veteran's Affairs concerning the recommendations of our commission—recommendations which focused on care being provided to our soldiers returning home from Iraq and Afghanistan.

I know that the purview of this committee, however, is limited to the care provided to and issues affecting our population of aging veterans, and I appreciate the spotlight you are shining on these heroes. Over 10 million of

America's 24 million veterans are over 65 years of age. For many, including myself, it has been over 60 years since they wore the uniform of our country. But time should not and must not diminish America's commitment to our veterans. It's no secret that like all federal departments, the Department of Veterans Affairs can be bureaucratic and confusing, and I am sure that will always be the case.

I know you have two very distinguished panels of experts who will testify this morning on a variety of important issues, including health care, homeless veterans, long term care needs of paralyzed veterans, and the mental health of veterans. The challenge I would give this committee, however, is to listen to these experts with an eye toward making recommendations on steps that can be taken to ensure that our aging veterans do not get lost in red tape.

Thank you again, Mr. Chairman, for your leadership on these issues, and I look forward to answering any questions.

Senator SMITH. We will now call up our second panel.

We are pleased to be joined by Dr. Michael Shepherd from the Office of Inspector General of the Department of Veterans Affairs. Today, Dr. Shepherd will discuss the Veterans Affairs Office of Inspector General's review of the VA's suicide prevention initiatives implementation.

Also on the panel are Mr. Larry Reinkemeyer, who is the director of the Kansas City Audit Operations Division for the Office of Inspector General. Today, he will discuss with us the Veterans Affairs Office of Inspector General's report on outpatient waiting times for care through the Veterans Health Administration.

Why don't we start with you, Doctor, and then we will go to Larry.

STATEMENT OF MICHAEL SHEPHERD, SENIOR PHYSICIAN, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL (OIG), DEPARTMENT OF VETERANS AFFAIRS, WASHINGTON, DC

Dr. SHEPHERD. Mr. Chairman and members of the Committee, thank you for the opportunity to testify today on the issue of suicide and veterans in our Nation. Thank you for the opportunity and the honor to hear Senator Dole testify today.

Suicide is an unequivocally tragic and often incomprehensible event.

CDC data indicate there were more than 30,000 known suicides in 2004, making suicide the 11th leading cause of death in the United States. Although older adults comprised roughly 12 percent of the population, those 65 years and older represented 16 percent of suicides, with men accounting for 3 out of 4 suicides in this age range.

Between 1 percent and 5 percent of older adults living in the community are estimated to have major depression. The incidence increases among those older adults requiring home health care or residing in long-term care settings.

Although many older adults prefer treatment for depression in a primary care setting, geriatric depression is often inadequately treated in this setting. Between 50 percent and 75 percent of older adults who die by suicide have had contact with a primary care provider within a month prior to their death.

There are approximately 25 million veterans in the United States, and 5 million receive care within the VA. In 2005, 45 percent of veteran enrollees were ages 65 or over.

In November 2004, VA finalized the 5-year Mental Health Strategic Plan. Among the action items were a number specifically aimed at the prevention of suicide.

In May of this year, the OIG published an assessment of the extent to which VA has implemented these suicide prevention initiatives. Although we found that most facilities reported availability of 24-hour mental health care in person or through a crisis hotline, this was not universal throughout the system.

On July 25 of this year, VA subsequently began operation of a national suicide prevention hotline. Through the end of August, 56 veteran calls have resulted in emergency rescues, and 165 calls resulted in VA hospital admission.

One of the more extensive efforts that began implementation during the last year is the Primary Care-Mental Health Integration Program. Two models for primary care-mental health integration include co-located collaborative care and a case management model.

The program, in which implementation began last winter, was at a handful of sites at the start of our inspection and is now presently running at 92 sites. It is hoped that the program will reduce stigma and enhance continuity of mental health treatment, especially for older adult veterans.

In terms of referral, although 95 percent of facilities reported that patients with moderate depression referred to Mental Health by primary care providers are evaluated within 4 weeks, approximately 5 percent of facilities reported a significant 4- to 8-week wait.

Prior suicide attempts are one of the better predictors of at-risk patients. An electronic registry of suicide attempts has been piloted in 2 VA health care networks. The aim of the registry is to enhance follow up for at-risk veterans and to help identify potential VA system issues.

On a national level, VA has been in the process of implementing suicide prevention coordinators at all VA medical centers to case manage at-risk veterans. At present, dedicated staff are reportedly in place at approximately 85 percent of facilities.

In terms of initiatives related to education, we found that half of facilities provide training for first contact nonclinical personnel about crisis situations involving at-risk veterans. But only one-fifth of these facilities include mandatory presentation of suicide response protocols. Likewise, though most facilities provide education to health providers on best practices for suicide, these programs were mandatory at only a small percentage of facilities.

Included in the recommendations were that VA facilities should provide for 24-hour crisis and mental health care availability either in person or via a functioning crisis line; that all nonclinical staff who interact with veterans should receive mandatory training that includes suicide response protocols; three, that all health care providers should receive mandatory education on identifying and addressing suicide risk; and four, that VA should establish a centralized mechanism to select among the emerging best practices for screening, assessment, referral, and treatment.

Preventing suicide is a complex, multifaceted challenge to which there is not one best practice but several promising but not proven approaches and methods.

VA has made ongoing progress toward implementation of the strategic plan initiatives for suicide prevention. However, more work remains to ensure a coordinated effort in achieving system-wide implementation.

Mr. Chairman, thank you again for this opportunity to testify. I would be pleased to answer any questions that you or other members of the Committee may have.

[The prepared statement of Dr. Shepherd follows:]

STATEMENT OF
MICHAEL SHEPHERD, M.D.
PHYSICIAN, OFFICE OF HEALTHCARE INSPECTIONS
OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS
BEFORE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ON
THE DEPARTMENT OF VETERANS AFFAIRS
IMPLEMENTATION OF SUICIDE PREVENTION INITIATIVES
FROM THE MENTAL HEALTH STRATEGIC PLAN
OCTOBER 3, 2007

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on the issue of suicide and veterans in our Nation.

Epidemiology

Suicide is an unequivocally tragic and often incomprehensible event. Centers for Disease Control and Prevention (CDC) data indicate that in 2004 there were more than 30,000 known completed suicides in the United States and suicide ranked as the 11th leading cause of death with an overall rate of 11.1 suicides per 100,000 U.S. population. It is estimated that each suicide intimately affects at least six other people. Based on the more than 750,000 cumulative reported suicides from 1980-2004, at least 4.5 million Americans have survived the loss of a family member or friend who died by suicide.

Although older adults comprised 12.4 percent of the population in 2004, those 65 years and older represented 16 percent of suicides with a rate of 14.3 per 100,000 U.S. population. Older adult men account for more than 3 out of 4 suicides in this age range. While the ratio of suicide attempts to completion for all ages combined is approximately 25 to 1, the ratio of attempts to completions is roughly 4 to 1 for older adults. These age and sex based disparities have been a consistent trend over time.

Throughout the lifespan, an increased risk of suicide is associated with the presence of a diagnosable mental or substance abuse disorder. Severe and recurrent mood disorders, particularly unipolar and bipolar depression, are associated with the highest suicide risk. Between 1 and 5 percent of older adults living in the community are estimated to have major depression. This estimate increases among those older adults requiring home health care and in long-term care settings. Most depression in older adults is treated by primary care practitioners. Of note, some studies have found that 50 to 75 percent of older adults who die by suicide have had contact with a primary care provider within a month prior to death.

Of the approximately 25 million veterans in the United States, 9.5 million are ages 65 and over with a median age of 59 years old. Of the 5 million veterans who receive care within VA, 45 percent of veteran enrollees were ages 65 or over as of 2005. In addition,

over the past few years, approximately 3 out of 4 veterans seeking mental health treatment for the first time through VA are Vietnam era veterans, many in the 55-64 year old age group.

VA's Mental Health Strategic Plan (MHSP)

In 2003, a VA mental health work group was asked to review the President's New Freedom Commission on Mental Health's 2002 report, to determine the relevance to veteran mental health programs of the Commission's goals and recommendations, and to develop an action plan tailored to the special needs of the enrolled veteran population. A 5-year action plan with more than 200 initiatives was ultimately developed and finalized in November 2004. Among the action items were a number specifically aimed at the prevention of suicide. In addition, endorsement and implementation of the goals from the Surgeon General's 2001 *National Strategy for Suicide Prevention*, and recommendations from the Institute of Medicine's 2002 report *Reducing Suicide: A National Imperative*, were incorporated into the VA Mental Health Strategic Plan.

OIG Report: Implementing VA's MHSP Initiatives for Suicide Prevention

During the past year, the Office of Inspector General undertook an assessment of the extent to which the VA has implemented initiatives for suicide prevention from the MHSP. Individual MHSP initiatives for suicide prevention were categorized and consolidated into the following domains:

- Crisis Availability and Outreach.
- Screening and Referral.
- Tracking and Assessment of Veterans at Risk.
- Emerging Best Practice Interventions and Research.
- Development of an Electronic Suicide Prevention Database.
- Education.

Crisis Availability and Outreach

Although we found that most facilities reported availability of 24-hour mental health care either through the emergency room, a walk-in clinic, or a crisis hotline, this initiative had not achieved system-wide implementation. In addition, although facilities in multiple regions had or were referring to external 24-hour crisis hotlines, availability of a 24-hour crisis hotline was not yet universal throughout the system. On July 25, 2007, VA subsequently began operation of a 24-hour national suicide prevention hotline for veterans. The hotline has reportedly received greater than 800 calls per week. Callers include veterans who previously would have called a non-VA suicide hotline, veterans who would not have utilized a non-VA hotline, family members and friends of veterans, and other distressed non-veterans. Fifty-six of the veteran calls have resulted in 911 emergency rescues, and 165 resulted in admission to VA hospitals. Hotline personnel facilitate referral of distressed non-veterans to a non-VA suicide prevention hotline through a partnership with the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration.

Studies from the geriatric psychiatry literature indicate that many older adults prefer treatment for depression in a primary care setting but geriatric depression is often inadequately treated in primary care settings. One of the more extensive system-wide efforts that began implementation in the first quarter of fiscal year 2007 is the Primary Care-Mental Health Integration Program. Two models for primary care-mental health integration include co-located collaborative care in which a mental health provider and primary care physician are located in the same clinic area or close proximity at the same time, and a case management model in which a primary care physician refers patients to a mental health care manager, usually a registered nurse, who conducts ongoing phone follow-up with patients regarding medication response and adherence, reinforces patient coping skills, provides education to patients and ongoing decision support to the primary care physician. The program will be implemented in 70-80 facilities. A few VA medical centers already have co-located clinics that had been locally developed and initiated over the past few years. These efforts may help to reduce the stigma associated with mental health issues. It is hoped that when the primary care-mental health integration program is implemented at multiple sites in multiple regions, access and continuity of mental health treatment will increase for all veterans, and especially for older adults.

Although many facilities have implemented innovative community based outreach/suicide prevention programs, the majority of facilities did not report community based linkages, for example, to senior centers. As local community demographics, needs, and resources differ, local strategies may be more appropriate then universal, centrally driven strategies. Similarly, less than 20 percent of facilities reported utilizing the Chaplain Service for liaison and outreach to faith based organizations in the community. For older adult veterans, this also may represent an under utilized avenue for facilitating mental health outreach.

Screening and Referral

Although the United States Preventive Services Task Force does not recommend screening of all primary care patients for suicidal ideation, screening for depression by primary care providers is recommended in practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up. VA has implemented system wide screening by primary care providers for depression and post-traumatic stress disorder (PTSD).

Approximately 40 percent of facilities reported local strategies by primary care providers to address positive depression screens with additional hierarchical inquiries. Most facilities reported development of local strategies to facilitate referral of veterans with risk factors to mental health care. While approximately 95 percent of facilities self-reported that patients with a moderate level of depression referred to mental health by primary care providers are seen within 4 weeks of referral, a small percentage (approximately 5 percent) reported a significant 4-8 week wait.

Tracking and Assessment of Veterans at Risk
A thorough evidence based risk assessment tool, electronically linked to the Computerized Patient Record System (CPRS), has been piloted for emergency room and mental health patients in the New York/New Jersey Veterans Healthcare Network. By its design, the tool targets identification of at-risk groups and periods of increased risk.

Prior suicide attempts are one of the better predictors of at-risk patients. An electronic registry of suicide attempts linked to CPRS progress notes has been piloted and tested in the VA Rocky Mountain Network and recently began pilot testing in the VA Healthcare Network Upstate New York.

Centrally, the VA Office of Mental Health Services is in the process of implementing suicide prevention coordinators at all VA medical centers. Plans are for the coordinators to maintain a case-load for case management of at-risk veterans. At present dedicated staff are reportedly in place at approximately 85 percent of facilities and "acting" suicide prevention coordinators are in place at the rest of the sites.

Emerging Best Practice Interventions and Strategies
We found that approximately 40 percent of individual facilities had locally initiated strategies to target special emphasis groups at acute and chronic risk for suicide. Suicide specific therapeutic interventions that are evidence based and have appeared promising in non-VA research settings are presently beginning or undergoing pilot testing in the VA Rocky Mountain Network (e.g., a specialized form of Cognitive Behavioral Therapy tailored for use in suicidal patients).

Development of an Electronic Suicide Prevention Database
Ascertaining an accurate rate of suicide among veterans is an essential element of a nationwide VA suicide prevention program. Currently a VA national rate tracking system is under development and testing but has not been fully implemented. The Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) at Ann Arbor, Michigan, has been working on two projects to attempt to accurately determine suicide rates for veterans.

Data of those who sought health care within VA in the year 2000 was matched with the same data for subsequent years through 2003. A database of patients who did not access VA care in subsequent years was identified. This data was then matched to enhanced data from the CDC's National Death Index to determine which patients no longer accessing VA care had died from suicide.

The National Violent Death Reporting System (NVDRS) is CDC's effort to develop a nationwide, state-based monitoring system for violent deaths. In a second effort, researchers at SMITREC reported cleaning and analyzing NVDRS data from Virginia and Oregon in recent months to try to determine an overall suicide rate for all veterans in these states. These rates could then be compared to the rates determined for VA utilizers who live in these states. SMITREC researchers hope that once rates are

determined, predictive models can be used to examine specific demographic and treatment factors.

Education

In terms of MHSP initiatives related to education, we found that 50 to 60 percent of facilities provide programs to train first contact non-clinical personnel about crisis situations involving veterans at-risk for suicide. Only one-fifth of these programs included mandatory presentation of suicide response protocols. The VA New York/New Jersey Veterans Healthcare Network has implemented a training module for all staff and a script for clerical staff is under development. QPR™ gatekeeper training is being piloted in the VA Healthcare Network Upstate New York facilities, and VA Readjustment Counseling Services vet center staff have received regional training based on the QPR™ community gatekeeper training model.

Almost all facilities provide education to health providers on suicide risks, ways to address these risks and best practices for suicide prevention. However, at only a small percentage of facilities were these programs mandatory.

Recommendations

Salient to the care of aging veterans, we made the following recommendations:

- VA facilities should make arrangements for 24-hour crisis and mental health care availability either in person, via a facility-run crisis line, or by facility referral to an established, functioning non-VA crisis/suicide hotline staffed by trained mental health personnel.

- All non-clinical staff who interact with veterans should receive mandatory training about responding to crisis situations involving at-risk veterans; this should include suicide protocols for first contact personnel.

- All health care providers should receive mandatory education about suicide risks and ways to address these risks.

- VA should establish a centralized mechanism to select emerging best practices for screening, assessment, referral, and treatment and to facilitate system-wide implementation, in order to ensure a single VA standard of suicide prevention excellence.

Conclusion

Preventing suicide is a complex, multifaceted challenge to which there is not one best practice but several promising but not proven approaches and methods. Since 2004, progress has been made toward implementation of the MHSP initiatives for suicide prevention. The progress is ongoing, with greater integration and at an accelerated pace. However, more work remains to ensure a coordinated effort in achieving system-wide implementation. At present, MHSP initiatives for suicide prevention are partially

implemented. It is therefore incumbent upon VA to continue moving forward toward full deployment of suicide prevention strategies for our Nation's veterans.

Mr. Chairman, thank you again for this opportunity to testify. I would be pleased to answer any questions that you or other members of the Committee may have.

Senator SMITH. Before we go to Larry, Doctor, I was curious. Your final comments there—there is no one specific treatment for someone susceptible to suicide.

Dr. SHEPHERD. I think there are many determinants. For instance, an older adult with major depression may have a certain set of needs compared to a young female with borderline personality disorder.

So, there is not one answer for everyone. But it is an issue of finding what is considered to be the best possible modes and initiatives out there.

Senator SMITH. There are many avenues that work, but for different people.

Dr. SHEPHERD. Right.

Senator SMITH. Is the reason there isn't one is because we haven't discovered it or because people are just different?

Dr. SHEPHERD. I think it is a mix of both. People are different and have different determinants in what ultimately leads to suicide.

Also, for some of these things, what would be an ideal screening tool are in the process of being developed at the Rocky Mountain Network in the VA system. The researchers there are doing a lot of work developing innovative tools. So they are having to essentially come up with those things from the start.

I think the next step is going from there to getting those things in place system-wide.

Senator SMITH. Very good.

Larry.

STATEMENT OF LARRY REINKEMEYER, DIRECTOR, KANSAS CITY OFFICE OF AUDIT, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS, WASHINGTON, DC

Mr. REINKEMEYER. Mr. Chairman and members of the Committee, I also thank you for the opportunity to testify on our audit of the VHA's outpatient waiting times that we issued on September 10, 2007.

Within the Department of Veterans Affairs, the Veterans Health Administration, commonly known as the VHA, has the mission to provide quality medical care on a timely basis to all authorized veterans.

We performed this audit at the request of the U.S. Senate Committee on Veterans' Affairs. Our objective was to follow up on our July 2005 audit, where we reported that VHA did not follow established procedures when scheduling medical appointments, resulting in waiting times and waiting lists that were not accurate.

VHA agreed with the findings and the 8 recommendations contained in our July 2005 report.

The objectives of this audit were to determine whether established scheduling procedures were followed and outpatient waiting times reported by VHA were accurate, whether waiting lists were complete, and whether prior OIG recommendations were fully implemented.

Our results showed the schedulers were still not following established procedures for making and recording medical appointments. As a result, the accuracy of VHA's reported waiting times could not

be relied on and the waiting lists at those medical facilities were not complete.

Also, to date, VHA has not taken the necessary actions to implement five of the eight recommendations from our July 2005 report.

In the Department of Veterans Affairs Fiscal Year 2006 Performance and Accountability Report, VHA reported that veterans were seen within 30 days of their requested appointment date for 96 percent of primary care and 95 percent of specialty care appointments.

To test the accuracy of VHA's reported waiting times, we selected a nonrandom sample of 700 appointments where VHA reported the veteran waited 30 days or less. We found that only 524 of the 700 veterans were seen within 30 days of their requested appointment date, for an error rate of 25 percent. This included 78 percent of veterans seeking primary care compared to VHA's reported 96 percent, and 73 percent of veterans seeking specialty care, compared to VHA's reported 95 percent.

These error rates occurred because schedulers were not following established procedures when scheduling appointments.

For example, VHA calculates a veteran's waiting time from the requested appointment date, which could either be requested by the medical provider or by the patient, to the actual appointment date. We found that instead of recording the requested appointment date, some schedulers would identify the date of the first available appointment and then record that as the patient's requested appointment date. This resulted in a waiting time of zero days.

We also found that some schedulers were not following procedures for placing veterans on the waiting list. The most significant underreporting we identified involved referrals from one clinic to another.

