

**MILITARY CONSTRUCTION, VETERANS AFFAIRS,
AND RELATED AGENCIES APPROPRIATIONS
FOR 2015**

HEARINGS
BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRTEENTH CONGRESS
SECOND SESSION

SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS,
AND RELATED AGENCIES APPROPRIATIONS

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PART 3A
DEPARTMENT OF VETERANS AFFAIRS BUDGET



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MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR 2015

THURSDAY, MARCH 27, 2014.

DEPARTMENT OF VETERANS AFFAIRS

WITNESS

HON. ERIK K. SHINSEKI, SECRETARY OF VETERANS AFFAIRS

CHAIRMAN CULBERSON OPENING STATEMENT

Mr. CULBERSON. The Appropriations Subcommittee on Military Construction and VA will come to order.

We are delighted to have with us today the Honorable Eric Shinseki, the Secretary of Veterans Affairs, who is accompanied today to help answer any questions the Committee might have by Dr. Robert Petzel, who is Under Secretary for Health—honor to have you here with us today, sir—Allison Hickey, Under Secretary for Benefits; Steve Muro, Under Secretary for Memorial Affairs; Stephen Warren, Executive in Charge for Information Technology; Helen Tierney, Executive in Charge for Office of Management and Chief Financial Officer.

And we are delighted today to welcome you, Mr. Secretary, for discussion of the President's proposed 2015 budget request.

And truly, among all the agencies in the Federal government, you know you are in a very special position because you have got the largest proposed increase for any cabinet department by our scoring, nearly \$1.9 billion, or 3 percent. The mandatory programs in your budget increased by a substantial \$8.8 billion, or more than 8 percent, to \$93.5 billion.

And while we, the Subcommittee, know the work that you have undertaken, the progress that you have made in the last year reducing the backlog of disability compensation claims, it remains something that we are all deeply concerned about.

Delighted for the progress you have made, but the continuing backlog of 300,000 claims is a deep concern to the Committee and the Congress and certainly something I know that disturbs you deeply. We are continuing to be immensely frustrated with that and are going to want to visit about that today.

Since we had our hearing with you last year, sir, the landscape on electronic health records has shifted dramatically.

I always remember vividly when I first was privileged to have this assignment Chairman Rogers bringing to our attention—I think you were here that day—he had a terrible story of the young

man who had lost his vision in one eye as a result of his service to the country overseas.

And when he left active duty and went into the VA system, because of the inability of the medical records in the Department of Defense to be read by the VA, couldn't get access to them quickly enough, this young man's eyesight was lost in his second eye and he is now permanently blinded. So it is just not acceptable.

I know that all of us in the Subcommittee and in the Congress want to see the medical records of a person in uniform transition seamlessly, immediately, to the Veterans Affairs when they leave active duty service.

However, the departments have chosen to go down separate paths, of course, as you know, developing electronic health records. So we need to, as a Subcommittee and as a Congress, do our best to help ensure that these two records are interoperable.

And we will be especially vigilant, Mr. Secretary, to be sure that, after the VA has spent billions of dollars on VistA, which we continue to hear good things about your medical records system that you have developed, that VA doctors will be able to exchange that information with the DOD and outside providers.

We will have questions for you today on these topics and other areas in your budget request. And because I know the press of time, that we finished a little earlier today on the floor than we thought, I would welcome at this time any comments from my dear good friend, Sanford Bishop, from the great state of Georgia.

Mr. BISHOP. Mr. Chairman, would it be in order for me to yield to the ranking member of the full Committee, Mrs. Lowey, who is with us, the gentlelady from New York?

Mr. CULBERSON. Yes. And if you will please forgive me, Mrs. Lowey.

MRS. LOWEY OPENING STATEMENT

Mrs. LOWEY. I will always forgive you. And I am very grateful because, as our distinguished ranking member knows, today has been a day where you could use roller skates running from one to another.

So I join you, Mr. Chairman, Mr. Ranking Member, in welcoming. We certainly are delighted that Secretary Shinseki is here with your team. We thank you for the very important work you do, and we know how essential it is to those who have fought for our country.

