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U.S. DEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE: THE CROWN JEWEL AND BEST KEPT SECRET

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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U.S. DEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE: THE CROWN JEWEL AND BEST KEPT SECRET

TUESDAY, MAY 19, 2009

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

The Subcommittee met, pursuant to notice, at 2:08 p.m., in Room 334, Cannon House Office Building, Hon. Harry Teague presiding.

Present: Representatives Teague, Snyder, Donnelly, Perriello, and Brown of South Carolina.

OPENING STATEMENT OF CHAIRMAN MICHAUD, AS PRESENTED BY HON. HARRY TEAGUE

Mr. TEAGUE [presiding]. The Subcommittee on Health will now come to order. I would like to thank everyone for coming today. This Subcommittee on Health hearing will assess the U.S. Department of Veterans Affairs' (VA's) responsibility to conduct an outreach program to veterans of all eras, including internal coordination that takes place between the Veterans Health Administration (VHA) and other administrations of the Department. We also seek a more complete understanding of the VA's outreach efforts and strategies, as well as the funding spent on these outreach activities.

Today there are over 23 million veterans who have served this country. Of this total, the VA estimates that the number of veterans enrolled in the VA health care system will reach 8.3 million in 2009, and that the VA will treat nearly 6 million of the enrolled veteran population. Six decades separate the newest generation from the oldest generation, and 9 million veterans are over the age of 65. According to the VA's Center for Minority Veterans, the minority veteran population comprises approximately 15 percent of the Nation's 23.4 million veterans. Women veterans are included in these minority groups as well.

This demographic data illustrates the sheer number of veterans who stand to benefit from improved VA outreach efforts. Additionally, it shows the importance of outreach strategies which must be individualized to meet the unique needs of subpopulations of veterans. For example, outreach strategies for older veterans should differ from that of younger veterans. Additionally, the outreach methods for rural areas may differ from that of urban areas. The VA is also faced with the challenge of developing effective outreach

strategies which are culturally competent and thus able to overcome potential cultural barriers.

Briefly recounting the legislative history of enacted legislation on outreach brings us to the Vietnam War. During the Vietnam War, increased awareness of veterans not receiving adequate information about health care benefits resulted in Congress enacting the Veterans Outreach in Congress Service Program, VOSP. To address this concern Congress charged the VA with the responsibility of actively seeking out eligible veterans and providing them with benefits and services. Under the current law, the Secretary is responsible for advising each veteran, at the time of discharge or release, of all benefits the veteran may be eligible for.

Next, Public Law 107–14, the Veterans Survivor Benefit Improvement Act, VSBIA, was enacted in 2001 to further expand outreach to eligible dependents. This law also provided that the Secretary ensure the availability of outreach services and assistance through the internet, veterans publication, and the media.

Finally, Public Law 110–389, or the Veterans Benefits Improvement Act of 2008, was enacted last year. Section 809 of this law gives the Secretary the authority to advertise in national media.

Despite these legislative authorities, the VA has a self-imposed ban against paid public advertising, including public service announcements which was only removed recently in June of 2008. Although the existing statute does not prohibit the VA from conducting media outreach, the VA has only implemented a single media campaign on suicide prevention to the Subcommittee's knowledge. VA has struggled in the past with effective outreach service. For example, pamphlets and other outreach material are often located in the VA's own medical center, which means that this important information does not reach those veterans who do not already utilize VA's services.

Another example is a memorandum issued on July 18, 2002, by the VA Deputy Under Secretary for Health for Operations and Management to all Veterans Integrated Services Networks (VISN) of the VHA prohibiting marketing geared toward increasing enrollment. This was an effort to limit the fast growing demand for health care services, which exceed the VA resources.

We also know that some veterans service organizations (VSOs) accuse the VA of not providing outreach to veterans and dependents in accordance with the law. Nearly 18 months later a second memorandum was issued by VHA instructing the directors to ensure that their facilities were in compliance with the responsibilities outlined in the outreach program.

Clearly, these are serious issues deserving of this Subcommittee hearing today. The Subcommittee looks forward to hearing from the witnesses of the panel as we embark on this important task of exploring effective ways to improve outreach to our deserving veterans.

I now recognize Ranking Member Brown for any opening statement that he may have.

[The prepared statement of Chairman Michaud appears on p. 37.]

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN of South Carolina. Thank you, Mr. Chairman. I will be brief. I know we have 9, 8 minutes and 55 seconds before the votes are closed. When our servicemembers come home from the battlefield they think about getting back to their families and their civilian lives. Often they do not think about connecting with the VA. Yet, the process of transitioning back to the civilian world can be challenging for veterans and their families. I am deeply troubled when I hear stories about a veteran not knowing what services exist, where services can be obtained, and whether they are eligible for those services.

Central to the mission of the VA is to reach out to make every veteran aware of what services are available to support them and assist them in using these services. That is why it is so important that we are holding this hearing today to examine how effective VA existing outreach is, and what more can be done to ensure that our Nation's heroes know and have access to the benefits and services they need and deserve.

It is encouraging that a high percentage of our returning warriors are seeking VA for their health care needs than in any previous war. I do want to commend former Secretary of Veterans Affairs, Dr. James Peake, for the great strides he made to improve outreach and the coordination of care for our veterans. Under his strong leadership, the VA launched a number of outreach initiatives, including lifting restrictions on advertising to promote awareness of VA programs and services, rolling out a new public service campaign about suicide prevention, establishing the Combat Veterans Call Center to telephone returning veterans to provide information about VA services, opening new rural outreach clinics, and expanding VA internet presence through *YouTube*, *Facebook*, and *MySpace* to reach younger veterans.

I would like to thank all of the witnesses for taking the time to appear before the Subcommittee today. I look forward to hearing about issues you see and ideas you have for improving VA's outreach, and relationships with the U.S. Department of Defense (DoD), State, local communities, and private organizations to help link veterans to VA services.

Thank you, Mr. Chairman, and I yield back my time.

[The prepared statement of Congressman Brown appears on p. 38.]

Mr. TEAGUE. Thank you, Mr. Brown. At this time, we will recess to go vote, and we will come back as soon as possible after the votes.

[Recess.]

Mr. PERRIELLO [presiding]. At this time I would like to introduce the first panel. John Rowan, National President of Vietnam Veterans of America (VVA); Reynaldo Leal, Jr., Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veteran and Representative of Iraq and Afghanistan Veterans of America (IAVA); and Richard A. Jones, Legislative Director of the National Association for Uniformed Services. You may please take your seats. Thank you so much for joining us today. Mr. Rowan, if you can please begin?

STATEMENTS OF JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA; REYNALDO LEAL, JR., REPRESENTATIVE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA (OEF/OIF VETERAN); AND RICHARD A. "RICK" JONES, LEGISLATIVE DIRECTOR, NATIONAL ASSOCIATION FOR UNIFORMED SERVICES

STATEMENT OF JOHN ROWAN

Mr. ROWAN. Good afternoon, Mr. Chairman.

Mr. PERRIELLO. Good afternoon.

Mr. ROWAN. And thank you very much. It is good to see everybody. We have submitted testimony which I will not read verbatim. I would just like to say a few words about this particular subject. And I had an opportunity to read my colleagues' testimony and Mr. Michaud's testimony, and the others. So I noticed that many of them are focusing on the efforts by the VA to reach out to the newer veterans coming back from OEF/OIF. And while we would agree that there has been a lot of activity in that regard, and that certainly the VA is doing a lot of effort to reach out to those veterans, we still have some concern, even, about how effective that is. But we must say just generally, for all the veterans that the VA is supposed to serve, we believe they are doing a woefully inadequate job.

Certainly for my veterans, the Vietnam Era veterans, and even for the Persian Gulf veterans from 1991, war changed somehow. And even if we go back to the World War II period, or even World War I with the gassing of the veterans in World War I, and of course in World War II we saw the atomic veterans. But when it came along to Vietnam, we had strange exposures to Agent Orange, for us. For the Persian Gulf veterans, of course, had all of these crazy things going on between the sarin gas and the oilfield fires, and depleted uranium shells, and it was like a toxic wasteland over there, which seems to be hanging around, by the way. From conversations that I have had with some Iraq and Afghanistan veterans that seem to run into these same situations. And of course, they have had other situations added on with anthrax shots and other kinds of things.

The real problem is that most of us who walked off the battlefield unscathed, and for some extent even those who may have been wounded or hurt but went through rehab and felt like, "Okay, I got wounded but now I have my prosthetic device, or whatever, and I can move on with my life," did not realize that 30 or 40 years later we could have, literally, diseases affecting us from our exposure from 30 and 40 years earlier that are literally killing us. Vietnam veterans are dying at a very high rate. We have very high rates of diseases like prostate cancer, diabetes, non-Hodgkin Lymphoma, and lung cancer, and a myriad of other different cancers. The number of diseases is becoming significant.

Because of this we created a Veterans Health Council. We will get each one of the elected representatives here a copy of this package. This Veterans Health Council is a group of health care providers in the private sector, academic institutions, advocacy organizations, some of our friends in the pharmaceutical industry, and others who have come together to try to explain to the private sec-

tor that 80 percent of the veterans are being treated by them and not by the VA. And that these veterans are basically going under the radar and they do not realize that the person sitting across the desk from them, the patient that they are talking to, the man or the woman, may have suffered exposures from their military service that are now impacting their health. Or, that because of those exposures they need even more concern about certain areas of interest such as Prostate Specific Antigens (PSA) screenings. PSA screenings may be important to all us old guys that turn over 50, and for those of us who are even over 60, but it is really important for Vietnam veterans. Because we are three times more likely to get prostate cancer than our peers.

So it is because of those programs and those problems that we are trying to create this program utilizing a Web site called veteranshealth.org. And we have created some fliers that we have worked with folks to reproduce. Not only to talk about the Vietnam veterans but also to talk about the Persian Gulf veterans and the OEF/OIF veterans. Because all of these veterans need to understand that they need to look at things many years after they get out. And so we would, we are really concerned that the VA needs to be forced to do the outreach that they say they do. And they need to talk not only to the new vets going home but to those of us who have been home as many as 40 years. And we are clogging the Veterans Benefits Administration (VBA), frankly, as much as the new kids with all of these service-connected disabled veterans.

And so frankly, we call upon you and your colleagues in the Subcommittee to take a look at creating legislation in that regard and we would certainly be happy to answer any questions you may have. Thank you.

[The prepared statement of Mr. Rowan appears on p. 38.]

Mr. PERRIELLO. Thank you very much, Mr. Rowan. Mr. Leal?

STATEMENT OF REYNALDO LEAL, JR.

Mr. LEAL. Mr. Chairman and Members of the Subcommittee, thank you for inviting me to testify today on behalf of Iraq and Afghanistan Veterans of America the Nation's first and largest nonpartisan organization for veterans of the current conflicts. I would like to thank you all for your unwavering commitment to our Nation's veterans.

My name is Reynaldo Leal and I served in Iraq as a Marine infantryman with 3rd Battalion 5th Marines. And during my first tour, I participated in some of the Iraq War's heaviest fighting during Operation Phantom Fury in Fallujah. And after that mission was complete, I assisted in securing the first democratic elections in that city.

I was deployed for a second time 8 months after my first tour and conducted counter insurgency operations along the Euphrates River. As an infantryman, I did my job well and performed my duties with honor.

When I was discharged from the Marine Corps in February 2008, there were two questions I feared the most. What was it like over there? And, did you kill anyone? Anxious about returning home, I delayed going back to South Texas for as long as possible. I could

not bear the thought of being around familiar faces, and that fear led me to push away those who cared about me the most.

As my wife prepared for the birth of our first child, I struggled with flashbacks and painful insomnia, which spiraled into a debilitating depression that alienated my family and threatened my marriage. I knew that my wife was suffering as much as I was and that I was not the same person she had fallen in love with. Suicide was not an option for me. But every day made me more and more anxious. It turned out I was suffering from a devastating invisible wound, post-traumatic stress disorder, or PTSD.

My struggle with PTSD left me dependent on the VA for mental health care. And since there is no VA hospital close to my home in Edinburg, Texas, I have to either travel 5 hours each way to the nearest VA hospital in San Antonio or take my chances at our local VA clinic. The lack of funding for a permanent VA psychologist at this clinic pits me against my fellow veterans of all generations for limited appointment slots.

Unfortunately, my experience is not unique. According to a 2008 RAND study, nearly 20 percent of Iraq and Afghanistan veterans are experiencing symptoms of PTSD or major depression, but less than half are getting adequate treatment. PTSD is a silent killer for this generation of veterans. Left untreated, it has the potential to destroy marriages, careers, and in far too many cases, lives. In January of this year, the U.S. Army reported that 24 soldiers in Iraq and Afghanistan committed suicide, a figure that surpassed all combat deaths in those two theaters combined.

But numbers and statistics are only part of the picture. This new generation of veterans is being left to fend for themselves because of an antiquated system that cannot seem to find a way to reach out to them. There are not any visible outreach campaigns to get these young men and women through the door of their local VA facility. When I was struggling with PTSD, there was never a sense that the VA was trying to reach out to me, or that anyone even understood. For me, there was the Corps, and then there was nothing. I felt that I had been abandoned and the fact that I had served my country honorably meant nothing. I did not know about the claims system. I did not know about the 5 years of medical care for Iraq and Afghanistan veterans. And I did not know that there were others that were going through the same situations that I was.

It was not until I saw IAVA's "Alone" ad on television and joined communityofveterans.org that I felt someone was trying to reach out to me. It is the responsibility of the Federal Government, and the Department of Veterans Affairs, to make sure every veteran feels this way.

But are we doing everything we can to reach out to the veterans who have done so much for us? The VA has taken some important steps, especially setting up suicide hotlines, but the answer is still no. We owe it to our veterans to provide the best mental health resources available and currently we are falling too short of that goal. By fully funding the VA health care budget 1 year in advance, we could provide a simple solution that would give VA hospitals and clinics across the country the ability to provide stable care for decades to come. With the ability to plan ahead, these hospitals and clinics could meet critical staffing and equipment needs so that

veterans like me are not left waiting. President Obama recently reiterated his support for advanced funding of the VA health care and we are glad to hear it. With the strong support of the President, and bipartisan leadership of Congress, advanced funding can and must move forward this year.

Real action cannot come at a more critical time. As we saw just last week with the tragic events of Camp Liberty, our servicemen and women are under an incredible strain. As a Nation, we must have the same emphasis on giving our veterans the necessary tools to readjust to civilian life as we have in giving them the tools to survive in combat.

Make no mistake about it, the veterans of this country want nothing more than to become successful and productive Members of the society we fought so hard to defend. Thank you.

[The prepared statement of Mr. Leal appears on p. 40.]

Mr. PERRIELLO. Thank you so much for your service to this country, and for your service to this Committee today, with your testimony. Mr. Jones.

STATEMENT OF RICHARD A. "RICK" JONES

Mr. JONES. Mr. Chairman, Members of the Subcommittee, on behalf of the National Association for Uniformed Services I am pleased to be here today as you examine the veterans health care system and its outreach to veterans. Your work is critical to ensure that VA outreach strategies bring the best possible care to returning troops, and a seamless transition to their well-earned civilian life.

Approximately 6 million veterans annually come to VHA for all or part of their personal health care. With the draw down of troops from the battlefield of Iraq, VA is likely to face increased enrollments. Through the last quarter of fiscal year, for example, 2008, over 400,000 Operation Enduring Freedom and Operation Iraqi Freedom veterans have used VA. And with passage of Public Law 110–329 last year, VA likely will have expanded enrollment of newly eligible veterans. Those are the Priority 8 veterans.

As we work toward enrolling these qualified veterans, who desire to do so, into the VA system, we must ensure that all veterans returning from combat areas are aware of, and if possible already signed up for, their 5 years of VA medical care. We recognize, however, that some long-term health conditions, such as post-traumatic stress disorder or Traumatic Brain Injury (TBI) may not manifest conditions until many years later. Therefore, we encourage further opening of access to sick and disabled veterans beyond the current 5-year allowance.

Recent Congressional successes in providing increases in VA spending present the Department with an opportunity to advance an awareness of VHA accessibility and a readiness to meet health care needs. We applaud all that has been done to date. However, we can do better. In some cases, a successful outreach can be a matter of life and death. Veterans need to hear that VA is part of our Nation's commitment to them. They need to hear that with appropriate care they can tackle stress and get themselves back on track.

Of course, there is financial cost to improve outreach. But if we do not make the investment and we do not make veterans aware of the benefits and services available to them, there is a hidden cost in lives lost, families disrupted, long suffering and homelessness, stress, and related problems for decades to come. We have learned that over the years. The Persian Gulf effort is one of those lessons.

We urge the Subcommittee to continue its excellent work with other champions in the Congress to ensure resources are ready, not only for the provision of a veteran's earned benefit but for the veteran's awareness of these services as well. It is important that we do so. After all, these brave men and women have shouldered a rifle, risked everything to accomplish their mission and protect freedom and our own country from harm.

As you know, Mr. Chairman, these brave men and women did not fail us in their service to country. They did everything our country asked and more. Our responsibility is clear. We must uphold our promises and provide the benefits they earned through honorable service in the military. Mr. Chairman, you and your Members of the Subcommittee are making progress. We thank you for your efforts and look forward to working with you as you work to protect and strengthen and enhance the benefits that we provide these great men and women. Thank you very much.

[The prepared statement of Mr. Jones appears on p. 42.]

Mr. PERRIELLO. Thank you, Mr. Jones, for being such a great resource and advocate with this Committee, in helping us understand ways that we can certainly improve and continue to hold feet to the fire and make sure we are reaching out to folks.

Mr. Rowan, you referred to the outreach as being woefully inadequate. And Mr. Leal, your story in many ways both captures everything wrong and also captures some hope. Wrong in that no one was reaching out to you at first. Hope in that that IAVA ad was able to reach you. I have seen those ads; they are powerful. I have talked to returning OEF/OIF veterans in my district about those and other ads.

The first question I have is, while we know the woefully inadequate side is there, what are the success stories we need to build on? What are the most successful examples of outreach that we need to be taking to scale either through the VSOs or directly through the communications of the VHA?

Mr. LEAL. Well, I think from the young veteran's perspective, IAVA and their ad campaigns, and communityofveterans.org, which is sort of like a *Facebook* for veterans, it really brings out what we do. We do not go to, at least the young veterans that I know, we do not go to halls, we do not do things that way, not this generation, not that it is a wrong way to do it. But we just do not, we communicate through the internet. We communicate through networks, through network sites and different things like that. So the fact that IAVA went electronically, they went out in the internet and they went out in TV ads and did their outreach in that way, really helped bring these new generation of veterans, these young veterans, and let them know that there was somebody out there for them. And let them know that they were not alone. And I think if the VA can look at somebody, or an organization, to try to out-

reach to young veterans, it would be IAVA and what they are trying to do today.

Mr. PERRIELLO. And a quick follow up before we go to Mr. Rowan. Is your sense that those are going to be better run in terms of tone, and a type of engagement, if they are independent but supported by the VHA? Or would you encourage that kind of online outreach, including the social networking functions, within the VHA itself? Do you think that these organizations are going to be better able to build that kind of networking?

Mr. ROWAN. Well I would think that even some of us old dogs learn some new tricks. And you would be surprised. It is amazing to me how many of my members have *Facebooks* and all kinds of things, and do use the internet. And, as I said, we created a Web site called veteranshealth.org. We are hoping to reach out and get our members, get veterans out in the public sector out there to reach out to learn about the illnesses that affect them from all the recent wars.

IAVA did a wonderful program. The thing is that the VA should have doing that program instead of IAVA. I mean, they were just lucky enough that someone was willing to give them a grant, and they were able to produce a very nice public ad that certainly has reached out to their colleagues. It is just sad that they had to rely on public sector, private-sector donations to do that. Meanwhile, the VA spends billions on health care, does nothing on outreach. And we think that is wrong.

And we think we need to reach out to our veterans. When we talk about suicides, I still have Vietnam veterans committing suicide. And we would, nobody knows how many Vietnam veterans killed themselves within the first few years after the War. I know personally, one of my things that I always say, I knew more people who died after the War than in the War. And a lot of that had to do with drug abuse but a lot of that drug abuse was fueled by PTSD. And was really trying to kill themselves in other ways.

So I would just encourage, again, as part of our ideas of getting some sort of legislation out there, some sort of funding, either through the VA directly or by the VA through VSOs or community-based organizations, to do the kind outreach we need to reach out to all the veterans, whether they came home 40 years ago or 40 days ago. It does not really matter.

Mr. PERRIELLO. Mr. Rowan, following up, the VA has discussed their collaboration with veterans services organizations, an effort aimed at expanding their outreach, has the VA really been working with the Veterans Health Council?

Mr. ROWAN. No.

Mr. PERRIELLO. Following up on that, what would you say is your vision of a comprehensive VA outreach effort? What does that dream, comprehensive effort look like?

Mr. ROWAN. Well, I think we need a couple of things. We need to talk about educating medical personnel, both inside the VA and in the private sector, about veterans health-related issues. Getting them to understand they have to ask the question, "Did you serve in the military?" of men and women, of course now today given the high percentage of women. And then depending on the answer, have to then ask follow-up questions depending on where they

served, when they served, what kind of work they did, how much they could be affected by PTSD, for example. All of those things that a doctor should ask of anybody. When they ask you, for example, what did you do for a living? If you may have been exposed to certain asbestos, or something, if you were in a particular line of work. Or worked in an area that was really polluted, or secondhand smoke. Just like any other patient they need to ask those veterans, the 80 percent of them that are sitting today, going to a private-sector physician, who I guarantee never asked them the question and in their patient history has no questions about military service. That is what we need to do. And the VA needs to do that. And inside the VA, frankly, they need to do that better. They need to do the patient history that they do not take as well as they should. So even inside the VA they do not ask enough questions about combat exposure, for example.

Mr. PERRIELLO. Mr. Jones, similarly to you, when you think about what a comprehensive VA outreach effort could look like, the gaps that are not being filled right now, what do you see as part of that vision?

Mr. JONES. Well, I hate to look backward into history but there was a time at the VA when there was an enormous number of folks who were enrolling in the Veterans Health Administration that had to be cut off. That cut, when they made that ban and prohibited certain veterans from seeking service in the system that was developed for them, has sent a shock signal into the veterans community. That has to be overcome. But we still recognize that today, though, VHA serves uniquely some 6 million veterans, nearly 8 million veterans are enrolled in the system. So at one point, VHA was doing a credible job of reaching out to veterans and letting them know about the availability. But recent decisions within the past decade have put a dent in that message. That message has to be recaptured and that would be my vision. I think the VHA, the medical centers, have done an extraordinarily good job in the past, but they have been handcuffed in the most recent past from searching out veterans and doing it through the stand downs that contribute to bringing veterans in from their homelessness. These are areas where VHA and the Veterans Affairs have been most helpful in making veterans aware of the services provided in the health care system.

Mr. ROWAN. I would like to add something to that, too, about the Category 8s, which I think is extremely important. Yesterday's zero-connected disabled veteran may be tomorrow's service-connected disabled veteran. And I am the classic example of that. I had, I never had a service connection, ever, when I walked away from the Air Force 40-some odd years ago. But I am now a 90 percent disabled veteran because of diabetes related to my connection to Agent Orange, having served in Vietnam, and my neuropathy, and other secondary conditions. So I went from a zero to 90 overnight, at the age of, it should have been 48, by the way, which is when I first got diagnosed with diabetes. But it was not until I was almost 58 when they finally gave it to me as a presumptive disease. So that was a big mistake, as was pointed out earlier. Because if they stay in the system, and they should be aware of things. But even then, I, when I was doing service rep work, had

clients who were being treated by the VA for diabetes, who were Vietnam veterans, and the VA never told them, "By the way, go file a claim for a service-connected disability."

Mr. PERRIELLO. In terms of the outreach that is going on right now, there is a certain amount of urgency in the sense that, in the Vietnam era, people were not treated early and cases became exacerbated because of the lack of care. Given the urgency with the folks coming home, what are the programs that are easiest for us to take to scale right away in terms of getting that outreach going right now?

Mr. ROWAN. I will just add that I think that one of the programs that we have seen that is starting to reach out is reaching out again into the private sector, particularly in the mental health community. The other thing is we need to talk about the whole picture, of the family of these veterans. Many of these veterans today, unlike my generation when most of us were single, most of them today are married. A lot of them have children. You need to have a family practice, almost, to deal with the mental health issue that is occurring. Because it is not just the veteran. It is the veteran and the impact to their family. It is the wife or husband, for that matter, who has been sitting home for a year, dealing with all the family issues, etcetera. It is the children who are dealing with an absentee parent for a year. And also, coming home with, you know, Daddy or Mommy who is not quite the same as when they left. And so the idea of working with community-based mental health programs, and taking care of the whole family picture, would go a long way to doing that. Especially with the fact that so many of these veterans today are from the rural communities. And as Sarge said here, he had a tough time finding one near him because of rural Texas. It is a hard place, and rural upstate New York is in the same ballpark. Or Montana. Everywhere you go. Arkansas. You got it, it is going to be a tough time finding help.