For example, if a veteran's primary care doctor refers him to the eye clinic, the eye clinic scheduler has 7 days to act on that referral by either scheduling the appointment or placing the veteran on the waiting list. This 7-day requirement prevents schedulers from creating unofficial waiting lists by holding on to referrals for extended periods until an appointment slot becomes available.

Although the 10 medical facilities we reviewed listed a little over 2,600 veterans on their specialty care waiting lists, we identified over 70,000 veterans who, according to VHA's records, had been waiting more than 7 days, did not have an appointment, and were not on the waiting list.

Part of the cause for these error rates was that medical facility schedulers were still not getting the necessary training to fully perform their job.

Although we did not investigate whether schedulers were intentionally gaming the system, we did find that schedulers at some facilities were interpreting guidance from their managers to reduce waiting times as instruction to never put the veterans on the waiting list.

Had VHA taken timely action to implement recommendations from our July 2005 report, they may have precluded some of these same conditions from occurring again.

The VHA agreed with four of our five recommendations on this audit, including routinely testing the accuracy of waiting times and

the completeness of waiting lists; ensuring consult referrals are acted on timely; ensuring all schedulers receive required annual training; and assessing alternatives to the current process of scheduling appointments and reporting waiting times.

The VHA did not agree to our recommendation to either create appointments within 7 days or use the desired date to calculate the waiting time for new patients.

In closing, we maintain that full compliance with established scheduling procedures is critical to ensuring patients are seen in a timely manner and that no one falls through the cracks. In addition to compliance, VHA management needs to establish effective mechanisms to ensure data integrity. VA and Congress must have accurate, reliable, timely information for budgeting and other decisionmaking purposes.

Mr. Chairman, I thank you again for the opportunity to testify. I would be pleased to answer any questions you may have.

[The prepared statement of Mr. Reinkemeyer follows:]

STATEMENT OF
LARRY M. REINKEMEYER
DIRECTOR, KANSAS CITY AUDIT OPERATIONS DIVISION
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
HEARING ON AUDIT OF THE VETERANS HEALTH ADMINISTRATION'S OUTPATIENT WAITING TIMES
October 3, 2007

INTRODUCTION

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify on our report on the *Audit of the Veterans Health Administration's Outpatient Waiting Times,* which we issued on September 10, 2007.

We performed the audit, at the request of the U.S. Senate Committee on Veterans' Affairs, to follow up on our *Audit of the Veterans Health Administration's Outpatient Scheduling Procedures* (Report No. 04-02887, July 8, 2005), where we reported that Veterans Health Administration (VHA) did not follow established procedures when scheduling medical appointments for veterans seeking outpatient care. Our July 2005 report concluded that waiting times and electronic waiting lists were not accurate; VHA agreed with the reported findings and eight recommendations for corrective action. However, as of today, five recommendations from our 2005 report remain unimplemented.

My testimony today will highlight our findings related to VHA's reported waiting times and waiting lists.

BACKGROUND

VHA calculates a patient's waiting time based on whether VHA considers the patient to be an established patient or a new patient. VHA defines established patients as those who have received care in a specific clinic in the previous 2 years; new patients represent all others. For established patients, (representing 90 percent of VHA's total outpatient appointments), waiting times are calculated from the desired date of care, which is the earliest date of care requested by either the veteran or the medical provider, to the date of the scheduled appointment. For new patients, VHA calculates waiting times from the date that the scheduler creates the appointment.

VHA implemented the electronic waiting list in December 2002 to provide medical facilities with a standard tool to capture and track information about veterans' waiting for medical appointments. VHA policy requires that all veterans with service-connected disability ratings of 50 percent or greater and all other veterans requiring care for service-connected disabilities be scheduled for care within 30 days of desired appointment dates. All other veterans must be scheduled for care within 120 days of

the desired dates. Veterans who receive appointments within the required timeframe are not placed on the electronic waiting list. However, veterans who cannot be scheduled for appointments within the 30- or 120-day requirement should be placed on the electronic waiting list immediately. If cancellations occur and veterans are scheduled for appointments within the required timeframes, the veterans are removed from the electronic waiting list.

WAITING TIMES

In the *Department of Veterans Affairs Fiscal Year 2006 Performance and Accountability Report*, issued November 15, 2006, VHA reported that 96 percent of all veterans seeking primary medical care and 95 percent of all veterans seeking specialty medical care were seen within 30 days of their desired dates. We reviewed a non-random sample of 700 appointments that VHA reported were seen in 30 days or less. The appointments were scheduled for October 2006 at 10 medical facilities in 4 Veterans Integrated Service Networks (VISN). Our audit results are not comparable to VHA's reported waiting times contained in its *Performance and Accountability Report* because we used a different set of clinics and timeframe of appointments. Further, our audit results cannot be extrapolated to project the extent that waiting times exceed 30 days on a national level because the medical facilities and appointments selected for review were based on non-random samples. Nevertheless, the findings of this report do support the fact that the data used to calculate veteran outpatient waiting times is not reliable.

We found sufficient evidence to support that 524 (75 percent) of the 700 veterans were seen within 30 days of the desired date. This includes 229 (78 percent) veterans seeking primary care and 295 (73 percent) veterans seeking specialty care. However, 176 (25 percent) of the appointments had waiting times over 30 days when we used the desired date of care that was documented by the medical providers in the medical records.

Established Patients

VHA schedulers must record the correct desired date to accurately calculate the waiting time of established patients. The desired date of care is the date requested by either the veteran or the medical provider. In total, 429 (72 percent) of the 600 appointments for established patients had unexplained differences between the desired date of care documented in medical records and the desired date of care the schedulers recorded in Veterans Health Information Systems and Technology Architecture (VistA). If schedulers had used the desired date of care documented in medical records:

- The waiting time of 148 (25 percent) of the 600 established appointments would have been less than the waiting time actually reported by VHA.
- The waiting time of 281 (47 percent) of the 600 established appointments would have been more than the waiting time actually reported by VHA. Of the 281 appointments, the waiting time would have exceeded 30 days for 176 of the appointments.

VHA personnel provided us several reasons for the unexplained differences we found between the desired dates of care shown in the medical record and the desired date of care the schedulers recorded in VistA. First, VHA told us the unexplained differences can generally be attributed to patient preference for specific appointment dates that differ from the date recommended by medical providers. VHA policy requires schedulers to include a comment in VistA if the patient requests an appointment date that is different than the date requested by the provider. We reviewed all comments in VistA and accepted any evidence that supported a patient's request for a different date. VHA personnel told us that schedulers often do not document patient preferences due to high workload. Without documentation in the system, neither we nor VHA can be sure whether the patient's preference or the scheduler's use of inappropriate scheduling procedures caused the differences we found.

Second, VHA personnel also told us that some VHA clinics use recall or reminder clinics to emphasize patient-driven scheduling. If a veteran is entered in a recall or reminder clinic, the scheduler will notify the veteran either by letter or phone about 30 days before the expected appointment date and ask the veteran to call the clinic to set up their appointment. VHA personnel said that some veterans may not call for their appointment or, in some cases, may wait several months before calling. If the scheduler does not document this situation, then the veteran's waiting time may appear to be longer than it actually was. If a patient fails to call in, VHA policy requires the facility to send a follow-up letter and to document all attempts to contact the veteran.

Lastly, VHA personnel told us that some providers are not specific when they document the veterans' desired date of care. For example, some providers will request the veteran to return to the clinic in 3 to 6 months. If a provider uses a date range, VHA policy requires schedulers to use the first date of the date range as the desired date of care or obtain clarification from the provider. When we found appointments with date ranges and no clarifying comments from the provider, we followed VHA policy and considered the first date of the range as the desired date.

New Patients

VHA uses the appointment creation date, instead of the desired date, as the starting point for measuring the waiting times for new appointments. VHA uses this method for new appointments because VHA assumes the new patient needs to be seen at the next available appointment. This is true for patients who are absolutely new to the system. However, VHA's definition of new patients also includes patients who have already seen a provider and have been referred to another clinic. In our opinion, while these veterans might be new to a specialty clinic, they are established patients because they have already seen a medical provider who has recommended a desired date.

For VHA to ignore the medical providers' desired date for this group of new patients understates actual waiting times. We reviewed 100 new patients VHA reported had waiting times of less than 30 days. Out of the 100, 86 had already seen a medical provider and were being referred to a new clinic. The other 14 were either new to the

VA or had not been to the VA in over 2 years; therefore they had no desired date. We found:

- For the 86 patients currently receiving care at the facility, we calculated the waiting time by identifying the desired date of care documented in the medical records (date of the consult referral) to the date of the appointment. We found that 68 (79 percent) of the 86 new patients were seen within 30 days. For the 18 patients not seen within 30 days, the actual waiting time for the 18 patients ranged from 32 to 112 days.
- For the 14 patients who were either new to the VA or new to the facility, we reviewed the VistA scheduling package and identified the date the veteran initiated the request for care (telephone or walk-in) and used that as the desired date for calculating the waiting time. All 14 veterans were seen within 30 days of the desired date.

WAITING LISTS

Of the 176 cases where veterans' waiting times were more than 30 days, we identified 64 veterans who were given an appointment past the 30- or 120-day requirement and should have been on the electronic waiting lists. This represented 9 percent of the 700 appointments reviewed. Further, VHA policy also requires that requests for appointments (including consults) be acted on by the medical facility as soon as possible, but no later than 7 calendar days from the date of request. If not, the veteran should be placed on the electronic waiting list. None of the 10 medical facilities we reviewed consistently included veterans with pending and active consults (referrals to see a medical specialist), that were not acted on within the 7-day requirement, on the electronic waiting list. Pending consults are those that have been sent to the specialty clinic, but have not yet been acknowledged by the clinic as being received. Active consults have been acknowledged by the receiving clinic, but an appointment date has either not been scheduled or the appointment was cancelled by the veteran or the clinic.

According to the consult tracking reports, the 10 medical facilities listed 70,144 veterans with consult referrals over 7 days old. In accordance with VHA policy, the medical facilities should have included these veterans on the waiting lists. To substantiate the data in the consult tracking reports, we reviewed 300 consults (20 active consults and 10 pending consults from each of the 10 medical facilities). Based on our review:

- Of the 200 active consults, 105 (53 percent) were not acted on within 7 days, and these veterans were not on the electronic waiting lists. Of this number, 55 veterans had been waiting over 30 days without action on the consult request.
- Of the 100 pending consults, 79 (79 percent) were not acted on within the 7-day requirement and were not placed on the electronic waiting list. Of this number, 50 veterans had been waiting over 30 days without action on the consult request.

At the time of our review, the total number of veterans on the 10 facilities electronic waiting lists for specialty care was only 2,658.

Also, medical facilities did not establish effective procedures to ensure that veterans received timely care if the veteran did not show up for their initial appointment or the appointment was cancelled. For 116 (39 percent) of the 300 consults we reviewed, subsequent actions such as a patient no-show placed the 116 consults back into active status. We identified 60 of the 116 consult referrals where the facility either did not follow up with the patient in a timely manner or did not follow up with the patient at all when the patient missed their appointment.

We interviewed 113 schedulers at 6 medical facilities and found that 53 (47 percent) had no training on consults within the last year, and that 9 (17 percent) of the 53 had been employed as a scheduler for less than 1 year. We also discovered that 60 (53 percent) of the 113 schedulers had no training on the electronic waiting list within the last year, and that 10 (17 percent) of the 60 had been employed as schedulers for less than 1 year. Schedulers and managers told us that, although training is readily available, they were short of staff and did not have time to take the training. The lack of training is a contributing factor to schedulers not understanding the proper procedures for scheduling appointments, which led to inaccuracies in reported waiting times by VHA.

While waiting time inaccuracies and omissions from electronic waiting lists can be caused by a lack of training and data entry errors, we also found that schedulers at some facilities were interpreting the guidance from their managers to reduce waiting times as instruction to never put patients on the electronic waiting list. This seems to have resulted in some "gaming" of the scheduling process. Medical center directors told us their guidance is intended to get the patients their appointments in a timely manner so that there are no waiting lists.

RECOMMENDATIONS

We made five recommendations to the Under Secretary for Health. The recommendations include:

- Establishing procedures to routinely test the accuracy of reported waiting times and completeness of electronic waiting lists.
- Taking action to ensure schedulers comply with the policy to create appointments within 7 days or revert back to calculating the waiting time of new patients based on the desired date of care.
- Amending VHA policy to clarify specialty clinic procedures and requirements for receiving and processing pending and active consults to ensure they are acted on in a timely manner.
- Ensuring all schedulers receive required annual training.
- Identifying and assessing alternatives to the current process of scheduling appointments and recording and reporting waiting times.

CLOSING

In closing, VHA needs to take timely action to implement recommendations as five of the eight recommendations from our July 2005 report remain unimplemented. Timely action may have precluded the same conditions from occurring again.

Mr. Chairman, thank you for the opportunity to testify. I would be pleased to answer any questions that you or other members of the Committee may have.

Senator SMITH. Thank you, Mr. Reinkemeyer.

Dr. Shepherd, in your testimony, you state that approximately 3 out of 4 veterans seeking mental health treatment are Vietnam veterans. Why?

Dr. SHEPHERD. You know, everywhere I have gone in the last year in terms of VA facilities, I ask the clinicians their take on that. I have talked to the people at the National Center for PTSD.

You get a list of theories, among which would be that one might be that since the VA instituted universal screening for depression and PTSD at primary care appointments, people are being picked up who would not have been picked up prior.

Some people say that perhaps the present war has reawakened anxiety or stress that had been dormant.

Some have mentioned emergence of symptoms in people who essentially were workaholics all their lives and just kind of lived with their symptoms, they now retire or slow down and the symptoms take on a lot more bothersome role in their lives.

With many aging adults, the co-morbid effect of the onset of new physical problems and functional impairments also adds to the mental health burden.

So that is 3 or 4 of among probably a list of 10 theories I have heard.

Senator SMITH. Interesting. OK.

Mr. Reinkemeyer, I want to applaud part of your report which notes that approximately 85 percent of VA facilities now have an acting suicide prevention coordinator. Is that correct?

Mr. REINKEMEYER. That wasn't my report. That might have been Dr. Shepherd's.

Senator SMITH. I am sorry. That is Dr. Shepherd's.

Dr. SHEPHERD. Yes. As of a conversation I had last week, approximately 85 percent have suicide prevention coordinators in place.

Senator SMITH. What is the next step? How do we get 100? Do these coordinators—is it working?

Dr. SHEPHERD. From what I understand, for the other 15 percent of the facilities, they have acting coordinators in place. I think they have ongoing recruitment for those positions.

In terms of people I have spoken to at the hotline, the coordinators are having an impact. The hotline staffers follow up with the suicide prevention coordinator at the facility to make sure that the veteran actually did get seen and evaluated. Then they are initiating and following up again at 2 weeks to see whether the patient got evaluated and then kind of was lost to further treatment or has stayed in treatment.

So I think it is starting to show some benefit. I think time will tell.

Senator SMITH. Thank you very much.

Senator Wyden.

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

I think Senator McCaskill identified a real priority on this wait issue and the question of sort of gaming the numbers. I think what I want to do is take it in a little bit different direction, although I think what Senator McCaskill has contributed is extremely important.

You IGs talk, has been my experience, Mr. Reinkemeyer. That IGs around the country talk. How widespread do you think this problem is based on the fact that you looked at a handful of facilities?

Mr. REINKEMEYER. Within the VA——

Senator WYDEN. Yes.

Mr. REINKEMEYER. I think it is probably pretty prevalent.

This effort was a short-timeframe audit requested by the Senate Committee on Veterans' Affairs in January. So we did not do a lot of interviews and questioning on the intentional gaming part.

Having said that, I can tell you that, back in July 2005 when we did the first report, we did extensive work in this area. We sent out a questionnaire to 30,000 schedulers. We had 15,000 responded. We asked questions such as, "Have you ever been directed by your supervisor to do this?" Or, "How would you schedule an appointment this way?"

The first question, if my memory serves me correctly, we had about 7 percent or 8 percent of schedulers nationwide that said that they were directed by their supervisors to circumvent the scheduling process to make sure that waiting times looked good.

So, although I can't answer that now, just by the scope of the audit that we just did, I can tell you that procedures have not changed all that much. We still found problems with schedulers following procedures. So we have no indication that some of this is still not going on.

Senator WYDEN. So you find these problems. You think they are fairly prevalent. You bring them to the VA. They say what? We don't agree with you? What is their response when you bring it to them?

Mr. REINKEMEYER. Well, on the first audit back in July 2005, we made 8 recommendations. They agreed with the findings and all 8 recommendations.

However, as I said in my statement, five of those have not been acted on or have not been implemented yet. You would have to talk to the department as to why.

Senator WYDEN. We are going to have to have some spirited discussions with them to make sure that they get those 5 done.

Mr. REINKEMEYER. I can tell you, for this audit they did not agree with some of our findings, primarily having to do with the methodology. It was not a statistical sample we didn't do a nationwide sample for this audit intentionally because of the short timeframes.

But, they have agreed with 4 of the recommendations.

Senator WYDEN. Let me ask you one other one.

My understanding is that there aren't a lot of statistics or good information on some of the groups that have really lost services in the past, like priority eight and priority seven. Is that your understanding?

Mr. REINKEMEYER. Yes. I really don't know, the extent of the number of priority eight veterans out there.

Senator WYDEN. Yes.

My sense is that there isn't a lot of good information about priority eight and priority seven folks who are being turned away. The statistics we have that several million veterans, 2 million veterans,

can't access care at all may not even be reflected in the VA statistics. We may not even have our arms around an accurate number of veterans who we ought to be thinking about.

Is that generally a point that you would share?

Mr. REINKEMEYER. I really couldn't speak to that. I think the department could probably address that.

I know we have not done any work looking at——

Senator WYDEN. You have not done any work.

Mr. REINKEMEYER. We have not done any work looking at the number of priority eights, for example, that are out there and not receiving treatment.

Senator WYDEN. Well, I am going to let Senator McCaskill continue to prosecute this cause of making sure the gaming issue gets addressed because my sense is one, it is pretty prevalent, and two, based on some issues relating to whether we are getting numbers on priority seven and priority eight. If anything, I think we are underestimating the number of folks that are getting lost and getting denied services.

So I thank both of you for your good work.

Doctor, we will spare you because I think Senator Smith covered it very well.

We appreciate both of you and your professionalism.

Senator SMITH. Senator McCaskill.

Senator MCCASKILL. Thank you, both, for being here. It doesn't get much better than an auditor from Kansas City, Mr. Reinkemeyer.

Mr. REINKEMEYER. Especially one from Jefferson City, so I was a Tigers fan.

Senator MCCASKILL. Two near and dear things to my heart.

I have reviewed an awful lot of GAO reports in preparation for this hearing. I want to take a minute to reference one of them that really got my attention from both of your perspectives within the IG system, within Veterans. That is a GAO report dating back from 2001 concerning the VA nursing homes and the reality that the nursing home inspections of the VA-operated nursing homes, unlike any other nursing home inspections done by CMS, are not available to the public.

I wondered if you all were aware of that, and if that is something that internally has been discussed in the IG community.

The interesting thing in this audit back in 2001, the VA said, oh, they had a plan to begin to look—you know, there are three different types of nursing homes that VA uses. One is the community nursing homes they contract with, one is the state-owned nursing homes that are owned by the various states, and then the vast majority of the average daily census in these veterans' nursing homes are actually VA-operated nursing homes.

Now, understanding that the community-based and the—in most instances—and the state-based are getting very thorough CMS inspections for quality of care issues, and all of those inspections are public records. The state facilities are also getting—and the community facilities—are also getting state surveys and inspections. Those are indeed public records.