As the subcommittee works on the fiscal year 2015 bill, we must ensure that the men and women who have faithfully served our Nation receive the recognition and benefits they earned. We can never renege on the promises made to our veterans.

Mr. Secretary, I commend you on the excellent work you have done in the past to substantially reduce veterans' homelessness. I am also pleased with your progress to help facilitate a smoother transition from active duty to civilian life, which will now be more important than ever.

But I cannot express how outraged I am with the veteran claims backlog. Last year, when you sat before this committee, the number was almost 600,000. The backlog of 350,000 today is still too high.

And the impending drawdown of forces in the military will only increase the number of men and women exiting the services and looking to the VA for health care and benefits. I worry that this will be too much pressure to add on to an already strained system. We all want to fix this shameful problem, yet it persists. I hope we can work together to address this pressing issue.

And, Mr. Secretary, I look forward to hearing your testimony. Thank you again for your service to our country.

Mr. BISHOP. Thank you, Mr. Chairman, Madam Ranking Member.

RANKING MINORITY MEMBER MR. BISHOP OPENING STATEMENT

Welcome to Secretary Shinseki and your executive team.

Mr. Chairman, we have done a lot to ease the burden of military service. For example, Congress passed the 9/11 GI Bill, the Hiring Heroes Act, the Caregiver's Act, all with strong bipartisan majorities.

However, we are still struggling in the claims process area, but we are making progress. The last update I saw, there were a total of 672,000 claims and, of that, 389,000 are considered backlogged.

So, Mr. Secretary, we still have a ton of work to do on this.

I have heard from many on the reasons for the backlog: Inclusion of Agent Orange, the winding down of the wars in Iraq and Afghanistan, the complexity of the new wounds, both physical and mental, which are causing multiple claims by our veterans, and then many more.

I completely understand this. But, Mr. Secretary, I am concerned about the current drawdown of troops and what effect it will have on the claims process. I look forward to a discussion on what the VA's plans are to handle this developing situation, which may very well in the not-too-distant future become a surge.

I want to talk about results and how this fiscal year 2015 budget is going to achieve these results, how are the initiatives and funding in this budget going to meet the Department's goal to end the backlog by 2015, which, if the VA stays on the current pace, the backlog would end November 2, 2015. So you will be cutting it pretty close.

Now, we can talk about increases in spending for VA until we are blue in the face with no results. We are just wasting time and resources. When it comes to wasting resources in the current budget climate, I can't tell you how frustrated and disappointed I am and all of us are with the electronic health record program.

Mr. Secretary, I hope that this new path that you and Secretary Hagel are going down will have some results, and I look forward to an update on this issue.

When I talk to veterans, their number one issue is always VA claims, and the number one issue being worked by my constituent services staff in Georgia is VA claims. The veterans in my district are growing impatient, and so am I.

But today is a very important hearing. I know I speak for all of my colleagues as well as for you, Mr. Secretary, when I say how frustrated we all are with the situation.

I know this is a problem that won't be fixed overnight, but it is my hope today that we can focus on how we can fix the problem

together and quickly, not just for the veterans waiting today, but for the future generations of veterans to come.

So, Mr. Chairman, I thank you for the opportunity to share my concerns. And I yield back and looked forward to hearing from our witness.

Mr. CULBERSON. Thank you, Mr. Bishop.

It is our privilege to recognize you, Mr. Secretary. And, of course, your written statement will be entered into the record in its entirety. And we welcome you today, sir, and any summary of your testimony that you would like to do, sir.

OPENING STATEMENT OF SECRETARY SHINSEKI

Secretary SHINSEKI. Okay. Well, thank you, Chairman Culber-son, Ranking Member Bishop, Ranking Member Lowey, other distinguished members of the Subcommittee.

Thank you for this opportunity to present the President's 2015 budget and 2016 advance appropriations requests for the Department of Veterans Affairs.