Mr. PERRIELLO. Well I have a lot of rural Virginia in my district and we have similar issues. Let me just ask one last question, Mr. Leal, to you. You know, coming from the "just say no" generation myself, there is a big difference between the effectiveness of the early anti-smoking ads that were written by adults and the later truth campaign ones written by actual teenagers in terms of effectiveness. How much of the problem right now is that we are simply not getting the message out? How much of it is that the message is not being written in a way that really connects with the younger generation of veterans? Do we do a good job of getting the message out, we just need better message delivery? Or is it both?

Mr. LEAL. I think it is a little bit of both. It has to be better. If your only message trying to get out to this generation of veterans is written on a pamphlet that is inside the VA clinic, how are we ever going to get it? How are we ever going to find it? How are we ever going to know about it? Unless 1 day somebody comes up to us and says, "Hey, you need help." And by that time, where are we? In what position are we by that time when somebody actually approaches us and says, you know, "Ray, you are not the same guy I knew before you left." Is that, that is the point where we have to actually go into the VA, where we see that it has been enough. And that is where we find the pamphlet. It cannot be that way. It

cannot continue that way. It has to be, it has to be before we go, when we come back, and everywhere in between. We have to be, there has to be something there to remind our veterans and to remind us that we are still, we are wanted and that people understand where we are coming from. And that there are programs out there to help us. Without that, you are going to continue seeing what you are seeing. If you continue to write pamphlets that are inside the facilities where we will never be able to see them unless we go.

Mr. JONES. The best institutions that are ready, shovel ready so to speak, for making veterans aware of the system are the veterans, the health care system itself. But there must be incentives there. What incentive is there for a medical care center to reach out to the veterans community to bring in additional veterans if they themselves are already stressed, if they lack doctors, if they lack the care, if they do not have the ability to hire caregivers. You need to get the hiring in place and to assure these communities that you will back them up. That the resources will be there if they will help make veterans aware that the system is ready to help them.

Individuals serve the system. And individuals, if you just pack too many demands on top of them, will break. So you have to have additional resources and personnel to reach out to veterans as well. The best system in place now to do the job is the veterans health care system. They can do a great job but they lack the incentive, until they have the resources in order. Now, Congress has done a terrific job over the last 3 years in pumping up the resources and making veterans and veterans health care a priority to this Nation. We applaud you for that. So perhaps those resources are there. But I do keep reading about doctor shortages. And those doctor shortages are not only lacking in the overall community but they are missing in the veterans health care system as well.

Mr. LEAL. If I may say something about that, sir? That is exactly why advance appropriations is so important. If we cannot even make sure that we have enough people to take care of these veterans that you want to outreach to, where is the VA going to be? How can they, how can they set money aside to outreach if they cannot even set money aside to make sure that there are two more psychologists at my clinic? I think that is important. That is why advance appropriations is so important. If you force the VA to outreach and they just continue to, I guess, shred medical records because they are getting all these people coming in and they cannot really adequately treat them, we have to see that it is more than just outreach. It has to be an overarching strategy to make sure that everyone gets the care they absolutely need.

Mr. PERRIELLO. With that, let me turn to my colleague Mr. Snyder and see if he has any questions for the panel.

Mr. SNYDER. Thank you, Mr. Chairman. I will just ask one. I know we got behind with votes and you have other panels. If I am trying to sell cars, I figure my best target to sell cars is the family that walks into my car dealership. It costs me a whole lot more money and a whole lot more effort to try to reach the person that is raking the leaves in their backyard, and I am trying to catch them with a radio ad or that night watching TV and they are fall-

ing asleep. How much of this burden on outreach do you think should be on the military while the family is still in the military, in terms of informing them about veterans and veterans benefits, and what is available out there for them, versus how much should the burden be on the VA health care system after the veteran is out?

Mr. JONES. Clearly the military system is an important element in making future veterans aware of what is available. The screening must occur. There must be, we would like to see a better screening of individuals as they leave.

Mr. SNYDER. Right.

Mr. JONES. We would like to see more information provided to families of what to look for with regard to various symptoms that may lead toward discovery of problems in health. So the families need to receive an awareness package of some sort. I am not sure exactly how families are brought into this transition, because the transition is usually military deployment to the demob base, and you are gone, you are out. And in instances of National Guard, you are far away from your family when that demob occurs. So I am not sure exactly how that works. But you are exactly right. The family needs to know what the symptoms are so they can help the individual that they love get back on track.

Mr. ROWAN. I would add that that is true. And I think that they, the military, plays a heavy role. And we keep talking about the seamless transition issue, which would take the health records right out of the military into the VA. But the real problem still gets to be with this exposure question that often does not manifest itself until years later.

I recently had a cousin of mine who is an Iraq veteran. He is 42 years old. He was a seabee reservist, did two tours in Iraq. And he has now got a Hodgkin's Lymphoma in his shoulder that he believes may be related to toxic exposure that he had dealing with toxic waste sites. Now that did not occur until 2 years after he was already back home, sitting back to work, back in his civilian life, you know, going to some meetings once in a while. But if he does not, if we do not have a continual education process over time they are not going to understand the connection between their military service and some of these things that do not manifest themselves until much later. And that is certainly true, it is obviously way too late for all of us Vietnam veterans, and even the Persian Gulf veterans. I mean, they are long out. Even the ones who were, many of them who may have been, you know, people who were, you know, 20-year and 30-year personnel, many of them are all still gone now. There is no Vietnam vets left hardly in the military, and there are very few even Persian Gulf vets left.

So it is a big issue, still. And so while the seamless transition thing is a good thing, and certainly a major improvement over our day, and certainly made simpler, perhaps, by the utilization of computerization, it still does not get past the point, we still have to do a continuing education process.

Mr. SNYDER. Thank you.

Mr. PERRIELLO. I want to thank you all for your expertise, for your time, and for your service. Again, we really appreciate all the ideas you have brought to us. This is an urgent issue and we hope

to be able to move forward on this and make a difference in the lives of those who have served our country. So with that, I dismiss the panel with our thanks.

Now let me call the second panel. Bruce Bronzan, President, Trilogy Integrated Resources; Barbara Van Dahlen Romberg, Founder and President, Give an Hour; John King, Co-Director, Veterans Community Action Teams Mission Project, Altarum Institute; Randall L. Rutta, Executive Vice President, Public Affairs, Easter Seals; Jeffrey W. Pollard, Ph.D., Director of Counseling and Psychological Services, George Mason University, American Psychological Association (APA); accompanied by Michael Johnson, Military and Veterans Liaison, George Mason University.

Mr. King, we will begin with you.

STATEMENTS OF JOHN KING, CO DIRECTOR, VETERANS COMMUNITY ACTION TEAMS MISSION PROJECT, ALTARUM INSTITUTE, ANN ARBOR, MI; BARBARA VAN DAHLEN ROMBERG, PH.D., FOUNDER AND PRESIDENT, GIVE AN HOUR, BETHESDA, MD; BRUCE BRONZAN, PRESIDENT, TRILOGY INTEGRATED RESOURCES, SAN RAFAEL, CA; RANDALL L. RUTTA, EXECUTIVE VICE PRESIDENT, PUBLIC AFFAIRS, EASTER SEALS, INC.; AND JEFFREY W. POLLARD, PH.D., ABPP, DIRECTOR, COUNSELING AND PSYCHOLOGICAL SERVICES, GEORGE MASON UNIVERSITY, FAIRFAX, VA, ON BEHALF OF AMERICAN PSYCHOLOGICAL ASSOCIATION; ACCOMPANIED BY MICHAEL JOHNSON, MILITARY AND VETERANS LIAISON, GEORGE MASON UNIVERSITY

STATEMENT OF JOHN KING

Mr. KING. Thank you, Mr. Chairman, Mr. Snyder, staff. We appreciate the opportunity to testify to you today. With me today is Dr. Lauren Thompson. She is a Deputy Group Director and a corporate sponsor of an innovative initiative titled Veterans Community Action Teams. I will further describe that. We call it VCAT. I will describe that in my testimony. Mr. Lincoln Smith, the Chief Executive Officer of Altarum Institute sends his greetings and regrets he could not be here with you today. He applauds your leadership in taking care of veterans and their families.

Altarum is a nonprofit health systems research consulting organization serving public and private clients. The Institute combines research and analysis with business acumen in providing comprehensive systems-based solutions for complex problems. Altarum is a nonprofit health systems research consulting firm. Last year they initiated three mission projects and committed $8 million to address childhood obesity, to foster innovations in community health centers, and to develop veterans community action teams. Since 2002, more than 870,000 servicemembers have transitioned from active duty to veteran status. They have joined the ranks of 23 million veterans. The multifaceted needs of both young and older veterans have created large service requirements on the Veterans Health Administration. We commend the VHA for their valiant efforts to improve access while maintaining the high quality of care that veterans deserve. However, we believe that no one en-

tity can solve the complex problems of outreach to improve access to VHA services.

Altarum's focus through the VCAT project is to build integrated community-based service networks to strengthen the safety net for veterans and their families who are experiencing issues and/or suffering the invisible wounds of war. We strive to complement the efforts of VHA by building bridges for well integrated community service providers to the national level VHA providers. We envision VHA's outreach as a top down effort and the integrated community providers' outreach efforts as a bottom up.

We know that VHA uses the media, web-based tools, and holds public events to encourage access to their medical centers, CBOCs, and veteran centers, and more. Veterans and their families often seek a wide range of community services when they need assistance. They go to churches, community health centers, housing authorities, public assistance, and many other services. The coordination, collaboration, and integration of these service providers focused on the immediate needs and the rights and benefits of the veterans community will complement VA's best efforts.

The VCAT project will develop a collaborative community-based model to integrate the outreach and delivery of services for veterans and their families. The project will test this model in selective pilot communities to demonstrate the value of community-based system of care for improving accessibility, scope, and quality of services available to veterans and their families.

The strategies employed to connect the current generation with services needs to be different than those used with past generations, because the methods by which this new population receives and processes information is vastly different. Consistent with the previous testimony of Mr. Leal, and efforts of IAVA, we agree that networks of service providers must connect in like manner to the communication and social networks of the younger generation.

Altarum recognizes the Nation's indebtedness to the families of our country's defenders. As mentioned before, the sacrifices of families are much greater than the general public either understands or appreciates. The well-served, well-informed family is better able to survive and thrive, and to assist their veteran Members when in need.

While our overarching goal is to improve the lives of veterans and their families, it is also our hope that the model we develop and the lessons we learn from our demonstration project will help inform other communities. Ultimately, we would like the VCAT model of community-based service integration to be replicated in other communities across the Nation. We hope to serve and share with you the lessons we learn and offer policy and programmatic change that may lead to increased outreach and access to all benefits and services for veterans and their families.

Thank you. That concludes my comments.

[The prepared statement of Mr. King appears on p. 52.]

Mr. PERRIELLO. Thank you, Mr. King. And my apologies for the personal disruption. Next, we will be going to Dr. Van Dahlen Romberg.

STATEMENT OF BARBARA VAN DAHLEN ROMBERG, PH.D.

Ms. ROMBERG. Good afternoon. Thank you for this opportunity to provide this testimony. As the founder and president of Give An Hour, a national nonprofit organization providing free mental health services to our returning troops, their families, and their communities, I am well aware of the many issues that now confront the men, women, and families within our military community.

Our Nation is confronting an emerging public health crisis. Since the conflict in Iraq began, nearly 1.9 million servicemembers have deployed. Many of these men and women have deployed more than once, some as many as four or five times. As those who have fought will attest, everyone is changed by the experience. Some suffer physical wounds that require medical attention. Others suffer wounds of war that are not always easy to see. As a Nation, we must provide comprehensive, long-term care for all of those affected by their experience of combat, and we must embrace the reality that combat stress and other psychological consequences of war are normal human reactions.

VA funding for the past 4 years is at unprecedented levels. We cannot assume that more money, more staff, more outpatient clinics, more Vet Centers, more clinics on wheels, and more organizational restructuring will enable the VA to meet the mental and physical health care needs facing this generation of combat veterans. This is a public health crisis that will take more than extended outreach. If returning troops are to truly and successfully reintegrate into our communities, then our communities must be involved in the solution.

The issue is bigger than the efficacy of the VA's current outreach efforts. The issue is, how can we systematize a broad range of services to sustain care for our veterans over the long term? Further, it is impossible to discuss this issue without also discussing DoD's response to the men, women, and families who serve. While the VA and DoD operate as if there are two populations that require care, military personnel and veterans, there is really just one. Too many returning warriors get caught between the two systems and fail to receive the care they need, when they need it.

No single agency, organization, or sector can adequately care for our returning warriors. I am proposing the development of a new kind of public works project and have outlined the support for such a program in great detail in my written statement. The need is clear: over 300,000 men and women have already returned from Iraq and Afghanistan with symptoms of severe depression or post-traumatic stress. Over 320,000 have suffered traumatic brain injuries. The Army calculates the current suicide rate is the highest in its history, a rate that is higher than the civilian rate. Seventeen percent of soldiers returning to War for another tour could have a traumatic brain injury. Many of our returning troops turn to substance abuse to ease the pain of wounds that they cannot see and they do not understand. Good kids end up in jail for crimes that no one believed them capable of committing. Divorce is on the rise in the military community, with about one in every five married servicemembers filing for divorce since 2001.

There is a tremendous need for a full range of easily accessible mental health services for our veterans. Many live a great distance

from formal VA services and many are reluctant to seek mental health services because of a perceived stigma. We need to develop additional education and treatment programs for servicemembers who suffer traumatic brain injuries. We need to develop programs that support employers who want to hire veterans, as well as veterans who want to be productive members of society. We need to develop programs specifically focused on the unique needs of women who serve, including programs that treat victims of sexual assault. We need to develop programs that train police, fire fighters, paramedics, and judges about veterans and the issues that come home with them.

Our military culture promotes pride and inner strength along with self-reliance and toughness. Only through education and practice can veterans learn to face their fears and work through the understandable pain associated with the experience of war. Systems charged with providing care for those who serve, including the VA and DoD, have failed in their efforts to reach those in need. Both DoD and VA have been reluctant to forge critical relationships with community-based organizations that have developed over the last 6 years. Opportunities have been missed for innovative collaborations that could have saved lives and healed families.

The best solution is a new kind of public works project. We need a system that can streamline and simplify the process of providing and receiving all manner of care for returning warriors and their families within their own communities. We need a plan that ensures our communities are able to assist and support veterans and their families so that their lives are working for them. In 1933, the Public Works Administration in an effort to heal our Nation's Depression-ridden economy. The goal was to heal our economy and ensure that our citizens were free to lead productive lives. Now we need to design and implement a similar public works project for the 21st century that will weave together the resources needed to heal our military community and ensure that our military personnel are free to lead productive lives.

But what do we need to do first? Bring together individuals representing organizations and entities that interact with veterans and military personnel. Form a group with these representatives to study efforts currently underway, including innovative and successful community programs. The primary task of this group will be to develop a plan that will serve to guide our communities throughout the country in their efforts to coordinate care. This group can assist with the implementation and the metrics needed to understand the success of this program.

We have the resources, we have the vision and the commitment to ensure that our veterans and their families receive the care they need and deserve through a new kind of public works project. Thanks to the efforts of dedicated people working in and across our country we have the potential to create this based on these organizations so that we can provide comprehensive long-term care to those who serve our country. This is a historic and unique opportunity to harness our Nation's resources and care for our military community. Thank you.

[The prepared statement of Dr. Van Dahlen Romberg appears on p. 46.]

Mr. PERRIELLO. Thank you very much, Doctor. And now, Mr. Bruce Bronzan.

STATEMENT OF BRUCE BRONZAN

Mr. BRONZAN. Thank you very much, Mr. Chairman and Members. I am Bruce Bronzan. I was a Program Director for Mental Health at the county level, and then a County Supervisor, and a California State Assemblyman with a 20 career in politics. I chaired the Health Committee and the Mental Health Committee. When I left elective office, I formed a partnership with Afshin Khosravi, who is behind me here in the audience, and we worked with the State of California with pilot projects called the Network of Care to try to do something different at the local level. Specifically, how do we get people more aware of all of the services that are available to them, regardless of the silo funds that connect to a given agency, Federal, State or local. The other way of looking at it is how do we connect a community more to the people in need within that community? There is actually a form of community organizing, county by county in the State of California.

This project called the Network of Care turned out to be quite successful. A Network of Care for mental health was developed almost 8 years ago. It spread all over California almost instantly, and then around the United States. And now it is in almost 30 States and some 500 locales. The Network of Care in aggregate reaches some 65 percent of the United States population and manages a total of 127,000 services that it serves up to people locally, in their own community.

During the work on the Network of Care for mental health we became acutely aware of the severe strain that is being exhibited by both community mental health, DoD, and VA services for the returning soldier. And we were asked some time ago by Congressman Kennedy and Congressman Farr, friends of mine, and a number of veterans leaders and mental health leaders across the country to do one specifically for veterans. After 3 years of work, the first two State/national models are ready to go. Maryland's has been launched about 4 weeks ago under the leadership of Lieutenant Governor Anthony Brown, who himself is the highest ranking elected official who is an Iraqi veteran. And this Friday at noon, in California, Governor Arnold Schwarzenegger will launch the California version of the Network of Care in each and every county in both States.

So what I am here to show you is something very different. I know, Mr. Chairman, the title of this hearing. But what we are going to show you, and have been asked to show you, is something different. And that is, rather than looking at outreach through the lens of any given silo funded agency, look at outreach through the lens of a veteran and their family and what they need in the community in which they reside. It is a different model, but it is quite exciting. If we could turn on the screen? Okay.

[Slide.]

Mr. BRONZAN. What I am going to show you is the Los Angeles version, which is going to be officially launched Friday but you will see it ahead of everybody. This, by the way, in both Maryland and California, was a process that was quite extraordinary. The vet-

erans community and military leaders reached out across the space to the mental health community, and they joined hands to try to do something important regardless of their agencies' parochial interests for the veteran. And I think you will see it had remarkable results.

On this homepage you see Governor Schwarzenegger, Lieutenant Governor Brown will also appear in a couple of days on the Maryland site, but I could just play a moment here for you. Do we have sound? Oh, we do not. Oh, do not worry.

Okay, well what he does is he gives a greeting saying how important it is for us to pay attention to the returning soldier and how they cannot be neglected, and that we have to reach out as members of a community to anyone that returns from War. These other tour guides are all veterans from different conflicts, different theaters of war, different backgrounds. Each one of them explains, as a veteran to a veteran, why it is important to use certain portions of the site. For example, the Vietnam veteran here, a good friend of ours down in San Diego, explains that when you are in crisis, you need help, it is okay to seek help and to deal with whatever situation you are facing right at that moment. Andre here, another good friend of ours from another part of the State, the Bay Area, talks about the fact that there is no shame in seeking shelter if you do not have it. Do not sleep out under the bridge, get some help. They direct the veterans who, or their family members who come to the site, to these buttons right here as the most important services that the site offers.

With one click, this is every single crisis intervention that is available, regardless of agency, in their own community, community by community, starting with the suicide prevention hotline. Relative to homelessness, it is every single shelter and homeless provision in their own community, with one click. Relative to employment assistance, there is not only every single agency that serves veterans relative to employment, we have a partnership with VetJobs, a remarkable organization, headed by a veteran himself. And what we do is collaborate with this organization. They seek out jobs that are available to veterans, specifically for veterans. And what we do is bring it into each individual local community. So a veteran can choose a particular category, click search, and what is brought up into this window are the actual specific jobs that are currently, that day, available to veterans that they can find in their own community. It is quite a remarkable service. To the best of my knowledge it has never existed in our history before.

Last, the fourth button that is on the homepage connects the person with whoever their county veterans services officer, often people extremely knowledgeable in helping them navigate the system. However, many of our returning soldiers simply do not know who they are or how to contact them. We put the name, the address, the phone number, and the email address with one click.

Relative to the rest of this homepage, there is community announcements. We allow, we give a tool to the community mental health director as well as the veterans service officer where they can post up information directly, 24 hours a day, to their own community. Nationwide news from around the country, we cull through

about 2,000 periodicals and post the top articles up every single morning at 6:00 eastern standard time. Exquisite translations that are both hand and culturally perfect, as well as audio/video presentations of those translations for family members who may not have literacy in a given language.

The main content of this site is in these huge portals here. By the way, in spite of the fact of it being rather clean and simple looking, these are very, very deep sites. This took a great deal of work locally. The site you are looking at is about 250,000 pages deep. There is about 3 million lines of code that run it, and it is upgraded every single day. In the service directory, the service directory is every single service, Federal, State, and local, every not for profit, community-based organization, non-Government organization at the Federal level, every single thing in the United States and in that community. If you notice the search engine, it does not really care what agency it is from, what silo fund, or what bureaucracy it belongs to. It goes by what a person needs. So, as you drill down into these categories, you find everything that is relative to that particular concern and it is refreshed on a regular basis.

When you get to an actual file, with one click you could drop that file into a personal health record. In the library section-oh, by the way, I am really sorry, I want to show you this. Just before we got started, we were approached by Military OneSource and a variety of organizations that formed together to form a joint family assistance program. We said, "We would be glad to help you. What is the situation?" They said, "Well, we have great programs but nobody knows we exist." Which is something that we have heard all over the country. So what we have done is integrate their information into, with one click, into this site. And here are all of these family support programs with 24-hour hotlines and for the first time they can be broadcast into each and every local community for people to find that they are there.

The library function is a huge library. It took a great deal of Maryland's and California's money to build it. It has 4,000 topics and some 35,000 separate articles. If you were to print it, it would be about 50,000 pages long. And if you were to print it, it would be that long. And it is refreshed four times a year.

Mr. PERRIELLO. Can you wrap up in the next 30 seconds?

Mr. BRONZAN. Yes, thank you. We have a full blown social networking program that is commercial free, a legislative advocacy tool, every assisted device that is made in North America, every link in the United States that is not-for-profit or Government sponsored, some 20,000, and a full blown HL7 certified personal health record that is a consumer-based record, not a provider-based one. Thank you, Mr. Chairman.

[The prepared statement of Mr. Bronzan appears on p. 45.]

Mr. PERRIELLO. Thank you very much. Mr. Rutta?

STATEMENT OF RANDALL L. RUTTA

Mr. RUTTA. Sure, thank you, Mr. Chairman. It is a pleasure to be here today to speak on behalf of Easter Seals. Easter Seals, like the VHA, actually has a significant interest in helping our veterans, particularly veterans with disabilities. We are concerned about the thousands of injured servicemembers that are returning

every month to this country looking to reintegrate into the community and lead their lives successfully. We are also concerned about other veterans who are working, they are raising families, they are aging in place, veterans of past conflicts, who have service-connected disabilities and other needs, and could use our help. We very much appreciate the good work of the VHA and the Veterans Affairs Department overall. Their broad spectrum of public benefits and private supports that are available to veterans is impressive, but we know that at any given time there are veterans with needs that fall through the cracks that are not getting the services they need, when they need them, where they need them.

We do recognize that the VA is vast and complex. It is charged with an enormous responsibility, a large mission, a large and diverse constituency. And like any organization, be it the VA or providers like Easter Seals, that presents some challenges that can be daunting. You need to overcome fragmentation, bureaucracy, self-contained service strategies, all of which really stand in the way of person-centered, veteran-centric, readily and consistently available services. We did note that in 2007 the GAO commended the VA for its work anticipating the needs of OEF and OIF veterans. But we saw and have shared in our concerns the VA not necessarily really reaching out to veterans in a way that they truly understood the services that where available to them; assuring that there was equal access, particularly in areas like rural areas where their facilities might not reach; and also were better at noting the implementation of infrastructure as opposed to services being delivered or the utilization of that infrastructure.

For 90 years Easter Seals has served people with disabilities including veterans and their families. We serve about 1.3 million people every year, including veterans. And actually just this past 2 years, we have really made a concerted effort to reach out and identify veterans much in the way those other members of the previous panel and this panel have said is important. Community-based agencies absolutely have a role to play as a partner with the VHA, as an extender of their reach, and as an information resource that they can benefit from.

Now we understand that as veterans fall through the cracks this is nothing new. People with disabilities oftentimes fall through the cracks. What we do not want is for that to continue to happen for veterans. It really is unacceptable. Let me just share a few things that are captured in our statement but I would like to have you note right now.

Obviously no one organization can be all things to all people, and so my most important point would be to the VHA, to the Veterans Affairs Department, and to Congress in its role supporting that agency, please do everything possible to engage the community and the resources within the community to leverage infrastructure, tap best practices, build capacity and share, in the same way that the VA is a tremendous resource with regard to medical education, in the same way the community can be a laboratory, a pilot test, a partner, in helping veterans, particularly those with disabilities.

Easter Seals supports the Gateway Initiative that was launched by the VA under former Secretary Peake. As far as we know, this initiative is still in place. It is an attempt to put a liaison office in

place at the VA for organizations like Easter Seals to know who to talk to to better understand what are the current priorities, what are the activities, what kinds of things might we do to support and echo the good work of the VA. And so we would encourage the VA to continue to fully implement and support that Gateway Initiative.