But for some reason, the VA nursing homes do not have any public review of the inspections of these homes.

I know that there are waiting lists for them. I know the kind of pressure that is on health care workers in that particular segment: long-term care. That the quality issues are a real problem in terms of care.

I was wondering, you know—and the thing that is really frustrating is, like so many of the GAO reports, you know, the response from the agency is, "Oh, we are on it. We are planning that. We are fixing all that." Of course, here were are in 2007 and my staff made inquiry and nothing has changed. That, in fact, they still are not using the CM—and, by the way, they should be relying on these CMS inspections.

They should allow—I mean, this system is very thorough, and it is, you know, public. People who are putting people in nursing homes, loved ones, can look at these reports and determine whether they believe this is a quality facility.

I was curious if either one of you are aware of this or if there has been any discussion within the IG community to take a more in-depth look at this in the near future.

Dr. SHEPHERD. I was unaware of that. If I may, I would like to respond in the record after I educate myself more on to what extent VA does look at its own nursing homes and not just the extent but with what quality.

Senator MCCASKILL. Well, I would—Mr. Reinkemeyer?

Mr. REINKEMEYER. Yes.

From an audit perspective, we have looked at nursing homes in the past but typically it would have to do with rates. What are we paying? What are we getting? Those aspects.

I know health care, which Dr. Shepherd is a part of, they will look at the quality of care aspect and maybe have looked in the past at why inspections are not visible. Certainly, as Dr. Shepherd indicated, he can, prepare a statement for the record later.

I just have not been the—Office of Audit typically will look at the contract side of it.

Senator MCCASKILL. Well, I would appreciate a response for the record.

I will follow up with that, Mr. Chairman, because I think this Committee would be a good place to look at that issue, particularly if we look at why in the world will they not make these reports public? I can't imagine what a good answer would be.

It seems to me that ought to be something—we are always looking for something we can actually get done around here. You know, because we can talk about things until we are blue in the face, but getting things done is a whole other matter.

It seems to me this ought to be low-hanging fruit that we ought to get accomplished for the veterans and their families. They ought to be able to look at the quality of care in these homes based on thorough inspections that are done on an ongoing basis.

I would hope that if you determine that what I have stated today is, in fact, accurate, that the IG's office would also take a look at this issue. Maybe between the IGs and this Committee, we can change that on behalf of the veterans and their families that are looking at nursing home care.

Thank you, Mr. Chairman.

Senator SMITH. Thank you, Senator McCaskill.

Senator Lincoln.

Senator LINCOLN. Thank you, Mr. Chairman.

Dr. Shepherd, as I mentioned earlier with Mr. Dole, we have got about 3,200 Arkansas National Guard and Reservists which will be deploying for Iraq after the first of the year. It will be their second deployment in 3 years.

One of the issues we have brought up in the debate under SCHIP is the kind of care that these Guard and Reservists look to for health care when they return home and after they have been home. We have a number that depend on SCHIP for their children. I was disappointed to see the president's veto of that.

But given that the National Guard soldiers only have access to TRICARE for a limited time upon their return from service, and given that some of the symptoms of PTSD and TBI may not become apparent right away, maybe you can let us know what safeguards are in place to provide for the mental health care needs of our citizen soldiers, as well.

Do you feel that our military and veterans' health care system are properly taking into account the increased service of our reserve components? we are seeing a tremendous number of our Guard and Reserve, and, of course, coming home, having had an experience in many instances very different than what they expected. Are there any unique challenges that we are confronted with in providing for them?

Dr. SHEPHERD. In terms of Guard and Reservists, beside the window for TRICARE, I believe there is a 2-year window to enroll in VA care.

One of the efforts I know that VA's making is that I think is one of the key things—is continuing to outreach to Guard and Reservists units to let people know that even if you are not having symptoms now, that with this type of problem, you can develop symptoms 6 months from now, 5 years from now, and the importance of when you are 22 or 24 of not thinking, "I am fine today. I don't need anything." But really encouraging, through outreach at Guard and Reservists bases, returning veterans to enroll in VA in case they do need this care down the line.

Senator LINCOLN. So they are able to apply for the VA services early.

Do they need detection? I mean, do they need to be tested, if it is going to be service connected, in order to get that benefit? I mean, is it something you would encourage them to do when they return before they have to—I mean, they have a limited window when they can apply for that, is that not right?

Dr. SHEPHERD. Right.

I know that the DOD and the VA do these post-deployment health assessment screenings and are supposed to do them, not just on deactivation but at 3 months and at 6 months, to try to capture some veterans who may not have been showing symptoms immediately post-deployment but are starting to show symptoms at 3 and 6 months.

Again, I think it is very important that the word keeps getting out there that, even if you are not having symptoms now, you may develop them. To get in, get enrolled.

If people do get in the system and do get seen during the window where they can be seen without having to have a service obligation connection, the primary care providers at their appointments should be mandatorily doing a PTSD and depression screen. So hopefully in that 2-year window some of these people, if they can be engaged to get into the system, will get picked up.

Senator LINCOLN. Are there recommendations of how we get that word out there in a better—or do you see us getting that word out in an efficient and effective way? Are we being effective about that? Or is there some recommendation of how we do a better job of getting that word out to these Guard and Reservists?

Dr. SHEPHERD. I don't have a specific recommendation or a specific sense of how well that effort is.

In terms of some vignettes that have been pointed out to me, one of the suicide prevention researchers goes out to Guard and Reservists bases pre-deployment and talks to Guard and Reservists about symptoms they may experience post-deployment.

I think that is an important consideration because if I was returning home, I am a young guy, I want to get home to my family. I might not be listening too much and be interested in getting home. Whereas I might have a lot more attention to what I am hearing pre-deployment when someone, you know, discusses possible mental health issues I may develop later and also ways to access the system.

I thought that was a very good initiative.

Senator LINCOLN. Well, that is a good suggestion. Doing it pre-deployment instead of, you are right, the anxiousness.

Just last question, Mr. Chairman.

We are certainly grateful to your work in the area of veterans' mental health and particularly the suicide prevention. It is such a crucial issue. You have done an important job in bringing about a greater awareness.

Senator Snowe and I recently introduced legislation that, among other provisions, seeks to increase the number of mandatory mental health assessments. It would include comprehensive screenings for mild, moderate and severe cases of TBI.

Kind of similar to my previous question, maybe you might briefly describe the way that we attempt to screen and detect those symptoms of PTSD and TBI in its early stages.

What is the methodology there that is used? How do we address and detect the instances of later occurring symptoms? If they are going to go in for these screenings, or they are going to go in, what is the methodology or the questions that we are using to try and have that early detection?

Dr. SHEPHERD. The screening questionnaires they use have about four or five questions about PTSD. So they are not extensive, comprehensive questionnaires or interviews.

If someone scores I forgot whether the number is 3 or 4 positives, then they are supposed to be referred for a more extensive evaluation. So that is the present methodology.

I think in terms of trying to detect PTSD in the presence of TBI, it is a very clinically challenging situation. I think, again, keeping the awareness among the clinicians that these things can co-exist and that they are not mutually exclusive, and that people can have

PTSD in the setting of TBI, and that the symptoms you see may not be ascribable to just one.

So I think basically more disseminated education regarding that is needed.

Senator LINCOLN. How much early information do they go back to?

I just remember reading an account in the news several months ago. A woman who was concerned that her husband—too much early background information, high school grades were used. She said, "Well, you know, if he was competent enough for the military to take him and send him off, you know, then why is it now a question as to whether his capacity or his mental health is at risk or is a problem because of those early grades?"

I thought that was interesting. How far back do they go?

Dr. SHEPHERD. I really couldn't answer that.

Senator LINCOLN. No?

Dr. SHEPHERD. I just don't know. That was not the focus of our review.

Senator LINCOLN. OK.

Thank you, Mr. Chairman.

Senator SMITH. Gentlemen, thank you for the work you have done, the work you are doing, and for adding so much to our hearing this morning.

We will now call up our third panel. They consist of Mr. Steven R. Berg. He is the vice president for programs and policy at National Alliance to End Homelessness. Today, Mr. Berg will testify on the unique needs of homeless veterans, including their complex health care needs.

He will be joined by Mr. Fred Cowell, who is the senior associate director of the health analysis program at Paralyzed Veterans of America. He is a veteran of the U.S. Navy and served two tours of duty in Vietnam assigned to the Naval Security Group. Mr. Cowell will testify on the long-term care needs of our veterans.

Finally, last but certainly not least, Dr. Mark Kaplan. He is a professor of community health at Portland State University and holds adjunct appointments in psychiatry and family medicine at the Oregon Health Sciences University and epidemiology and community medicine at the University of Ottawa. Today, Dr. Kaplan will testify on the study he published earlier this year on the rate of suicide for veterans, which garnered national attention.

Gentlemen, a vote has just started. With your indulgence so as not to shortchange you, I will rush real quickly, vote, and be right back, so that we in no way lose what you have to present to us.

So, if you have no objection, we will take a very brief recess and be right back. [Recess.]

Thank you, gentlemen, for your understanding. I just simply note that the leaders on the Senate floor don't often check with the Aging Committee as to when they time the votes. But we do want to make sure we give full consideration to your testimony.

So, Steven, why don't we start with you.

STATEMENT OF STEVEN R. BERG, VICE PRESIDENT FOR PROGRAMS AND POLICY, NATIONAL ALLIANCE TO END HOMELESSNESS, WASHINGTON, DC

Mr. BERG. All right.

Thank you, Senator Smith, for having us at this hearing. I am with the National Alliance to End Homelessness, as you know. Thank you, also, for the work you have done personally, I know, and your staff has done, on this issue in a whole range of different ways.

Part of the homelessness issue that is particularly vexing, particularly infuriating, is the high rates of homelessness among veterans. We are in the middle of a major research project to try to put some numbers on that problem, look at some of the factors that go into it. That is research that will be released in early November, but I would like to share some of our preliminary findings today that I think are worth noting.

First of all is just that it is a sizable problem. Our estimate is that over 195,000 veterans are homeless on any given night in the United States, which is—there are different ways to look at it. It is like a whole medium-sized city. You cleared everyone out and filled the whole city up with homeless veterans. That is the size of the problem.

Of particular relevance to this Committee is that many homeless veterans are older and have disabilities. It is sort of a commonplace within the homeless services field that homeless veterans are older and sicker than homeless people generally. That is particularly seen among homeless veterans who are considered chronically homeless.

That is a term the Federal Government uses to describe homeless people who are on their own, have severe disabilities, have been homeless for a long time, for a year or more. Our estimate is that between 44,000 and 64,000 veterans fit that definition of chronic homelessness, which makes this very much a health care issue because besides housing those are all people who need treatment, many times for mental health conditions accompanying substance abuse conditions and a whole range of physical ailments.

Veterans are disproportionately represented among homeless people. In other words, veterans in the United States are more likely to be homeless than are Americans who are not veterans. There has been a whole range of theories put forward as to why that should be the case. We are trying to address some of those in this research that we are doing.

One of the key contributors to homelessness among veterans and anyone else is housing affordability and high housing costs.

Most veterans do pretty well in terms of incomes, in terms of their ability to afford housing. In fact, for veterans in general their incomes and their ability to afford housing are better than non-veterans.

But there is a subset of veterans who don't do as well, who have high housing cost burdens, who are paying a disproportionate percentage of their income in rents. That is particularly the case among women veterans, among veterans who have a disability, and also among veterans who are older. The sort of World War II and

Korea-era veterans are far more likely to have a high housing cost burden than veterans who are younger.

So it is a sizable problem. But we view the problem of homelessness—and particularly homelessness for veterans—as a problem with a solution.

Several years after sort of the Federal Government and Congress, we like to, you know, we hope we had some small part to play in this, announced new initiatives to try to get communities to work less at managing the problem of homelessness and more at ending homelessness.

We see communities around the country who are undertaking local plans to end homelessness a lot of times with the participation of the VA. We have good models all around the country.

You mentioned Central City Concern in Portland. There are similar kinds of programs all over the country that are doing similar kind of work.

The most important thing is we are starting to see results. In a small handful of cities that have undertaken some of these best program models, we are seeing the number of homeless people decline.

People in the homeless services field, I will say, talk about the Portland miracle, based on the reductions in the number of people who are homeless in Portland.

I lived in Portland back in the 1970's, and even then there were lots of people living on the street and had been for a long time. In recent years, those numbers have really demonstrably declined because of work that people like Central City Concern, people with the city are doing to adopt a range of strategies that we know really work.

Now, our feeling is that this should be easiest for veterans for a number of reasons. One, because one of the key components of the strategy that works is health care. Veterans have a system of health care that other Americans don't have access to that should work to deal with mental health problems, to deal with substance abuse problems.

The VA keeps a lot of information about veterans. They do a good job of knowing which people that their health care system serves are homeless at the time they are being served. So it is a matter of identifying people who are experiencing the problem.

Now, they have some tools there to deal with even things like the numbers.

I mean, in Wisconsin, for example, the work the VA did to identify the number of homeless veterans came up with the number 828 veterans in the State of Wisconsin. You can fill this room pretty well with 828 people.

But in a State that size, it gives people an understanding of what they are up against. That is the kind of number where sort of one big push could make a significant impact on that problem. Knowing that, having the VA able to tell you that number, I think, helps people on the ground adopt strategies that are going to work.

Finally, the VA exists as a mechanism for ongoing support for veterans.

I mean, Senator Dole and Senator Wyden talked about the idea of a care coordinator. The idea that there is a system in place that could adopt that kind of intervention is a big plus for veterans.

Yet despite all these sort of advantages that veterans have in terms of dealing with homelessness, still it is a problem that disproportionately affects veterans. So there needs to be—we have a lot of work to do in this area.

We have some recommendations for Federal policy. In my written testimony, I have gone through a number of those.

The basic ideas are to provide funding and incentives for some of these key strategies that we know work: for discharge planning so that people have—the risks of homelessness are identified early on at the time people leave the military; emergency prevention; rapid re-housing so that when people do experience homelessness or are on the verge of experiencing homelessness, it is treated as a true emergency, intervention is in place.

We know the kind of intervention that works. There just needs to be systems set up so that those interventions are applied to people who need it right at the time they need it.

Another key element is permanent supportive housing, particularly for the older veterans who have the chronic health care problems and have been homeless a long time.

Low-cost housing, combined with treatment, combined with case management, this is a very cost effective intervention that we know works. I know we have talked to you and your staff about this.

There are a number of specific things that Congress could do that I have mentioned there. One thing I just want to mention, because it is sort of a hot item right now, is something called the HUD-VASH Program, HUD-VA Supportive Housing Program.

This is a program that matches rent subsidies from HUD with supportive services, treatment, and sort of case coordination provided by the VA. It has been put into effect in the past.

There haven't been new HUD-VASH vouchers put in place for a number of years. But in this year's appropriations bill for HUD, particularly the Senate bill, there is a substantial investment in the HUD bill for new HUD-VASH vouchers. In the Senate bill, there is probably enough to do 8,000 new vouchers.

So two aspects of that. One, it is very important that as that bill goes through the process—I know the whole appropriations process is very uncertain this year—but as that bill goes through, it is important that the funding for HUD for those VASH vouchers stay in there.

Two, it is incredibly important that the VA understand that it is Congress' intent and expectation that the VA will do their part in putting this program into effect.

The VA services are paid for by the regular health care program. There isn't a need for a special appropriation for the VA share of this.

But it is important—again, as Senator Wyden mentioned—this is an organizational challenge issue to ensure that in every city where the Housing Authority gets funding for some of these VASH vouchers, that the VA hospital is coordinating with the Housing Authority, making sure that the veterans who need the help the

most are referred for the vouchers, making sure that the case manager and that the VA is part of that is put into place.

We can house thousands of veterans with what is in the appropriations bill now. But everybody needs to do their part.

So thank you, once again, for inviting me. I am happy to answer any questions.

[The prepared statement of Mr. Berg follows:]

Testimony of
Steven R. Berg
Vice President for Programs and Policy
National Alliance to End Homelessness

Before the Senate Committee on Aging

Hearing on Health Issues Affecting Aging Veterans

October 3, 2007

Thank you, Chairman Kohl, Ranking Member Smith, and the honorable members of this committee on behalf of our Board of Directors and partner members for providing this opportunity to address the committee on homelessness among veterans in the United States. I would like to start by congratulating this committee on its interest in addressing the need of homeless and other vulnerable veterans in our nation. The National Alliance to End Homelessness believes that ending homelessness among veterans is well within our reach. The population is small enough for our collective effort to eradicate this deplorable existence for men and women who have served our country.

The National Alliance to End Homelessness is a nonpartisan, nonprofit organization that was founded in 1983 by a group of leaders deeply disturbed by the appearance of thousands of Americans living on the streets of our nation. We have committed ourselves to finding permanent solutions to homelessness. Our bipartisan Board of Directors and our 5,000 nonprofit, faith-based, private and public sector partners across the country devote ourselves to the affordable housing, access to services, and livable incomes that will end homelessness. The Alliance is recognized for its organization and dissemination of evidence-based research to encourage best practices and high standards in the field of homelessness prevention and intervention and we wish to share our insights with you today.

As our name implies, our primary focus is ending homelessness, not simply making it easier to live with. We take this idea very seriously. There is nothing inevitable about homelessness among veterans in the United States. We know more about veteran homelessness and how to address it than we ever have before, thanks in part to extensive research. We know a great deal about the pathways into homelessness, the characteristics of veterans who experience homelessness, and interventions and program models which are effective in offering reconnection to community, and stable housing.

We have been asked today to summarize the research available on the size and characteristics of the problem, and the most promising solutions that are under implementation around the country.

Homelessness Among Veterans

Far too many veterans are homeless in America. Homeless veterans can be found in every state across the country and live in rural, suburban, and urban communities. Many have lived on the streets for years, while others live on the edge of homelessness, struggling to pay their rent. Serious health problems and disabilities are both a cause and an effect of homelessness, and as is true of veterans generally, the homeless veteran population is aging – it is generally accepted that homeless veterans are older and more likely to have disabilities than are homeless Americans who are not veterans.

History clearly illustrates that as a nation we need to do more to protect veterans from falling through the cracks and becoming homeless. As the country struggles to resolve the ongoing wars in Afghanistan and Iraq, it is important to underscore the aftereffects of war, to ensure that government policies are supporting troops as they return home, and to do more for veterans who are already homeless.

A forthcoming research report (November 2007) from our Homelessness Research Institute analyzes data from the Department of Veterans Affairs and the Census Bureau to examine homelessness and severe housing cost burden among veterans. The report will highlight the following findings:

- In 2006, approximately 195,827 veterans were homeless on a given night—an increase of 0.8 percent from 194,254 in 2005. More veterans experience homeless over the course of the year. We estimate that 495,400 spent some time homeless over the course of 2006.

- Veterans make up a disproportionate share of homeless people. They represent roughly 26 percent of homeless people, but only 11 percent of the civilian population 18 years and older. This is true despite the fact that veterans are better educated, more likely to be employed, and have a lower poverty rate than the general population.

- A number of states, including Louisiana, California, and Missouri had high rates of homelessness among veterans. In addition, the District of Columbia had a high rate of homelessness among veterans with approximately 7.5 percent of veterans experiencing homelessness.

- In 2005 approximately 44,000 to 64,000 veterans were chronically homeless (i.e., homeless for long periods or repeatedly and with a disability).

- In 2005, nearly half a million (467,877) veterans were severely rent burdened and were paying more than 50 percent of their income for rent.

- More than half (55 percent) of veterans with severe housing cost burden fell below the poverty level and 43 percent were receiving foods stamps.