I am now working my sixth budget cycle, Mr. Chairman, and I always say my thanks to the members of this committee. I deeply appreciate your unwavering support for veterans and all the help you have provided us over the years to get our programs right for them.

I want to also acknowledge representatives of our Veterans Service Organizations who are present here in the room today. Their insights and support have been very helpful to me personally over the past 5 years. They have been helpful in enabling us to craft programs that better care for, better support, our veterans, their families, and survivors.

Mr. Chairman, thanks for introducing the members of the panel sitting here with me today. I also have a written statement which I ask to be submitted for the record.

Mr. CULBERSON. Without objection. It will be submitted for the record.

Secretary SHINSEKI. Thank you, Mr. Chairman.

The fiscal year 2015 budget and 2016 advance appropriations request demonstrate once again President Obama's steadfast commitment to our Nation's veterans.

His leadership, the support of the Congress, especially the members of this Subcommittee, and the insights of the Veterans Service Organizations I just referred to have allowed us for 5 years now to answer President Lincoln's charge from 149 years ago when he asked the American people to care for those who shall have borne the battle and for their families and survivors.

I thank the Members again for your commitment to veterans, and I seek once again your support of these budget requests.

The President's vision reflected in these budget requests is about empowering veterans to help lead the rebuilding of the middle class in this country, much as they did following World War II, through access to quality health care, to benefits, to education and training and employment opportunities that enable achieving the American dream.

VA's 2015 budget request seeks \$163.9 billion. \$68.4 billion of that amount is in discretionary funding, including medical care col-

lections, an increase of 3 percent above our 2014 enacted funding level, and \$95.6 billion goes to mandatory funding.

This budget also requests \$58.7 billion for the fiscal year 2016 advance appropriations for medical care, an increase of \$2.7 billion, Mr. Chairman, as you reflected, or 4.7 percent above the 2015 budget request we are submitting.

This is another strong budget, and your support of it is critical to our providing veterans the care and benefits they have earned through their service and sacrifice. It will enable VA to further the three key priorities that we have had now for 5 years. They have been the same three: Expanding veterans' access to benefits and services, eliminating the disability claims backlog in 2015, and ending the rescue of homeless veterans in 2015 as well.

Since 2009, we have focused the resources you have provided to address these three key priorities, not just these three, but primarily and heavily underwriting these three to best serve veterans.

In terms of access, more than 2 million additional veterans have enrolled in VA health care. We opened our 151st VA Medical Center, the first in 17 years, and we have increased our community-based outpatient clinics by a net total of 55, bringing our total CBOC count to 820.

More than a million veteran and family member students have received educational assistance and vocational training. Nearly 90 percent of all veterans now have a burial option within 75 miles of where they live, and we expect to increase that to roughly 96 percent by 2017.

In terms of disability claims, the backlog has declined over 40 percent in the past 12 months. We are transitioning from paper to digital processing, and we are on track to end the backlog next year, in 2015.

In terms of veterans' homelessness, the estimated number of homeless veterans fell by 24 percent between 2010 and 2013, and we expect another reduction when this year's point-in-time count, which was just conducted in January, is tallied.

These are some of the key accomplishments that we have reported. Momentum is up. We are making good progress across the board.

We will continue to leverage every resource in these budget requests to do what is right for veterans and, as we have for 5 years now, I assure you that we will use these resources that Congress provides effectively, efficiently and accountably, for the best care for our veterans.

Again, Mr. Chairman, thank you for the opportunity to appear here today, and we look toward to your questions.

[The information follows:]

**STATEMENT OF THE HONORABLE ERIC K. SHINSEKI
SECRETARY OF VETERANS AFFAIRS**

**FOR PRESENTATION BEFORE THE
HOUSE APPROPRIATIONS COMMITTEE, SUBCOMMITTEE ON MILITARY
CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES**

BUDGET REQUEST FOR FISCAL YEAR 2015

March 27, 2014

Chairman Culberson, Ranking Member Bishop, Distinguished Members of the House Appropriations Committee, Subcommittee on Military Construction, Veterans Affairs and Related Agencies:

Thank you for the opportunity to present the President's 2015 Budget and 2016 advance appropriations requests for the Department of Veterans Affairs (VA). This budget continues the President's historic initiatives and strong budgetary support for Veterans, their families, and survivors. We value the sustained support that Congress has demonstrated in providing the resources and legislative authorities needed to honor our Nation's promises to these unique and special citizens. Let me acknowledge our partners here today – the Veterans Service Organizations – whose insight and support make us better at fulfilling our mission.