We also see that the VA has implemented 50 mobile clinics, primarily dedicated to helping veterans, particularly those living kind of far afield from the facility-based systems, with their mental health services. Easter Seals and others have offered to host those VA clinics when they come into town, be a partner in outreach making sure that enough people know about those services that they are fully utilized. And then be present in the community when that mobile clinic leaves so that those veterans and their families have continuity of care, some follow along services, a way to connect back to the VA that provided those services originally.

We applaud the VA and the VHA for its efforts to reach out to younger veterans in ways that are meaningful to them. They are doing great things with regard to their Web site and leveraging social networking tools, much as we are trying to do as a nonprofit organization. We also say probably the most important thing we found is that to connect with veterans you have to reach them early, you have to reach them in the context of their family. These individuals respond very well to us when we engage in pre-deployment and post-deployment activities, and we are there as the individual transitions from military service. And so they recognize us as partners and friends to them bringing them into the VA system as a collaborator.

So I would just encourage you to keep the community-based systems very much in mind as something for the VHA to reach out to, to partner with, contract with, outsource, and leverage in whatever way possible. We will certainly be there as a partner and a friend. Thank you.

[The prepared statement of Mr. Rutta appears on p. 55.]

Mr. PERRIELLO. Thank you so much, Mr. Rutta. Now we will go to Dr. Pollard.

STATEMENT OF JEFFREY W. POLLARD

Mr. POLLARD. Mr. Chairman, please allow me to express appreciation for the opportunity to speak on behalf of the 150,000 members and affiliates of the American Psychological Association regarding outreach activities for veterans on college campuses. I am the son of a decorated World War II veteran captured on December 7, 1941, released in September 1946, and buried in Arlington National Cemetery. I have spent 30 years working as a psychologist committed to the mental and behavioral health of students on college campuses. Meeting the needs of increasing numbers of our Nation's veterans, particularly on college and university campuses, is extremely significant to me.

Our ability to diagnose and treat combat-related mental and behavioral health problems, including depression, traumatic brain injury, and post-traumatic stress disorder, has improved dramatically in recent years. Estimates suggest that between a quarter and a third of all veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom will display symptoms of mental dis-

order within a year of leaving military service. Many of these veterans are expected to benefit from the new Post-9/11 GI Bill by furthering their education at our Nation's colleges and universities. These facts point to the important role that colleges and universities must play in our national efforts to meet the mental and behavioral health needs of our servicemembers and veterans.

During the past year, George Mason University has been involved in a number of important activities to enhance our outreach to military personnel and veterans on campus. First we hired Mr. Michael Johnson to serve as our full-time Military and Veterans Liaison in our Military Veterans Office. Mr. Johnson, who has accompanied me here today, is a veteran of 17 years, both as an enlisted member and an officer in the United States Marine Corps. Mr. Johnson and his colleagues in the Military and Veterans Office currently serve approximately 1,000 active duty, Reserve, National Guard, and veteran students, offering assistance and information regarding issues such as veterans services and academic counseling, as well as information about the many benefits to which they are entitled through State and Federal Government programs.

In addition, George Mason University has recently completed a needs survey of our military and veteran student population and established connections between the new Military and Veterans Liaison and virtually every component within the University. We have also established the Mason Military Outreach Group, which is a collaboration of students, faculty, and staff in support of our servicemembers, veterans, and their families. Further, the Mason Veteran Peers Initiative involves a group of veterans who are working with counseling and psychological services to provide peer support to veteran students.

Last month, George Mason University was one of only 20 institutions of higher education awarded a Success for Veterans Award Grant sponsored by the American Council on Education and the Walmart Foundation. This $100,000 grant will help George Mason University Military and Veterans Office evolve further into a compliance-coordinated one-stop resource and support center to ensure academic, psychological, and transition support. We are grateful for this award. However, like most grants it will not cover the predicted level of need and it is time limited.

Just as the community mental health system is stretched far too thin, so are college and university mental health resources. In fact, campus mental health faces significant systematic challenges, including an insufficient number of service providers, such as psychologists, psychiatrists, and case managers. Data indicate that students on college and university campuses are increasing arriving with more severe preexisting mental and behavioral health patterns, or develop these health concerns during their college careers. The increasing civilian mental and behavioral health needs on campus make it even more challenging for colleges and universities to provide sufficient services and support for the growing population of servicemembers and veterans on campus.

While we at George Mason and our colleagues at colleges and universities around the country have been taking important steps to reach out to servicemembers and veterans on campus, much work remains ahead. I would like to provide a few recommenda-

tions that may help our institutions of higher learning meet the mental and behavioral health needs of our military and veteran student population.

First, sufficient resources must be made available to support targeted efforts on campus to address mental and behavioral health needs among servicemembers and veterans, including the concern of suicide. In recent years some, important Federal initiatives have been created through the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the national problem of increased mental and behavioral health concerns on campus, including suicide. However, much more needs to be done.

Senators Durbin and Collins and Representative Schakowsky have recently introduced the Mental Health on Campus Improvement Act and its programs will complement SAMHSA's Campus Suicide Prevention Program to offer the full range of prevention and intervention services currently needed on college and university campuses. In addition, this legislation calls on grant applicants to include a plan, when applicable, to meet the specific mental and behavioral health needs of veterans attending institutions of higher education.

Second, continuing education and training opportunities must be readily available for colleges and university mental and behavioral health professionals regarding some of the unique deployment and reintegration issues facing servicemembers, veterans, and their families. Both the Department of Defense and the Department of Veterans Affairs have unique knowledge and expertise in this domain.

I recently had the privilege of attending a week-long training conducted by the DoD's Center for Deployment Psychology, in which leading experts in the field provided clinical training regarding the deployment cycle, trauma and resilience, behavioral health care for the severely injured, and the impact of deployment on families. These are high quality programs and are worthy of continued attention and support.

Third, we must develop mechanisms to conduct appropriate outreach to servicemembers and veterans who are beginning their post-secondary education online. Such online education opportunities may present unique challenges for our military and veteran students because of their potential isolating effect. Servicemembers and veterans who are enrolled in online education programs and experiencing mental and behavioral health problems are often more isolated than their on-campus colleagues, and this isolation can be contraindicated for their healthy readjustment and recovery.

APA and the psychology community looks forward to continuing work with Congress, the VA, the DoD, and the veterans service community to welcome home our men and women in uniform, and to ensure that they receive the mental and behavioral health services and support on college and university campuses and in the larger community that they so honorably have earned. Thank you.

[The prepared statement of Mr. Pollard appears on p. 59.]

Mr. PERRIELLO. Thank you, Dr. Pollard. Congratulations to George Mason on the grant, and thank you for the heroism and sacrifice of your father as well.

Mr. POLLARD. Thank you.

Mr. PERRIELLO. Let me begin by asking a question of the panel. Many of you talked about the importance of the VA forming partnerships with the VSOs and other private groups to help reach more veterans, and community-based strategies. Could you say a little more about whether the barriers to that right now are primarily a cultural mindset? Is it bureaucratic and regulatory? Is it financial? And what specifically could the VA be doing better to develop those kinds of partnerships and community-based strategies you note?

Ms. ROMBERG. I think it is all of the above that you mentioned. Maybe the least being financial, in terms of it has to start with conversations and dialog. And thus far, while in our case, our organization, initially the message was that the VA responded that they had it covered in terms of the mental health care. That was 4 years ago. As time has gone on, we have developed a really nice relationship with the VA philosophically in terms of that we exist, and that we can be a resource. But there has been no systematic relationship formed so that throughout the country VA hospitals know about the free mental health services that our providers give. I think that it has, there has to be some conversations at the very top to change the culture, to open the doors. Not just with VA, but DoD as well, so that we can look at, I mean, just listening to this panel there are so many tremendous opportunities and organizations out there. Here in Maryland, there are some programs in Montana, in California, collaborative efforts. But they do not function together. No group or no State is able yet to access and speak to others in the other States so that we have a comprehensive system.

So outreach is important, but if the people then do not know where to go from that initial point of outreach to the various organizations, the Easter Seals, George Mason University, for somebody with the GI Bill. So it really needs to be at the top level, that a change in culture and a structure needs to be developed so that we can knit these together.

Mr. BRONZAN. Yes, I think it is a great question and it is a very important thing. I mean, in our work in these two States, county by county, we found two kinds of folks. There were some that were very inbred in their thinking that if they did not, whether it is VA or DoD or a private agency, that if they did not make it they did not want to do it. Or, if they could not control it they did not want to do it. And they did not really want to collaborate with anyone. But there are others who are, I think, of a much more newer thinking. That they cannot do it alone. They have to reach out and they have to work with other people, especially community-based organizations where people live. And it is that group that we worked with, and were fortunate enough in the two States because there was an outpouring of it.

In fact, we had one State director, VA director, say to us that what he liked about the Network of Care as one model is that it was outside the VA and it was easier to connect with all the community-based organizations on behalf of the vet, which is a rather extraordinary comment that I am not sure you would have heard just a few years ago. So I think there is a new generation of thinking. And that thinking has to be encouraged and supported so that

these two sides can reach across the space to each other and help the veteran in a more meaningful way.

Mr. RUTTA. I would definitely agree with what has been said. I think two other perspectives. One, the Easter Seals really takes an individualized but family centered approach. And I think the VHA and the VA generally would do well to really look at the veteran in terms of the context of family, and how the family truly can be supportive and actually help the system overcome the resiliency training that many of these veterans carry from their military days where it is difficult for them to accept help, difficult for them to identify a problem. And so the extended family and organizations that they trust, like ours, can actually be a partner to the VA in that effort. But the VA has to recognize that important role of family in the holistic support of the veteran.

The other piece would be for older veterans there is a lot of collaboration with the community-based organizations around adult day services. Although the Veterans Affairs Department and VHA does indeed offer adult day services themselves, they do frequently outsource that service within a tremendous amount of information sharing and mutual learning that occurs, which benefits the veterans and their families. There are some 1,300 other adult day centers that are out there that could really be a partner to the VA in maybe diverting some older veterans who might otherwise end up in VA supported nursing homes or in hospitals, helping them stay in the community. So reach out to the aging network, the Administration on Aging as a partner, in that natural other system of care that could be a partner to them.

Mr. PERRIELLO. Let me ask a follow up question to that. You know, I represent a district that includes Charlottesville, Virginia, the University of Virginia, a very highly educated small town with a lot of hospital care. But it also goes to the North Carolina border. About two-thirds of my district is highly rural. How much of a discrepancy are you finding in interest in these strategies for, say, rural versus urban? And how much in terms of need are you seeing in geographical discrepancies?

Ms. ROMBERG. Well there is a tremendous need in the rural communities. We are now developing State initiatives, and our first State initiative was with West Virginia because they have so few resources available. We are also working in Arkansas for the same reason. So the need, again, to develop a strategy to link together. That is what is missing. There has not been, yet, a strategy from, for our country to step up. This is not a VA issue. It is not a DoD issue. It is not a community-based resources issue. It is a national issue. And until we figure out a strategy and a plan to organize who is available in the rural communities—it is very doable. We are starting to look at that in States like West Virginia. Something very innovative, like working with the Council of Churches. Because they are who, those folks, the ministers, the pastors, they often see the veterans and their families first. But who do they contact to develop an approach in that way, is critical for those rural communities. Because there is not anyone there to provide services.

Mr. BRONZAN. In our work, because we are statewide in many States, we are able to do surveys and learn some things. And it is very interesting, the Network of Care, looking at rural and urban.

In the urban areas the sites are used more than all other mental health services in the county combined. But in the rural areas, they are used as much as three times as much as they are in the urban areas. And it is because modern internet technology is a way for people who are in rural, isolated areas to get information and to connect with other people.

So it should never be underestimated, the value of internet technology, to gain information in the rural area. They use it very heavily.

Mr. RUTTA. And I would just say for Easter Seals, because we are a nationwide organization, we have a special interest in outreach to rural residents with disabilities. In fact, almost 20 years ago, we worked with Congress to create a program called AgrAbility. It helps farmers and ranchers with disabilities. A significant percentage of those individuals are veterans. And what we found is, they frequently encountered the geographic barriers. They were not able to tap the VA services as often as they would like. And in some instances, those local VAs, often working through the State veterans office, would indeed engage Easter Seals or others in helping those veterans. And it would just provide some continuity, a watchful eye, someone to help that veteran and their family stay connected in a way that really benefited the larger organization.

I know in Iowa our AgrAbility Program has got a contract with the VA to help do the home assessments and modifications. It is a wonderful role for us to play. It is a modest reimbursement to us, but critical, and that would be something we would like to see replicated. But what was mentioned on the panel is that that is often a case that has to be made, you know, medical facility by medical facility, very locally. It would be good to have that leadership from Central Office.

Mr. POLLARD. In preparation for our conversation today, I spoke to my colleagues in counseling centers across the country using our listserv and asked them about their concerns. And it was interesting to hear from communities that are more rural and more separated having spent 23 years on a college campus that was quite rural before coming to Virginia. What I found was that there is tremendous concern on campuses that are distanced from resources that the Government provides, and that there is, that concern runs along these lines. One or two, three or four, veterans with high need could throw the resources in some of these colleges into a very difficult position. There is no way for them to really cope with some of the special needs that our returning veterans are displaying. And they are tremendously concerned. Some of the most heartfelt outreach from some of my colleagues came from places that talked about the fact that it may cost them literally thousands of dollars a week to accommodate a soldier who lost hearing because of a, you know, an explosion nearby. And these small universities are already on a very tight string, and that kind of cost puts them in a position where they are beyond their ability to, you know, the tuition does not take care of it. So they are very, very concerned that the returning vet on some of these campuses, especially with the GI Bill, is just not going to help. They are going to be going in negative territory.

Mr. KING. The observation I would make is that, you know, the VCAT initiative is all about assessing communities, looking at the fabric of that community, the chemistry of the service providers that make services accessible to veterans. It was mentioned in the Network of Care and on the previous panel that one of the essential ingredients to a high functioning community is the accredited service officers, and the role they play, whether they are State, county, or national service organizations. And whether you are rural or urban, to be able to have veterans referred to someone who will serve as their legal advocate, develop a well-developed claim ready to rate, and produce the outcomes that basically requires the Federal Government, then, to perform. Those are pretty essential ingredients to sustainable outcomes for veterans and for the community. It is a return on the investment. If you cannot figure it out from here and here, let us help you understand from the pocketbook about how important it is to pursue the rights and benefits of veterans and their families.

Mr. PERRIELLO. I really want to thank you all again for your contributions. I think it will be interesting to see, as Mr. King and Mr. Bronzan discussed the extent to which the internet does bridge this gap. Not just the establishment of a Web site but the interactive components of Web 2.0 technology, the social networking, telemedicine, and other issues, and how that may prove to be part of this conversation. Where it is not simply a producing of information but a dialog. We really appreciate all of your comments. Thank you for your time. And with that, I will dismiss the panel.

Let me call up Paul Hutter, Chief Officer, Legislative, Regulatory, and Intergovernmental Affairs for the VHA; accompanied by Ev Chasen, Chief Communications Officer, Veterans Health Administration; John Brown, Director of Operation Enduring Freedom and Operation Iraqi Freedom Outreach Officer for the VHA; and Emily Smith, Deputy Assistant Secretary for Intergovernmental Affairs and the Officer of Public and Intergovernmental Affairs at the VA.

Mr. Hutter, thank you for joining us. You may begin.

STATEMENT OF PAUL J. HUTTER, CHIEF OFFICER, LEGISLATIVE, REGULATORY, AND INTERGOVERNMENTAL AFFAIRS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY EV CHASEN, CHIEF COMMUNICATIONS OFFICER, VETERANS HEALTH ADMINISTRATION; JOHN BROWN, DIRECTOR; OPERATION ENDURING FREEDOM AND OPERATION IRAQI FREEDOM OUTREACH OFFICER, VETERANS HEALTH ADMINISTRATION; AND EMILY SMITH, DEPUTY ASSISTANT SECRETARY FOR INTERGOVERNMENTAL AFFAIRS, OFFICER OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF PAUL J. HUTTER

Mr. HUTTER. Mr. Chairman, thank you for providing me this opportunity to discuss VHA's outreach activities to veterans. I am accompanied today by Emily Smith, Deputy Assistant Secretary for Intergovernmental Affairs; and to my right Ev Chasen, who is

VHA's Chief Communications Officer; and on my immediate left, John Brown, Director of the VHA OEF/OIF Outreach Office.

VA's mission is to care for those who have borne the battle, to honor those who have worn the uniform by providing them the highest quality health care and benefits available. This mission can only be accomplished when veterans know the full range of services we offer. VA is committed to reaching out to veterans and their families where they are to support these ends. This includes not only reaching into rural communities but entering virtual communities and establishing communications and connections there as well.

Before I move on, Mr. Chairman, I want to say on behalf of the Department, I want to thank Mr. Leal of the previous panel for his service and his sacrifice, and appreciate this testimony and suggestions concerning outreach. I also thank Mr. Rowan, Mr. Jones, and Mr. Johnson for their service and their suggestions on behalf of veterans. And I also want to extend out thanks to the previous panel, the Members of the previous panel who are not veterans, who are still dedicated to their mission and to help us reach out to veterans in an effective way.

My written statement, which I ask to be submitted for the record, highlights four forms of outreach. Direct outreach to separating servicemembers, program specific outreach, outreach to rural areas, and outreach using new technologies. In the few minutes I have now, I would like to show you some examples of the outreach we are doing and the new initiatives that we have underway.

I would like to begin by showing two public service announcements (PSAs) that VA has produced and are currently airing across the country. The first features Deborah Norville, a two-time Emmy Award winner. The second features Gary Sinise, an Academy Award winner, whose portrayal of Lieutenant Dan in the movie *Forrest Gump* put an unforgettable voice and face to veterans returning from Vietnam. Mr. Sinise's PSA is directed toward veterans, and Ms. Norville's is aimed at the family members of veterans who may be in need of VA's suicide prevention hotline. With the Chair's permission, I would like to show those two videos now.

[PSA video featuring Deborah Norville shown. Text of PSA video by Deborah Norville appears below:]

> "You may be seeing warning signs of depression or suicide. Some of these warning signs can be that the veteran seems disconnected from family or friends, starts to give away prized possessions, displays anger or rage, or overreacts to problems. The VA is reaching out to help so please reach back. If your loved one is a veteran, and if you even think you see these warning signs, call 1–800–273–TALK and press one. That is 1–800–273–TALK and press one. Do not second guess yourself. Reach out for help.".

[PSA video featuring Gary Sinse was not shown due to technical difficulties.]

Mr. HUTTER. Cannot get it to go? Okay. Mr. Chairman, the second PSA announcement from Mr. Sinise has in the last 6 months between October 13, 2008, and April 13, 2009, this PSA was broadcast more than 8,700 times by 155 stations in almost 100 markets. During this same time period, VA's suicide prevention hotline received approximately 50,000 calls across the Nation, an increase of approximately 25 percent based on the previous 6 months.

Last year, VA advertised the suicide prevention hotline on buses and Metro trains in the Washington, DC, area resulting in a significant increase in calls to the hotline from the area. This year we have begun advertising in Spokane, Washington, and will soon advertise on public transit systems in Miami, Los Angeles, San Francisco, Oakland, Phoenix, Las Vegas, and Dallas metropolitan areas, all locations where the suicide rate among veterans is higher than the national average. In addition, VA is working with a company to purchase advertisements on 20,000 buses nationwide. You have probably seen the advertisements VA displayed on Metro buses and railcars. Here are two pictures of our advertising in the Spokane, Washington, public transit system.

So this, again, is focused on the suicide prevention hotline. In addition to these 20th century forms of outreach, VA has leaped into the 21st century by developing Web sites accessible to mobile devices, and by venturing into portions of the cyber community where veterans are most likely to congregate or visit. Thirty years ago VA's outreach strategy was to visit the local VFW or, more recently, VVA halls. Today we post blogs and videos accessible to veterans wherever they are.

We have two images of VA's Web site as viewed on a mobile handheld device. So this is available on an iPod or something similar as well. First you can see an easy to use menu with information at the touch of a button. Second, you can see a news story, complete with image, that provides information to veterans about benefits or services that strike their interest. We understand veterans are busy and may need information on the go. So we are adapting our systems to meet their needs. These sites are available through any cell phone or other handheld device with internet access.

The next slide provides a demonstration of VA's presence on Second Life, a free, three-dimensional, virtual world where users can socialize and interact with one another. VA offers information and points of contact where veterans or family members can learn more about our programs. The following slide shows VA's *Facebook* page.

Here you can see images of VA's winter sports clinic, a great venue for outreach and inspiration, where VA partners with our colleagues at Disabled American Veterans to support the rehabilitation of wounded or injured veterans.

I am also proud to say that even bureaucrats can use *YouTube*. VA now posts videos with stories or services that impact the lives of veterans.

And finally, Mr. Chairman, VA has also created a new Web site for returning veterans that provides useful information about eligibility, benefits, health care, and other services. This Web site features a blog with comments from veterans and family members. We recognize we must develop social networking strategies, including nontraditional outlets, and a wide variety of new media to communicate VA's message about our services.

I want to point out, Mr. Chairman, that on the right side of this you see what is called a panel, and the more visible areas are the ones that veterans have clicked on to get those services. And that gives us an indication of how many, I am told that the word is not hits but encounters, on that particular part of the Web site.

The other thing I wanted to mention is that the social networking sites that I mentioned earlier are also available from this central location, this central Web site.

These new technologies have entered into health care delivery. One VA facility has begun piloting a program that uses text messaging to help veterans send their home-based blood pressure readings to their clinicians. Researchers found veterans who used this text messaging achieved their blood pressure goals 2 weeks sooner than those who used other methods.

More broadly, VA could not serve veterans to the degree it does without the immeasurable help of veterans service organizations (VSOs), faith-based, and community groups. I would like to thank the Committee for inviting Mr. Leal as well as the representatives of the other panels to share their views. Because we see these hearings as an opportunity for exchanging information and for listening to those who matter most to us, our veterans.

VA maintains constant contact and holds regular meetings with VSOs and groups at all levels of the organization to provide information about VA's programs and offerings while soliciting feedback about concerns present in the community. Working with these community partners helps significantly expand VA's reach to millions of people who may not otherwise hear of our offer of care and service.

In conclusion, Mr. Chairman, VA understands that different veterans will receive messages in different ways and at different times. It is our duty to notify veterans of the repayment our Nation offers in gratitude for the sacrifices they have made. We must continue programs that are successful and develop new methods when our current measures are insufficient. Our mission is to reach out to family members, employers, community stakeholders, Reserve and National Guard units, and veterans to make sure they know how to access help when they need it.

Thank you again, Mr. Chairman, for the opportunity to testify. My colleagues and I are prepared to answer any questions that you may have.

[The prepared statement of Mr. Hutter appears on p. 61.]

Mr. PERRIELLO. Thank you very much to you, Mr. Hutter, and to your team for being here today. It is exciting to see that the VA is working hard on the new technologies and other areas to break ground. Let me ask a few follow up questions. One is, with the increase in calls to the call centers, this is obviously a very urgent topic to all of us. My understanding from your submitted testimony is that you have had over 660,000 calls, but only been able to speak with about 160,000 folks. What is the strategy for follow up being conducted with those that you do not reach?

Mr. HUTTER. Mr. Chairman, I am going to defer that question to my colleague, Mr. Brown, who can address that directly.

Mr. BROWN. Thank you, Mr. Hutter. Mr. Chairman, we started the call center, combat veteran call center, in May of 2008, that was directed by Secretary Peake. Our attempt was to go back to October 2001 for all of those individuals, OEF/OIF, servicemembers that have separated, since October 2001 through December 2008. We had a twofold purpose. The first purpose was to call the servicemembers that we knew were injured. And that amounted to

about 15,600. They were either severely injured, or they were ill or impaired. The purpose of that was to call them to find out whether their case managers were doing the right thing by them, whether they were actually being seen on time, and to ask whether they had any other issues that needed to be addressed, such as benefit issues. All of these things were documented. The second population were clearly those who had separated and had not had an encounter with the VA health care system. That was the 550,000 population.

To date, your numbers are correct. The numbers that we submitted are on target. Out of the 660,000 that we have attempted to call, we have spoken with 160,000. This does not include the messages that have been left on answering machines or messages left with loved ones. If you look at that percentage it is not 24 percent, it is 74 percent.

Our leadership, to include Mr. Hutter, thought it would be best that we show real numbers, the veterans that we actually spoke with. That is important. The attempt now is to look for a search engine, a database that would review financial records, Internal Revenue Service (IRS) records, and update phone numbers, and we will try to call him again.

Mr. HUTTER. Mr. Chairman, if I could add to that answer? One of the things that you may have noted in our written testimony is that we are reaching out particularly to Reserve and National Guard servicemembers as they return in an iterative way. As they come back, Mr. Brown and our colleagues at our 153 medical centers are reaching out to each of these Reservists and National Guardsmen and signing them up, if you will, by filling out an enrollment form, our 1010EZ. And they are filling that out as they come back. We are then taking those forms and Fedexing them now, soon to be sending them electronically, to the medical centers where they will receive care. Because as they come to a demob center they are not necessarily going to receive care in that particular locus.