- Rhode Island, California, Nevada, and Hawaii were the states with the highest percentage of veterans with severe housing cost burden. The District of Columbia had the highest rate, with 6.5 percent of veterans paying more than 50 percent of their income toward rent.

- Female veterans, those with a disability, and unmarried or separated veterans were more likely to experience severe housing cost burden. There are also differences by period of service, with older veterans who served during the Korean War and WWII more likely to have severe housing cost burdens.

- In 2005, approximately 89,553 to 467,877 veterans were at risk of homelessness. At risk is defined as being below the poverty level and paying more than 50 percent of household income on rent. It also includes households with a member who has a disability, a person living alone, and those who are not in the labor force.

A state-by-state count of homeless veterans, and percent of all veterans who are homeless, is attached at the end of this testimony.

Communities are working to end homelessness among veterans. Across the country, thousands of stakeholders—policymakers, advocates, researchers, practitioners, former and currently homeless people, community leaders, and concerned citizens—have joined together to create 10-year plans to end homelessness. While most plans are geared toward ending homelessness among *all* people, many outline strategies that focus on meeting the targeted needs of homeless veterans. Strategies to end homelessness among veterans include more aggressive outreach targeted to veterans, greater coordination between local VA and homeless service agencies, targeted rental subsidies for veterans who are chronically homeless, permanent supportive housing that is linked to mental health services and other supports. While some communities are making progress, challenges remain daunting.

Federal Policy Response

There are a number of steps the federal government could take to reduce the number of veterans who experience homelessness.

Prevention of homelessness -- Using basic measures, our analysis shows that a high number of veterans are at risk of homelessness. To end homelessness among veterans, we have to prevent it from occurring in the first place.

> *Assessment and discharge planning* -- Everyone leaving active duty should receive basic information about housing and the resources available through the VA, and be assessed for risk of homelessness. Those with characteristics associated with risk of homelessness should receive more extensive discharge planning, including referral to existing housing resources and coordination with local VA offices to ensure follow-up support for stable housing.

Emergency prevention/rapid rehousing – The VA needs flexible resources to intervene when veterans are on the verge of homelessness. Payment of back rent, help with employment and benefits to improve incomes, mediation with property owners or roommates, or assistance with searching for new living options are among the services that need to be available. Outreach to veterans needs to take place to ensure that they know about available resources.

Housing homeless veterans – For veterans who are already homeless, procedures should be established within the VA to ensure a crisis response to return them to housing. For many homeless veterans, the emergency prevention/rapid rehousing approach outlined above will be all that is needed. Other veterans, particularly those with disabilities, will need more intensive supportive services and/or treatment to stabilize their housing.

Permanent supportive housing -- Approximately 44,000 to 66,000 veterans are chronically homeless. Homeless veterans who have been on the streets for a long time, have severe physical or mental disabilities, or have chronic substance abuse problems will need permanent supportive housing—housing linked with intensive supports—to help them maintain housing stability. A number of research studies show that permanent supportive housing is a cost effective approach that helps people who have intensive needs maintain stable housing, and some evidence shows that once back in housing they are likely to access health and substance abuse treatment. Supportive housing requires funding for operating costs, services, and capital costs.

HUD-VASH vouchers – The existing HUD-VA Supportive Housing program provides rent vouchers from HUD for homeless veterans, combined with treatment, case management and supportive services from the VA. This is a proven program that provides housing stability for veterans with the most severe disabilities. Ending homelessness for these veterans can be accomplished with the addition of 20,000 of these vouchers; the Senate T-HUD appropriation bill would provide for $75 million for this purpose next year, enough to house approximately 8,000 veterans.

Services for HUD-VASH – The HUD-VASH program requires that the VA have resources available to provide the case management, treatment and support services that are a key part of this intervention. Funded through VA Health Care, an amount approximately equal to the appropriation from HUD will be necessary.

Treatment and services through nonprofits – A number of bills over the past two years have sought to authorize the VA to provide grants to nonprofits, community-based organizations to provide supportive services to veterans with the lowest income, including those who have been homeless, who are now in permanent housing. In addition, the Services

for Ending Longterm Homelessness Act, S. 593, would provide funding for this purpose for all homeless people including veterans. Nonprofits have proven to be effective in this role.

Capital for supportive housing – To the extent that supportive housing for veterans requires the production of new housing stock or the rehabilitation of existing buildings that are not fit for habitation, there is a need for an authorized program to provide capital funds.

Homeless Grant and Per Diem upgrade for transitional housing – For veterans whose disabilities are not so severe that they need permanent supportive housing, but do need a stable living situation combined with supportive services for a period of time up to two years, transitional housing is a proven model, especially effective for homeless veterans who are working to overcome addiction. The Homeless Grant and Per Diem program provides VA funds to nonprofits to run transitional housing for homeless veterans. The program has achieved positive results. It is not, however, funded at a level sufficient to meet the need, as demonstrated in a recent GAO study. Congress should increase funding to $170 million for FY 2008 and $200 million for FY 2009.

More housing options – It is crucial that federal resources focus on veterans who are homeless now, and on those who are on the brink of falling into homelessness. At the same time, this problem requires a commitment that decent housing will be something that all veterans can count on, just as health care through the VA is something they can count on now. Access to permanent housing is consistently the number one service need identified by those concerned with veteran issues (VA staff, community providers, local government agencies, public officials, and former and currently homeless veterans themselves). Further, reports indicate that veterans returning from Iraq and Afghanistan are seeking help with housing sooner than past cohorts of veterans. Congress should consider options for providing comprehensive housing assistance to all veterans who need it.

Monitoring and managing progress – The VA must take the initiative to monitor the progress of communities across the country at ending homelessness among veterans. It has a data system that is capable of tracking use of the veterans' health care system by veterans who are homeless, which would allow it to target resources to those whose health is the worst. The issue must be regarded as a critical priority.

Homelessness Among Veterans by State

State	Homeless Veterans 2005	Homeless Veterans 2006	Total Veterans 2005	% of Veterans Who Are Homeless
AK	450	600	74,482	0.6
AL	816	824	403,950	0.2
AR	1,350	850	259,304	0.52
AZ	3,637	3,970	538,880	0.67
CA	49,546	49,724	2,193,336	2.26
CO	3,895	1,203	402,091	0.97
CT	4,675	5,000	261,294	1.79
DC	2,400	2,500	31,959	7.51
DE	500	550	79,151	0.63
FL	19,394	18,910	1,717,801	1.13
GA	5,715	3,297	731,466	0.78
HI	800	800	116,793	0.68
IA	600	547	249,911	0.24
ID	350	500	132,844	0.26
IL	2,243	2,197	853,338	0.26
IN	1,300	1,200	505,259	0.26
KS	620	601	238,506	0.26
KY	963	425	341,752	0.28
LA	10,897	9,950	331,822	3.28
MA	1,680	1,700	453,249	0.37
MD	3,100	3,300	480,654	0.64
ME	120	100	145,352	0.08
MI	3,110	3,513	782,823	0.4
MN	493	523	407,255	0.12
MO	4,800	3,325	226,398	2.12
MS	1,136	1,579	533,517	0.21
MT	247	232	100,637	0.25
NC	1,601	1,659	723,831	0.22
ND	1,000	1,000	58,479	1.71
NE	460	770	154,607	0.3
NH	350	257	129,603	0.27
NJ	6,500	6,500	546,437	1.19
NM	902	860	177,687	0.51
NV	4,600	4,715	233,633	1.97
NY	12,700	21,147	1,098,272	1.16
OH	1,698	1,710	982,418	0.17
OK	770	500	314,464	0.24
OR	6,940	5,891	350,365	1.98
PA	2,691	2,784	1,088,379	0.25
PR	75	80	135,988	0.06
RI	175	175	88,971	0.2
SC	1,375	1,375	400,152	0.34
SD	165	170	400,152	0.04
TN	2,515	2,844	509,881	0.49

State	Homeless Veterans 2005	Homeless Veterans 2006	Total Veterans 2005	% of Veterans Who Are Homeless
TX	15,434	15,967	1,612,948	0.96
UT	585	530	143,301	0.41
VA	911	870	757,224	0.12
VT	20	30	57,633	0.03
WA	6,567	6,800	628,595	1.04
WI	915	828	444,679	0.2
WV	357	347	175,697	0.2
WY	111	98	55,519	0.2

Senator SMITH. Steven, for the record, I have your testimony here. But can you list 3 or 4, maybe 5 features of the best practices models? What is working?

Mr. BERG. Right. I think——

Senator SMITH. It is affordable housing, access to health care, what else?

Mr. BERG. Yes.

I think that some of the key models—I mean, I mentioned permanent supportive housing, which is affordable housing combined with the health care, the case management, particularly treatment for mental health and substance abuse issues closely targeted to veterans with the worst health care needs and who have been on the street the longest, has very good results in terms of taking people who really are, you know, most people would have given up a long time ago, and getting them into housing. They tend to stay in the housing. They tend to get better, when they hadn't gotten better while they were living on the street.

Senator SMITH. So affordable and permanent housing.

Mr. BERG. Permanent. Yes.

Senator SMITH. Any other feature?

Mr. BERG. Other features that work well are the idea of sort of a rapid re-housing program, having people available who know the local rental market, who know landlords who are willing to rent to tenants who might not sort of on paper look like the best risks in the world, and who have sort of short-term flexible resources available to deal with things like security deposits, deal with things like a bad credit history.

These kind of programs have been very effective in a number of places and it is the kind of thing that, you know, if you had a care coordinator at the VA, that that kind of person could help make sure people have access to either as soon as they find out they are homeless or preferably before they ever become homeless but when they are experiencing a housing crisis.

Those are some of the real best practices——

Senator SMITH. You know, I was struck, Steve, that according to your testimony, 2 percent of all Oregon veterans are homeless?

Mr. BERG. Yes.

Senator SMITH. If this is accurate, Oregon appears to be fifth in the Nation for the percentage of veterans in a state who are homeless. That is pretty high.

Mr. BERG. It is pretty high. I mean, and——

Senator SMITH. We don't have any active duty military bases, so why Oregon?

Mr. BERG. Right.

Senator SMITH. Why Oregon?

Mr. BERG. Right.

Well, we are trying to figure—one of the reasons it is taking us so long to get this report out, as I was just speaking to someone else, is that we are trying to figure out what some of the factors are behind some of those differences.

Some of it is just some people do—I mean, as you probably know, the VA is a fairly decentralized agency. These numbers are all based on local VA counts. Each local VA does it a little differently so some of it is just counting.

But it is also the case we know that, for example, veterans in Oregon are more likely to have a higher housing cost burden. That we know based on census data that is done the same in every State. It is part of just a housing affordability issue that varies State to State.

Senator SMITH. Is that an unintended consequence of urban growth boundaries?

Mr. BERG. That is something you would know more about than I would.

Senator SMITH. I know I shouldn't get into that. But, I mean, don't they, as part of land use planning, require certain amounts of affordable housing to go in to deal with that issue?

Mr. BERG. That is a matter of State law.

I know Oregon has been a leader in that for a long time. But it is, I mean, it is also the case housing costs—there are a whole range of factors behind housing costs.

I think it is the case that Oregon has seen sort of rents grow faster than a lot of parts of the country just because of population changes. It is a good place to live and people want to live there.

It is supply and demand. There are a lot——

Senator SMITH. Well, it is strange to me that, without an active military base, which you would think would be something of a magnet to veterans who are, you know, when they go home, that the homelessness would correlate to where those exist. But Oregon is obviously an exception to that.

Mr. BERG. That is true. We are trying to get some answers to that. It is a range of different factors.

Senator SMITH. Well, when you get those answers, please share them with us.

Mr. BERG. Absolutely.

Senator SMITH. I am very interested.

Mr. BERG. Absolutely.

Senator SMITH. Thank you, Steve.

Fred Cowell.

STATEMENT OF FRED COWELL, ASSOCIATE DIRECTOR OF HEALTH POLICY, PARALYZED VETERANS OF AMERICA, WASHINGTON, DC

Mr. COWELL. Thank you, Mr. Chairman.

Before I begin my oral testimony, I would just like to take a second, with your indulgence, on behalf of the Paralyzed Veterans of America, I would like to express our sincere gratitude and profound respect that we have for Senator Dole for his service to our country, our Nation's veterans, and all Americans with disabilities.

Senator SMITH. Thank you.

Mr. COWELL. It was a real honor to be on the same panel with him today.

Mr. Chairman and members of the Committee, the Paralyzed Veterans of America is pleased to present its views concerning access to, and availability of, quality VA long-term care services for our Nation's veterans.

In the interest of time, PVA's oral testimony will briefly focus on five long-term care issues of importance to America's veterans.

More detailed information on these and additional topics is contained in our written testimony.

The long-term care needs of younger OIF-OEF veterans.

Mr. Chairman, PVA believes that age-appropriate VA institutional and non-institutional programming for younger OIF-OEF veterans must be a priority for VA and your Committee. New VA institutional and noninstitutional programs must come online and existing programs must be re-engineered to meet the various needs of a younger veteran population.

Changes to VA's noninstitutional long-term care programs will be required to assist younger veterans with catastrophic disabilities who need a wide range of support services, such as personal attendant services, programs to train attendants, family caregiver training, peer support programs, assistive technology, and hospital-based home care teams which are trained to treat and monitor specific disabilities.

VA's institutional programs must change direction, as well. Nursing home services created to meet the needs of aging veterans will not serve younger veterans well. VA must make every effort to create an environment that recognizes younger veterans have different needs.

These younger veterans must be surrounded by forward-thinking administrators and staff that can adapt and design programs to meet youthful needs and interests. For example, therapy programs, living units, meals, recreational programs and policies must be changed to accommodate younger veterans entering the VA long-term care system.

Veterans with spinal cord injury or disease.

PVA is concerned that many aging veterans with spinal injury and disease are not receiving the specialized long-term institutional care they require.

Today, VA's SCI-D long-term care capacity cannot meet current or future demand. Waiting lists exist at the 4 existing designated SCI-D long-term care facilities, which only have a total of 125 beds nationwide and geographic accessibility is a major problem because none of these 4 existing facilities are located west of the Mississippi River.

VA data projects an SCI-D long-term care bed gap of 705 beds in 2012 and a larger bed gap of 1,358 for the year 2022.

Currently, VA's construction budget submission for 2007 includes provisions for new VA nursing homes in Denver, CO, Las Vegas, NV, and Des Moines, IA. A 15 percent bed allocation at each of these new facilities would be a good first step toward closing the looming long-term care bed gap for veterans with SCI-D.

Mr. Chairman, PVA needs the Committee's support to ensure that new VA nursing home construction planning includes a 15 percent bed allocation for SCD-D residents.

Waiting lists for VA noninstitutional long-term care.

PVA is concerned about reports from our members and from VA health care professionals that long waiting lists exist for aging veterans who need access to certain segments of VA's noninstitutional care program list. PVA calls upon Congress to review the demand, availability, and associated waiting times for care in VA's home-

based primary care program. Recommendations for appropriate funding would then depend on the outcome of the program review.

Assisted living.

VA conducted an assisted living pilot project mandated by the Millennium Benefits and Health Care Act between January of 2003 and June 2004. VA's subsequent report on the pilot project was forwarded to Congress by then-VA Secretary Principi in November 2004.

The report revealed a number of positive findings, including information on cost, quality of care, and veteran satisfaction.

The authors of the independent budget have called on VA's assisted living project to be replicated in at least three VA networks with high concentrations of elderly veterans to determine if the findings of the original pilot are valid.

Finally, VA's strategic plan for long-term care.

Mr. Chairman, Congress recently passed a comprehensive package of veteran proposals which became Public Law 109–461. Section 206 of the law mandated the secretary of Veterans Affairs to publish a strategic plan for the provision of long-term care within 180 days of enactment. To date, VA has not complied with the law.

The aging of the veteran population and the subsequent increasing demand for long-term care services has been well documented for over a decade by both VA and the General Accountability Office.

Mr. Chairman, PVA calls upon members of this Committee to investigate VA's delay in publishing its urgently needed strategic plan for long-term care as soon as possible.

Mr. Chairman, that concludes my remarks. I will be happy to answer any questions.

[The prepared statement of Mr. Cowell follows:]

STATEMENT OF FRED COWELL

SENIOR ASSOCIATE DIRECTOR, HEALTH ANALYSIS

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

CONCERNING

THE DEPARTMENT OF VETERANS AFFAIRS

LONG TERM CARE PROGRAMS

OCTOBER 3, 2007

Mr. Chairman and members of the Committee, the Paralyzed Veterans of America (PVA) is pleased to present its views concerning access to, and the availability of, quality long-term care services received from the Department of Veterans Affairs by our nation's veterans.

The Committee's interest in long-term care services provided by the Department of Veterans Affairs (VA) is both timely and important. VA estimates the total veteran population to be 23.4 million. The median age of all living veterans today is 60 years. Veterans under 45 constitute 20.2 percent of the total veteran population; veterans 45 to 64 years old, 41.4 percent; veterans 65 to 84 years old 33.9 percent; and veterans 85 and older, 4.5 percent. The number of veterans 85 and older is nearly 1,075, 000. BY 2011, the number of veterans 85 and older will grow to 1.3 million. This large increase in the oldest segment of the veteran population has had, and will continue to have, significant ramifications for the demand for VA health care services, particularly in the areas of long-term care and home-based care.

Today, PVA's testimony is focused in three areas. First, we would like to draw your attention to the long-term care needs of America's returning heroes from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Thousands of these brave young men and women are facing life long challenges because of the severity of their wounds and will depend on VA non-institutional and institutional long-term care programs for much, if not all, of their lives. Second, our testimony will address the unique long-term care needs of veterans with spinal cord injury or disease (SCI/D) and the looming gap in providing specialized care for these men and women. Finally, we will address a number of other long-term care issues affecting America's veterans and how a VA long-term care strategic plan can make a positive difference in their care.

Currently, VA provides an array of non-institutional (home and community-based) long-term care programs designed to support veterans in their own communities while living in their own homes. Additionally, VA provides institutional (nursing home) care in three venues to eligible veterans and others as resources permit. VA provides nursing home care in VA operated nursing homes, under contract with private community providers, and in State Veterans Homes.

Mr. Chairman, PVA is a long time supporter of VA's non-institutional long-term care programs because they have the capacity, in many cases, to enable newly injured young veterans and aging veterans with catastrophic disabilities to live independent and productive lives in their own communities. PVA has always believed that nursing home care must always be the choice of last resort and that no veteran should be forced into a nursing home just because of his/her injury or disease.

However, many young and aging veterans with catastrophic disabilities live on a slippery slope even with the support of VA's non-institutional long-term care services. For example: slight changes in function, a serious medical episode related to a secondary condition, or the loss of a caregiver can plunge even a young veteran with a catastrophic disability down that slippery slope from independent living at home into institutional nursing home care.

Therefore, Mr. Chairman, it is imperative that VA continue to provide quality nursing home care not only for aging veterans but for those younger catastrophically injured veterans who cannot benefit from non-institutional long-term care services.

Young OIF/OEF Veterans

Mr. Chairman, PVA believes that the development of age-appropriate VA non-institutional and institutional long-term care programming for young OIF/OEF veterans must be a priority for VA and your Committee. New VA non-institutional and institutional long-term care programs must come on line and existing programs must be re-engineered to meet the various needs of a younger veteran population.

VA's non-institutional long-term care programs will require innovation to assist younger veterans with catastrophic disabilities. These veterans will need a wide range of support services such as: personal attendant services, programs to train attendants, peer support programs, family caregiver training , assistive technology, hospital-based home care teams that are trained to treat and monitor specific disabilities, and accessible transportation services.

These younger veterans need expedited access to VA benefits such as VA's Home Improvement/Structural Alteration (HISA) grant, and VA's adaptive housing and auto programs so they can leave institutional settings and go home as soon as possible. PVA also believes that VA's long-term care programs must be linked to VA's new poly-trauma centers so that younger veterans can receive injury specific annual medical evaluations and continued access to specialized rehabilitation, if required, following initial hospital discharge.

VA's institutional nursing home care programs must change direction as well. Nursing home services created to meet the needs of aging veterans will not serve younger veterans well. As pointed out in The *Independent Budget,* VA's Geriatric and Extended Care staff must make every effort to create an environment for younger veterans that recognizes they have different needs. Younger catastrophically injured veterans must be surrounded by forward-thinking administrators and staff that can adapt to youthful needs and interests. The entire nursing home culture must be changed for these individuals, not just modified. For example, therapy programs, living units, meals, recreation programs, and policy must be changed to accommodate younger veterans entering the VA long-term care system.

Veterans with Spinal Cord Injury or Disease (SCI/D)

PVA is concerned that many veterans with spinal cord injury and disease are not receiving the specialized long-term care they require. VA has reported that over 900 veterans with SCI/D are receiving long-term care outside of VA's four SCI/D designated long-term care facilities. However, VA cannot report where these veterans are located or if their need for specialized medical care is being coordinated with area VA SCI/D centers.

Today's VA SCI/D long-term care capacity cannot meet current or future demand for these specialized services. Waiting lists exist at the four designated SCI/D facilities. **Currently, VA only operates 125 staffed long-term care (nursing home) beds for veterans with SCI/D.** These facilities are located at: Brockton, Massachusetts (30 beds); Castle Point, New York (15 beds); Hampton, Virginia (50 beds); and 30 beds at the Hines Residential Care Facility in Chicago, Illinois. **Geographic accessibility is a major problem because none of these facilities are located west of the Mississippi River.** New designated VA SCI/D long-term care facilities must be strategically located to achieve a national geographic balance to long-term care to meet the needs of veterans with SCI/D that do not live on the East coast of the United States.

VA's own Capital Asset Realignment for Enhanced Services (CARES) data for SCI/D long-term care reveals a looming gap in long-term care beds to meet future demand. VA data projects an SCI/D long-term care bed gap of 705 beds in 2012 and a larger bed gap of 1,358 for the year 2022. VA's proposed CARES SCI/D long-term care projects would add needed capacity (100 beds) but are very slow to come on line. CARES proposes adding 30 SCI/D LTC beds at Tampa, Florida; 20 beds at Cleveland, Ohio; 20 beds at Memphis, Tennessee; and 30 beds at Long Beach, California. The CARES Tampa project is currently under construction but is not scheduled to open for another two years and the Cleveland project is currently in the design phase but remains years from completion. The Memphis and Long Beach projects have not even entered the planning stage at this time.

Methods for closing the VA SCI/D long-term care bed gap and resolving the geographic access service issue are part of the same problem for PVA. VA's Construction Budget for 2008 includes plans for new 120 bed VA nursing homes to be located in Las Vegas, Nevada and at the new medical center campus in Denver, Colorado. Also, VA has announced construction planning of a new 140 bed nursing home care unit in Des Moines, Iowa.

Mr. Chairman, PVA needs your support to ensure VA construction planning dedicates a percentage of beds at each new VA nursing home facility for veterans with SCI/D. PVA requests that Congress mandate that VA provide for a 15 percent bed set-aside in each new VA nursing home construction project to serve veterans with SCI/D and other catastrophic disabilities. These facilities will require some special architectural design improvements and trained staff to meet veteran need. However, much of the design work has already been accomplished by PVA and VA's Facility Management team. This Congressional action will help reduce the SCI/D bed-gap and help meet the current and future demand for long-term care. While a 15 percent bed allocation in new VA nursing home construction plus the proposed CARES LTC projects do not solve the looming bed gap problem in the short run it is a good first step and these additions will improve VA's SCI/D long-term care capacity in the western portion of the country.

Public Law 109-461 required VA to develop and publish a strategic plan for long-term care. PVA congratulates Congress on understanding the importance of this issue to ensure that America's catastrophically disabled and aging veteran population is well cared for. During the organization of VA's strategic long-term care plan, PVA calls on VA and Congress to pay careful attention to the institutional and non-institutional long-term care needs of veterans with SCI/D and other catastrophic disabilities. We request that PVA and other veteran service organizations have an opportunity to provide input and assist VA as it moves forward in the development of this important document.

Mr. Chairman, in the past and even today many veterans with spinal cord injury or disease and other catastrophic disabilities have been shunned from admittance to both VA and community nursing homes because of their high acuity needs. PVA believes that catastrophic disability must never be grounds to refuse admittance to VA or contract VA

long-term care services. PL 109-461 requires VA to include data on, "the provision of care for catastrophically disabled veterans; and the geographic distribution of catastrophically disabled veterans." This information is critical if VA's strategic plan is to adequately address the needs of this population.

VA's Nursing Home Capacity Mandate

Congress has mandated that VA maintain its nursing home average daily census (ADC) at the 1998 level of 13,391 but VA has not done so (Chart 1.). Instead, VA has been steadily shifting its institutional long-term care workload to State Veterans Homes and to contract community (private sector) providers (Chart 2.). According to the Government Accountability Office (GAO) (GAO Report # 06-333T), VA's overall nursing home workload for 2005 is split as follows: 52 percent State Veterans' Homes, 35 percent VA nursing homes, and 13 percent Contract Community nursing homes.

Chart 1. ADC for VA's Nursing Home Care Program

Year	Average Daily Census
1998	13,391
2004	12,354
2005	11,548
2006	11,434
Decrease 1998 – 2006	1,957

Chart 2. ADC Increases in VA's Contract Community Nursing Home Program and in the State Veterans Homes Program.

Contract Community Providers		**State Veterans Homes**	
Year	ADC	Year	ADC
2004	4,302	2004	17,328
2005	4,254	2005	17,794
2006	4,395	2006	17,747
Increase 2004-2006	**93**	Increase 2004-2006	**419**

Despite clear VA data that highlights the aging of the veteran population and an associated increasing demand for services, the ADC for VA nursing home care continues to trend downward. This is especially concerning because of the nation's large elderly population. According to VA data, (VA Strategic Plan FY 2006-2011) veterans 85 and older represent 4.5 percent of the total veteran population and VA projects that by 2011, the number of veterans age 85 and older will grow to more than 1.3 million. Veterans 65 to 84 years old represent 33.9 of the total veteran population; and veterans 45 to 64 years old represent 41.4 percent of the total veteran population. VA goes on to say that the median age of all living veterans today is 60 years old.

Mr. Chairman, PVA calls upon Congress to enforce and maintain the nursing home capacity mandate as outlined in the Millennium Benefits and Health Care Act. This capacity mandate sets a minimum floor of VA nursing home care at a critical time in our nation's history. This is a critical point in time because members of America's "greatest generation" our World War II veterans, desperately require quality nursing home care and because of the demand being created today as America's newest and most severely wounded heroes are returning from Iraq and Afghanistan.

State Veterans Home's Life-Safety Issues

PVA's testimony has pointed out that State Veterans' Homes have been shouldering an increasing share of VA's nursing home care workload over the last few years. VA has found it cost-effective to utilize State Veterans' Homes because the expense of this care is shared by both VA and the States. However, as increased numbers of veterans utilize the State Veterans' Homes program VA must accept increased responsibility for the up-keep of these facilities. Congress and VA must move quickly to provide needed funding to address life-safety construction issues that exist in these State Veterans' Homes. The *Independent Budget* supports an appropriation that provides $150 million to correct these facility deficiencies. While $150 million does not meet the $250 million overall cost needed to correct the entire priority-1 life-safety problem list, it is a good first step toward bringing these facilities into a safer condition.

Waiting Lists for VA Non-Institutional Long-Term Care

PVA is concerned about reports from our members and from VA officials that long waiting lists exist for aging veterans who need access to VA's non-institutional long-term care programs. Many of VA's Home-Based Primary Care programs have extended waiting lists for veterans who need the range of services associated with that program. Some waiting times are approaching almost a year before a veteran can enter the program and receive nursing visits at home. PVA also understands that VA's Adult Day Care Program, its Contract Adult Day Care Program, and it Homemaker/Home Health Aide Services programs also have extended waiting periods for admission.

These are the types of VA non-institutional long-term care programs that can prevent, in many cases, or delay more expensive and more restrictive nursing home care. Mr. Chairman, in plain economical terms the return on investment related to VA's non-institutional long-term care programs is overwhelmingly positive. Additionally, these programs are exactly what veterans want. America's aging veterans want to remain in their own homes and communities as long as possible. We call on your Committee to review the demand, availability and associated waiting lists for VA non-institutional long-term care programs and to provide the resources necessary to enable VA to expand these valuable programs that are favored by veterans.

VA's Care Coordination Program

VA's Care Coordination/Home Telehealth (CCHT) Program provides a range of services designed to help older veterans with chronic conditions such as diabetes, heart failure, and Post Traumatic Stress Disorder to remain in their own homes and receive non-institutional VA care services.

CCHT is a relatively new VA program that resulted from a VA pilot program in VISN 8 between 2000 and 2003. VA implemented its national care coordination program in July of 2003. Each veteran patient being supported by CCHT has a care coordinator who is usually a nurse practitioner, a registered nurse or a social worker. In some complex cases physicians coordinate the patients care.

PVA believes that care coordination is an important element in VA's medical service toolkit that can help reduce expensive episodes of inpatient hospital care and enable newly injured younger veterans and aging veterans with chronic conditions to remain in their homes longer than ever before. This valuable VA program's reach should be extended and closely linked to VA's Geriatric and Extended Care Program in order to serve additional chronic care patients and bring the advantages of modern medical technology to their doorstep. VA's strategic plan for long-term care should find ways to integrate its CCHT program into a comprehensive mix of services for younger OIF/OEF newly injured veterans and for older veterans with catastrophic disabilities as well.

Assisted Living

Assisted Living has proven itself to be a desired alternative to nursing home care for many Americans. Consequently, Congress mandated that VA, via the Millennium Benefits and Health Care Act, conduct a pilot project to provide assisted living services for veterans. VA did so between January of 2003 and June of 2004. The pilot project was conducted in VISN-20 and included seven medical centers in four states. VA's subsequent report on the project was forwarded to Congress by Secretary Principi in November of 2004. The report revealed a number of positive findings including information on cost, quality of care and veteran satisfaction.

The *Independent Budget* has called for the Assisted Living Pilot Project to be replicated in at least three VISN's with high concentrations of elderly veterans. VA's strategic long-term care plan must explore all available programs and services that provide quality community-based long-term care. An extension of VA's original assisted living project is one of those opportunities.

Conclusion

Mr. Chairman, PVA believes that one of the most positive moves by Congress in recent years has been to require VA to develop a strategic long-term care plan. However, for this new VA plan to be a success it must have positive and achievable recommendations and provisions for accountability. Performance measures, program evaluation, wait times, patient satisfaction surveys, and outcome measures are all elements that must be used in the development, monitoring and periodic revision of a strategic plan for long-term care. PVA believes that VA' strategic plan for long-term care must not just be a static, one time, report but one that is a living document that receives constant review and up/dates to be capable of responding to changing veteran needs and innovations in long-term care services.

PVA supports a VA strategic long-term care plan that monitors the appropriate balance between non-institutional and institutional long term care programs. When periods of projected peak program demand exist, VA and Congress must be flexible enough to concentrate resources to meet that demand. For example, the growing number of veterans 85 and older is well documented and their increased need for nursing home care must force VA to maintain adequate levels of nursing home bed space to accommodate that need. Correspondingly, when veteran demographics and demand shift, resources should follow demand and flow to alternative services.

PVA believes that VA's strategic plan will enable Congress to make better informed decisions regarding the provision of adequate financial resources to support VA care. Additionally, the strategic plan will assist VA's planning and monitoring efforts to ensure appropriate programming, system-wide availability and quality of services. We hope that the Senate Special Committee will encourage VA to quickly develop and implement a strategic plan for VA long-term care that meets the needs of America's veterans.

Mr. Chairman and members of the Committee this concludes my written remarks.

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As Senior Associate Director of the Health Analysis Program, Fred is responsible to review the programs and services of the Veterans Health Administration (VHA) and make appropriate recommendations to PVA's leadership that will improve VA's health care service delivery system. These service improvement recommendations are not limited to VA's Spinal Cord Injury Program but include the full continuum of VA health and long-term care services.

Fred is also responsible for monitoring changes to the Medicare and Medicaid programs. His duties include filing comments to the Centers for Medicare and Medicaid Services (CMS) regarding Federal Rule changes that effect both Medicare and Medicaid services. Fred is currently representing PVA on CMS's Medicare Education Coordinating Committee and has been asked to serve on a Medicare Advisory Committee representing persons with disabilities.

Fred has held a number of important positions at PVA including: PVA's Executive Director; PVA's National Advocacy Director; Staff Director, Health Policy Department; and currently as a Health Policy Analyst for the Government Relations Department.

Fred has authored or co-authored a number of Health Policy documents used to educate PVA leadership, its members and the general public regarding issues important to PVA. Examples include: PVA Principles for Managed Care; Managing Personal Assistants: A Consumer Guide; Selecting an Assisted Living Provider; PVA Guide to Federal Health Programs. Fred has also collaborated on a number of PVA membership surveys designed to gather important health utilization information to help PVA understand the frequency and type of health services needed by its members.

Fred is a graduate of Southern Illinois University with degrees in Business and Anthropology. He is a U.S. Navy veteran and served two tours of duty in Vietnam assigned to the Naval Security Group.

Fred, a PVA member, received a spinal cord injury, as a result of an automobile accident in 1975, and graduated VA's spinal cord rehabilitation program at the VA Jefferson Barracks Spinal Cord Injury Center in St. Louis, Missouri.

Senator SMITH. Thank you very much, Fred.

In your testimony you mentioned that there are many veterans who are denied admission or care through the VA or through community nursing homes due to high acuity needs, spinal cord injuries specifically. What happens to them?

Mr. COWELL. Well, many times they are not able to get the proper care they need. They are relegated to stay at home with caregivers that are also aging.

This is probably the first time in our Nation's history that we have a generation of aging veterans that have survived with spinal cord injury. So they heavily depend on those specialized services the VA can provide.

VA currently only has a current capacity of 125 beds for trained staff to meet the needs of this aging population.

These veterans are staying home longer than they need to be or should be. They are not receiving the proper care they do. Many of them wind up in VA acute care hospitals for long periods of time because there are no nursing homes that can treat them.

Senator SMITH. Obviously, the point you are making is, in previous wars, those with these kinds of injuries would simply die.

Mr. COWELL. That is right.

Senator SMITH. Clearly, they are performing miracles on the battlefield now. They are not dying. But I think you are highlighting a real shortcoming in our VA capacity.

Mr. COWELL. Yes, sir. It is absolutely true.

Senator SMITH. In a nutshell, that is the problem. So we have got to ramp that up.

Is this something you see a lot of or a growing amount of because of the survivability rates now?

Mr. COWELL. It is an increasing issue for PVA.

We are a member organization with an aging membership. More and more of our members are in their sixties, seventies, and some are reaching their eighties. They are just simply not able to live independent lives any longer.

Senator SMITH. Yes.

Mr. COWELL. Even with the advent of many breakthrough programs in a noninstitutional care, they are designed to keep veterans at home as long as possible, and we certainly support all of those programs. There is just an increasing demand.

VA's own data shows a lack of capacity to treat these aging veterans. There really needs to be more work done in this area.

We have brought this attention to the Strategic Group of Spinal Cord Injury in the VA. We are trying to work to get new long-term care beds created that can meet the needs of this population. It has just been an uphill battle, to be quite frank.

Senator SMITH. So if I understand your other point about—I think you were speaking of authorizations and appropriations for new veterans nursing homes, you are saying they should have a 15 percent bed requirement——

Mr. COWELL. Yes, sir.

Senator SMITH [continuing]. To deal with high acuity cases.

Mr. COWELL. Most of these new facilities that are in VA's 2007 construction budget were located west of the Mississippi. Currently, the 4 facilities the VA has for our members today are all

on the East Coast. There is nothing west of the Mississippi for this membership.

So they are relegated to nursing homes, community nursing homes, state veterans' homes, if they can get in. They don't have the trained staff to meet their needs. So it is a major problem.

Senator SMITH. Is 15 percent the right percentage, or is it——

Mr. COWELL. We would be happy to talk about that with VA.

When we look at only 125 beds being available nationwide, we think 15 percent is a good first step. We could step back from these original facilities, these new proposed facilities and see how that is working and try to get a handle on, "Is it meeting the demand or is there a greater need for a higher percentage?" Senator Smith. Thank you very much, Fred.

Mr. COWELL. Absolutely.

Senator SMITH. Dr. Kaplan, thank you for your patience.

STATEMENT OF MARK S. KAPLAN, PROFESSOR OF COMMUNITY HEALTH, PORTLAND STATE UNIVERSITY, PORTLAND, OR

Dr. KAPLAN. Thank you.

Good afternoon, Mr. Chairman. I am Mark Kaplan, professor of community health at Portland State University.

I want to thank you and the Committee for the invitation to testify before this Committee on this critical public health issue affecting the aging veteran population.

I should note, interms of the demographics that today approximately 70 percent of older males are veterans.

I applaud the Committee for embracing the critical issue of veterans' mental health and particularly the emphasis on suicide risk and prevention.

I should point out here that I have been an active suicide researcher since 1992. Most of my work has focused on late life suicide. I am an elected member of the American Association of Suicidology Council of Delegates, as well as a member of SPAN USA National Scientific Advisory Council.

Before I move on to my presentation, let me just take this opportunity to thank you, Senator Smith, for your leadership on these important issues.

Senator SMITH. Oh, you are welcome.

Dr. KAPLAN. As you know, Mr. Chairman, suicide remains a serious public health problem. Reducing suicide is a national imperative.

To the best of our knowledge, more than 30,000 people in the United States take their lives every year. Approximately 1 million make an attempt on their lives, as well. Veterans are particularly vulnerable to suicide compared to their civilian counterparts.

So what I want to do in my testimony today is review some of the research that I have done with my colleagues back in Oregon and highlight some of the key findings and then end with some policy-oriented recommendations for the Committee.

To start, in Oregon veterans are more than twice as likely to die of suicide than their nonveteran peers. The age-adjusted suicide rates among male veterans was 46.05 per 100,000 and for non-

veteran males, the rate was 22.09 per 100,000. So the rate is twice as high as the nonveteran population.

Senator SMITH. Mark, can I stop you there——

Dr. KAPLAN. Sure.

Senator SMITH [continuing]. Can I ask you this question? It sort of relates to what I was asking Steven.

Dr. KAPLAN. Of course.

Senator SMITH. Because they are veterans and they have access to other resources, why is the suicide rate higher?

Dr. KAPLAN. Well, I don't think anyone really has an answer on that. As we noted in the publication that you alluded to, that the risk of suicide was twice as high as their non veteran peers.

We did a slightly different analysis where we looked at vets who use and don't use VA facilities. There is not a whole lot of information out there on the vets who are not part of the VA system.

According to a veteran survey done in 2001, only about one out of every five uses the VA. Most don't. So there is a gap in our knowledge in our understanding of why veterans might be at risk.

But the fact is that independent of the era they served in, veteran status alone is an independent predictor of suicide.

Senator SMITH. Does it relate to combat experience?

Dr. KAPLAN. We don't really know. It might relate to combat. In studies that have been done within the VA system, obviously combat experience is a key factor. PTSD, depression, and a whole host of other forms of psychiatric morbidity have been linked to suicidal behavior.