So the idea, then, is to sign them up as they come in. We have now approximately a 93 percent enrollment rate based upon those folks that have come back using either the demobilization process—strike that. The demobilization event, or the post-deployment health assessment event, or the post-deployment reassessment event. And these occur iteratively because of the fact that as the soldier, sailor, airmen, Marine, Coast Guardsmen come back they are not particularly interested immediately after they get off the airplane or train in signing up for VA health care. So what we do is we track them and hit them at iterative spots. So we get to the teachable moment when they are most poised to listen to our message and realize the benefit.

Mr. PERRIELLO. Sticking, for a moment, with this issue of the new technology communication, your fourth category, what indicators are you looking at for whether this is actually working? Is it number of friends on *Facebook*? And also, related to that, to what extent is this largely hitting our most recent veterans versus Vietnam vets and others who are also accessing the same technology?

Mr. HUTTER. Mr. Chairman, I am going to defer that question to Mr. Chasen who is VA's guru of the web.

Mr. CHASEN. Paul, I do not think I accept that title. But I can answer the question, sir. There are several measurements that we are using. The most important one is the American Customer Satisfaction Index, and you have seen these on Web sites. As you click on a Web site it asks, "Would you take a moment and take a survey for us?" We have that on all our Web sites. If you click six times, you reach the sixth click, you are asked to take a survey. We take those surveys very seriously. They provide us information both on customer satisfaction and on the kind of information that those who are looking at the Web site are looking for, and whether they have what we need.

We have had, I think, mixed success. Our ratings, other Federal agencies do the same thing, our ratings are now in the middle of the pack. We certainly hope to do better and to continue to do better.

As far as *Facebook* goes, our best measurement, and we have been live on *Facebook* for about 6 months but we have actually been publicizing it only for the last couple because of cyber security issues. We have 1,800 fans. We hope to get a lot more. I do not know what to judge that against, other than the entire population of veterans. But we do look at it. We are looking for continued increase, not necessarily a number.

The other thing that you asked about is who is using it. The answer from ACSI is veterans of all ages. Some of our sites, the OEF/OIF Web site, obviously, is for veterans of Iraq and Afghanistan. But what we found is that in our more general portals and information that we have a lot of Vietnam veterans, some World War II veterans and family members. Everybody uses the web now. It is not just something for our newest veterans.

Mr. PERRIELLO. Well, 1,500 fans out of 23 million veterans does not jump off the page at me. I think I may have more friends than that on *Facebook*. But it is early in the process and I think looking at the strategies that have been more or less successful, and having some experimentation there is a good thing.

If I can also ask the panel to address some of the concerns and frustrations that were raised in the earlier panels? And specifically, comment on the issue of more partnership with communities and community-based strategies from the last panel.

Mr. HUTTER. Mr. Chairman, as the Easter Seals representative indicated, in the last Administration we attempted to create a collaborative relationship with many of the community-based organizations that offered help, but did not know exactly where and how to connect and how to provide that help. As a result, we created a gateway and an ombudsman position whereby that person would take the good efforts and offers from community-based organizations and would direct those organizations to where the VA could use that help the most. And although the new Administration is working on this it is a work in progress and a partnership in progress. But we have taken the first steps to get that organized.

Mr. CHASEN. Mr. Chairman, if I could add, tomorrow morning, this evening I am going to get on a plane to fly to Houston. Tomorrow morning I am going to be speaking to VA's great effort in collaborative work with communities and community organizations which is our voluntary service program. We do have 140,000 volun-

teers. We do have, I think the number is 59 organizations who work with us and provide volunteer support to our hospitals and clinics, and to veterans. We are very, very grateful for that. I am not sure it is the model for the new issues that were raised, but we certainly have long had a great deal of involvement with community organizations and groups.

Ms. SMITH. I would also like to add, if I could, first of all prior to coming to VA I was, I am, a licensed clinical social worker and ran a community mental health center in rural Iowa. So much of what our panel spoke to I related to from my prior experience.

I have only been at VA for a little under 60 days. I have been incredibly impressed with the efforts that, across VA, are being made on behalf of our veterans, and the outreach that is taking place. There is a strong desire by the Secretary and by my boss, Tammy Duckworth, to coordinate those efforts throughout VA and the outreach that we are doing. We would also like to look at opportunities, in fact the Secretary tasked me just last Friday with coming up with a list of all the community organizations nationally that are interested in partnering with VA. So there is a huge desire to build those relationships as we move forward as a new Administration.

Mr. PERRIELLO. Thank you. And we certainly appreciate Ms. Duckworth's service to her country as well. Some of the VSOs have expressed concern—this is another metrics question—about how the VA tracks outreach expenditures. Could you say a little more about how the VA budgets and funds outreach activities? Is funding allocated on a facility-by-facility basis? And how has that been trending during the OEF/OIF period?

Mr. HUTTER. If I could attack that question from VHA's perspective and perhaps defer to Ms. Smith with respect to the Administration's intent overall? With respect to VHA we use the medical centers as our bases of outreach. Each of our medical centers, for example, has an OEF/OIF program coordinator, whereby they provide outreach to the community and participate in the various welcome home events, the yellow ribbon program that is described in my written testimony, and partnering with DoD activities in the local communities. In terms of expenditures, then, that is those expenditures are rolled up, if you will, from the field based operations up through the networks and up to the headquarters in terms of those activities.

That is certainly the basis not only of reaching out to OEF/OIF veterans but also with respect to any other targeted groups that we need to provide outreach for. Mr. Chasen mentioned our voluntary services coordinators and others in the medical centers who also do this outreach and the welcome home activities, and partner with community-based groups to reach out to older era veterans, or past era veterans, if you will. And so it is primarily a field-based operation that gets rolled up to the headquarters.

Ms. SMITH. I think the Secretary's vision for outreach for VA will look like a centralized management structure with decentralized execution. So hopefully, we will move to a point where much of our outreach is funded from one source.

Mr. PERRIELLO. Right now most of the media campaign that has been run has been focused on suicide and suicide prevention. There

is an obvious sense of urgency there. Is there a sense of moving into other issues that need to be communicated? Other health and benefits issues? Or is the current plan to focus primarily on that?

Mr. HUTTER. Mr. Chairman, I will take just a moment to discuss that and then turn it over to Mr. Chasen. There are several programs that are teed up right now and ready to move out. And I would like to defer to Mr. Chasen to describe at least one of those in detail.

Mr. CHASEN. Thanks, Paul. Mr. Chairman, first of all the suicide prevention program has a very, very simple message which is to get that number to a veteran or a loved one when he or she needs the number. So it is an ongoing program that will not stop, that we will continue to find new ways to get that information in front of people. That being said, we are working, and Dr. Victor Wahby who is in the audience behind me is responsible for some of these programs. We are looking at the issue of destigmatization of mental illness, which is very important to us. And we will be rolling out products related to that. We are going to be working on health literacy. Last year we did a considerable amount of work to try to inform veterans about the dangers of diabetes and the need to exercise and eat healthy. And we will continue to use the power of the media and our ability to mount campaigns to try to keep veterans healthier through the media.

Mr. PERRIELLO. One of the things that I hear a lot anecdotally from veterans, and from those who have had some of the experiences we have heard about today, is that there has been at least as much success if not more reaching the families of veterans as reaching the veterans themselves. What strategies are we seeing to reach those families? Is there any indication that there is more or less success in those outreach efforts?

Mr. HUTTER. Again, Mr. Chairman, we go back to the very successful efforts that we have had in reaching veterans as they come home, and iteratively reaching out to them. The Yellow Ribbon Program is a DoD program that we are heavily invested in as partners with DoD. And we talk to veterans and their families before the veterans deploys. We talk to families during the deployment phase so that we can get the family when the veteran is out of the country. Thirdly, we talk to families not at the demobilization but at welcome home events and at events that are targeted at the 30-day, the 60-day, and the 90-day mark after the veteran returns from deployment. All of these events are attempts to make sure that that families are aware of the health care benefits that the veteran is entitled to. For example, the 5 years that the veteran can use VA health care without otherwise being eligible. Also, the 180 days of dental care that the veteran is entitled to. These are numbers and programs that resonate with the families. And so that they, even if it does not resonate with the veteran upon return, their family members will prompt the veteran to take advantage of these programs when they come back. So if you look at the deployment cycle as a circle, we are invested in every axis, if you will, of that circle along a radius so that the veteran and the family gets that advantage.

One other point that I would like to make. We recently had a Post-Deployment Health Reassessment (PDHRA) event in Indian-

apolis for the 76th Brigade Combat Team that came back. About 3,200 soldiers came back, and we did the post-deployment reassessment at that location. Those reassessments were conducted at VA hospitals in Indianapolis itself, Fort Wayne, and in Evansville. The soldiers were able to see not only what a VA medical center looked like, but were also able to see how much VA employees cared about them and made sure that they understand what a warm welcome and a warm battlefield handoff, if you will, there was between military health care, DoD health care, and VA health care. During that weekend, there were, tragically, a soldier was indicating suicidal tendencies. But that soldier was able to be taken care of right there on the spot during that reassessment program. Another soldier indicated homicidal tendencies. And we were able to get him into health care and into mental health care immediately onsite. So my point, sir, is that the VA's forward leaning and working closely with DoD is enabling that family to see what the advantages of VA health care are.

Mr. PERRIELLO. Thank you very much for that answer. Thank you again for your time today. We really appreciate it. The Subcommittee will be sending follow up questions for the record. And with that, this hearing is adjourned.

[Whereupon, at 4:45 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

I would like to thank everyone for coming today.

This Subcommittee on Health hearing will assess the VA's responsibility to conduct an outreach program to veterans of all eras, including internal coordination that takes place between the Veterans Health Administration and the other administrations of the Department. We also seek a more complete understanding of the VA's outreach efforts and strategies, as well as the funding spent on these outreach activities.

Today, there are over 23 million veterans who have served this country. Of this total, the VA estimates that the number of veterans enrolled in the VA health care system will reach 8.3 million in 2009 and that the VA will treat nearly 6 million of the enrolled veteran population. Six decades separate the newest generation from the oldest generation and 9 million veterans are over the age of 65. According to the VA's Center for Minority Veterans, the minority veteran population comprises approximately 15 percent of the Nation's 23.4 million veterans. Women veterans are included in these minority groups as well.

This demographic data illustrate the sheer number of veterans who stand to benefit from improved VA outreach efforts. Additionally, it shows the importance of outreach strategies which must be individualized to meet the unique needs of sub-populations of veterans. For example, outreach strategies for older veterans should differ from that of younger veterans. Additionally, the outreach methods for rural areas may differ from that of urban areas. The VA is also faced with the challenge of developing effective outreach strategies which are culturally competent and thus, able to overcome potential cultural barriers. Briefly recounting the legislative history of enacted legislation on outreach brings us to the Vietnam War. During the Vietnam War, increased awareness of veterans not receiving adequate information about health care benefits resulted in Congress enacting the Veterans Outreach Services Program (VOSP). To address this concern, Congress charged the VA with the responsibility of actively seeking out eligible veterans and providing them with benefits and services. Under the current law the Secretary is responsible for advising each veteran at the time of discharge or release of all benefits the veteran may be eligible for.

Next, Public Law 107–14, the Veterans' Survivor Benefits Improvement Act (VSBIA) was enacted in 2001 to further expand outreach to eligible dependents. This law also provided that the Secretary ensure the availability of outreach services and assistance through the internet, veterans publications, and the media.

Finally, Public Law 110–389 or the "Veterans' Benefits Improvement Act of 2008" was enacted last year. Section 809 of this law gave the Secretary the authority to advertise in national media.

Despite these legislative authorities, the VA has imposed a self-imposed ban against paid public advertising, including Public Service Announcements which was only removed recently in June of 2008. Although the existing statute does not prohibit the VA from conducting media outreach, the VA has only implemented a single media campaign on suicide prevention to the Subcommittee's knowledge.

VA has struggled in the past with effective outreach services. For example, pamphlets and other outreach materials are often located in the VA's own medical center, which means that this important information does not reach those veterans who do not already utilize VA services. Another example is a memorandum issued on July 18, 2002 by the VA Deputy Undersecretary for Health for Operations and Management to all Veterans Integrated Services Networks of the VHA prohibiting marketing geared toward increasing enrollment. This was an effort of to limit the fast growing demand for health care services which exceeded the VA's resources.

We also know that some Veteran Service Organizations accused the VA of not providing outreach to veterans and dependents in accordance with the law. Nearly 18

months later a second memorandum was issued by VHA instructing the directors to ensure that their facilities were in compliance with responsibilities outlined in the outreach program.

Clearly, these are serious issues deserving of this Subcommittee hearing. Today, the Subcommittee looks forward to hearing from the witnesses of the panels as we embark on the important task of exploring effective ways to improve outreach to our deserving veterans.

Prepared Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you Mr. Chairman.

When our servicemembers come home from the battlefield, they think about getting back to their families and their civilian lives. Often, they do not think about connecting with the Department of Veterans Affairs (VA).

Yet, the process of transitioning back to the civilian world can be challenging for veterans and their families. And, I am deeply troubled when I hear stories about a veteran not knowing what services exist, where services can be obtained, or whether they are eligible for those services.

Central to the mission of the VA is to reach out to make every veteran aware of what services are available to support them and assist them in using these services. And, that is why it is so important that we are holding this hearing today to examine how effective VA's existing outreach is and what more can be done to ensure that our Nation's heroes know and have access to the benefits and services they need and deserve.

It is encouraging that a higher percentage of our returning warriors are seeking VA for their health care needs than in any previous war. And, I do want to commend former Secretary of Veterans Affairs, Dr. James Peake, for the great strides he made to improve outreach and the coordination of care for our veterans. Under his strong leadership, the VA launched a number of outreach initiatives including: lifting restrictions on advertising to promote awareness of VA's programs and services; rolling out a new public service campaign about suicide prevention; establishing the Combat Veteran Call Centers to telephone returning veterans to provide information about VA services; opening new rural outreach clinics; and expanding VA internet presence through "You Tube", "Facebook" and "MySpace" to reach younger veterans.

I would like to thank all of the witnesses for taking the time to appear before the Subcommittee today. I look forward to hearing about issues you see and ideas you have for improving VA's outreach and relationships with the Department of Defense, states, local communities and private organizations to help link veterans to VA services.

Thank you, Mr. Chairman. I yield back my time.

Prepared Statement of John Rowan, National President, Vietnam Veterans of America

Good afternoon, Chairman Michaud, Ranking Member Brown, and Members of this distinguished Subcommittee. On behalf of the Members of Vietnam Veterans of America and our families, I am pleased to offer VVA's views on outreach activities of the Department of Veterans Affairs.

The VA, by any standard, does an entirely inadequate job of reaching out to veterans and their families to inform them of the benefits to which they are entitled by virtue of their service, and health conditions that may derive from their time in service. I can't tell you how many calls and e-mails we get from veterans, or their loved ones, with questions about illnesses that may be associated with their exposure to Agent Orange (dioxin) during their tour of duty in Vietnam. I can't tell you how many times, when we meet with veterans and talk about health and health care issues, we are greeted with something akin to astonishment because no one has ever mentioned this to them before.

Almost 80 percent of veterans do not use the VA for their health care. While most veterans have insurance that enables them, and their families, to go to private physicians of their choice, many of these folks are only a paycheck or two away from losing their insurance. Posters that decorate walls and pamphlets that populate kiosks at VA medical centers and outpatient clinics do not reach these folks. Nor do the video productions that are supposed to be run on televisions in the waiting areas

of these facilities: Veterans waiting to be seen by a clinician watch CNN, or ESPN, or Oprah.

It is precisely because the VA has, in our estimation, fallen down on the job that VVA, in concert with dozens of health advocacy organizations, health care firms, and others concerned about improving the health of our Nation's veterans, has created the Veterans Health Council. The Council aims to fill a void that has long threatened to become an abyss. By working together, we hope to reach out to veterans and their families to inform them not only of the benefits to which the veteran is entitled by virtue of having donned the uniform, but about those diseases and other maladies that may derive from their time in service. We hope, too, to reach out to the wider health care community, to educate them about such health care conditions. It is our hope, through the Council's Web site, www.veteranshealth.org, and the Web sites and publications of our partners, that we might reach hundreds of thousands of veterans who otherwise might not know that the disease that is plaguing them and eating away at their savings may be associated with their service in Vietnam, or Korea, or Kuwait, or Iraq, or Afghanistan, and that they are eligible for treatment and may qualify for disability compensation and pension as well as other benefits from the VA.

You in Congress have been most generous in the past few years in providing the funds that the VA health care system needs to meet the demand for its services. But we ask you: Can you discern, from the VA's budget submission, how much money is being allocated for outreach? We have long supported the efforts of Senator Russ Feingold to enact into law the requirement that there be a line-item amount for outreach not only for the entire department but also for its individual entities. The Senator's bill this year, S. 315, the Veterans Outreach Improvement Act of 2009, would require the Secretary of Veterans Affairs to "establish a separate account for the funding of the outreach activities of the Department, and shall establish within such account a separate subaccount for the funding of the outreach activities of each element of the Department."

While we have every confidence that Secretary Shinseki and his team will endeavor to make far greater efforts at outreach, we nevertheless believe that what is needed from Congress is legislation that would require the VA to devise with a coordinated outreach plan attached to budget numbers. Mr. Feingold's bill, if enacted, is not enough, although it ought to be part of such legislation. Additionally, this legislation would:

- mandate that a veteran's military medical/health history (please see attached) be part of his/her treatment record if a veteran uses VA facilities or is able to and chooses to go to private clinicians;
- require that clinicians ask, in the patient history that all of their patients fill out, if that patient ever served in the U.S. military and, if so, a series of follow-up questions to learn if the veteran was wounded or otherwise exposed to trauma, or was exposed to blood, or participated in any experimental projects, or was exposed to noise, chemicals, gasses, demolition of munitions, pesticides, or special paints; and
- require that all VA clinicians, particularly primary care providers, take and receive certification for the VA's Veterans Health Initiative curriculum every 3 years.

In conclusion, I want to reiterate: Far too many of our veterans simply are unaware of what they are entitled to and, more importantly, are ignorant about health issues that are associated with their time in service. It's about time that we do something to fix this situation. VVA and the participants in the Veterans Health Council are doing our part. We hope that Congress will recognize the situation and do what is needed to rectify it.

Mr. Michaud, and Mr. Brown, thank you for holding this very important hearing. I would be more than pleased to answer any questions you may pose.

Appendix: Military History Card

Military Health History Pocket Card

What is the Military Health History Pocket Card?

The Military Health History Pocket Card is a pocket-sized resource to provide all **VA health professions trainees** a guide to understanding health issues that are unique to veterans.

VA's students and trainees generally are **young** while our **veteran patients are older** and have had experiences in a different time and place. This card helps to **bridge that gap**.

The card suggests questions that invite the veteran to tell his/her own story while the Web site provides information that will offer **greater insight** into the veteran's story.

It is important to make the patient aware that his/her unique experiences as a veteran are of concern to VA clinicians.

Who should receive the Military Health History Pocket Card?

All health professions trainees.

How is the Military Health History Web site used?

It provides background information related to the questions on the Pocket Card. Summaries of veterans' health issues as well as links to other Web sites are provided.

The Card can be used to capitalize on many learning opportunities:

- Give trainees better understanding of the veteran's perspective.
- Encourage trainees and staff to take more careful, veteran-centered histories.
- Stimulate case discussions augmented by information found on the Web site.
- Consider discussing issues presented on the card during daily work rounds or informal case-based conferences.

http://www.va.gov/oaa/pocketcard/FactSheet.asp

Prepared Statement of Reynaldo Leal, Jr., Representative, Iraq and Afghanistan Veterans of America, (OEF/OIF Veteran)

Mr. Chairman and Members of the Subcommittee, thank you for inviting me to testify today. On behalf of Iraq and Afghanistan Veterans of America (IAVA), the Nation's first and largest non-partisan organization for veterans of the current conflicts, I would like to thank you all for your unwavering commitment to our Nation's veterans.

My name is Reynaldo Leal, and I served in Iraq as a Marine Infantryman with the 3rd Battalion 5th Marines. During my first tour, I participated in some of the Iraq War's heaviest fighting during Operation Phantom Fury in Fallujah, and after that mission was complete, I assisted in securing the first democratic elections in that city. I was deployed for a second time, 8 months after my first tour, and conducted counter-insurgency operations along the Euphrates River. As an Infantryman, I did my job well and performed my duties with honor. After my two combat tours, I returned stateside seemingly unscathed, one of only two men in my platoon with that good fortune.

But coming home from war was much harder than I imagined. I was still in the Marine Corps, and I remember being good at our Urban Combat training. Not because I was a natural at it, but because when I began to hear the popping and yelling I felt that I was back in Fallujah. I could feel and see myself fighting the enemy again. It would always take me a while to get back to reality after these training exercises.

When I was discharged from the Marine Corps in February 2008, there were two questions I feared the most: "What was it like over there?" and, "Did you kill anyone?" Anxious about returning home, I delayed going back to south Texas for as long as possible. I couldn't bear the thought of being around familiar faces, and that fear led me to push away those who cared about me the most. As my wife prepared for the birth of our first child, I struggled with flashbacks and painful insomnia, which spiraled into a debilitating depression that alienated my family and threatened my marriage. I knew that my wife was suffering as much as I was, and that I wasn't the same person she had fallen in love with. Suicide wasn't an option for me, but everyday made me more and more anxious. It turns out I was suffering from a devastating invisible wound: Post-traumatic stress disorder (PTSD).

My struggle with PTSD left me dependent on the VA for mental health care. Since there is no VA Hospital close to my home in Edinburg, Texas, I have to either travel 5 hours each way to the nearest VA hospital in San Antonio or take my chances at our local clinic. The lack of funding for a permanent VA psychologist at this clinic pits me against my fellow veterans for limited appointment slots. If I can't get through on the first of the month to book an appointment, or if both of the psychologist's 2 daytime slots are full, I'm out of luck until the next month.

Unfortunately, my experience is not unique. According to a 2008 RAND study, nearly 20 percent of Iraq and Afghanistan veterans are experiencing symptoms of PTSD or major depression. But less than half are getting adequate treatment.

PTSD is the silent killer for this generation of veterans. Left untreated, it has the potential to destroy marriages, careers and, in far too many cases, lives. In January of this year, the U.S. Army reported that 24 soldiers in Iraq and Afghanistan committed suicide; a figure that surpassed all combat deaths in those two theaters combined. That alarming statistic does not include other branches of services like the Marines, or veterans who have already come home from the war.

But the numbers and statistics are only part of the picture. This new generation of veterans is being left to fend for themselves because of an antiquated system that cannot seem to find a way to reach out to them. There aren't any visible outreach campaigns to get these young men and women through the door of their local VA facility. If they don't know about their benefits, or even where their clinic or hospital is, how can they get the help they need?

When I was struggling with PTSD, there was never a sense that the VA was trying to reach out to me or that anyone even understood. For me, there was the Corps and then there was nothing. One day I had the best health care and support system available for both me and my family, and the next day it was gone. I felt that I had been abandoned and that the fact that I had served my country honorably meant nothing. I didn't know about the claims system, I didn't know about the 5 years of medical care for Iraq and Afghanistan veterans, and I didn't know that there were others that were going through the same situations that I was. It wasn't until I saw IAVA's "Alone" ad on television and joined Community of Veterans that I felt someone was trying to reach out to me.

It is the responsibility of the Federal Government and the Department of Veterans Affairs to make sure every veteran feels this way. But are we doing everything we can to reach out to the veterans who have done so much for us? The VA has taken some important steps, especially setting up a suicide hotline, but the answer is no.

We owe it to our veterans to provide the best mental health resources available, and currently we are falling far too short of that goal. At my VA hospital in San Antonio, the psychologist only works 2 days a week because that Texas clinic, like many VA clinics and hospitals throughout the country, has to stretch its funding to make sure the money lasts the whole year. They don't know how much funding they'll have next year because the VA budget is routinely passed late. In fact, in 19 of the past 22 years, the budget has not been passed on time.

So despite the fact that the VA's mental health budget has doubled since 2001, thanks to the dedication of veterans' supporters in Congress, the VA is still forced to ration care for the almost 6 million veterans that depend on its services.

By fully funding the VA health care budget 1 year in advance we could provide a simple solution that would help give VA hospitals and clinics across the country the ability to provide stable care for decades to come. With the ability to plan ahead, these hospitals and clinics could meet critical staffing and equipment needs, so that veterans like me are not left waiting. President Obama recently reiterated his support for advance funding of VA health care, and we were glad to hear it. With the strong support of the President and bipartisan leadership of Congress, advance funding can and must move forward this year.

Real action cannot come at a more critical time. As we saw just last week with the tragic events at Camp Liberty, our service men and women are under incredible

strain. As a Nation, we must have the same emphasis on giving our veterans the necessary tools to readjust to civilian life as we have in giving them the tools to survive in combat.

Make no mistake about it, the veterans of this country want nothing more than to become successful and productive Members of the society we fought so hard to defend.

Very Respectfully.