Senator SMITH. Does combat experience increase the likelihood of substance abuse, alcohol——

Dr. KAPLAN. The two are correlated.

Senator SMITH. They are correlated. OK.

Dr. KAPLAN. Absolutely; substance abuse and co-morbid conditions. Rarely do you find a case of somebody simply having a substance abuse but it often goes hand in hand with a variety of other psychiatric conditions.

Senator SMITH. It may or may not be triggered—that substance abuse may or may not be triggered by combat experience, but combat experience does seem to have some linkage——

Dr. KAPLAN. Exactly.

Senator SMITH [continuing]. Then, of course, substance abuse leads to suicide.

Dr. KAPLAN. Exactly.

Well, we already heard about the risk for homelessness that is a big factor. So people who experience downward mobility, unemployment, a breakup in their relationships, and a whole host of other circumstances that may trigger suicidal behavior. So it is a very complex problem—remarkably, we know very little.

Senator SMITH. Yes. Sorry for the interruption——

Dr. KAPLAN. That is fine.

Senator SMITH [continuing]. But I am trying to learn from you.

Dr. KAPLAN. That is fine.

Veterans tend to have—along with what has already been said—veterans tend to have more disabilities that limit their ability to function, which in turn may lead to social isolation and depression. Disabilities that limit functioning are an important suicide risk fac-

tor among veterans compared to nonveterans in the general population.

Again, referring to the study that we published over the summer, one of the key predictors of suicide over a 12-year period was disability. That is, in male veterans who reported at baseline some form of disability were at an elevated risk of completing suicide.

Veterans are also more likely than their civilian counterparts to use firearms as their primary mode of suicide. This is also an important factor. I will say a little bit more about this. I will also address this in my recommendations.

The National Violent Death Reporting System data reveals that the proportion of suicides involving firearms was significantly higher among veterans than their nonveteran peers. This is remarkable.

Seventy-two percent of veterans use guns to complete suicide, while their nonveteran peers, the percentage there was only 56 percent. Equally ominous, female veteran suicide decedents were also significantly more likely than other nonveteran counterparts to use guns. Here again, female veterans, nearly 50 percent of them used guns to complete suicide, while their nonveteran counterparts, the rate there was only 33 percent.

I should note here, and this might surprise you, we reported some years ago that the most common method used among elderly women happens to be firearms, 40 percent. More elderly women use guns than poison.

Senator SMITH. Is it generational or what is——

Dr. KAPLAN. Well, it might—I have often looked at that as sort of the masculinization of suicidal behavior. We are seeing that crossing generations. It is becoming the most common method across ages. But remarkably, we found that to be the case among elderly women.

Male and female veteran suicide decedents are respectively 47 percent and 76 percent more likely than their nonveteran peers to use guns. These statistics are important because what we did, we tried to statistically control for confounding factors. So, again, it seems to be a little higher for females.

Similarly, older male and female veterans were also significantly more likely than their younger veterans to use firearms. This is based on the National Violent Death Reporting System.

So we did some analysis where we tried to address some factors and found that the older vets, male and female, were more likely to use guns than their younger counterparts.

So, again, one can look at guns as not just a method of completing suicide, but it also sends a message that there is a determination to end their lives and that there is very little that one can do. That window of opportunity to intervene, to prevent, is almost shut.

So we need to begin thinking about ways of intervening with people who are going to attempt suicide with a gun as opposed to what some might characterize as a cry for help with some other less lethal methods.

The rate of lethality is extremely high with guns. Ninety-five percent plus, maybe close to 99 percent.

I would like to conclude my testimony today with several policy-oriented recommendations. The first one is—and I think this touches on what some of the other witnesses have said today—No. 1, clinical and community interventions directed toward patients in both VA and non-VA care facilities will be needed. I want to underscore the word both here because I think we know a lot more about those users of VA than we do about the nonusers.

Second, Congress should direct the Department of Veterans Affairs to provide reimbursement for primary care depression detection and management for veterans unable to be served within the Veterans Affairs system for a variety of reasons that we have discussed today, including geographic issues.

I remember being on call-in shows during the summer in response to my piece. Many veterans called in and were—very dissatisfied with the quality of care in the VA system. Many thought of it as just an extension of the military and did not feel very comfortable in that culture.

So there were a lot of reasons, but I heard that a lot. As I said, there is a survey of veterans done in 2001 that showed that only one out of every five was using the VA. Others were not for many different reasons.

Another recommendation is training primary care physicians in suicide assessment, management and referral within the VA and outside.

An interesting statistic here is that there has been a declining rate of primary care physicians in this country. Unlike other advanced industrialized countries, we are seeing a rise in specialists and a decline in primary care physicians.

Senator SMITH. Isn't that about compensation and all of that?

Dr. KAPLAN. Excuse me? Compensation. Right. Right. Absolutely.

I spent some time in Canada as a Fulbright Scholar a few years ago. I studied the Canadian public health system. But what impressed me was the fact that over 50 percent of their physicians are primary care providers.

Senator SMITH. When you go to medical school—and I am not a medical doctor—but is there a real hierarchy of specialties and the social pressure to go into one of those as opposed to somehow a primary physician being a lesser professional?

Dr. KAPLAN. I am not a physician, but I have studied physicians. I must say that, at least anecdotally, you do hear that.

Senator SMITH. Yes. That is what I figured. That is how it is in——

Dr. KAPLAN. That would be an interesting project, actually. Medical sociologists do that kind of thing.

Another recommendation is that there is a critical need to collect more comprehensive epidemiological information on the proximal and distal circumstances surrounding suicide morbidity and mortality.

Here I want to make the point that I think we have looked at suicide in very narrow ways. We tend to focus on the immediate risk factors. But sometimes these are more distal, both in time and in space, such as homelessness.

I mean, I am listening here and I am thinking we need to develop a more holistic, more proactive approach to suicide preven-

tion, a more community-oriented approach as opposed to the reactive.

Quite often the system is geared up to respond to people who call in, for instance. An interesting side note here is that most elderly people who are suicidal don't call up, do not use crisis lines.

Another recommendation is that currently there are only funds to operate the National Violent Death Reporting System, run by the Centers for Disease Control, in 17 states. This is important in terms of developing a better database.

At least $20 million is required to fully implement and maintain the NVDRS in all 50 states. It is now running in just a handful and, as I said, in 17 states. Oregon happens to be one of those.

However, congressional funding has remained flat at about $3.3 million. So there is a real need to increase that budget, as I see it.

Senator SMITH. We are going to do that.

Dr. KAPLAN. Thank you.

Another recommendation: Firearms are responsible for significant suicide mortality in the older veteran population. Many studies offer evidence linking accessibility of firearms to suicide with guns.

More research is needed to study the interaction between firearm usage and suicidal behavior in the older adult population. We know so little about that.

I had this conversation earlier today. Quite often we refer to it as suicide, but in many cases with older adults, 80 percent of older men, men over the age of 65, white men in particular use guns to complete suicide. The firearm issue, and I know it is a highly charged question, but it is the elephant in the room when we talk about reducing suicide in the U.S.

Senator SMITH. It is actually something that, while I haven't seen legislation, it is one of the first issues after Virginia Tech that actually has gotten the NRA and gun opponents or mental health advocates actually talking constructively because I think even the gun advocates——

Dr. KAPLAN. Right.

Senator SMITH [continuing]. NRA and others——

Dr. KAPLAN. Right.

Senator SMITH [continuing]. Understand that gun ownership comes with gun responsibility. When people have diminished capacity, there needs to be some kind of a standard whereby we help them by removing guns from their proximity.

Dr. KAPLAN. One additional recommendation related to that is that unfortunately for too long we have looked at the gun issue, gun violence as a criminal justice, as opposed to a public health problem.

Senator SMITH. Yes.

Dr. KAPLAN. I think we need a paradigm shift in that regard.

A couple of other points that I just want to run through quickly.

I would like to see a congressional mandate for studies on the role of firearms in suicide specifically. Funding should be increased at the Centers for Disease Control and Prevention and other Federal agencies, such as NIMH, for research involving this type of firearm violence.

Health care providers—another recommendation—need to be more attentive to the critical role that firearms play in suicidal behavior among veterans. Many physicians find it difficult to ask patients directly about suicide, fearing that they might prompt a case of suicide.

Some years ago, my colleagues and I studied primary care physicians and found that only half of primary care physicians who identified an elderly patient as suicidal would inquire about their access to firearms. However, 70 percent asked about their misuse of medications.

So there is an unwillingness or reluctance to probe with patients who are at risk about their access to guns.

Another point: It is very important for medical providers to ask people if they have been in the military and then screen for health problems, mental health issues, and suicide in this population. This relates to this question of veterans who are not using the VA.

There is also a need—and this is important—to incorporate more geriatric and gender-specific content into the programs in the VA. By that I mean, quite often we don't—when we look at suicide prevention programs, we haven't incorporated male-specific content, even though most individuals who complete suicide are males, particularly older males.

Finally, according to the American Psychiatric Association, men in psychological distress face appreciable stigma and barriers and are less likely to seek help than are equally distressed women.

Thank you for the opportunity to testify before you today. I would be happy to respond to any questions you may have and look forward to working with you in the future.

[The prepared statement of Mr. Kaplan follows:]

Testimony of

Mark S. Kaplan, DrPH

Professor of Community Health

Portland State University

Portland, Oregon

Before the Senate Special Committee on Aging

Herb Kohl, Chair

Gordon H. Smith, Ranking Member

October 3, 2007

Washington, DC

Good morning Mr. Chairman and distinguished members of the Special Committee on Aging. My name is Mark S. Kaplan and I am a professor of community health at Portland State University. Thank you for the invitation to testify before this Committee on this critical public health issue affecting the aging veteran population. I applaud the Committee for embracing the critical issue of veterans' mental health and particularly the emphasis on suicide risk and prevention. As an active suicide researcher since 1992, I have focused on population-wide data to understand suicide risk factors among senior populations. the National Institute of Mental Health, the National Institute on Aging, and private foundations have supported my research.

As you know Mr. Chairman, suicide remains a serious public health problem and reducing suicide is a national imperative. To the best of our knowledge, more than 30,000 people take their lives every year (the real number is probably higher, some experts think as high as 100,000); and nearly 650,000 people are seen in emergency departments after they attempted suicide, according to the Institute of Medicine. Suicide is now the 11th leading cause of death (8th leading cause of death for males). Suicide disproportionately affects those aged 65 years and older (i.e., 12 percent of the population is over 65, but 18 percent of suicides are over 65). Four times as many men as women complete suicide; among older adults the proportion of men may be as high as 90 percent. Equally important, more people kill themselves (11.1 per 100,000) than are killed by others (5.9 per 100,000). In Oregon, suicide accounted for nearly 74 percent of violent deaths in 2005, according to the Oregon Violent Death Reporting System. Two-thirds of the individuals who completed suicide visited with a physician in the month preceding their death. Firearms are the most common method for completing

suicide among men and women (including those aged 65 and older) in the United States. Veterans are another important group that is particularly vulnerable to suicide compared to their civilian counterparts. In my testimony today, I will review our research on veteran suicide and end with some recommendations for the committee.

A recent editorial in The Oregonian newspaper asked: "What is it about these veterans among us that makes them twice as likely to take their lives?" According to state data for 2000-05, the age adjusted suicide rate among male veterans was 46.05 per 100,000 and for nonveteran males the rate was 22.09 per 100,000—meaning that veterans in Oregon were more than twice as likely to die by suicide than nonveterans. Veterans tend to have more disabilities that limit their ability to function, which can make them more isolated and depressed. Oregon veteran suicide decedents are more likely to use firearms. The story is similar at the national level.

The research literature shows that suicide risk factors common in Department of Veterans Affairs (VA) patients include gender (male), race (white), older age, diminished social support, substance dependence, homelessness, family history of suicide, combat-related trauma, medical and other psychiatric conditions (depression and post-traumatic stress disorder, in particular), marital disruption, gambling problems, lower military rank, prior attempts, and availability and knowledge of firearms. Although many of these studies provide important epidemiologic evidence regarding the circumstances and risk factors associated with suicidal behavior, the reliance on data obtained from VA clinical samples is particularly limiting.

According to the 2001 National Survey of Veterans, three out of every four veterans do not receive health care through VA facilities. Consequently, little is known

about suicide risk factors among veterans outside the VA system. Estimates of suicide risk may be inaccurate because the characteristics of veterans who use the VA system differ from those of the larger population of veterans. In light of the high incidence of physical and mental disabilities among veterans of Iraq and Afghanistan, it is important to examine the risk of suicide among veterans in the general population (i.e., VA users and non-users).

Our recent study published in the *Journal of Epidemiology & Community Health* (see Attachment 1) of more than 320,000 men nationwide showed that veterans are twice as likely as their civilian counterparts to complete suicide. The study was conducted in such a way that potential confounding variables were statistically controlled, leading to findings that are presented as objectively as possible. The purpose of the study was to examine the risk factors for suicide in the general population. In pursuing this goal, we used a large, nationally representative, prospective data set (653 deaths from suicide during the follow-up period) to: (1) assess the relative risk of suicide for male veterans in the general population, (2) compare male veteran suicide decedents with those who died of natural and external causes, and (3) examine the effects of baseline sociodemographic characteristics and health status on the subsequent risk of suicide.

My colleagues and I found that veterans made up 16% of the sample and comprised 31% of the suicides (according to the Oregon Violent Death Reporting System, of 543 suicide decedents in Oregon in 2005, 153, or 28 percent, were veterans). Our findings showed that over time veterans were twice as likely (Relative Risk = 2.13, $p < .05$) to die of suicide compared to male nonveterans in the general

population. The story is similar in Oregon where male veterans were more than twice as likely to kill themselves as males who never served in the military, according to the Oregon Department of Human Services. Following other studies, we also found that the risk of death from "natural" causes (diseases) and the risk of death from "external" causes (accidents and homicides) did not differ between the veterans and the non-veterans after adjusting for potential confounding factors.

Our results showed that disabilities that limit functioning are an important suicide risk factor among veterans compared to nonveterans in the general population. Health care providers are well positioned to intervene with at-risk veteran patients who have physical and/or mental disabilities. Primary care physicians, as gatekeepers and the de facto mental health care system, along with other specialists, have important roles to play in the assessment and management of depression and suicidality among veterans in clinical settings.

Another important characteristic of suicidal behavior among veterans is the higher probability that they use firearms as a primary mode of suicide. Our recent analysis of 2003-05 National Violent Death Reporting System (NVDRS) data reveals (see Attachment 2) that the proportion of suicides involving firearms was significantly higher among veterans than nonveterans (71.5 percent vs. 55.7 percent, $p < .01$). Equally important, female veteran suicide decedents were also significantly more likely than their non-veteran peers to use guns (48.6 percent vs. 32.9 percent, $p < .01$). Further analysis of the NVDRS shows that male and female veteran suicide decedents are, respectively, 47 and 76 percent more likely than their non-veteran counterparts to use firearms. Older male and female veterans were also significantly more likely than

younger veterans to use firearms. Data from the National Mortality Followback Survey (NMFS) also showed that veteran suicide decedents were 58 percent more likely than nonveterans to use firearms versus other suicide methods, after controlling for sex, age, marital status, race, education, region, metropolitan status, psychiatric visit in the last year of life, number of half-days in bed for illness or injury in the last year of life, and alcohol use. Furthermore, an analysis of veteran suicide decedents in the NMFS revealed that those who owned guns were 21.1 times more likely to use firearms than were those who did not own guns after adjusting for sex, age, marital status, race, education, region, and metropolitan status. Other data also show that current and former military personnel are more likely to own and use firearms to complete suicide. According to recent data from the Behavioral Risk Factor Surveillance System, veterans are substantially more likely to own guns than the nonveteran population (46 percent vs. 32 percent).

Although there is an ongoing debate among suicidologists and policymakers about the association between the availability of firearms and risk of suicide, the preponderance of the evidence suggests that a gun in the house, even if unloaded, increases the risk for suicide in adults. For example, case-control studies on the prevalence of guns and suicide risk have shown significant increases in suicide in homes with guns, even when adjustments were made for other factors, such as education, arrests, and drug abuse.

Overall recommendations

I would like to conclude my testimony with several recommendations for the Committee.

1. With the projected rise in functional impairments and psychiatric morbidity among

veterans from the conflicts in Afghanistan and Iraq, clinical and community interventions directed toward patients in both VA and non-VA health care facilities will be needed.

2. Congress should direct the Department of Veterans Affairs to provide reimbursement for primary care depression detection and management for veterans unable to be served within the Veterans Affairs system.
3. There is a critical need to collect more comprehensive epidemiological information on the proximal and distal circumstances surrounding suicide morbidity and mortality.
4. The National Violent Death Reporting System, run by the Centers for Disease Control and Prevention, tracks all circumstances surrounding a suicide – for example, whether someone who died by suicide was being treated for depression, had discussed their intention with someone else or was in a difficult life circumstance - so that a complete picture of the suicide is created. Currently, there are only funds to operate this tracking system in 17 states. At least $20 million is required to fully implement and maintain NVDRS in all 50 states; however, Congressional funding has remained flat at about $3.3 million.
5. Firearms are responsible for significant suicide mortality in the older veteran population. Many studies offer case-control and ecological evidence linking availability of firearms to suicide with guns. More research is needed to study the interaction between firearm usage and suicidal behavior in older adulthood. I would like to see a congressional mandate for studies on the role of firearms in suicide. Funding should be increased at the Centers for Disease Control and Prevention and

other federal agencies for research involving this type of firearm violence.

6. Because older veterans are familiar with and have greater access to firearms, health care providers need to be more attentive to the critical role that firearms play in suicidal behavior among veterans. Many doctors find it difficult to ask patients directly about suicide. My colleagues and I found that only half of the primary care physicians who identified patients as suicidal would inquire about their access to firearms.
7. It is very important for medical providers to ask people if they have been in the military and then screen for health problems, mental health issues and suicide in this population. There is also a need to incorporate more geriatric and gender-specific content into programs in the VA. According to the American Psychiatric Association, men in psychological distress face appreciable stigma and barriers and are less likely to seek help than are equally distressed women.

Thank you for the opportunity to testify before you. I would be happy to respond to any questions you may have and look forward to continuing to work with you to address veterans' mental health issues.

Appendix 1

RESEARCH REPORT

Suicide among male veterans: a prospective population-based study

Mark S Kaplan, Nathalie Huguet, Bentson H McFarland, Jason T Newsom

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Objectives: To assess the risk of mortality from suicide among male veteran participants in a large population-based health survey.

Design and setting: A prospective follow-up study in the US. Data were obtained from the US National Health Interview Surveys 1986–94 and linked to the Multiple Cause of Death file (1986–97) through the National Death Index.

Participants: The sample comprised 320 890 men, aged ≥18 years at baseline. The participants were followed up with respect to mortality for 12 years.

Results: Cox proportional hazards analysis showed that veterans who were white, those with ≥12 years of education and those with activity limitations (after adjusting for medical and psychiatric morbidity) were at a greater risk for completing suicide. Veterans were twice as likely (adjusted hazard ratio 2.04, 95% CI 1.10 to 3.80) to die of suicide compared with non-veterans in the general population. The risk of death from "natural" causes (diseases) and the risk of death from "external" causes did not differ between the veterans and the non-veterans. Interestingly, male veterans who were overweight had a significantly lower risk of completing suicide than those who were of normal weight.