Prepared Statement of Richard A. "Rick" Jones, Legislative Director, National Association for Uniformed Services

Chairman Michaud, Ranking Member Miller, and Members of the Subcommittee:

On behalf of the National Association for Uniformed Services (NAUS), I am pleased to be here today as you examine the effectiveness of VBA outreach efforts. Your work is critical to ensure that VA outreach strategies bring the best possible care to returning troops and a seamless transition to their well-earned civilian life.

The National Association for Uniformed Services celebrates its 41st year in representing all ranks, branches and components of uniformed services personnel, their spouses and survivors. NAUS Membership includes all personnel of the active, retired, Reserve and National Guard, veterans community and their families. We also serve as the main contact for the Society of Military Widows, a support organization for women whose husband died in military service or in retirement. We support our troops, honor their service, and remember our veterans, their families and their survivors.

It is well known that the Department of Veterans Affairs Veterans Health Administration (VHA) is the largest provider of health care in the Nation. Approximately 6 million veterans annually come to VHA for all or part of their personal health care.

As we take a measure of satisfaction in the quality of care provided at VHA hospitals and clinics, it is important to recognize that many veterans continue to view VA care through the eyes of a past era when VA care was sub-par or in some instances not realizing that the system is available to them.

While we can never fully repay those who have stood in harm's way, a grateful Nation has a duty and obligation to provide benefits and health care to its veterans as a measure of its share of the costs of war and national defense.

As the National Association for Uniformed Services assesses the effectiveness of VHA outreach, we believe it is important that we first have an understanding on the number of OEF/OIF troops using the Department's health care system.

At present, nearly 2.0 million troops have served in the two theatres of operation since the beginning of the conflicts in Iraq and Afghanistan. In addition, with the drawdown of troops from the battlefields of Iraq, VA is likely to face increased enrollment.

Through the last quarter of fiscal year 2008, 400,304 separated Operation Enduring Freedom and Operation Iraqi Freedom veterans have used VA health care. And with passage of Public Law 110–329, VA will develop provisions for expanded enrollment for certain Priority 8 veterans.

In fact, the final rule for the regulation of accepting these newly eligible veterans is June 15, 2009, which is just around the corner.

Expansion of Priority 8 Veterans

Public Law 110–329 provides funding to allow an approximate 10 percent expansion on the numbers of Priority 8 veterans enrolled and treated at VA medical facilities. The proposed regulations were published in the Federal Register on Jan. 21, 2009, and are expected to be finalized by mid-June.

Eligibility will be based upon means testing and will be geographically based to allow for the variances in cost of living in the various regions of the country.

VA expects approximately 266,000 additional Priority 8 veterans to be enrolled in FY 2010. We are pleased to hear the VA's Under Secretary For Health state that Priority 8 enrollment is not capped. Any veteran who meets the requirement will be enrolled in the VA health care system. We applaud the effort to end the enrollment ban on veterans.

The budget submission provides more funding to continue this expansion so that by fiscal year 2013 an additional 500,000 qualified veterans will gain access to VA.

Although not specifically addressed in the budget, we would hope that part of the funding for outreach would be used to ensure that everything possible is done to bring awareness of the change in policy to those newly qualified veterans.

The National Association for Uniformed Services is concerned that well-meaning intentions of the VA might not be enough to spread the word on the expansion of benefits to veterans who have been denied VA medical access for over 6 years.

Many Priority 8 veterans tried to enroll after the January 17, 2003, prohibition and were denied, therefore, access to VHA care. We believe that the VA plan to mail all individuals previously denied enrollment is a good first step. We are hopeful that there will be follow-up to make sure measures are taken to contact those veterans. Enrolling those qualified veterans who desire to do so into the VA medical system should be a very high priority.

In addition, we must ensure that all veterans returning from combat areas are aware of and if possible, already signed up for their 5 years of VA medical care. Both of these sets of veterans need to be aware of their benefits.

We do recognize, however, that some long-term health conditions, such as post-traumatic stress disorder or traumatic brain injury, may not manifest conditions until many years later. Therefore we encourage further opening of access to sick and disabled veterans beyond the current 5-year allowance.

Of course, Veteran and Military Service Organizations will gladly help spread the word to their memberships and others. That way we can, together, be better assured that more veterans will be advised of the changes.

VA Budget Outreach Initiatives

The National Association for Uniformed Services is encouraged that the fiscal year 2010 veterans' budget request has numerous outreach programs that will help get the message about VHA to many more veterans and survivors.

These initiatives include reaching out to veterans who live in rural areas of America. The funding requested would allow the VA to more aggressively reach out to these veterans and to possibly set up additional rural outreach clinics to help reach our National Guard and Reserve troops. There is also funding requested for more aggressive tactics to reach those who have mental health issues with expansions of outreach services at Veterans Clinics.

The budget also includes additional funding for outreach by the newly created Office of Survivor Assistance (OSA) to help serve the numerous survivors who may not have the information on benefits they may be entitled to or apply for.

Advancement in Battlefield Medicine

As is well known, advancement in battlefield medicine has improved the chances of survival in warfare. However, many of our present day wartime casualties suffer from multiple severe injuries such as amputation, Traumatic Brain Injury (TBI) and post-traumatic stress disorder (PTSD). Care for these individuals requires an intense management of treatment for their injuries and special consideration of their families who stand by these returning heroes.

Reports from VA indicate that, from fiscal year 2002 through the end of 2008, 39 percent (325,000) of the total separated OEF/OIF veterans have obtained VA health care. Among this group, 96 percent were evaluated and been seen as outpatients only, not hospitalized. The remaining 4 percent (13,000) OEF/OIF patients have been hospitalized at least once in a VA health care facility.

Last year, VA informed the National Association for Uniformed Services that of the OEF/OIF veterans who have sought VA health care approximately 166,000 were former active duty troops and 159,000 were Reserve and National Guard Members. The population seeking care is nearly half active duty and half Reserve Component troops.

In total, over the last 6 years VA reports that 6 percent of the 5½ million veterans in the VA medical care system are veterans of the most recent military conflict, OEF/OIF veterans.

The Department attributes the rate of VA health care used by recent veterans to two major factors. First, the department says that recent combat veterans have ready access to the VA system, which is free of charge for 5 years following separation. In addition, the Department attributes a high rate of veteran-participation is due to an extensive outreach effort developed by VA to inform veterans of their benefits, including "a personal letter from the VA Secretary to war veterans identified by DoD when they separate from active duty and become eligible for VA benefits."

The National Association for Uniformed Services applauds efforts under the direction of the Department to establish a dedicated outreach program directed at nearly 570,000 Afghanistan and Iraq combat veterans. The effort, according to VA, is to make sure these veterans are aware of VA's medical services and other benefits for which they are entitled.

The VA Outreach program targets OEF/OIF veterans who have been separated from military service but have not sought VA care or services. We encourage the

VA health care community to continue its efforts to inform veterans and their families, as well as the medical community, about the availability of VA health care.

The National Association for Uniformed Services asks VA it leave no stone unturned to reach these veterans.

In examining the effectiveness of the outreach effort, it is important to recognize the stark difference in today's VA's efforts compared to those used in the recent past several years.

While we commend the positive change in expression and tone, we remain attentive to see that the most recent effort and the improved tone it reflects does not fail. Clearly there are concerns. Though the system is clearly no longer our grandfather's VA system, negative residue from a previous more closed-minded attitude remains within the system.

Last year, for instance, we received callous reports about a message issued from a VA Medical Center, in Temple, Texas, that suggested time and money could be saved if diagnosis of PTSD were stopped or deeply discounted in its degree of severity.

A PTSD program coordinator and psychologist at the Olin E. Teague Veterans Center sent an email with the subject line "Suggestion" to several VA staffers working with PTSD cases. The email suggested that VA doctors and clinicians give altered diagnosis to patents exhibiting symptoms of PTSD in order to save time and money. In the email, the staffer said, "We really don't . . . have time to do the extensive testing that should be done to determine PTSD."

While VA has long since repudiated the wrong-headed message, it does represent a concern we all should share, namely that VA care may be arbitrary, directed more by budget considerations than the consideration of the treatment necessary for the health of the men and women who served in the Armed Forces.

The incident is deeply troubling because veterans not only need to hear about the services they earned and deserve; they need to know that once they come to VA their exams are completed and their services are delivered.

Awareness of Services

Mr. Chairman, as we head toward Memorial Day next week, your Subcommittee takes a good, well-traveled road. In sending young men and women to defend our Nation, it is important that we let them know what our great and generous country provides them following their service. Indeed, it is critical.

It is clear to the National Association for Uniformed Services that veterans are generally more aware about the availability of benefits and services than they were four to 6 years ago. But the value of timely, reliable outreach programs cannot be understated.

Six years ago, for instance, the Administration was deeply opposed to spending resources aimed at making veterans aware of the benefits and services available at the Veterans Department. And facilities were in decline.

At one point in that past period, a former Secretary of Veterans Affairs told the Nation that the Department budget was adequate. "Not a nickel more is needed," he said. However, only a month later the Secretary reversed his statement to tell the Nation that his Department would fall $1½ billion short of the resources needed to carry veterans services through the remainder of the year.

Prior to this revelation, the National Association for Uniformed Services and other associations had presented ample witness to deficiencies throughout the system. We pleaded with Congress and the Administration that funding levels were totally inadequate and, if not addressed, would lead to critical reductions in the availability of veterans health care services, cuts in veterans education benefits, and logjams in veterans disability claims for service connected injury or illness.

During that period, things were so bad that a memorandum sent out by the Deputy Under-Secretary for Operations and Management (July 19, 2002) actually directed all of its health care providers to stop marketing VA programs to veterans.

In basic, the July 2002 memo said too many veterans were coming in for services and VA was spending too much money. It directed VA officials across the country to "Stop Outreach to Veterans." VA employees were directed to stop participating in VA health fairs, Stand Downs and related outreach events that informed veterans about programs available to them. Medical facilities were prohibited even from putting out newsletters informing veterans about the services they were legally entitled to receive.

We are thankful that we are beyond that deeply troubling period. If similar incompetence were in place today, many of OEF/OIF would struggle alone with their symptoms and illnesses following deployment.

Stress and the Risk of Health Issues

Studies conducted by The Army surgeon general's Mental Health Advisory Team clearly show that our troops and their families face incredible stress today. According to the Department of Defense (DoD), 27 percent of noncommissioned officers on their third or fourth tour exhibited symptoms commonly referred to as post-traumatic stress disorder. That figure is far higher than the roughly 12 percent who show those symptoms after one tour and the 18½ percent who demonstrate these disorders after a second tour.

And among the approximately ½ million active-duty soldiers who have served in Iraq, more than 197,000 have deployed more than once, and more that 53,000 have deployed three or more times.

A recent Rand Corp. study suggests that almost half of these returning troops will not seek treatment. Many of these veterans do not believe they are at risk or they fear that admitting to a mental health problem will mean being stigmatized. Yet if these brave individuals and their families are made aware of access to VA facilities, to which they are entitled, they are likely to find a treatment therapy that leads to health.

If not addressed, stress symptoms can compound and lead to more serious health consequences in the future.

Congress Champions Resources for VA

Recent Congressional successes in provided increases in VA spending presents the Department with an opportunity to advance an awareness of VHA accessibility and readiness to meet health care needs.

We applaud all that has been done to date. While commendable, we can do better and should do more. In some cases, a successful outreach can be a matter life and death. Veterans need to hear that VA is part of our Nation's commitment to them. They need to hear that with appropriate care, our veterans can tackle stress and get themselves back on track.

NAUS believes that your interest in targeting information to veterans marks a turning point in outreach efforts. We are optimistic. But it is clear that more needs to be done, including followthrough throughout the VA system, within the veterans community and in our educational assistance programs.

Of course, there is a financial cost to improved outreach. But as important is the fact that if we do not make veterans aware of the benefits and services available to them, there is a hidden cost in lives lost, families disrupted and long suffering in homelessness and related problems for decades to come.

We urge the Subcommittee to continue its excellent work with other champions in this Congress to ensure resources are ready not only for the provision of a veteran's earned benefits but for the veteran's awareness of these services as well. It is important that we do so. After all, these brave men and women shouldered a rifle and risked everything to accomplish their mission, to protect another people's freedom and our own country from harm.

As a Nation, we need to understand that the value of their service is far greater than the price we pay for their benefits and services.

Appreciation for Opportunity to Testify

As a staunch advocate for veterans, the National Association for Uniformed Services recognizes that these brave men and women did not fail us in their service to country. They did all our country asked and more. Our responsibility is clear. We must uphold our promises and provide the benefits they ***earned*** through honorable military service.

Mr. Chairman, you and the Members of your Subcommittee are making progress. We thank you for your efforts and look forward to working with you to ensure that we continue to protect, strengthen, and improve veterans benefits and services.

Again, the National Association for Uniformed Services deeply appreciates the opportunity to examine with you outreach efforts to veterans, families and survivors on the benefits available to them.

Prepared Statement of Bruce Bronzan, President, Trilogy Integrated Resources, San Rafael, CA

Serving Those Who Served

Maryland and California have taken an important step as national models in the way of local web portals that use the most advanced communication and internet technology to form a bridge between all Federal, state, local, and non government

services and veterans and their families. It is called the Network of Care. The launching of the sites in Maryland was led by Lieutenant Governor Anthony Brown. The California launch will be led by Governor Schwarzenegger this coming Friday.

The Network of Care project has been a creative joint effort between the mental health and veteran's leadership in Maryland and California, the state and county governments, and Trilogy Integrated Resources.

Last, this service is, in fact, an excellent "transition" resource of the first order. Every single veteran is able to access this comprehensive resource in their own community thus representing the most complete, permanent, and continuously accessible place for information and assistance possible. Given that within the Network of Care we currently have the database 120,000 service providers covering 65 percent of the Nation, this model can be replicated into every local jurisdiction in the United States within a year.

DEMO OF THE NETWORK OF CARE

1. Home Page
   —Crisis intervention, Shelter, employment,
2. Service Directory
3. Library
4. Social Networking
5. Legislate
6. Assistive Devices
7. Links
8. Personal Health Records

Prepared Statement of Barbara Van Dahlen Romberg, Ph.D., Founder and President, Give an Hour, Bethesda, MD

Thank you for this opportunity to provide testimony regarding the Department of Veterans Affairs' current outreach efforts for OEF/OIF veterans. It is an honor to appear before the Subcommittee on Health of the House Committee on Veterans' Affairs and to offer my assistance to those who serve our country.

As the Founder and President of Give an Hour, a national nonprofit organization providing free mental health services to our returning troops, their families, and their communities, I am well aware of the many issues that now confront the men, women, and families within our military community.

There is little doubt that our Nation is confronting an emerging public health crisis. It has been 6 years since the conflict in Iraq began. Since that time, nearly 1.9 million servicemembers have deployed. Many of these men and women have deployed more than once; some, as many as four or five times. National Guardsmen and Reservists compose approximately half our Nation's fighting force. As those who have experienced war will attest, everyone is changed by the experience. Some suffer physical wounds that require medical attention and care. Others suffer wounds of war that are not always easy to see. As a Nation, we must provide comprehensive, long-term care for all of those affected by their experience of combat, and we must embrace the reality that combat stress and other psychological consequences of war are normal human reactions to horrific experiences.

My area of expertise is the young men and women who are returning OIF and OEF veterans. 58 percent are 29 years old or younger. If we expand this demographic to include one additional age range, then 80 percent of our fighting force is 39 years old or younger. Clearly, a huge number of young veterans with young families need our care now. Our Government is clearly working hard to assist this generation of combat veterans and families. VA funding for the past 4 years is at unprecedented levels and continues to grow. We cannot assume, however, that more money, more staff, more outpatient clinics, more Vet Centers, more "clinics on wheels," more organizational restructuring, and more (and different) leadership will enable the VA to meet the mental and physical health care needs facing this generation of combat veterans. We see from all the statistics, which I will cover shortly, that this is a public health crisis that will take more than extended outreach. Yes, current outreach efforts are clearly insufficient. But even if the current outreach efforts were sufficient, it is evident that the system does not have the capacity to meet the growing and ongoing needs of OIF and OEF veterans who are experiencing a full range of ongoing physical and mental health concerns upon returning home. Finally, even if outreach efforts were sufficient and the VA had the capacity to meet

most of the needs of returning servicemembers, this solution would still be inadequate. If returning troops are to truly and successfully reintegrate into our communities, then our communities must be involved in the solution. So the issue is bigger than the efficacy of the VA's current outreach efforts. The issue is how we can systematize a broad range of services to sustain care for our veterans over the long term.

A current article in *Health Affairs* (May/June 2009) by behavioral scientists from the Rand Corp. addresses the problems associated with providing adequate mental health care for returning OEF/OIF veterans. Although the article focuses on mental health care—arguably the most pressing current need within the military community—the conclusions drawn are applicable for the entire range of services necessary to care for our returning troops and their families. The authors note, "Improving the quality of mental health benefits and services in the DoD and VHA is undoubtedly a key step in improving care for this population. However, they are only part of the systems of care needed to address the mental health problems of returning veterans. Improvements in access to and quality of community based services outside of the DoD and VHA will also be very important."

Consistent with the findings of this most recent offering by Rand, I propose the development of a new kind of public works project. Before describing this project in detail, I would like to provide the Committee with the story behind the need for such a program.

But before doing *that* I need to make one additional point. Although this Committee's focus is on the outreach efforts of the VA, I will frequently make reference throughout my testimony to the Department of Defense and its efforts to care for those who serve. It is impossible to discuss issues affecting our veterans without discussing DoD's response to the men, women, and families who serve. While the VA and DoD operate as if there are two populations that require care—military personnel and veterans—there is really just one. Too many returning warriors get caught between the two systems and fail to receive the care they need when they need it. The failure of coordination between these two bureaucracies erodes the sense of trust that returning troops have in our military and in our Government. No amount of outreach can overcome the potential damage that is done by what is often experienced as a betrayal.

Background

According to a 2008 Rand Corp. study, over 300,000 men and women have already returned from Iraq and Afghanistan with symptoms of severe depression or post-traumatic stress. Over 320,000 have suffered a traumatic brain injury. And only about half of these men and women have sought treatment.

There are on average 18 suicides a day among America's 25 million veterans, with more than one-fifth of those being committed by patients undergoing treatment by the VA. Army officials calculate the suicide rate at 20.2 per 100,000 soldiers, the highest in its history—a number that exceeds the civilian rate for the first time since the Vietnam War. Last year, our Nation lost more Soldiers and Marines to suicide than to combat deaths.

Roughly 20 percent of U.S. combat troops who fought in Iraq or Afghanistan come home with signs they may have had a concussion, and some do not realize they need treatment. In fact, 17 percent of the soldiers returning to war (for another tour) could have a traumatic brain injury. The lifetime risk of suicide among those who have suffered a moderate to severe traumatic brain injury is three to four times higher than among those who have not.

Many of our returning troops turn to substance abuse to ease the pain of the wounds that we can't see and they don't understand. Parents routinely contact Give an Hour reporting concerns about a son or daughter who returned home from the war and began drinking or drugging heavily. Family members are frightened and uncertain about how to help prevent the dangerous deterioration they see. And they have reason to be concerned. Sadly, we are already seeing a number of this newest generation of veterans joining the ranks of the homeless on our streets.

Some veterans are getting into minor, and major, scrapes with the law and becoming entangled in the judicial system. Countless stories have been told in media reports of "good kids" who end up in jail for crimes that no one believed them capable of committing. Fortunately, several Veterans Courts have sprung up throughout the country, where veterans are assessed for symptoms of combat-related psychological injuries and given treatment in addition to, or instead of, jail time. While the veteran's court is a superior solution to the alternative, it does not address the underlying issue—that many men and women who are willing to die for their country are not receiving the care they need and deserve.

One young woman telling her story in the hope that it will allow others to receive help was 17 years old when she joined the Army. She served in the fourth rotation of Operation Enduring Freedom in Afghanistan in 2003. Her experience left her with severe post-traumatic stress and, unfortunately, she returned to a community that did not reach out to her. She felt confused and ashamed of the symptoms she experienced. She began using drugs and ended up homeless, living out of her car. Eventually, she sought care through the VA, but the experience was not a positive one and she turned to our organization for help. Fortunately, she found a provider who helped her understand what was happening to her, and she began to rebuild her life. Today, at 25, she proudly reports that while she still experiences symptoms of post-traumatic stress, the symptoms no longer control her life. She is married and has a beautiful baby girl. Although this young woman has become a successful Member of her community, her painful story is all too typical of what we hear from the men and women returning from these conflicts.

Clearly the toll on military families is tremendous. Of those deployed, more than 800,000 are parents with one or more children. Of these, 40 percent have been deployed more than once. Almost 35,000 troops have been separated from their children for four or more deployments. More than 2 million children have a parent who has been deployed; 40 percent of these children are younger than age five. Children whose parents have post-traumatic stress are at a higher risk of themselves developing symptoms of post-traumatic stress, anxiety, and depression. And studies have linked depression, anxiety, and emotional disorders in children to a parent's deployment.

Furthermore, when deployments began, reports of abuse quickly jumped from 5 in 1,000 children to 10 in 1,000. Children from military families are twice as likely to die from severe abuse as other children are, and rates of abuse and neglect rise dramatically (40 percent) during the time the soldier is deployed.

Divorce is also on the rise in the military community with about 1 in every 5 married servicemembers filing for divorce since September 2001. In a November 2008 study, Army spouses were seen to have rates of mental health problems comparable to the rates among soldiers.

And parents who proudly launched their adult children into the world find themselves in the distressing position of watching their son or daughter fail in their efforts to reintegrate into their communities. One mother spoke to me about her son, who committed suicide after returning home from his tour of duty. While he appeared withdrawn and quiet, his family never suspected the depth of his despair. This grieving mother reported that her son had been through so much during the war that her family just wanted to give him some space. She felt such sadness that she hadn't known the right questions to ask.

Needed Services

Returning veterans and their families need access to a number of services to ensure that they are able to move forward in their lives once they return to our communities.

Mental health treatment. There is a tremendous need for effective and accessible treatment for the full range of mental health issues affecting those who serve, including post-traumatic stress, substance abuse, depression, anxiety, suicide, marital difficulties, family conflict, sexual dysfunction, behavioral and emotional symptoms in children, and domestic violence. There are also additional difficulties: many veterans live a great distance from formal VA services, and even those in closer proximity are often reluctant to seek mental health services because of a perceived stigma associated with treatment. We need to implement an ongoing screening program so that all who serve are periodically assessed for signs of psychological strain associated with their service.

Traumatic Brain Injury (TBI) programs. There is a need to develop additional educational programs for servicemembers who suffer a TBI and their family members. Similarly, we need to expand, improve, and accelerate the delivery of neuropsychiatric services for all veterans, especially those returning from OEF/OIF. Finally, we need to make mental health services, rehabilitation, and job training opportunities available to those who have suffered a TBI.

Care, training, and support for our wounded. Our wounded warriors receive the finest medical care available in the world while in our military facilities. Too often, however, they do not receive the continuity of care they need once they return to their communities. We must develop better coordination with community resources to ensure that our wounded (and their families) successfully heal from their physical and psychological injuries. In addition, we must provide appropriate job training **and** ongoing support once these wounded warriors return to the job force.

Women's support. We need to develop programs specifically focused on the unique needs of women who serve, including programs that treat victims of sexual assault.

Employment. Employers want to hire veterans but often fear they are poorly prepared to support returning warriors. We need to develop programs that support the employers who want to hire veterans as well as the veterans who want to be productive Members of society.

Police, judicial, and first-responder training. Many returning veterans find their way into the criminal justice system as a result of their combat experience. We need to continue to develop programs that train police, firefighters, paramedics, and judges about veterans and the issues that come home with them.

Benefits and compensation. The system that determines benefits and compensation needs to be reworked. The current system leaves many veterans feeling dismayed, dismissed, or distressed, as they struggle to determine what benefits and compensation they are entitled to.

Financial management. Many military families are poorly prepared to manage their finances, causing additional strain and distress. We need to develop programs to train the military community—especially the youngest Members who serve—how to make good financial decisions.

Public education. Many veterans do not realize there are a variety of services and peer support opportunities available in their own communities that could be beneficial to them. There is also a dire need to educate family members about the unique needs and conditions of returning veterans.

While the list of the services needed clearly presents us with a tremendous challenge, it is also true that we have a remarkable opportunity before us—the opportunity to create a comprehensive system of integrated care for the brave men, women, and families who sacrifice so much and ask so little.

Barriers to Care

Several factors contribute to our failure to adequately care for returning veterans and their families. Some of these factors lie within the systems responsible for providing appropriate care, while others stem from deep-seated beliefs and conflicts within the military culture and our society regarding the acknowledgment of needs and limitations.

Regarding mental health care, these barriers are well known and documented. As discussed in the most recent study by Rand, the attitudes and beliefs of military servicemembers and veterans prevent them from seeking mental health care. Our military culture promotes pride and inner strength along with self-reliance, toughness, and the ability to brush off ailments or injuries. In addition, as humans, it is not our nature to turn toward emotional pain. We tend to deny problems until they overwhelm us. Sometimes, being overwhelmed provides us with the opportunity to address our struggles, but often we continue to deny their existence and continue to live an impaired or diminished life. Only through education and practice can veterans learn to face their fears and work through the understandable pain associated with the experience of war. Our society does not yet embrace this concept and so we do little to encourage our returning warriors to address their invisible wounds.