Conclusions: Veterans in the general US population, whether or not they are affiliated with the Department of Veterans Affairs (VA), are at an increased risk of suicide. With a projected rise in the incidence of functional impairment and psychiatric morbidity among veterans of the conflicts in Afghanistan and Iraq, clinical and community interventions that are directed towards patients in both VA and non-VA healthcare facilities are needed

Suicide is a major cause of death in the US: approximately 30 000 people commit suicide every year, and nearly 650 000 people are seen in emergency departments after they have attempted suicide.[1] The suicide rate for men (17.6/100 000 in 2003) is four times that for women (4.3/100 000 in 2003).[2] Compared with the general adult population, US veterans may have an increased risk of suicide.[3] Studies conducted among US veterans have focused on samples derived from patient populations in the Department of Veterans Affairs (VA) system.[3 4 5 6 7] Risk factors for suicide common in patients of VA include the male sex, the elderly, those with diminished social support, medical and psychiatric conditions associated with suicide, and the availability and knowledge of firearms.[3] Equally important is that much of the research on suicide has been based on Vietnam-era veterans.[3 7 8] Many studies have also focused on suicidal ideation and attempts (morbidity) of veterans, rather than on mortality from suicide.[9 10]

The reliance on VA clinical samples is particularly limiting from a population-based perspective because three-quarters of veterans do not receive healthcare through VA facilities.[11] Consequently, little is known about the risk factors for suicide among veterans in the general US population. Estimates of the risk of suicide may be biased, to the extent that the characteristics of veterans who use the VA system differ from those of the larger population of veterans. In light of the high incidence of physical and mental disabilities among veterans of the conflicts in Iraq and Afghanistan,[13–15] it is important to examine the risk of suicide among veterans in the general population.

The purpose of this paper was to examine risk factors for suicide among veterans in the general population. In pursuing this goal, we used a large, nationally representative, prospective dataset (with 653 deaths from suicide during the follow-up period) to: (1) assess the relative risk of suicide for male veterans in the general population; (2) compare male veteran suicide decedents with those who died of natural and external causes; and (3) examine the effects of baseline sociodemographic circumstances and health status on the subsequent risk of suicide.

METHODS

Data sources

This study used data from the 1986–94 National Health Interview Survey (NHIS).[16] In the NHIS, which was conducted by the National Center for Health Statistics, people from the 50 states and the District of Columbia who were not institutionalized were sampled. NHIS uses a multistage probability sampling design. In the first stage, 198 primary sampling units were selected out of 1900 geographical areas (a county, a small group of contiguous counties, or a metropolitan statistical area). The second stage sampled households within each geographical area. Personal (face-to-face) household interviews were conducted, with response rates ranging from 94% to 98%.

The total sample of male veterans for the combined NHIS used in the analyses was 104 026. The demographic profile for the NHIS veteran sample closely matched that of other surveys, including the National Survey of Veterans[12] and the Current Population Survey for September 1989.[17]

The NHIS 1986–94 data file was linked to the Multiple Cause of Death file (1986–97) through the National Death Index (NDI).

Abbreviations: BMI, body mass index; HR, hazard ratio; ICD-9, International Classification of Diseases, ninth revision; NHIS, National Health Interview Survey; NHIS-NDI, National Health Interview Survey-National Death Index; VA, Veterans Affairs

NHIS participants aged ≥18 years were matched from the date of interview through December 1997 using 12 weighted criteria: social security number, first and last names, middle initial, race, sex, marital status, birth date (day, month and year), and state of birth and residence.[18] We used the recommended National Center for Health Statistics scoring cut-off, which corresponds to an estimate of 97% correctly classified deaths.[19]

Measures

The main outcome variable was death by suicide. Suicide cases were identified using the International classification of diseases, ninth revision, clinical modification (ICD-9 E950–E959). Respondents were identified as veterans if they answered in the affirmative to "did you ever serve on active duty in the Armed Forces of the United States?" Covariates, from the baseline interview, included age (18–44, 45–64, or ≥65 years), marital status (married, widow/divorced/separated, or single), living arrangement (alone or with others), race (white or non-white), education (<12 or ≥12 years), employment status (employed, unemployed, or not in the labour force—that is, retired, disabled or not looking for a job), region of residence (northeast, midwest, south, or west), place of residence (rural or urban), body mass index (BMI), number of chronic non-psychiatric medical conditions (ICD-9 001–289 and 320–779), number of psychiatric conditions (ICD-9 290–316), self-rated health, and activity limitations. In the analyses, a dichotomous variable was constructed from self-rated health, with "good health" (excellent, very good, or good) opposed to "poor health" (fair or poor). Following Adams *et al*,[20] activity limitations were ascertained with the question: "does any health problem now keep you from working at a job or business, keeping house, going to school, or something else?", with the reply options (1) "unable to perform major activities", (2) "limited in kind/amount of major activities", (3) "limited in other activities" and (4) "not limited". The first three categories were collapsed and henceforth are referred to as "limited".

Statistical analyses

The Cox proportional hazards model was used to estimate the relative hazard of suicide adjusting for demographic characteristics, socioeconomic factors and health. Cox regression coefficients (b) measure the impact of predictors on time to death.[21] All the variables were entered simultaneously into the Cox model. Time to death was measured from the month of the interview to the month of suicide completion. The reference group consisted of individuals who were censored at the time of their death due to other causes or, if they survived through the entire period, in December 1997.

In addition, competing risk analyses were performed to compare the relative risk of suicide to other causes of death among veterans versus non-veterans. This procedure allowed us to compare coefficients from two Cox proportional hazards models (b_1 and b_2) using the Wald χ^2 statistic with the following formula[22]:

$$\chi^2 = \frac{(b_1 - b_2)^2}{[s.e.(b_1)]^2 + [s.e.(b_2)]^2}$$

Analyses were weighted to adjust for differential response rates and variation in probabilities of selection into the sample. The Taylor series linearisation procedure using SUDAAN (Release 9.0.1; Research Triangle Institute, Research Triangle Park, North Carolina, USA.) was used to adjust significance tests for the complex sample design. Because there were too few female veterans in the sample who completed suicide (n = 6), we did not include women in the analyses. However, separate analyses with both men and women showed that the results were virtually identical to those in the model with men only (data not shown).

RESULTS

Table 1 shows the baseline characteristics of the veterans and non-veterans in the NHIS-NDI. Veterans were proportionally more likely than were non-veterans to be older, white, married and overweight.

Veterans represented 15.7% of the NHIS sample but accounted for 31.1% of the suicide decedents. Figure 1 shows that over time veterans were twice as likely (adjusted HR 2.13, 95% CI 1.14 to 3.99) to die of suicide compared with male non-veterans in the general population. Conversely, the risk of death from natural (diseases) and the risk of death from external (accidents and homicides) causes did not differ between the veterans and the non-veterans after we adjusted for confounding factors.

Table 2 provides descriptive information on the predictor variables for those who committed suicide. At baseline, veteran suicide decedents were significantly ($p<0.05$) more likely than were non-veteran decedents to be older, white, and high-school graduates, and less likely to never be married. Veteran suicide decedents had more activity limitations at baseline than non-veteran decedents. Furthermore, at the time of death, veterans were more likely to have committed suicide using a firearm than their non-veteran counterparts.

Table 3 shows the predictors of suicide risk among veterans. The results indicate that whites, those with >12 years of education and those with activity limitations (after adjusting for medical and psychiatric morbidity) were at a greater risk for suicide completion. An interesting result was that relative to those with normal weight (BMI 20.0–24.9 kg/m^2), overweight (BMI 25.0–29.9 kg/m^2) male veterans were at lower risk of completing suicide.

DISCUSSION

Using prospective (NHIS-NDI) population-based health and mortality data, we examined risk of suicide among male veterans of military service. The results revealed that male veterans are at increased risk of suicide relative to non-veterans. Contrary to studies conducted in the UK,[23 24] the findings showed that veterans were at greater risk of dying from suicide compared with a non-veteran cohort. The results of this study are particularly noteworthy because they were derived from a sample representative of all veterans in the US general population, whether or not they sought care in the VA system. Conversely, nearly all previous studies have examined suicide in VA-based samples and such studies may over- or underestimate risk of suicide because the VA serves only a fraction of veterans.[12]

A surprising finding was that veterans who were overweight had a lower risk for suicide. This finding is consistent with a recent longitudinal study. In a 31-year analysis of more than one million Swedish male military conscripts, Magnusson *et al*[25] concluded that the risk of suicide decreased with increasing BMI. Other studies that examined the association between overweight and obesity and depression—a critical psychiatric condition preceding suicide—yielded conflicting results.[26 29] According to Magnusson and colleagues, rather than directly reducing the risk of suicidal behaviour, a growing body of research suggests that raised BMI may be negatively associated with depression and suicidal behaviour through biological pathways. Two recent studies suggest that insulin resistance influences free fatty acids in the blood, tryptophan metabolism and serotonin levels in the brain.[30 31] Serotonin deficiency in turn is implicated in suicidal behaviour.[32]

Table 1 Characteristics of male veterans and non-veterans in the NHIS-NDI, National Health Interview Survey-National Death Index

	Veterans (n = 104 026) %*	Non-veterans (n = 216 864) %*
Sex		
Female	4.77	62 48
Male	95.23	37 52
Age (years)		
18–44	24.82	70 28
45–64	44.98	20.40
≥65	30.20	9 32
Race/ethnicity		
White	85.72	73.50
Non-white	14 28	22.65
Marital status		
Married	79.15	63 63
Widowed/divorced/separated	13.49	8.79
Never married	7.36	21.20
Living arrangements		
With others	87.43	87.65
Alone	12 57	12 35
Education		
<12 years	17.41	22 51
≥12 years	82 59	77.49
Employment status		
Employed	62.13	77.34
Unemployed	2.47	3.74
Not in labour force	35 40	18.92
Region of residence		
Northeast	19.72	20 51
Midwest	25.36	25.08
South	33.17	32.55
West	21 76	21.86
Place of residence		
Rural	25 00	23.40
Urban	75.00	77.33
Self-rated health		
Good	93.70	96.14
Poor	6.30	3 86
Body mass index		
Underweight (0 0–19.9 kg/m^2)	2 50	4 46
Normal weight (20.0–24.9 kg/m^2)	34 25	40.80
Overweight (25.0–29 9 kg/m^2)	46.99	40.41
Obese (≥30 0 kg/m^2)	16.26	14.33
Has at least one chronic non-psychiatric condition	51.75	38.02
Has at least one psychiatric condition	1 53	2.03
Activity limitations		
Not limited	76.30	85.03
Limited	23.70	14.97
Military service era		
World War I	0.32	–
World War II	28.01	–
Korean conflict	15.95	–
Vietnam era	29.02	–
Post-Vietnam	9.91	–
Other service	16.79	–

–, not applicable.
*Weighted percentages.

Our results also show that activity limitation is an important risk factor for suicide among veterans. Healthcare providers are well positioned to intervene with at-risk veterans who have physical and/or mental disabilities. Primary care physicians, as gatekeepers of the healthcare system, along with other specialists, have important roles in the assessment and management of depression and suicidality among veterans in clinical settings.[33]

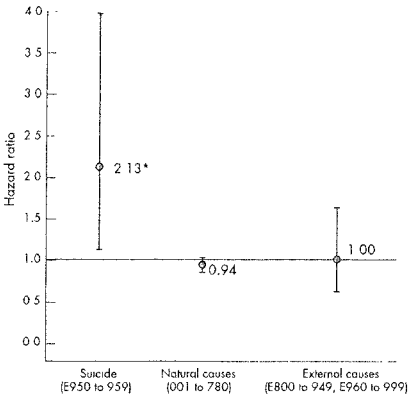

Figure 1 Comparison of cause-specific risk of mortality among veterans versus non-veterans. Risk adjusted for age, marital status, living arrangement, race, education, family income, employment status, region, interval since last visit to doctor, self-rated health, and body mass index. Reference group was non-veterans. Error bars indicate 95% CI. For each model, survivors and decedents from other causes of death were considered censored. International classification of diseases, ninth revision codes appear in parentheses.*Significant difference ($p<0.05$) between suicide and other causes of death using competing risk comparisons.

Another important finding was the higher probability that US veterans used firearms as a mode of suicide compared with non-veterans. Supplementary analyses with data from the National Mortality Followback Survey (NMFS)[34] showed that veteran suicide decedents were 58% (OR 1.58, 95% CI 1.08 to 2 33) more likely than non-veterans to use firearms than other suicide methods, after adjusting for sex, age, marital status, race, education, region, metropolitan status, psychiatric visit in the last year of life, number of half-days in bed for illness or injury in the last year of life, and alcohol use (data not shown). Furthermore, an analysis of veteran suicide decedents in the NMFS revealed that those who owned guns were 21 1 times more likely to use firearms than were those who did not own guns (OR 21.10, 95% CI 9 12 to 48.83), after adjusting for sex, age, marital status, race, education, region, and metropolitan status. Other data show that military personnel on active duty are more likely to own and use firearms to commit suicide than the non-military population.[35] According to recent data from the Behavioral Risk Factor Surveillance System,[36] veterans are substantially more likely to own guns than are individuals in the general population (45.7% vs 32.3%, $p<0.001$)

Although there is a debate among suicidologists and policy makers about the association between the availability of firearms and risk of suicide, the preponderance of evidence suggests that a gun in the house, even if unloaded, increases the risk for suicide in adults.[37] Case–control studies on the prevalence of guns and risk of suicide have shown significant increases in suicides in homes with guns, even when adjustments were made for other factors, such as education, arrests,

Table 2 Characteristics of male veteran and non-veteran suicide decedents in the National Health Interview Survey-National Death Index

	Veteran suicide (n = 197)	Non-veteran suicide (n = 311)	
	N (%)§	n (%)§	p Value
Age (years)			
18–44	45 (22 38)	230 (69.65)	
45–64	76 (37 23)	35 (11 72)	‡
≥65	76 (40.39)	46 (18.63)	†
Race/ethnicity			
White	175 (95 53)	248 (72 35)	‡
Non-white	21 (4.47)	60 (27.65)	
Marital status			
Married	139 (72 09)	155 (50 86)	
Widowed/divorced/separated	45 (18 73)	40 (8 40)	
Never married	13 (9.19)	116 (40.74)	*
Living arrangements			
With others	152 (75 71)	258 (88 12)	
Alone	45 (24.29)	53 (11.88)	
Education (years)			
<12	52 (12 30)	91 (26.11)	
≥12	145 (87.70)	217 (73 89)	*
Employment status			
Employed	96 (52.92)	214 (68.41)	
Unemployed	6 (1 88)	17 (6.28)	
Not in labour force	95 (45.19)	80 (25.31)	
Region of residence			
Northeast	26 (12 14)	52 (11 46)	
Midwest	42 (17 92)	81 (33.14)	
South	86 (42 63)	107 (29.89)	
West	43 (27 31)	71 (25 51)	
Place of residence			
Rural	62 (43 43)	90 (76.96)	
Urban	135 (56 57)	221 (23 04)	
Self-rated health			
Good	142 (90 92)	269 (90.08)	
Poor	24 (9 08)	17 (9 92)	
Body mass index			
Underweight (0 0–19 9 kg/m^2)	13 (8 70)	27 (13 25)	
Normal weight (20 0–24 9 kg/m^2)	88 (51.77)	135 (44.41)	
Overweight (25.0–29.9 kg/m^2)	71 (30.32)	109 (31 33)	
Obese (≥ 30 0 kg/m^2)	22 (9.21)	27 (11.02)	
Has at least one chronic non-psychiatric condition	115 (68.53)	137 (50 95)	
Has at least one psychiatric condition	7 (3 03)	16 (1.61)	
Activity limitations			
Not limited	134 (45.99)	238 (76.88)	
Limited	63 (50.98)	73 (23.12)	*
Suicide method			
Firearm (ICD-9 E955 0–E955.4)	152 (83 51)	185 (55 11)	†
Non-firearm (ICD-9 E950.0–E953.0 and E955 5–E959.0)	45 (16.49)	126 (44.89)	
Military service era			
World War I	1 (0 23)	–	
World War II	88 (47.06)	–	
Korean conflict	21 (5.29)	–	
Vietnam era	43 (25 77)	–	
Post-Vietnam	14 (7.53)	–	
Other service	25 (14 12)	–	

–, not applicable.
ICD-9, International classification of diseases, ninth revision, clinical modification.
*p< 05; †p<0 01; ‡p<0.001
§Unweighted N and weighted percentage with bivariate logistic tests.

Table 3 Risk factors for suicide among male veterans in the National Health Interview Survey-National Death Index 1986–97

	Adjusted HR (95% CI)§
Age (years)	
18–44	1.00
45–64	0.90 (0.31 to 2.65)
≥65	1.46 (0.51 to 4.15)
Race/ethnicity	
White	3.23 (1.75 to 5.88)‡
Non-white	1.00
Marital status	
Married	1.00
Widowed/divorced/separated	0.58 (0.03 to 10.77)
Never married	0.72 (0.02 to 26.41)
Living arrangements	
With others	1.00
Alone	3.48 (0.14 to 87.97)
Education (years)	
<12	1.00
≥12	2.67 (1.38 to 5.17)†
Employment status	
Employed	1.00
Unemployed	0.56 (0.10 to 3.10)
Not in labour force	1.03 (0.44 to 2.41)
Region of residence	
Northeast	1.00
Midwest	1.02 (0.24 to 4.43)
South	2.02 (0.46 to 8.78)
West	1.87 (0.40 to 8.63)
Place of residence	
Rural	1.00
Urban	0.44 (0.17 to 1.18)
Self-rated health	
Good	1.00
Poor	0.54 (0.15 to 1.98)
Body mass index	
Underweight (0.0–19.9 kg/m^2)	2.44 (0.46 to 12.84)
Normal weight (20.0–24.9 kg/m^2)	1.00
Overweight (25.0–29.9 kg/m^2)	0.45 (0.22 to 0.92)*
Obese (≥30.0 kg/m^2)	0.41 (0.14 to 1.17)
Number of chronic non-psychiatric conditions	1.08 (0.68 to 1.72)
Number of psychiatric conditions	0.41 (0.14 to 1.26)
Activity limitations	
Not limited	1.00
Limited	4.44 (1.33 to 14.80)*

*$p<0.05$ †$p<0.01$. ‡$p<0.001$
§Model comparing suicide death to alive or other cause of death.

and drug misuse.[38] Because veterans are familiar with and have greater access to firearms, healthcare providers need to be more attentive to the critical role that firearms play in suicidal behaviour among veterans. Unfortunately, some doctors find it difficult to ask patients directly about suicide.[39] Kaplan *et al*[40] also found that only half of the primary care physicians who identified patients as suicidal would inquire about their access to firearms.

This study has several potential limitations. The first limitation concerns the reliability of suicide data derived from death certificates. In this regard, Fuse[41] reported that "there is general agreement that suicides are likely under-reported for such reasons as the beyond-a-reasonable-doubt criterion used and for some socio-cultural reasons that may bias the reporting. There is not, however, much agreement as to the degree to which true suicides are undercounted." Fuse concluded that errors in collective suicide statistics are usually random and should not bias the present findings. Second, a further constraint of the NHIS-NDI design was the absence of time-varying covariates. However, most suicides occurred shortly after the interview (ie, 75% died within 3 years) so there was a limited opportunity for baseline measures to change (eg, marital status). Third, data were unavailable on important measures such as suicide attempts, source of healthcare coverage, or combat experience—all of which are associated with suicide risk. Fourth, psychiatric conditions are critical risk factors in suicide. One would expect over 90% of suicide decedents to have psychiatric illness.[1 42] However, little information about baseline psychiatric morbidity was available in the NHIS. Therefore, we were unable to examine the role of well-established risk factors such as major depressive disorders or post-traumatic stress disorder because of the small number of suicide decedents and because major depressive disorders and post-traumatic stress disorder were not available as separate psychiatric conditions in the NHIS-NDI dataset. Finally, we could not address cohort and period effects associated with suicide rates. For example, there have been major developments in suicide prevention since the NHIS was conducted, particularly the enormous changes in rates of antidepressant prescriptions and reduced suicide rates in the last 10 years.

Despite these limitations, the results have substantial clinical and public health implications. Clinicians outside the VA system need to be alert for signs of suicidal intent among veterans, as well as their access to firearms. Similarly,

Policy implications

With the projected rise in functional impairments and psychiatric morbidity among veterans of the conflicts in Afghanistan and Iraq, clinical and community interventions directed towards patients in both Veterans Affairs and non-Veterans Affairs healthcare facilities are needed.

What is already known

- Veteran suicide decedents are more likely to be men, older, to have diminished social support, medical and psychiatric conditions, and the availability and knowledge of firearms.
- Most, if not all, previous studies on veteran suicide focused on patients of the US Department of Veterans Affairs and/or on those who served during the Vietnam War era.
- Little is known about the risk of suicide among veterans in the general population.

What this paper adds

- Compared with non-veterans in the general population, male veterans are more likely to die of suicide but are not more likely to die of external causes or diseases.
- Impaired functional status increased the risk for mortality from suicide among male veterans.

healthcare facilities that serve veterans outside the VA system should also recognise the increased risk of suicide in this population. With the projected rise in functional impairments[13] and psychiatric morbidity[14 15] among veterans of the conflicts in Afghanistan and Iraq, clinical and community interventions directed towards patients in both VA and non-VA healthcare facilities are needed

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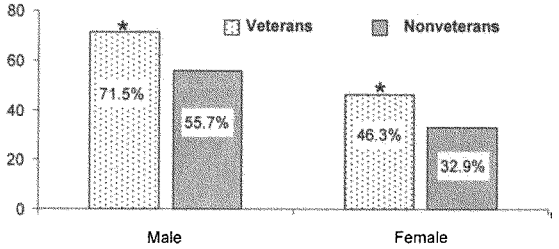
Appendix 2

Proportion of Suicides Involving Firearms, by Gender



Data Source. NVDRS 2003-05 Note Astensks denote significant differences (p< 01) between veterans and nonveterans.

Correlates of Firearm Suicide by Gender in the NVDRS 2003-05

	Male AOR (95% CI)	Female AOR (95% CI)
Veteran status	1.47 (1.35-1.61)***	1.76 (1.21-2.56)**
Age		
18-34	1.00 (reference)	1.00 (reference)
35-64	1.01 (0.93-1.11)	0.94 (0.78-1.14)
65+	2.63 (2.29-3.02)***	1.38 (1.06-1.80)*
Marital Status		
Married	1.21 (1.12-1.31)***	1.65 (1.42-1.92)***
Not married	1.00 (reference)	1.00 (reference)
Race		
White	1.41 (1.27-1.57)***	1.61 (1.26-2.06)***
Nonwhite	1.00 (reference)	1.00 (reference)
Region of residence		
Northeast	1.00 (reference)	1.00 (reference)
Midwest	3.07 (2.69-3.51)***	4.96 (3.37-7.31)***
South	1.84 (1.54-2.20)***	1.96 (1.21-3.19)**
West	2.43 (2.11-2.80)***	3.18 (2.12-4.76)***

AOR: Adjusted Odd Ratio; 95%CI: Confidence Intervals; ***p<.001; **p<.01

Senator SMITH. Thank you very much, Mark.

We will leave the Senate record open for a period.

I apologize. My colleagues are gone. It is not any reflection on you. That is how life is around here.

You have all contributed importantly to the Senate record and to our understanding. There may be written questions submitted. If there are, if you can answer them, great. We appreciate that.

But you have come a long way. We value your work. That is why it was important to me that we not in any way shortchange your testimony and the contribution you have made here today.

So thank you. I don't know how to say it better than just thank you.

Keep it up. We need you to keep succeeding at what you do.

With that, we are adjourned.

[Whereupon, at 12:40 p.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR ROBERT P. CASEY

I want to thank my colleague, Senator Gordon Smith, for chairing this important hearing to address health care for aging veterans. I look forward to continuing our work through this committee to meet their needs and ensure that the services this nation promised them are delivered.

The 110th Congress is focusing a good deal of attention to veterans' health care and with good reason. Those who have sacrificed so much for America's security and freedom deserve the most advanced medical care and comprehensive benefits our country has to offer, and the government is obligated to guarantee them. It is troubling, however, that it takes events like those of the past year at Walter Reed and throughout the Department of Defense and the Veterans' Administration health care systems to propel this issue to the forefront of our concerns in Washington.

As the wars in Iraq and Afghanistan continue, we can only expect more casualties. Thanks to brilliant medical advances, many of these casualties will be survivors returning home to cope with debilitating physical and mental injuries and illness. The VA will face the challenge of caring for these veterans. Modern medicine has found a way to keep them alive, but our government bureaucracy has not kept pace with serving their increased needs.

While our efforts to expand our health care system to accommodate these young men and women are crucial, it is equally imperative that we not neglect our older veterans who have fought valiantly in combat in previous wars. In addition to the problem of obtaining their health care and other benefits, older veterans also confront the issues of long term care and, in the most tragic cases, homelessness. Combat veterans from World War II and the Korean War are now in the ranks of our older citizens. Many of those who served in Vietnam have retired, adding thousands to the Veteran Administration's health care rolls. Men and women who fought in the Gulf War of 1991 have unique physical and mental health care concerns, the evidence of which has appeared in the years following the end of that war. With a quarter of the nation's population potentially eligible for VA benefits and services, we cannot cast our older veterans aside in our urgency to devote health care resources to veterans of the wars in Afghanistan and Iraq.

I have met with members of the Pennsylvania chapter of the American Legion twice this year. I asked these distinguished gentlemen about their experiences with the VA hospitals in Pennsylvania. The response was almost unanimous: the VA hospital consistently offers the finest health care they could hope for—if they could manage to get an appointment. While this evidence is anecdotal, it illustrates the greatest problem the VA faces: its own bureaucracy. The numbers are staggering: the VA operates 155 medical centers, over 1,400 sites of care, including 872 ambulatory care and community-based outpatient clinics, 135 nursing homes, 45 residential rehabilitation treatment programs, 209 Veterans Centers and 108 comprehensive home-care programs. Despite the challenges of managing such a sprawling system, technology and good planning would streamline VA health care and benefits administration and deliver comprehensive services to our aging veterans promptly.

In fiscal year 2006, the VA reported that nearly 1.1 million veterans reside in Pennsylvania. Over 480,000 were 65 or older. In 2004, the VA spent $2.5 billion on health care for veterans in Pennsylvania, and that number continues to increase year by year.

I am grateful to Senator Smith for calling attention to these critical issues and I look forward to the testimony of our witnesses. We must do whatever is necessary to meet the physical, psychological and emotional needs of our veterans and ensure that America keeps its promise to our aging heroes. We owe them our services, as we still enjoy the freedoms that they served to protect many decades ago.

REPONSES TO SENATOR SMITH'S QUESTIONS FROM DR. SHEPHERD

Question. In your testimony you mention that approximately three out of four veterans seeking mental health treatment for the first time through the VA are Vietnam era veterans; many of whom are in the 55–64 year-old age group. Why do you think this is the case, and are these numbers growing from years past?

Answer. There are many hypotheses offered to explain the influx if aging veterans into the VA mental health system over the past few years. All of the following rationales can account for some portion of increase in the numbers of these veterans:

• Universal screening for depression and PTSD by primary care physicians.

• As a result of educational initiatives, media coverage, and mental health outreach efforts following the attacks of September 11, 2001, and/or related to the current Global War on Terror, veterans have gained a heightened awareness of PTSD and have recognized symptoms described in the media as akin to their own experience.

• Some veterans in this group successfully suppressed and avoided their PTSD symptoms through the years by overachievement and sublimation to their work identity. As the specter of retirement and idle time becomes more apparent, they experience a decreased ability to evade symptoms, which then begin to impair their quality of life.

• Veterans experience subsequent traumas, such as death of a spouse, career change, criminal victimization, etc., which causes emergence or reemergence of mental health symptoms.

• Veterans progressing in the life cycle may begin to experience physical decline, functional impairments, and illness which, in turn, diminish their overall reserve and capacity to function. This co-morbid effect may impact vulnerability to onset of mental health problems or may decrease resiliency and coping with mental health symptoms that were already present at a sub-clinical level.

• There are a small, but reported number of cases of patients experiencing PTSD symptoms for the first time years after the military exposure event.

• Ongoing changes and reductions in employer provided health care benefit plans and/or the specter of having to provide for one's own health care coverage upon retirement may contribute to a decision by eligible veterans to shift to VA care.

Follow up a. We know that overall, older males have increased risk for depression and suicide. We also know that being a veteran increases those risks. What do you think this means for the VA Mental Health system as these veterans continue to age and increase in number?

Answer. In light of the ongoing Global War on Terror, the mental health needs of Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans are in the forefront of our public consciousness. At present, the number of OIF/OEF veterans seeking mental health treatment is approximately 15 percent. Over time, we do not know whether this rate will remain steady, whether and when it will change, and if so, at what velocity this change will occur. Simultaneously, increasing numbers of aging veterans are seeking mental health treatment in VA, and other aging veterans represent potential influx. We also do not know whether this trend will plateau, continues at present rate, or accelerate. I believe that the ability to adequately assess, plan for, and make ongoing adjustments to meet the access and programmatic needs at both ends of the age spectrum will be a primary challenge facing the VA mental health system.

Follow up b. Is the VA prepared to adequately respond to the needs of these veterans?

Answer. This will, in part, depend on VA's ability to simultaneously meet the needs that may arise from the increase in veteran utilization at both ends of the age spectrum described in the response to part A. Recruitment of mental health professionals, especially in rural areas, is a challenge in all sectors, public and private. I believe that a related consideration will be the ability for VA to recruit and/or efficiently match clinician skill sets with regional patient sub-populations. For example, it will be an advantage to have a higher density of clinicians particularly skilled and adept at treating geriatric depression and dementia related issues at VA facilities where there are a high concentration of patients with these mental health problems; likewise, having an increased density of clinicians adept at cognitive behavioral therapy such as prolonged exposure therapy is especially important in areas with high concentrations of returning OIF/OEF veterans.

Question. In your testimony you discuss the recent effort by the VA Office of Mental Health Services to ensure each VA medical center had a suicide prevention coordinator. You also mention that approximately 85 percent of facilities have at least an "acting" suicide prevention coordinator at this point—which I applaud. However, I am wondering about the next step—do you think that once a problem is identified

that there are appropriate numbers of mental health care professionals in the VA system or affiliated with to ensure timely follow-up and treatment?

Answer. In our work, we have found that over the past year, VA efforts at systematic suicide prevention have been more aggressive. VA Clinician researchers, especially in the Rocky Mountain Network, VA Stars and Stripes Network (Pennsylvania region), and New York/New Jersey Network have piloted or implemented some innovative programs. In our report, we encouraged VA to choose among emerging best practices for identifying, assessing, referring, tracking, and treating veterans at risk and for system-wide implementation with ongoing evaluation and modification. In our inspection, we did not look at access to mental health care. Access can be thought of in terms of multiple domains including waiting times, geographic location, patient eligibility, provider availability, and programmatic availability, among others. This would be a relevant topic for future examination by VA and our office.

Question. In your testimony you talk about the implementation of a new hotline through the VA, and in cooperation with SAMSHA, to help respond to the emergency mental health needs of veterans. I applaud the VA and SAMSHA for their efforts and hear that since the end of July when the hotline went into effect; more than 170 Oregon veterans have been helped. Do you know how the training for those who answer the calls from veterans differs from the training for those who help on the nationwide hotline that SAMSHA runs for the general population?

Answer. The primary difference between training for the VA suicide hotline and training for other major suicide hotlines is the specific focus on veterans and their issues. VA hotline officials reported that the phones are staffed with 9 social workers, 7 psychiatrically focused registered nurses, and 4 addiction therapists. Prior to taking calls, clinical staffers receive approximately 40 hours of suicide prevention training, which initially is general in nature but then moves to veteran specific issues with role plays based on actual calls from veterans.

Question. In your testimony you mention that the VA does not adequately tap into the linkages in communities that serve older veterans such as the aging network, including senior centers, as well as faith-based organizations and other groups that work with or serve seniors who are veterans. Why do you think this is the case and how can we encourage the VA to reach out more frequently and consistently to groups we know can help identify needs for aging veterans?

Answer. One of the initiatives in the Veterans Health Administration Strategic Plan concerns using the VA Chaplaincy service to facilitate community outreach. As of the time of our inspection, no central action had taken place on this initiative, although some individuals facilities had implemented innovative outreach programs on a local level. I do not know why VA has not optimized community linkages for reaching out to aging veterans. I believe that it would benefit VA to look at and evaluate the more promising of these pockets of innovation and community outreach as applicable to aging veterans and to consider implementing similar efforts on a system wide basis.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM LARRY REINKEMEYER

Question. In your testimony you mention that more than 70,000 veterans in the 10 VA medical facilities you audited had consult referrals from their doctors that were more than seven days old and that, according to VA policy, they should have been included on the VA wait list. However, you later mention that these facilities actually had a combined wait list of only 2,600. Does this mean that these 10 facilities alone are excluding more than 67,000 veterans from their wait list and therefore vastly under-reporting need?

Answer. The facilities were under-reporting the number of veterans on their waiting lists but the exact number is unknown and because our review was based on a non-random sample, we cannot project our conclusion across the entire 70,000 consults. VHA's data (consult tracking report) identified over 70,000 consults for veterans who did not have an appointment and were not on the facilities waiting list. According to medical facility personnel, the consult tracking report did not always reflect the actual consult status because clinic personnel did not always update the consult after action was taken. To substantiate VHA's data, we reviewed a non-random sample of 300 consult referrals and found that 61 percent of the associated veterans should have been on the waiting list and more than half of those had been waiting more then 30 days. The remaining referrals had already been acted on but facility personnel had not updated the records to reflect the true status (for example, completed or discontinued).

Follow up a: What impact do these huge discrepancies have on the VA's budgeting and planning processes?

Answer. A basic premise to budgeting and planning is that budgeting should meet demand. If the demand is under-reported, then information relied upon for budgeting and planning decisions are potentially flawed and could result in insufficient allocation of staff and other resources.

Follow up b: Is Congress getting accurate information with which to make decision?

Answer. No, our report clearly shows that waiting times and waiting lists are not reliable.

Question. In your testimony you discuss your audit findings that many of the veterans who were waiting on a consult request to actually be scheduled, had no action on that request by schedulers for more than 30 days. You mention many factors that could contribute to this, including a shortage of scheduling staff, but one you don't really mention is physician availability. Did you look into the possibility that they are not putting veterans on waiting lists or even attempting to schedule appointments because of a lack of time for existing physicians to see them?

Answer. We did not determine the impact of physician availability on waiting lists during this review.

Follo up: Does the VA need more medical professionals?

Answer. The focus of our audit was on waiting times and not on staff resources.

Question. Your testimony mentions the fact that schedulers may have been incorrectly interpreting the guidance from their managers to reduce wait times and therefore were essentially gaming the scheduling process. Do you think that this gaming was unintentional or do you think there are incentives for managers and facilities in place that would encourage some of these practices?

Answer. Because of the audit's short timeframe, we did not address the intentional gaming of the system on this audit. However, we did find indications that this was happening in our July 2005 audit and, based on results of this audit, it is possible that it is still occurring.

In 2005 we conducted a nation-wide survey of schedulers where over 15,000 schedulers responded and found that:

- 7 percent were directed by their supervisors or managers to schedule appointments contrary to policy.
- 41 percent were directed to find the first available appointment slot and then use that as the desired date of care effectively reducing the waiting time to 0 days.
- 10 percent felt pressure from leadership to keep waiting lists short which caused them to circumvent established scheduling procedures.

The visibility and the emphasis to reduce waiting times and waiting list would certainly provide an incentive to some managers to manipulate the system in order to show better performance.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM MARK KAPLAN

Question. What do you feel are the most important characteristics of veterans that make more at risk for suicide than the general population?

Do you feel that there are other factors that are unique or more acute for veterans that put them at greater risk for suicide such as the fact that they served in a war, that there is greater stigma in the military, or perhaps there is a difference between access to treatment through the VA system versus other community-based mental health systems?

Answer. Indeed, there are several factors that put veterans at a higher risk for suicide compared to their nonveteran counterparts. In a national study of more than 320,000 men, we showed that those who served in the military, regardless of age or era of service, were twice as likely as their nonveterans to complete suicide. Although we did not draw firm conclusions about what makes veterans more at risk for suicide than the general population, we did find that that veterans with disabilities that limited their ability to function in their daily activities was one of the highest suicide risk factors. With the projected increase in veterans with disabilities among those who served in the Afghanistan and Iraq conflicts, there will be a need for more interventions by both VA and community-based mental systems. Furthermore, I noted in my testimony that men in psychological distress face stigma and barriers and are less likely to seek treatment than equally distressed women.

Question. What do you feel is the best way to help these veterans and to ensure that the doctors who are seeing them, whether they are mental health specialists or their general physician, are appropriately trained on the specific needs of veterans?

Answer. According to my colleague and co-author, Dr. Bentson McFarland, Professor of Psychiatry at the Oregon Health and Science University, primary care physician assessment and management of depression and suicide prevention for veterans could be encouraged by expanding reimbursement so that primary care providers can implement and sustain evidence-based procedures aimed at detection and treatment of veterans with major depressive disorder. Federally funded research projects over the past twenty years have shown that primary care providers can do an excellent job at detecting and treating people with major depressive disorder. The key to success is inclusion in primary care practices of "care managers" who have expertise in mental health. Care managers are nurses or counselors (usually with masters degrees) who follow protocols for detection and treatment of people with depression. Primary care providers facilitate treatment by prescribing medication as needed. This care management approach has been well studied and shown to be effective. Unfortunately, this model has rarely been sustained owing to lack of reimbursement. Primary care providers nowadays are notinfrequently in financial difficulty and are unable to sustain evidence-based practices such as care management. Congress should direct the Department of Veterans Affairs to provide reimbursement for primary care depression detection and management for veterans unable to be served within the Veterans Affairs system.

NOV 14 2007

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

The Honorable Claire McCaskill
United State Senate
Washington, DC 20510

Dear Senator McCaskill:

At the October 3, 2007, hearing of the Special Committee on Aging, you raised the issue of public availability of inspections of VA-owned nursing homes. I responded that I would provide information for the hearing record.

The VA supports nursing home care for eligible veterans in three distinct venues: VA-owned and operated nursing homes, state veterans homes, and community nursing homes. Each has an oversight body whose responsibility is to assure that veterans are receiving care according to the specified standards.

Community nursing homes are surveyed by state survey agencies under Centers for Medicare and Medicaid (CMS) criteria. CMS requires the posting of survey results in a public place in each community nursing home. Information about community nursing home care is also available on the Nursing Home Compare website, www.medicare.gov/NHCompare/home.asp. This site contains information about nursing home deficiencies, staffing, and quality indicators.

The primary oversight body for VA nursing homes, a majority of which are located on or near the campus of a VA Medical Center, is the Joint Commission Organization, formerly known as the Joint Commission on Accreditation of Healthcare Organizations. While information on VA nursing homes is available on their website, www.jointcommission.org, it is not easily retrievable. The Department would be better able to discuss their reasoning for not posting information on the www.va.gov website concerning VA-owned and operated nursing homes.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

Michael L. Shepherd M.D.

Michael L. Shepherd, M.D.

cc: The Honorable Herb Kohl
Chairman, Special Committee on Aging

The Honorable Gordon Smith
Ranking Member, Special Committee on Aging

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