The internal barriers that keep our warriors from seeking appropriate care for mental health concerns also play a role in preventing them from seeking assistance for other needs such as financial assistance, employment difficulties, and ongoing physical care. While it seems self-evident that someone who is in need of physical therapy for an injury suffered in conflict would follow up with recommendations for additional care, the decision to pursue care is often intertwined with other psychological reactions to seeking care, needing ongoing care, or being "less than" they once were. Moreover, if that care is difficult to find or access, and if it is recommended by someone the veteran has little if any relationship with, the likelihood of compliance with the recommendation is severely diminished.

Systems charged with providing care for those who serve—including the VA and DoD—have failed in their efforts to reach those in need. Not that the task is simple, indeed it is extremely complex and labor intensive. Nonetheless, along with a strategic and innovative public education program, outreach is a critical component of a successful effort to care for the military community. While there are a few exceptions to this rule, too often these systems expect our veterans to come to them. As a result, many veterans and families who might benefit from the truly effective programs housed within never even know the programs exist.

Similarly, both DoD and VA have been reluctant to forge critical relationships with community-based organizations that have developed over the last 6 years to

fill some of the clear gaps in care. Opportunities have been missed for innovative collaborations that could have saved lives and healed families.

As is true of DoD, there are many honorable and dedicated individuals within the VA who are working diligently to serve our veterans. Certainly, some VA systems receive praise for their efforts and ingenuity. In addition, the VA Medical Centers clearly provide the best medical care in the world. The problem comes when warriors and family members leave the medical units and return to their communities. They complain that there is little continuity of care or collaboration with community efforts; that they must drive long distances to reach the VA in order to receive services; that they wait for months or years for their disability claims to be resolved.

Ultimately, it appears that at this time the VA is severely limited in its ability to create a successful and comprehensive system of care for our veterans. I recently spoke with a colleague who is in a senior position at a VA Medical Center in the Northeast. This mental health professional is a well-respected expert in post-traumatic stress and has been an advocate for the care provided by the VA for years. He told me in a moment of brutal honesty, "This is a disaster." I asked what he meant by the statement, and he replied that he saw far too many veterans falling through the cracks and feared that the OEF/OIF generation would surely be "lost." This was a very sobering admission from a man who has spent his professional life working within and championing the VA.

The Big Problem: Operating without a Comprehensive System

No single agency, organization, or sector can adequately care for our returning warriors. Several organizations—governmental and nonprofit—have attempted to organize the vast array of programs and services now available to servicemembers and veterans. But most of these efforts have resulted in cumbersome lists of available resources that do little to advance the mission of providing easy, accessible care to those who serve. Efforts to reach out to military personnel and their families can be successful only if we have a system in place that can reach everyone who serves and provide ongoing support to them. If we are willing and able to knit the available resources together into an integrated system of care that is available within our communities, we will succeed in our effort to provide for those who serve.

The Best Solution: A New Kind of Public Works Project

To effectively and efficiently care for our veterans, we need a system that can streamline and simplify the process of providing and receiving all manner of care for returning warriors and their families within their own communities. We need a plan that ensures our communities are able to assist and support veterans and their families so that their lives are "working" for them. There is no question that our citizens, our communities, and our Government supports the returning troops and their families. Everyone wants to help. The problem has been a lack of a coherent plan that will guide communities in this effort.

In 1933, the Public Works Administration was formed in an effort to heal our Nation's depression-ridden economy. Designed to provide unemployed workers with wages as well as to stimulate various industries, the PWA's main focus was to design and implement large-scale construction projects. The goal was to heal our economy and ensure that our citizens were free to lead productive lives. Now we need to design and implement a similar public works project that will weave together the resources needed to heal our military community and ensure that our military personnel are free to lead productive lives.

We have the resources to assist our returning veterans and their families. We have the desire to care for those who serve. We now need to organize and coordinate efforts across the country to assist our military personnel. With this public works mindset we can more effectively fill the current gaps in care, reduce the duplication of services, and enhance programs that are innovative and effective.

Next Steps

To realize the vision of a public works project that supports our returning troops and their families in their communities, the following steps are necessary:

1. Bring together individuals representing organizations and entities that interact with veterans and military personnel including but not limited to the VA, the DoD, nonprofit and nongovernmental organizations, community-based mental health programs, public health organizations, higher education institutions, the faith-based community, law enforcement entities, and the U.S. Chamber of Commerce.
2. Form a working group with these representatives to study efforts currently under way including innovative and successful community coordination pro-

grams in Rhode Island, California, New York, Colorado, and Montana, to name a few.

3. Assign this working group the primary task of developing a strategic plan that will serve to guide our communities in their efforts to coordinate care among service providers for the military community and to engage in outreach to military citizens.
4. Direct the working group to assist with nationwide efforts to implement the strategic plan. While state and local communities will refine the plan to fit the specifics of their population, the working group will be able to provide guidance and support as needed.
5. Develop metrics to assess the implementation and effectiveness of this public works project. The strategic plan should be refined as data are gathered on the success of its efforts.

Two technologically based initiatives currently being developed promise to contribute to the success of the public works project to support our military community.

The Network of Care is an impressive platform that has already been shown to be effective in delivering a variety of services to millions of Americans throughout the country. One of the network's components, the Network of Care for Behavioral Health, is itself an award-winning Web-based service developed by the California Department of Mental Health in partnership with Trilogy Integrated Resources and San Diego County Mental Health. The comprehensive Web portal spread rapidly throughout the country and now is implemented in more than 25 states over 400 local areas and is one of the leading "transformation grant strategies" in the Nation.

At the request of congressional, military, veteran, and mental health leaders, Trilogy began the development of the special portal for veterans. The following information, from the network's project statement, provides a description of how it works and its potential to become the cornerstone for a national response to the needs of our veterans.

> The states of California and Maryland in conjunction with Trilogy, the creators of the Network of Care, are developing a virtual community and locally based Web portals for comprehensive, one-stop information resources specifically targeted to returning vets, other service personnel, their families and their communities. In addition to a comprehensive directory of all local, state and Federal services and support groups, the portal will contain innovative, user-friendly technology for: information-sharing and social networking, educational training programs, interactive recovery tools and strategies, best practices from around the Nation, and consumer based, interactive Personal Health Records. **This valuable locally based service will serve as a critical information bridge for the individual veteran to tie together for the first time, all Federal, state and local service as well as programs and veterans themselves from all over the United States.**

The project has the formal support of the National Association of State Mental Health Program Directors, the National Association of County Behavioral Health Directors, the National Alliance on Mental Illness, andMental Health America.

Maryland launched the Network of Care for Veterans and Servicemembers site in March. California will launch its site on May 22. Once established in Maryland and California, the program will be available for replication throughout the country. Funding is currently being explored in order to create a nationwide application. The cost for ongoing maintenance will be the responsibility of each local jurisdiction.

Patients Like Me, founded in 2004 by three MIT engineers, is a privately funded company dedicated to making a difference in the lives of patients diagnosed with life-changing diseases or conditions. The goal of the company is to enable people to share information that can improve the lives of these patients. Accordingly, the creators of Patients Like Me developed a method for collecting and sharing real world, outcome-based patient data. In addition, they are establishing data-sharing partnerships with doctors, pharmaceutical and medical device companies, research organizations, and nonprofit organizations.

The company's creators are now developing a new version of their Web site, called Warriors Like Me, specifically for veterans, who will be able to share information with one another regarding treatments and procedures they find effective or promising. Providers and researchers will be able to access this data to determine best practices for conditions affecting those who serve, such as post-traumatic stress and traumatic brain injury.

The effort to create a comprehensive and well-coordinated system of care within our communities for our veterans and their families can only be as successful as our

efforts to educate those in need about the issues they face and the resources that are available.

A significant public education campaign must accompany the public works project. Many different organizations have launched public awareness and educational efforts since the beginning of the wars in Afghanistan and Iraq. Many have been creative and compelling. It is not clear how effective any have been. While any one public education campaign can be effective in educating those who serve about the conditions they face and activating them to access the services available to them, successful outreach occurs when a variety of approaches are utilized. As with most complex situations, one size will not fit all. Technology has its advantages, but sometimes the human touch is required to make a connection and ensure follow through.

To give but one example: Give an Hour recently provided the mental health support for a conference attended by many OEF/OIF veterans. One of our providers encountered a veteran who shared some of her personal struggles. Our provider offered to connect this young woman with a mental health professional in her city who participates in our network. The young woman accepted the offer and in a lovely e-mail message noted that she probably would not have followed through with the idea of counseling if our provider hadn't gone the extra mile to direct her to someone offering care.

Conclusion

We have the resources, the vision, and the commitment to ensure that our veterans and their families receive the care they need and deserve. Thanks to the efforts of dedicated people working in and across organizations and localities all over the country, we have the potential to create an effective community-based, cohesive, and organized service delivery system capable of providing comprehensive, long-term care to those who serve our country. This is a historic and unique opportunity to harness our Nation's resources and care for our military community.

Prepared Statement of John King, Co Director, Veterans Community Action Teams Mission Project, Altarum Institute, Ann Arbor, MI

Good afternoon, Chairman Michaud, Ranking Member Brown, and Members of the Subcommittee.

Thank you for inviting Altarum Institute to testify before this oversight hearing of the Subcommittee on Health. We appreciate the opportunity to offer our views on ***VA Medical Care: The Crown Jewel and Best Kept Secret***. In our testimony today, we will address the methods and activities through which we have observed the Veterans Health Administration (VHA) communicating the availability of services to veterans. We also will share our observations regarding the differences in outreach strategies for the current generation of new veterans versus those used for older veteran populations.

Altarum Institute (Altarum) is a nonprofit health systems research and consulting organization serving Government and private-sector clients. We provide objective research and tailored consulting services that assist our clients in understanding and solving the complex systems problems that impact health and health care. Our unique model combines the analytical rigor of a research institution with the business acumen of a traditional consultancy to deliver comprehensive, systems-based solutions that meet unique needs.

In 2008, Altarum launched its Mission Projects Initiative, committing more than $8 million in internal resources to three critical areas of societal need. The purpose of the initiative is to solve pressing health care issues using our systems methods at the institutional, organizational, and community levels in partnership with the public and private sectors, with the goal of improving the quality of life for millions of Americans.

Our Mission Projects are focused on three areas: developing systems changes to prevent childhood obesity, fostering innovation in community health centers, and facilitating integration and coordination of community health and social services for veterans and their families. Today's testimony will focus on the last area.

As you are well aware, since 2002, we have seen a tremendous influx of servicemembers transitioning from active duty to veteran status. More than 870,000 servicemembers have separated from the active military and Reserve Component forces and transitioned to civilian life. These newly created veterans are returning to communities throughout the country after having served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). These returning veterans and

the existing population of aging veterans have multifaceted service requirements that are generally met by a number of independently administered services. Their requirements include health care, vocational rehabilitation, employment and training, care giving, social services, housing, and independent living assistance, to name just a few.

Current public and private initiatives providing these services to veterans and their families have limited resources, not only to reach out and administer their programs to this growing population, but to integrate their services with other complementary programs being offered in the community. The increasing number of new initiatives, when added to an already confusing array of existing organizations and services, often leaves veterans and their families searching for the programs and services that best meet their needs. It is the absence of the integration of these services that presents the greatest challenge to veterans and their families, who are forced to navigate a complex web of care and programs that often are not well coordinated. This situation forces undue stress and burden on those who we believe are the most deserving of our support.

We believe that veterans and their families deserve access to an integrated system of community services to achieve economic security, receive better health care, and improve their overall quality of life. With improved communication, coordination, and integration, a streamlined and responsive community-based system will enhance access to public, private, nonprofit, and volunteer services for veterans and their families. In turn, community service organizations will be more efficient and effective at delivering services, optimizing existing resources, and enhancing the population and community development.

It is our observation that no one entity can meet all of these requirements. Altarum's Veterans Community Action Teams (VCAT) Mission Project was started specifically to strengthen the web of care that currently exists for veterans and their families. Through the VCAT project, Altarum works with community service providers and advocates who not only understand the National debt to veterans and their families but are also the ones in the best position to render the appropriate services.

The VCAT project will develop a collaborative, community-based model to integrate the outreach and delivery of services from public, private, and nonprofit organizations to veterans and their family members. The VCAT project will test this model in selected pilot communities to demonstrate the value of the community-based system of care for improving the accessibility, scope, and quality of services available for veterans and their families. Multiple governmental agencies, nongovernmental organizations, and community-based organizations are being invited to collaborate.

Currently, VCAT project leaders are communicating with leaders of communities with large veteran populations as well as public, private, and nonprofit organizations within those communities to establish the VCAT project pilot site(s). Strategic partnerships are already under way to ensure that the VCAT model will have long-term sustainability in the demonstration communities. Altarum will continue the VCAT project in partnership with the selected pilot communities through the end of 2010.

Altarum's focus through the VCAT project is concentrated on building integrated community-based service networks that strengthen service "safety nets" for veterans and family members who are experiencing readjustment issues and/or suffering the "invisible wounds" of war.

Based upon our collaborations with VHA in our search for the first VCAT pilot community, we have observed a significant level of cooperation and coordination among the VHA; the Veterans Benefit Administration; the Department of Defense; State, county, and local governments; and public and private organizations. The VCAT initiative is an effort to complement the work of the VHA by building bridges from community-level services to the National-level efforts of outreach and access. The footing for these bridges will be built from the community up, namely through the coordination, the collaboration, and ultimately the integration of the community providers. The community providers include Federal, State, and local governments; private and nonprofit organizations; and voluntary service providers. Some of the services include community mental health, spiritual wellness, law enforcement, education and training, and legal advocacy (including Veterans Service Organizations or VSOs).

VHA accomplishes outreach to the veteran population through the media and network efforts of the Veterans Affairs Medical Centers, community-based outpatient clinics, and veteran centers and through partnerships with public and private VSOs. All of these outreach efforts are focused on connecting veterans and their family members to the health care services provided by VHA. This high level of collabora-

tion has the additional result of connecting veterans and families with organizations that offer other programs and services that are not necessarily health related (e.g., job placement centers, housing assistance, childcare providers). Our plan is to look at current "best practices" and to provide assistance to further integrate the community service providers. The goal is to develop models that can serve as guides for other communities to replicate the development of highly integrated community service networks. In the face of financial constraints on the Nation, which are felt especially at the community level, the efficacy of this initiative will enhance integration of existing programs and more effective and efficient use of associated resources.

The outreach strategies employed to connect the current generation of OEF/OIF veterans with services needs to be different than those used with past generations. The methods used by this new population to receive and to process information are vastly different. What has not changed is the tendency of veterans (past and present) to base their trust of service organizations on familiarity; they trust other veterans and servicemembers and those to whom their trusted comrades refer them. It is the method by which they share this information that is different and that must drive the changes that the VHA and all other veteran service organizations must make in their outreach efforts. Our observation is that it is no longer adequate to simply create and launch a Web site of an organization's services or even a portal to connect veterans to many organizations' services. The current generation of veterans communicates through social networks that connect individuals based upon common interests, requirements, and mindset. Outreach is accomplished by connecting organizations and networks of providers in like manner to the social networks of the younger veterans.

While our VCAT project will have a particular focus on OEF/OIF veterans and their families in the immediate future, we believe that well-integrated community providers will have the inherent capacity to serve all veterans regardless of age. The VCAT project has been up and running for almost a year; we are applying our existing knowledge and learning new information on the complex needs of veterans and their families to better understand the multifaceted services arena. Community providers need the collaborative support from all levels of Government and private partners so that they can "wrap" their services around veterans and their families. Services need to be seamless to ensure that no veteran or family member is lost as servicemembers transition from active duty to veteran status and continue to access services throughout their lives. The ease of access to services for veterans is the ultimate outcome that integrated communities are striving toward.

The early evidence from our initial engagement of public and private partners within our potential VCAT pilot communities supports our hypothesis that the key to improving the delivery of services to veterans and families is the integration and improved collaboration of service providers. The degree to which the delivery of services is enhanced and outreach is improved within a community is directly related to the level of communication, coordination, and collaboration of public and private service providers from all levels within that community. Barriers to communications must be eliminated, bridges of relationship between all VSOs need to be built, and cooperation across those bridges must be promoted.

While our overarching goal is to improve the lives of veterans and their families, it is also our hope that the model that we develop and the lessons that we learn from our demonstration project will help inform other communities. Ultimately, we would like the VCAT model of community-based service integration to be replicated in other communities across the Nation. We hope to share with you the lessons that we learn from the VCAT project soon and offer policy and programmatic changes that may lead to increased outreach to veterans and their families.

In conclusion, we see the VCAT project as a great opportunity to support and assist our Nation's veterans in receiving the care, support, and services that they need, ensured by an integrated network of organizations and service providers. As a nonprofit organization, Altarum Institute is committed to its mission: We serve the public good by solving complex health care systems problems to improve human health. I can imagine no greater reward than to help fulfill this mission by serving those who have given so much in service to our Nation.

Mr. Chairman, this concludes my statement. I will be pleased to respond to any questions.

Thank you.

Prepared Statement of Randall L. Rutta, Executive Vice President, Public Affairs, Easter Seals, Inc.

Chairman Michaud, Ranking Member Brown, Members of the Subcommittee, on behalf of Easter Seals, thank you for the opportunity to come before you today to share our views on issues relating to the Department of Veterans Affairs' Veterans' Health Administration and its outreach to and care of our Nation's veterans. My name is Randall Rutta and I am Easter Seals' Executive Vice President of Public Affairs.

NEED

The crisis facing our Nation in meeting the physical and mental health needs of the 1.8 million members of the armed forces who served in Iraq and Afghanistan, as well as the needs of 23.4 million other veterans, is overwhelming and continues to grow. Thousands of injured servicemembers are returning home to communities nationwide with hopes of transitioning to a successful civilian life. While a broad spectrum of public benefits and private resources exist across the country, many servicemembers and veterans with disabilities are encountering barriers to accessing health care, job training and employment, housing, recreation and transportation as they transition back into their civilian communities. Nationwide, many communities are simply not fully equipped to respond appropriately and effectively to this population's unique needs, nor are they aware of how to best coordinate with military and veterans systems in the process. These barriers often limit the ability of veterans and their families to live, learn, work, and play as full participants in civilian community life.

In 2008, the RAND Corp released a study indicating that 1 in every 5 returning OEF/OIF servicemembers expressed indicators for post-traumatic stress disorder (PTSD) and 1 in every 5 had some level of Traumatic Brain Injury (TBI). This observation warrants concern as PTSD and TBI are among the leading medical conditions facing our returning heroes. According to Dr. Evan Kanter, a staff physician for the VA, who wrote in a November 2007 study by Physicians for Social Responsibility, titled "Shock and Awe Hits Home," that "as many as 30 percent of injured soldiers have suffered some degree of traumatic brain injury." These combat injuries significantly complicate a veteran's ability to successfully transition from active duty to civilian life. Moreover, unlike injuries to a soldier's limbs, injuries to a soldier's brain are often difficult to diagnose and treat in a timely manner, and are often not apparent until months later.

In a GAO report, the VA was commended for its efforts to prepare to meet these demands. However, concerns were noted about ensuring that all veterans have "equal access" when wide geographic territories define a service catchment area. Concern was also expressed about the efficacy of several service strategies that appeared to build infrastructure, but did not provide direct service. Issues of access to and availability of fundamental services and supports are unfortunately a common part of daily experiences for an individual living with a disability in our country. It is reasonable, then, to conclude that such challenges will be a part of life for a veteran with a service-connected disability. Easter Seals believes that these barriers need not be inevitable for these veterans – or for the broad population of individuals with disabilities. We are committed to creating and implementing solutions to these challenges in work and in life, so that all veterans with disabilities have the opportunity to lead full and productive lives.

EASTER SEALS BACKGROUND

For 90 years, Easter Seals has been providing and advocating for services that change and improve the lives of those living with disabilities and their families. With a network of 78 affiliate organizations, we are the Nation's largest provider of disability related services to individuals with disabilities and their families—touching the lives of more than 1.3 million people annually. We have a long history of helping veterans with disabilities through job training and employment opportunities, adult day services, medical rehabilitation, home modifications for accessibility needs, and recreation. Easter Seals is positioned to offer military and veterans systems of care with viable options to support and augment current transition and reintegration efforts. Additionally, Easter Seals has former servicemembers in leadership positions to guide program development and to train staff on how to be attuned to military and veteran cultural issues. In fact, Easter Seals has made Military and Veterans Initiatives a foundational pillar of Vision 2010, which is the guiding mission for the organization's current work and resource allocation priorities.

The vision of our Military & Veterans Initiative is that Easter Seals is a recognized and trusted partner with the Departments of Defense and Vet-

erans Affairs, and is a significant source of essential information, services and support for America's military servicemembers, veterans with disabilities, and their families.

EASTER SEALS CURRENT SERVICE CAPACITY AND EXPERIENCE

Currently, Easter Seals provides a broad range of community-based services and supports—job training & employment, childcare, adult day services, medical rehabilitation, mental health services, transportation, camping & recreation, respite and caregiver services, and accessibility solutions and technology for home, work, and independent living—to military servicemembers and veterans with disabilities, and their families in civilian programs throughout the Nation. A summary of a few of these activities follows.

Job Training & Employment

Historically, Easter Seals has had considerable experience with the VA in providing employment related services to veterans with disabilities. Our affiliate in Hartford, CT provides vocational evaluations and assessments to veterans with disabilities. Easter Seals in Middle Georgia provides direct work experience for veterans with disabilities. With grant funding from the McCormick Foundation, Easter Seals headquarters is developing an educational curriculum to train employers on best practices for hiring, retaining, managing and accommodating veterans with disabilities, especially those with PTSD, TBI, and amputations that are trying to reenter the workforce. A number of Easter Seals' corporate partners are pursuing strategies to hire veterans with disabilities throughout their organizations nationwide.

Adult Day Services

Several Easter Seals affiliates have contracts with the VA to provide adult day services to older veterans and are exploring potential opportunities for veterans with disabilities, specifically for younger veterans with significant injuries. Easter Seals Greater Washington-Baltimore Region operates a new intergenerational facility that delivers comprehensive services in Silver Spring, Md., approximately one mile from Walter Reed Medical Center. Plans call for the center to have resources for veterans and their families to support them during their time Washington, D.C. and in transition to their respective hometowns across the country.

Community OneSource™

A significant disconnect in the continuum of care exists between active duty recovery at military treatment facilities and post-discharge reintegration to civilian life and life with a disability for servicemembers with disabilities and their families in communities nationwide. The report issued by the *President's Commission on Care for America's Returning Wounded Warriors* supports the implementation of a comprehensive "Recovery Plan" that will help servicemembers obtain essential services promptly and in the most appropriate care facilities in the Departments of Defense and Veterans Affairs, and civilian settings. Easter Seals is responding to the Commission's call to action for civilian settings by developing and implementing a "Community OneSource™" reintegration model program.

Community OneSource™ is a dynamic national initiative that will support successful community reintegration of America's wounded, ill or injured servicemembers and veterans and their families. The program's approach fosters systems change throughout the country to rally and support communities and regions in responding to the needs of this deserving population, while specifically establishing points of contact that will coordinate and provide services and supports to families. Community OneSource™ leverages, integrates, and builds community capacity through convening and collaborative efforts amongst Federal, state, and local public and private systems and providers of service to meet specific needs for information, assistance, case management, system and resource navigation, and essential services from active duty demobilization or discharge to civilian status and successful community integration.

SUGGESTED IMPROVEMENT AREAS

Easter Seals recognizes and applauds the good work that the Veterans Health Administration (VHA) does for our Nation's veterans community. The VHA has 7.8 million veterans enrolled in its health care system and provided 5½ million unique patient visits in 2007. In an effort to reach the entirety of today's 23.4 million veterans, Easter Seals commends the many and varied communication and outreach strategies that VA utilizes to inform its service population. Efforts such as active participation in demobilization briefs (Transition Assistance Program, Disabled Transition Assistance Program), partnerships with Veteran Service Organizations, combined efforts with state VA efforts (county outreach coordinators), the implemen-

tation of online strategies, and the use of traditional media, public service announcements, brochures, billboards, and others have heightened public awareness and gone far to informing today's veterans of the availability of support and care provided through the VA.

Despite these good efforts, a strategic resource has yet to be fully leveraged in this process— capitalizing on the infrastructure, established networks, and grassroots reach of community-based organizations such as Easter Seals.

1. *Collaboration:* No one organization can provide all the services that an entire segment of a population needs—and the VA cannot be all things, to all veterans, in all places. Veterans and their families are not all located conveniently near VA facilities, many live in rural areas where they are geographically isolated from VA services. Additionally, the VA does not maintain a full compliment of services at every one of its facilities nationwide, creating service gaps for those whose needs cannot be met locally.

   ***Recommendations:* VA should use community-based NGOs as a vehicle for both outreach AND service delivery. The VA must reach out to community-based NGOs to leverage their best practices and service capacity in meeting the needs of veterans and their families in areas where VA services either do not exist, are inaccessible, or are insufficient through partnerships and outsourcing. This would allow the VA to formally recognize the capacity, ability, and desire of the community-based sector to serve veterans and their families. Additionally, VA should develop a strategic plan for teaming with and leveraging the Nation's human service system in meeting their mission.**

2. *NGO Access:* Many Federal agencies have an established point of contact to facilitate organizational partnerships, learning, and team efforts. They serve are liaisons for understanding and supporting the organization's strategic vision and service needs. The VA has a Veteran Services Organization (VSO) liaison that acts as an entry point for accessing to VA internal agencies for the VSOs.

   ***Recommendation:* In support of the VA's Gateway Initiative, VA needs to hire an NGO liaison, VA Ombudsman to fully realize this entry point for interacting with the VA and outside organizations seeking to help veterans. This staff Member would not only understand VA and veteran needs, but also the NGO system—including how to interpret their desire to partner and leverage resources.**

3. *Mobile Vet Centers:* The VA has established 50 mobile Vet Centers that specifically target veterans in more remote areas where VA mental health services do not exist. While Easter Seals applauds the VA for thinking outside the box with this initiative, we would ask what happens to veteran needs after the mobile Vet Center leaves the community.

   ***Recommendations:* The VA should formally partner with local community NGOs like Easter Seals to host the mobile Vet Center during its visit, and contract for services that ensure continuity of care before and after the visit. Then once the mobile Vet Center leaves, the local community based NGO would be able to provide a level of follow up services to the veteran and/or family. Such a partnership should include outreach for VA services conducted by the NGO.**

4. *Younger Veterans:* The VHA has taken a number of steps to reach younger veterans, initiating age appropriate strategies to accomplish this objective. Online efforts such as a section within the VA's Web site designed explicitly for Operation Enduring Freedom and Operation Iraqi Freedom veterans and My Health*e*Vet provide useful and relevant health care and benefits information. The VA has also initiated strategies to leverage the power of web-based social networking to reach out to younger veterans, with a growing presence on Facebook, informational videos on YouTube and involvement with Second Life. The involvement of OEF/OIF coordinators in reintegration events such as Stand Downs and Yellow Ribbon Reintegration events also targets getting information to today's younger veterans as they seek to shift into civilian life.

   ***Recommendations:* While these efforts are both appropriate and strategic, the VA could enhance their outreach efforts to younger veterans through increasing activities designed to target a veteran's family—their parents or spouse. One unique strategy that has proven effective for National Guard Members is Easter Seals New Hampshire's Veterans Count program, where Easter Seals, in partnership with the Guard and New Hampshire's Department of Health and Human Serv-**

ices, initiates contact with Guard Members and their families pre-deployment. The Veterans Count staff then work with these families to prepare them for deployment, support the family while the servicemember is deployed, and then are positioned to support them post-deployment because of time invested with the family over the prior 18 to 20 months. Such an approach significantly reduces the likelihood that a veteran will fall the cracks or be lost in the bureaucratic process in their attempts to return to their families. Easter Seals is then able to ensure that the veteran and his or her family is connected with the resources they need to successfully transition back into civilian life. This early intervention model provides a unique boots on the ground approach to outreach and is one that Easter Seals would like to see implemented across the country.

5. *Older Veterans Strategies:* While Easter Seals applauds the efforts of the VHA to develop appropriate and targeted approaches to reaching younger veterans, we remain concerned that older veterans are not receiving similar organizational attention. While some older veterans will likely be able to found through younger veteran approaches, many of the over 9 million veterans who are 65 and above will not benefit from these efforts, particularly those who are low-income, have limited access to health care or lack access or skills to utilize current technologies. This short-coming results in those most in need of services and supports being left out or looked over by the very system designed to meet their needs.

   Recommendations: **VHA should actively pursue a collaborative relationship with the administration on Aging (AoA) and create joint marketing and outreach strategies and materials which leverage the national network of senior services under the authority of AoA. Such a partnership could result in such outreach efforts as including information in Meals on Wheels deliveries about age appropriate veterans benefits for beneficiaries of this AoA service. Additionally, VHA should create partnerships with senior service organizations to utilize their networks across the country to provide information to seniors served by their systems. Further, local VHA facilities such as Vet Centers, Veterans Hospitals and Outpatient Clinics should actively reach out to local Area Agencies on Aging to install outreach strategies within their service delivery mechanisms and facilities such as senior centers or activities buildings.**

   Finally, VHA should establish strategic relationships with our Nation's adult day service network, which provides service to over 150,000 seniors daily through a network of over 3,400 local centers. While adult day service is a fairly new offering from the VA, being added to the veteran benefit package through the Millennium Health Act 1999, the larger adult day service market has been strong for decades, and projects significant growth in the coming years as our Nation's baby boomers age and desire the services provided by this industry. Many of the 9 million senior veterans are likely to need and receive these services. Easter Seals has worked with the VHA for a number of years on promoting the use of ADS within the community of veterans accessing VA services. We have also encouraged the VA to more actively engage the non-VA ADS network as strategic partner that could both extend information about VA benefits and provide quality services to older veterans. Non-VA ADS staff should be trained to identify, refer as appropriate and meet the unique service needs of older veterans; the VA is the logical entity to lead such efforts.

6. *Insular Culture:* Many of the systems and departments providing services to veterans within the VA operate in a very insular manner, most notably at the local level. Specific functions are carried out in silos and stop short of shepherding the veteran to much needed additional resources during their community-based transition, continued recovery and rehabilitation. Often times Veterans Integrated Service Network (VISN) staff reflect this insular operational methodology in attitudes concerning the use and value of utilizing local NGOs to meet veterans' needs. One significant outcome of this cultural insularity is lost opportunity, for the VA to meet its objectives and, sadly, for the veteran who either gets lost in the system or cannot access the full array of available services in his or her community. More often than not, our local affiliates' expe-

rience in attempting to partner with the local VA is met with initial resistance and then inability to execute.

Recommendations: **The VA must encourage key decision-makers in each VISN to embrace collaborative relationships to meet the needs of veterans within their service delivery region. VHA community leaders should partner with other local community NGOs to help meet the needs of the veterans they serve. Easter Seals offers services and supports that can augment those provided by VHA, especially when the veteran transitions to his or her home community. Additionally, Easter Seals would recommend systemic VA organizational culture change that changes the service delivery approach to veteran-centric.**

SUMMARY

America's warriors serve their country, fully, bravely and without question. Now, all Americans must rise together to fulfill our promise to care for those who have borne the battle and sacrificed so much, by assuring that our veterans have access to the services they need, wherever they live. Just as it takes a village to raise a child, so too does it take a village to welcome a veteran back home.

As Executive Vice President of one of the Nation's largest nonprofit disability health care organizations, I can say with an unwavering confidence that the VA has much to gain by embracing community-based organizations, like Easter Seals, in collaborative relationships that compliment the current array of Federal and state outreach and service efforts to our struggling veterans. It is these community-based organizations that hold the infrastructure to help meet this urgent need and should be viewed as an ally to further supplement, and not supplant, the efforts of the VA. Easter Seals is poised to substantially expand assistance to servicemembers and veterans with disabilities and their families. We have proven service solutions in place or within easy reach to address these immediate and long-term needs. The central challenge facing us in bringing needed information, services and supports to this population is the limited extent, to date, on the part of the Departments of Defense and Veterans Affairs to partner and outsource at substantial levels with private, nonprofit service providers to seed and sustain financial resources to conduct pilot projects and replicate effective models of service delivery nationwide that promote success in attaining individual and family goals and full community participation.

As Secretary Shinseki stated earlier this year during his Senate confirmation hearing "... three fundamental attributes mark the starting point for framing a 21st Century Organization: people-centric, result-driven, and forward-looking." A 21st Century VA must reach out across the table to community-based organizations to leverage best practices and local infrastructure in order to provide more effective services and supports to America's heroes and their families ... Easter Seals has its hand extended.

Thank you again for the opportunity to address this Committee and for all that you do for our Nation's veterans. I would be pleased to respond to any questions that you may have.

Prepared Statement of Jeffrey W. Pollard, Ph.D., ABPP, Director, Counseling and Psychological Services, George Mason University, Fairfax, VA, on behalf of American Psychological Association

Mr. Chairman and Members of the Subcommittee, please allow me to express appreciation for the opportunity to speak on behalf of the 150,000 members and affiliates of the American Psychological Association regarding outreach activities to veterans on college campuses. I am the son of a decorated WWII veteran captured on December 7, 1941, released in September 1945, and buried in Arlington National Cemetery. I have spent 30 years working as a psychologist committed to the mental and behavioral health of students on college campuses. Meeting the needs of the increasing numbers of our Nation's veterans—particularly on college and university campuses—is extremely significant to me.

Our ability to diagnose and treat combat-related mental and behavioral health problems, including depression, traumatic brain injury, and post-traumatic stress disorder has improved dramatically in recent years. Estimates suggest that between a quarter and a third of all veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom will display symptoms of a mental disorder within a year of leaving military service. Many of these veterans are expected to benefit from the new Post-9/11 GI Bill by furthering their education at our Nation's colleges and universities. These facts point to the important role that colleges and universities

must play in our national efforts to meet the mental and behavioral health needs of our servicemembers and veterans.

During the past year, George Mason University has been involved in a number of important activities to enhance our outreach to military personnel and veterans on campus. First, we hired Mr. Michael Johnson to serve as our full-time Military and Veterans Liaison in our Military and Veterans Office. Mr. Johnson, who has accompanied me to today's hearing, is a veteran of the United States Marine Corps, where he served for 17 years as both an enlisted Member and an officer. Mr. Johnson and his colleagues in the Military and Veterans Office currently serve approximately 1,000 active duty, reserve, National Guard and veteran students, offering assistance and information regarding issues such as veteran services and academic counseling, as well as information about the many benefits to which they are entitled through state and Federal Government programs. The office also assists veterans in adapting to collegiate life, connecting them to each other, and supporting them as they pursue their studies.

In addition, George Mason University has recently completed a needs survey of our military and veteran student population and established connections between the new Military and Veterans Liaison and virtually every component within the university. We have also established the Mason Military Outreach group, which is a collaboration of students, faculty and staff in support of our servicemembers, veterans, and their families. Further, the Mason Veteran Peers (MVP) initiative, involves a group of veterans who are working with Counseling & Psychological Services to provide peer support to veteran students.

Last month, George Mason University was one of only 20 institutions of higher education awarded a "Success for Veterans Award Grant" sponsored by the American Council on Education and the Wal-Mart Foundation. This $100,000 grant will help George Mason University's Military and Veterans Office evolve further into a comprehensive, coordinated one-stop resource and support center to ensure academic, psychological, and transition support. We are grateful for this award. However, like most grants, it will not cover the predicted level of need, and it is time limited. Furthermore, our university may be unable to continue the program upon completion of the grant. Unfortunately, servicemembers and veterans attending colleges and universities that have not received such grant funding will not be able to benefit from the additional support to aid in the successful completion of their academic work.

Just as the community mental health system is stretched far too thin, so are college and university mental health resources. In fact, campus mental health faces significant systemic challenges, including an insufficient number of service providers, such as psychologists, psychiatrists, and case managers. Funding for colleges and universities to provide the specialized mental and behavioral health care required by many servicemembers and veterans is unavailable. As more servicemembers and veterans are utilizing college and university mental health services, these facilities are experiencing the strain of increasing caseloads and case management needs.

Data indicate that students on college and university campuses are increasingly arriving with more severe preexisting mental and behavioral health problems or developing these health concerns during their college careers. The increasing civilian mental and behavioral health needs on campus make it even more challenging for colleges and universities to provide sufficient services and supports for the growing population of servicemembers and veterans on campus.

While we at George Mason University and our colleagues at colleges and universities around the country have been taking important steps to reach out to servicemembers and veterans on campus, much work remains ahead. I would like to provide a few recommendations that may help our institutions of higher learning to ensure that we are doing all that we can to meet the mental and behavioral health needs of our military and veteran student population.

First, sufficient resources must be made available to support targeted efforts on campus to address mental and behavioral health needs among servicemembers and veterans, including risk of suicide. In recent years, some important Federal initiatives have been created through the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the national problem of increased mental and behavioral health concerns on campus, including suicide.

While these SAMHSA grants currently support education and outreach efforts related to suicide prevention on college and university campuses, there are currently only 49 programs in place to create greater awareness about suicide and strengthen suicide prevention efforts. Much more needs to be done. Initiatives are underway to enable SAMHSA to support direct services for students on campus, an increasing

number of whom will be servicemembers and veterans, so that the full range of their mental and behavioral health needs can be met.

Senators Durbin and Collins and Representative Schakowsky have introduced the *Mental Health on Campus Improvement Act* (S. 682/H.R. 1704) and its programs will complement SAMHSA's Campus Suicide Prevention program to offer the full range of prevention and intervention services currently needed on college and university campuses. In addition, this legislation calls on grant applicants to include a plan, when applicable, to meet the specific mental and behavioral health needs of veterans attending institutions of higher education. This bill would also establish a College Campus Task Force, which includes representation from the Department of Veterans Affairs, to discuss mental and behavioral health concerns on college and university campuses.

Second, continuing education and training opportunities must be readily available for college and university mental and behavioral health professionals regarding some of the unique deployment, reintegration, and readjustment issues facing servicemembers, veterans, and their families. Both the Department of Defense (DoD) and the Department of Veterans Affairs (VA) have unique knowledge and expertise in this domain. I recently attended a week-long training conducted by the DoD Center for Deployment Psychology in which leading experts in the field provided critical training regarding the deployment cycle, trauma and resilience, behavioral health care for the severely injured, and the impact of deployment on families. These are high quality training programs that are worthy of continued attention and support.

Third, we must develop mechanisms to conduct appropriate outreach to servicemembers and veterans who are beginning their postsecondary education online while deployed or upon their return from service. Such online education opportunities may present unique challenges for our military and veteran students, not because these education programs are unworthy or ineffective, but because of their potential isolating effect. Servicemembers and veterans who are enrolled in online education programs and experiencing mental and behavioral health problems are often more isolated than their on-campus colleagues, and this isolation can be contraindicated for their healthy readjustment and recovery.

APA and the psychology community looks forward to continuing to work with Congress, the VA, the DoD, and the veterans service community to welcome home our men and women in uniform and ensure that they receive the mental and behavioral health services and supports—on college and university campuses and in the larger community—that they have so honorably earned.

Prepared Statement of Paul J. Hutter, Chief Officer; Legislative, Regulatory, and Intergovernmental Affairs, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Subcommittee, thank you for providing me this opportunity to discuss the Veterans Health Administration's (VHA's) outreach activities to Veterans. I am accompanied today by Ev Chasen, VHA's Chief Communications Officer, John Brown, Director of the VHA Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Outreach Office, and Emily Smith, Deputy Assistant Secretary for Intergovernmental Affairs, Office of Public and Intergovernmental Affairs. VA's mission is to care for those who have borne the battle—to honor those who have worn the uniform by providing them the highest quality health care and benefits possible. This mission can only be accomplished when Veterans know the full range of services we offer. VA is committed to reaching out to Veterans and their families where they are to support these ends; this includes not only reaching into rural communities, but entering virtual communities and establishing connections there as well. My testimony today will highlight four forms of outreach VHA is conducting: direct, traditional outreach to separating servicemembers; program-specific outreach; outreach to rural areas; and outreach using new technologies.

Outreach to Separating Servicemembers

VHA currently maintains a variety of programs to respond to the specific needs of separating OEF/OIF servicemembers to assist them in transitioning from military service to Veteran status. The Department of Veterans Affairs (VA) and the Department of Defense (DoD) have established a comprehensive, standardized enrollment process at 60 demobilization sites (15 Army, 3 Navy, 3 Marines, 3 Coast Guard and 36 Air Force). Through this process, VA has contacted more than 41,000 Members

of the Reserve and National Guard and enrolled more than 38,000 of them for VHA health care. DoD provides VA with dates, numbers of servicemembers demobilizing and locations for demobilizing events. At these events, VHA staff representatives from the local VA medical center, benefits specialists and Vet Center counselors provide standardized 45-minute briefings during mandatory demobilization events. During the briefing, VA representatives provide demobilizing servicemembers information about health care enrollment and eligibility, including the most recent expansion extending VA health care enrollment period to 5 years to those servicemembers who served in combat following their separation from active duty. They are also educated about the period of eligibility for dental benefits, which Congress recently extended from 90 days to 180 days following separation from service, through the National Defense Authorization Act for Fiscal Year 2008.

VA streamlined this enrollment process and, during the demobilization events, VA representatives show Veterans how to complete the Application for Health Benefits (1010EZ). This begins the enrollment process for VA health care. VHA staff members also discuss how to make an appointment for an initial examination for service-related conditions and answer questions about the enrollment process. VA representatives collect the completed forms at the end of each session. VA staff at the supporting facility match the 1010EZ with a copy of the Veteran's DD Form 214, the discharge papers. Presently, data from these forms are entered into the Vista health record system. An email is sent to the Veteran's preferred facility to complete the enrollment. A new process has been developed through a pilot program at Ft. Bragg to overnight all records from each of the 60 sites to VA's Health Eligibility Center to complete the enrollment process. A letter is then sent from the Health Eligibility Center to the Veteran verifying their enrollment.

In response to the growing numbers of Veterans returning from combat in OEF/OIF, the Vet Centers initiated an aggressive outreach campaign to welcome home and educate returning servicemembers at military demobilization and National Guard and Reserve sites. Through its community outreach and brokering efforts, the Vet Center program also provides many Veterans the means of access to other VHA and VBA programs. To augment this effort, the Vet Center program recruited and hired 100 OEF/OIF Veterans to provide the bulk of this outreach to their fellow Veterans. To improve the quality of its outreach services, in June 2005, the Vet Centers began documenting every OEF/OIF Veteran who received outreach services. The program's focus on aggressive outreach activities has resulted in the provision of timely Vet Center services to significant numbers of OEF/OIF Veterans and family members.

Every VA medical center has established an OEF/OIF Program. The Program Manager, usually a social worker or nurse, manages programs for OEF/OIF Veterans, coordinates the efforts of clinical case managers and Transition Patient Advocates, links with military treatment facilities to ease transfers of patients and works with the Veterans Benefits Administration (VBA) to track claims. Each VISN has also identified an OEF/OIF Program Manager to coordinate inter-facility issues and practices. OEF/OIF case managers initiate contact with patients and families before they transfer from a military treatment facility (if they have received care there, otherwise, they work with patients and their families as they present for care) and assist an interdisciplinary team assigned to treat the Veteran's medical needs. The OEF/OIF case manager is responsible for planning and coordinating all of the patient's health care needs.

In May 2008, VA began a Veteran Call Center Initiative to reach out to OEF/OIF Veterans who separated between FY 2002 and December 2008. We are now reaching out to Veterans who have separated through March 2009. The Call Center representatives inform Veterans of their benefits, including enhanced health care enrollment opportunities and determine if VA can assist in any way. This effort initially focused on approximately 15,500 Veterans VA believed had injuries or illnesses that might need care management. The Call Center also contacted any combat Veteran who had never used a VA medical facility before. Almost 38 percent of those we spoke with requested information or assistance as a result of our outreach. The Call Center Initiative continues today, focusing on those Veterans who have separated since 2001. As of May 6, 2009, VA has called 660,000 Veterans and spoken with more than 160,000 of them. We have sent almost 36,000 requested information packages to Veterans.

Another area in which VA is supporting OEF/OIF transition is through the Yellow Ribbon Reintegration program. VA has assigned a full-time liaison with the Yellow Ribbon Reintegration Program office in DoD to facilitate VA support of the development and implementation of the program. The Yellow Ribbon Reintegration Program is currently active in 54 states and territories, and engages servicemembers and their families during the pre-, during and post-deployment stages, including 30,

60, and 90 days after deployment. At the local level, VA supported 275 Reserve and Guard Yellow Ribbon Events during FY 2008 and through mid-February 2009. A total of 39,000 servicemembers have attended these events, along with 25,000 members of their families.

VHA has been providing support to DoD's Reserve and National Guard (RC) Post-Deployment Health Reassessment (PDHRA) Initiative since its beginning in November 2005. VA has supported over 1,850 PDHRA events at local Reserve and National Guard Units along with supporting referral efforts from DoD's 24/7 PDHRA Call Center operation. The RC PDHRA initiative has generated over 57,000 referrals to VA medical centers and over 24,000 referrals to Vet Centers during this time.

For severely injured Veterans and servicemembers, VHA has stationed 27 social work or nurse case manager liaisons at 13 military treatment facilities across the country to identify and address the patient's clinical needs as they transfer from a DoD facility to a VA facility. Similarly, VA houses approximately 90 military liaisons in VHA facilities to provide on-site, non-clinical support for Veterans or servicemembers at VA's Polytrauma facilities and other locations.

In October 2007, VA partnered with DoD to establish the Joint VA/DoD Federal Recovery Coordination Program (FRCP). Federal Recovery Coordinators identify and integrate care and services for the seriously wounded, ill, and injured servicemember, Veteran, and their families through recovery, rehabilitation, and community reintegration. The FRCP is intended to serve all seriously injured servicemembers and Veterans, regardless of where they receive their care. The central tenet of this program is close coordination of clinical and non-clinical care management across the lifetime continuum of care.

Program-Specific Outreach

VHA's program offices and facilities also engage in outreach in their own areas in coordination to increase awareness of benefits and services they offer. VA employs management tools to ensure control and oversight of promotion efforts through coordinated messages with valid and up-to-date information. VHA's Chief Business Office is undertaking efforts to increase awareness of the Universal Health Service Plan task force recommendations, including a streamlined health benefits application web portal and other robust communication products.

Perhaps the most notable example of program-specific outreach VHA has done is the Suicide Prevention public service announcements (PSAs) featuring Gary Sinise and Deborah Norville. In the 6 months between October 13, 2008 and April 13, 2009, the PSA featuring Gary Sinise was broadcast more than 8,700 times by 155 stations in almost 100 markets. During this same time period, VA's Suicide Prevention Hotline (1–800–273–TALK) received approximately 50,000 calls across the Nation, an increase of roughly 25 percent based on the previous 6 months when the Hotline received approximately 40,000 calls. Last year, VA advertised the Suicide Prevention Hotline on buses and metro trains in the Washington, D.C. area, resulting in a significant increase in calls to the hotline from the area. This year, we have begun advertising in Spokane, WA, and will soon advertise on public transit systems in the Miami, Los Angeles, San Francisco/Oakland, Phoenix, Las Vegas and Dallas metropolitan areas (all locations where the suicide rate among Veterans is greater than the national average). In addition, VA is working with a company to purchase advertisements on 20,000 buses nationwide.

More broadly, VA could not serve Veterans to the degree it does without the immeasurable help of Veterans Service Organizations (VSOs), faith-based and community groups. VA maintains constant contact and holds regular meetings with VSOs and organizations such as the Knights of Columbus, the American Red Cross, and the Salvation Army (among others) to provide information about VA's programs and offerings while soliciting feedback about concerns present in the community. Working with these community partners helps significantly expand VA's reach to millions of people who may not otherwise hear of our offer of care and service.

Our facilities also conduct local outreach that, while essential, often goes unheralded. These efforts are possible because of the dedicated work of VA professionals who have established relationships with local communities, and their work continue to pay dividends. For example, in April alone:

- The Little Rock VA Medical Center participated in two Post-Deployment Health Assessments for Members of the 39th Infantry Brigade of the Arkansas Army Guard; of the more than 850 soldiers screened, we initiated 252 new case appointments;
- The West Palm Beach VA Medical Center participated in an outreach activity at the Palm Beach Community College, providing information to students who are Veterans on enrollment, benefits and employment;

- The VA Central Texas Health Care System joined the Family Readiness Group of the 126th Forward Surgical Team for a welcome home celebration at Fort Hood as the Unit returned from a tour in Afghanistan;
- The VA Palo Alto's Polytrauma Rehabilitation Center and the Men's Trauma Recovery Program held a small town hall meeting for all active duty soldiers being cared for in these programs, providing information on Medical Boards and other DoD issues related to their time at VA;
- The Indianapolis, Fort Wayne and Evansville, Indiana Medical Centers hosted Post Deployment Health Reassessments for the 76th Brigade Combat Team for over 2,800 soldiers who returned from Iraq in December 2008; and
- The VA San Diego Health Care System participated in a demobilization briefing at Camp Pendleton that approximately 800 Marines attended.

Mr. Chairman, these are but a few of the many actions taken by VA staff Members to inform Veterans and to establish contact with them. I highlight these cases not to draw special attention to these facilities or any specific program, but as evidence of a trend too often missed. VHA Directive 2007–017, enacted in May 2007, requires each VA medical center to host an annual "Welcome Home" event for OEF/OIF Veterans and active duty servicemembers, their families, and the community at large. These events are well-attended and offer health screenings, benefits information, and increase awareness about programs such as VA's Safe Driving Initiative.

The Department's Safe Driving Initiative is an innovative effort designed to address an important concern. VA has determined that motor vehicle crashes are a leading cause of death among combat Veterans during the first years after their return home, and is working with the Department of Transportation and DoD to reduce these accidents. We have begun a new program designed to identify needed research and to increase awareness of the importance of safe driving among newly-demobilized Veterans. The program has included a summit meeting among leading researchers, posters, a soon-to-be-released Public Service Announcement featuring race driver Richard Petty, a Web site, and other activities. During calendar year 2009, every VA medical center has been tasked to hold a safe driving event to inform returning Veterans of the need to drive safely.

Our Vet Centers also provide services and points of access to Veterans in communities across the country. Vet Centers welcome home Veterans with honor by providing quality readjustment counseling in a supportive, non-clinical environment. By the end of FY 2009, VA will have 271 Vet Centers and 1,526 employees to address the needs of Veterans; any county in the country with more than 50,000 Veterans will have services available through a Vet Center. A fleet of 50 Mobile Vet Centers are being put into service this year and will provide access to returning Veterans and outreach to demobilization military bases, National Guard and Reserve locations nationally. This type of outreach spans across the range of areas covered today, as these Mobile Vet Centers utilize new technologies to reach younger Veterans, those immediately separating, those in rural or remote areas, and those in need of services.

Rural Health Outreach

Particularly important to VA is outreach to geographic areas, particularly rural and highly rural communities. Both the Office of Rural Health (ORH) and Veterans Integrated Service Networks (VISNs) participate in outreach efforts for these populations. VISN Rural Consultants collaborate with local communities to educate, support case management, and increase awareness. Additionally, VA's Rural Health Resource Centers serve as regional satellite offices and educational repositories to expand and develop relationships with academic institutions and a range of other partners in communities across the country. VA understands that successful outreach must be tailored to local needs and conditions, and one of ORH's primary aims has been to support this approach.

ORH is supporting expansion of the Mental Health Care Intensive Care Management-Rural Access Network for Growth Enhancement (MHICM–Range) Initiative to provide community-based support for Veterans with severe mental illness. VA has been adding mental health staff to CBOCs, enhancing our capacity to provide telemental health services and using referrals to Community Mental Health Services and other providers to increase access to mental health care in rural areas. ORH collaborated with the South Central Mental Illness Research, Education and Clinical Center in VISN 16 to fund four research studies investigating clinical policies or programs that improve access, quality and outcomes of mental health and substance abuse treatment services for rural and underserved Veterans.

VA has also taken the lead in opening new rural health care facilities, such as Rural Outreach Clinics. Last September, VA announced the opening of 10 new

Rural Outreach Clinics this Fiscal Year; four of these are currently operational, including sites in Houlton, ME; Perry, GA; Juneau, AK; and The Dalles, OR. VA utilizes Rural Outreach Clinics to offer services on a part-time basis, usually a few days a week, in rural and highly rural areas where there is insufficient demand for full-time services or it is otherwise not feasible to establish a full-time CBOC. Rural Outreach Clinics offer primary care, mental health services, and specialty referrals. Each Rural Outreach Clinic is part of a VA network and meets VA's quality standards. Veterans use Rural Outreach Clinics as an access point for referrals to larger VA facilities for specialized needs.

VA recently announced a Mobile Health Care Pilot Project in VISNs 1, 4, 19, and 20. The health care vans associated with this program will be concentrated in 24 predominately rural counties, where patients would otherwise travel long distances for care. VA is focusing on counties in Colorado, Maine, Nebraska, Washington, West Virginia and Wyoming. This pilot will collaborate with local communities in areas our mobile vans visit to promote continuity of care for Veterans. It will also allow us to expand our telemedicine satellite technology resources and is part of a larger group of mobile assets. ORH is developing evaluation methodologies and measures to determine the effectiveness of this program and to identify areas for improvement.

Outreach Using New Technologies

VHA is not limiting itself to traditional forms of outreach. In order to become a 21st century VA, we must add to the past methods used in communicating to reach a new generation of Veterans. By fostering and creating linkages across offices and throughout the Department, VA is harnessing new technology and venues, including Twitter, Second Life, Facebook, YouTube, and the television channel MTV to provide information to younger Veterans where they are most likely to see it and in media familiar to them. We have adapted our Web site to be viewable on mobile devices (m.va.gov) so Veterans and others can receive up to date information on VA services and locations wherever they are. VA is also employing public service announcements to raise awareness about VA, and has launched a new initiative to provide colleges and universities with information concerning the health care needs of returning Veterans. This latter effort provides training and education materials for administrators and students to help foster more accommodating academic environments for Veterans.

VA has also created a new Web site for returning Veterans that provides useful information about eligibility, benefits, health care, and other services (http://www.oefoif.va.gov/). This site also features a blog with comments from Veterans and family members (http://www.blogs.va.gov/returningservicemembers/). We recognize we must develop social networking strategies, including nontraditional outlets, and a wide variety of new media to communicate VA's message about our services.

These new technologies have even entered into health care delivery. One VA facility has begun piloting a program that uses text messaging to help Veterans send their home-based blood pressure readings to their clinicians. Researchers found Veterans who used text messaging achieved their blood pressure goals 2 weeks sooner than those who used other methods.

Conclusion

VA understands different Veterans will receive messages in different ways and different times. It is our duty to notify Veterans of the repayment our Nation offers in gratitude for the sacrifice they have made. We must continue programs that are successful and develop new methods when our current measures are insufficient. Our mission is to reach out to family members, employers, community stakeholders, Reserve and National Guard units and Veterans to make sure they will know how to access help when they need it. Thank you again for the opportunity to testify. My colleagues and I are prepared to answer any questions you may have.

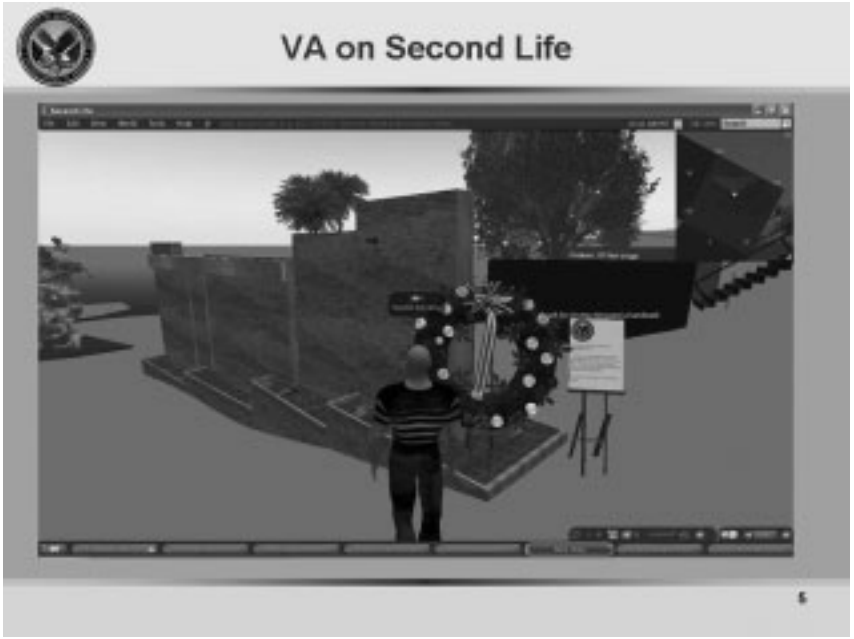
VHA Outreach: U.S. Department of Veterans Affairs Medical Care: The Crown Jewel and Best Kept Secret

Committee on Veterans' Affairs
Subcommittee on Health
U.S. House of Representatives
May 19, 2009

Suicide Prevention Metro Advertising Spokane, WA

VA Website Mobile Access: m.va.gov
AT&T 3G 12:31 PM
Department of Veterans Affairs
In The News
VA News Releases
Facility Locations
Returning Service Members
Suicide Prevention Awareness
Benefits for Veterans & Dependents
The American Veteran
VAnguard Magazine
Contact Us
3

VA Website Mobile Access: m.va.gov
AT&T 10:44 AM
Department of Veterans Affairs
In The News
Paperless Benefits Delivery at Discharge
VA's Benefits Delivery at Discharge - "BDD" - program has gone paperless. The program, which allows service members to apply for disability compensation benefits from VA before retiring or separating, has a goal of providing benefits within 60 days after release or discharge from active duty. For that to happen, it is important that service members apply at least 60 days before separation. Electronic images are made of medical records and other supporting
4


VA on Second Life
5

VA on Facebook
Veterans Health Administration (VHA) - U.S. Department of Veterans Affairs
6

VA on YouTube
VetSuccess: Ability Not Disability
Ability
Not Disability
7

VA OEF/OIF Website
(http://www.oefoif.va.gov/)
What's Popular
care
assistance
benefits
Dental Department
family
Guard
health
Information
members
military
National
Program
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service
services
transition
veterans
This Tag Cloud is a list of popular terms related to the web site. The text size of the word shows its relative popularity.
9

Statement of Rear Admiral LeRoy Collins, Jr., USNR (Ret.) Executive Director, Florida Department of Veterans Affairs

Mr. Chairman and distinguished Members of the Subcommittee, thank you for the opportunity to provide a statement to address the Veterans Health Administration's outreach to veterans.

Florida has almost 1.8 million veterans. The Florida Department of Veterans Affairs (FDVA) is a state veterans' service agency created by the Florida Legislature following a successful constitutional initiative to authorize this department. We provide information, advocacy and quality long term health care services to our veterans. We maintain strong positive working relationships with both the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) leadership in Florida.

We are an arm of state government which has statutory responsibilities concerning state veterans benefits and citizen services, as well as service delivery responsibilities representing veterans in their dealings with the claims process in VBA. FDVA continues to expand veterans' facilities and services in Florida, primarily through the growth in the State Veterans Homes program and through new outreach programs to contact more of the veteran population in Florida. As a result of strong advocacy on behalf of veterans and dependents, their economic and health status is improved with benefits earned through military service to our Nation. FDVA currently employs 912 staff members.

The primary challenge our Veterans Claims Examiners (VCEs) have in Florida is timely access to VA information concerning veterans, particularly those wounded in combat, returning to our state. Improved case information flow to state government is needed and vital to improving the timely delivery of state benefits information to these warriors and families. Our Florida Seamless Transition Program, the first of its kind in the Nation and adopted nationwide by the VA in February 2007, has helped, but more must be done. Electronic contact information of our state's veterans upon separation would be a desirable enhancement (e.g. e-mail address on the DD 214 form).

Enhanced outreach to veterans in large population states deserves more attention and resources to meet the needs of our newest generation of veterans. We appreciate the VA's efforts to keep the various state departments of veterans' affairs better informed on key topics of interest. We hope the VA will provide the states with an electronic list of the names, addresses and e-mail addresses of Veterans who claim that state as their home of record. Our newest veterans communicate via electronic social networking and tend to keep their electronic lines of communication consistent. Sharing this vital link is essential.

We support the transitional efforts of the VA under Secretary of Veterans Affairs Eric K. Shinseki. His Veteran-centric approach to incorporate new technologies in the operation of the department should pay huge dividends, and Florida enthusiastically endorses his focus on modernizing outreach. In addition, we hope that the success of the Public Service Announcement by actor Gary Sinese on Veteran suicide prevention will lead to other high-visibility PSAs on Post-Traumatic Stress Disorder and Traumatic Brain Injury.

Furthermore, we appreciate the VA's response to the Post 9/11 GI Bill, but believe the agency should fund and certify campus veterans' representatives, as they did following the Vietnam War. These campus VET–REPs can help veterans facilitate access to substance abuse and mental health services, enrollment in health care, issue resolution, claims development and advocacy. The hour is late to get this VET–REP effort underway nationwide in time to implement the new G.I. Bill in August 2009. FDVA convinced the Florida legislature to approve a VET–REP position for each state college and university campus, but the funding for the initiative eluded us. We believe the VET–REP issue needs your attention.

Thank you for the opportunity to comment. This Subcommittee's efforts to improve America's benefits and services to our veterans is a noble cause.

Statement of Hon. Cliff Stearns, a Representative in Congress from the State of Florida

Thank you, Mr. Chairman.

I am pleased to be here this afternoon to examine the status of the Veteran Health Administration's outreach efforts to all categories of veterans. The VA has a wealth of resources and services available to those who served our Nation, but these resources are wasted if no one knows about them. Unfortunately, that is what

we often hear from our constituents and the veteran service organizations that represent them.

Admiral LeRoy Collins, Jr. (Rear Admiral, U.S. Navy Reserve, Retired), who is the Executive Director of the Florida Department of Veterans Affairs, has submitted a statement for the record on the status of the VHA's outreach to veterans in the State of Florida, and I would like to highlight a few of his key points.

Florida is home to the second largest veterans population in the country, which is almost 1.8 million veterans. The goal of the Florida Department of Veterans Affairs (FDVA) is to provide information, advocacy, and quality long-term health care services to veterans. Additionally, the FDVA regularly and effectively communicates with the VHA and VBA leadership in Florida. These strong working relationships go a long way to ensuring veterans in Florida know about the VA's services. However, it would be helpful if the VA could provide all states with an electronic list of the names, addresses, and e-mails of veterans who claim that state as their home of record. Sharing this information is essential to ensuring that claims examiners have timely access to key information and can reach specified groups of veterans.

Importantly, Admiral Collins states that enhanced outreach to veterans deserves more attention and resources in order to meet the needs of our newest generation of veterans—those returning from Iraq and Afghanistan. The VA Secretary should be regularly using national media outlets to advertise VA services and draw attention to key health issues. Many also believe there is a need for more "high visibility" public service announcements such as the recent PSA by actor Gary Sinese on Veteran Suicide Prevention. The VA should create other effective PSAs on Traumatic Brain Injury (TBI) and Post-traumatic stress disorder (PTSD) to help erase the stigma associated with these increasingly prevalent behavioral disorders.

The VA should never have to be pushed by Congress to legislate outreach efforts. I hope this hearing today affords us the chance to have a better dialogue with the VA on the need for differentiated outreach strategies to address the dynamic group of veterans in its health care system.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
June 3, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20240

Dear Secretary Shinseki:

Thank you for the testimony of Paul Hutter, Chief Officer for Legislative, Regulatory and Intergovernmental Affairs of the Veterans Health Administration at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Oversight Hearing on "VA Medical Care: The Crown Jewel and Best Kept Secret" that took place on May 19, 2009.

Please provide answers to the following questions by July 15, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. In your testimony you mentioned a pilot program currently being conducted at Fort Bragg. In this program, VA seeks to expedite enrollment by overnighting records from demobilization sites to VA's Health Eligibility Center. Has this program been effective in streamlining the enrollment process?
2. Your testimony largely centered on outreach efforts targeting OEF/OIF veterans.
   a. What programs does VA have that focus on Vietnam veterans and other such populations?
   b. How do programs targeting specific veterans groups differ from each other.
3. You mentioned that VA has harnessed new technology such as Twitter, Second Life, Facebook, and YouTube. Can you elaborate on VA's efforts toward utilizing these new mediums?
4. Can you talk a bit about how local outreach conducted by VA facilities fits into the structure of VA's overall effort? What does the central office do to support these local efforts?
5. Some VSOs have noted the outreach efforts that will be required by VA's upcoming effort to expand enrollment in VHA among veterans in priority group 8. Is there a plan in place to notify veterans in this group that they may be eligible for enrollment?
6. What are the roles and responsibilities with respect to outreach for the communications director for VHA? How does this compare to the roles and responsibilities of the now defunct office of Deputy Undersecretary for Coordination?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by July 15, 2009.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Question for the Record

The Honorable Michael H. Michaud, Chairman
Subcommittee on Health
House Committee on Veterans' Affairs
Department of Veterans Affairs Medical Care: The Crown Jewel and Best Kept Secret

May 19, 2009

Question 1: In your testimony you mentioned a pilot program currently being conducted at Fort Bragg. In this program, VA seeks to expedite enrollment by overnighting records from demobilization sites to VA's Health Eligibility Center. Has this program been effective in streamlining the enrollment process?

Response: The Veteran Health Administration (VHA) Chief Business Office (CBO) Health Eligibility Center (HEC) proposed to VHA Outreach Office that the HEC provide additional administrative assistance to the medical center staff currently engaged in providing demobilization (DEMOB) site support. The pilot program which was initiated at Fort Bragg, North Carolina, commenced on May 1, 2009, and is expected to run through August 31, 2009. The goal of the pilot is to streamline the Department of Veterans Affairs (VA) enrollment process, reduce the administrative workload of VA's staff and improve Veterans' satisfaction with timely enrollment into VA health care. Once the pilot program is complete, VA will evaluate its effectiveness and determine whether to expand the program nationwide. We expect to make that decision by October 1, 2009.

Since May 1, 2009, the HEC staff has successfully processed all enrollment applications submitted from the DEMOB site pilot program at Fort Bragg, North Carolina, within 72 hours of receiving these applications.

Question 2(a): Your testimony largely centered on outreach efforts targeting OEF/OIF Veterans. What programs does VA have that focus on Vietnam Veterans and other such populations?

Response: VA has developed a great number of initiatives in response to the unique health issues and concerns of Veterans of the Vietnam War. Perhaps more than for any other U.S. military deployment, the Vietnam War generated a lasting and vivid impression among Veterans and all Americans about the environmental impact of this war on those who served. Today, VA has made it easier for Vietnam Veterans and, in some cases, their children to receive benefits and services for any illnesses or injuries they suffer that may be related to herbicide exposure.

Eligible Vietnam Veterans have access to VA's comprehensive health care system that includes programs specially tailored to their special concerns and needs. In 1978, VA established a special health examination registry known as the Agent Orange Registry examination, in response to mounting concerns about health effects from herbicide exposure among Vietnam Veterans. The program offers a medical examination at all VA health care facilities, as well as the chance for Veterans to discuss their health concerns with a knowledgeable health care provider. The Agent Orange Registry is a computerized record of these examinations, and as of June 2009, the program has provided for more than 542,174 individual Vietnam Veterans, including over 8,000 women Vietnam War Veterans. Each VA medical center has an environmental health clinician responsible for conducting Agent Orange Registry examinations, and an environmental health coordinator responsible for coordinating the exam and reporting results. Any Veteran who had active military service in the Republic of Vietnam between 1962 and 1975, and who expresses a concern relating to exposure to herbicides, may participate in the registry.

VA is also working to ensure that all Veterans who served on the ground and inland waterways of Vietnam are aware of the conditions for which they may be presumptively service-connected. The Veterans Benefits Administration (VBA) and VHA are working together to identify in-country Vietnam Veterans who have received treatment in a VA facility for a condition related to herbicide exposure, but have not applied for disability compensation. Last year, approximately 28,000 "in-country" Vietnam Veterans were contacted and provided with information on the presumptive disabilities associated with agent orange exposure and where to apply for VA benefits for these conditions.

Since the end of the Vietnam War, VA has developed many ways to communicate with Veterans about these issues, including:

- The Agent Orange Review newsletter mailed to every Vietnam Veteran who has used VA. In 2004, the circulation of the newsletter increased to nearly 800,000 copies mailed to Veterans' homes. The last newsletter was published in August 2008 and a new one is in preparation and will be published this summer. It is also available on our Web site;
- An agent orange Web site;
- A national toll-free telephone number;
- The popular *Federal Benefits for Veterans and Dependents and Survivors* booklet, and
- A series of agent orange fact sheets, agent orange brochures, and agent orange posters distributed throughout VA.

VA's Web site for agent orange-related matters is at *www.va.gov/AgentOrange*, which has virtually all of VA's outreach material for Vietnam Veterans, including all the newsletters, brochures and posters, as well as information about special programs such as the Agent Orange Health Registry.

Similar programs are in place for radiation-exposed Veterans, and Gulf War Veterans, as well as Veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF).

Question 2(b): How do programs targeting specific Veterans groups differ from each other?

Response: The programs only differ in areas of concentration, i.e., radiation vs. agent orange. VA programs may target specific populations of Veterans, for example, minority and women Veterans, but benefits and services are open to eligible Veterans from every period of service. Eligible Veterans of every era have comprehensive health care benefits through VA from basic primary care issues to the most extensive traumatic brain injury care network in the world. Disability compensation, education, home loan guaranty, insurance and vocational rehabilitation are also available to Veterans who met the entitlement criteria.

Question 3: You mentioned that VA has harnessed new technology such as Twitter, Second Life, Facebook, and YouTube. Can you elaborate on VA's efforts toward utilizing these new mediums?

Response: VA began establishing a Web 2.0 presence on Facebook, YouTube and Second Life in May 2008. The Second Life virtual world presence was recently enhanced from a small "office" to an "island" in May 2009. VA currently has three official Facebook accounts, VA, VHA and a Welcome Home (event) page, with plans to stand-up a fourth account for VBA in the near future. VA also has one official YouTube channel with over 50 videos posted and 1,076 subscribers to date. A Twitter account was recently enabled in May 2009 and VA currently has 570 followers which include many National Veterans Service Organizations. There is also a returning servicemember blog and a tag cloud on *www.oefoif.va.gov*.

VA is currently planning to redesign its Web sites over the next 2 fiscal years. The redesign project will be focused primarily on content and usability. Improvements to the Web site will allow additional mediums of communication or Web 2.0 tools to be added.

Question 4: Can you talk a bit about how local outreach conducted by VA facilities fits into the structure of VA's overall effort? What does the Central Office do to support these local efforts?

Response: Aside from the more obvious support of staffing, VHA's central office provides detailed guidelines, up-to-date information and coordination of research for the staff in the field who reach out to our Veterans each day. Nearly 20 different program offices function within VA's central office to concentrate on issues of homelessness, rural health, minority and women Veterans, research, quality and safety, and other programs designed to acquaint Veterans with the services and benefits offered by the Department. These offices work directly with field staff in order to ensure that Veterans in local communities have the most relevant and updated information and are treated with proven evidence-based practices.

To further enhance the coordination between central office and the field stations, the Office of Public and Intergovernmental Affairs (OPIA) is responsible for overseeing and coordinating all outreach activities Department-wide.

Question 5: Some VSOs have noted the outreach efforts that will be required by VA's upcoming efforts to expand enrollment in VHA among Veterans in priority group 8. Is there a plan in place to notify Veterans in this group that they will be eligible for enrollment?

Response: Yes. VA is engaged in the implementation of a communications and outreach strategy that leverages technology and partnerships with other stakeholders to educate Veterans and their families about Priority 8 eligibility.

- Direct Veteran Contact: VA has contacted, by mail, the approximately 420,000 Veterans who previously tried to enroll for health care benefits but were rejected because of their income level. The letter explains that eligibility requirements have changed and provides Web-based and paper enrollment options for Veterans to use. VA will also use micro-targeting to mail to an additional 150,000 Veterans who have not previously applied but live in low-income neighborhoods. If this test mailing is successful, VA will expand the universe to reach out to more Veterans using additional micro targeting criteria.
- Web Content: VA has developed and released Web content and tools to help communicate with Veterans, their families, and other stakeholders. This con-

tent has been deployed to VA's Web sites, other Government sites, and sites such as Wikipedia.

- Expanded Web Outreach and Communications: VA is currently developing additional approaches to perform targeted Web-based outreach and communications.
- Media: VA has placed op-eds and Web-based stories about Priority 8 in targeted media outlets. VA is also using traditional media sources and bloggers to communicate. VA is in the process of contracting with a public relations firm to develop additional outreach strategies to reach Veterans who might be eligible. Strategies will likely include a highly targeted, paid media campaign.
- Partnering with Veteran Service Organizations (VSO), State Veterans Affairs Directors, County Veterans Service Officers, and Other Stakeholders: VA has partnered with stakeholders to communicate with the Veterans they serve. VA has educated stakeholders about the new eligibility criteria and placed content, links, and even Web-based eligibility calculators on its Web sites. VA is in the process of identifying other stakeholders to partner with. For example, the Office of Congressional and Legislative Affairs will provide a widget and an eligibility calculator that Members of Congress can post on their own Web sites.

Question 6: What are the roles and responsibilities with respect to outreach for the communications director for VHA? How does this compare to the role and responsibilities of the now defunct office of Deputy Undersecretary for Coordination?

Response: VHA's chief communications officer supports, OPIA in the public affairs aspects of VA outreach, including news releases, internet communications and the possible use of paid advertisements to reach Veterans of all eras. VHA's Office of Legislative, Regulatory and Intergovernmental Affairs (OLRIA) is responsible for outreach to OEF/OIF Veterans. The chief communications officer manages overall outreach policy and encourages VHA field organizations to implement advertising and direct contact campaigns to ensure that the opportunities for benefits and services are communicated to all Veterans. VHA's OLRIA organization manages 11 different outreach programs focused on returning OEF/OIF Veterans to ensure their awareness of VA benefits and services, and to provide a "warm hand off" to Veterans from military health care to VA health care. These three offices have worked in the past, and will continue to do so in the future, to prepare and implement plans to reach out to Veterans and their families, informing them of the health care benefits they have earned. VA is unfamiliar with any position titled the "Deputy Undersecretary for Coordination" currently or in the recent past.

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