After more than a decade of war, many Servicemembers are returning home and making the transition to Veteran status. As the war in Afghanistan enters its final chapter, our work is more urgent than ever. The current generation of Veterans will help to grow our middle class and provide a significant return on the Nation's investments in them. The President fully supports Veterans and their families, and by providing them the care and benefits they have earned, we pay tribute to the sacrifices that Veterans have made for this Nation.

The 2015 Budget for VA requests \$163.9 billion – \$68.4 billion in discretionary funds, including medical care collections, and \$95.6 billion in mandatory funds for Veterans benefits programs. The discretionary request reflects an increase of \$2.0 billion (3.0 percent) above the 2014 Budget level. The Budget also requests a 2016 advance appropriation for Medical Care of \$58.7 billion, an increase of \$2.7 billion (4.7 percent) above the 2015 Budget. The President's 2015 Budget will allow VA to operate the largest integrated healthcare system in the country, including nearly 1,750 VA points of healthcare and approximately 9.3 million Veterans enrolled to receive healthcare; the ninth largest life insurance provider, covering both active duty Servicemembers and enrolled Veterans; an education assistance program serving nearly 1.1 million students; a home mortgage program with a portfolio of over 2 million active loans, guaranteed by the agency; and the largest national cemetery system that

leads the Nation as a high-performing organization, with projections to inter 128,100 Veterans and family members in 2015.

Growing Demand for VA Services and Benefits

Long after conflicts end, VA requirements continue to grow, due to the substantial needs of Veterans. VA's budgetary requirements arise from our Nation's national security engagements, which are not within our control. As the President said on Veterans Day last November, "when we talk about fulfilling our promises to our Veterans, we don't just mean for a few years; we mean now, tomorrow, and forever." Over the next decade, the Department of Defense (DoD) predicts that military separations will approach three million. This growing population is demanding more services from VA than ever before. Currently, 11 million of the approximately 22 million Veterans in this country are registered, enrolled, or use at least one VA benefit or service, and this number will undoubtedly continue to grow.

Meeting VA's Top Three Goals

In 2015, our challenges are clear and significant. VA must deliver on the ambitious goals we established 5 years ago, which are to:

- Increase Veterans' access to VA benefits and services;
- Eliminate the disability claims backlog in 2015; and
- End Veterans' homelessness in 2015.

The 2015 Budget is critical to VA meeting these goals. Without the proper level of funding to meet the growing demand for benefits and services, investing in our physical and Information Technology (IT) infrastructure to assure reliable access, eliminating the disability claims backlog, and ending Veterans' homelessness become even more difficult. VA remains committed to meeting these challenges and appreciates the continued support of the Congress.

Stewardship of Resources

At VA, we are committed to responsible stewardship, using resources effectively and efficiently and aggressively identifying budget savings. Over the past three years, we have averaged \$1.6 billion annually in efficiencies and budget savings, and in 2015, that commitment to budget efficiencies and savings is more than \$2 billion. We are attentive to areas in which we need to improve our operations, and are committed to taking swift corrective action to eliminate any practices that do not deliver value for Veterans. For 15 consecutive years, VA delivered clean financial audits, during which time material weaknesses were reduced from four to one, and in 2013, for the first time, we had no significant deficiencies, having eliminated 16 prior significant financial

deficiencies. This is an area of major accomplishment in our internal controls and fiscal integrity.

Information Technology

To serve Veterans as well as they have served us, we are working to deliver a 21st century VA that provides medical care, benefits, and services through a secure digital infrastructure. IT affects every aspect of what we do at VA. It has a direct impact on the quality of healthcare we provide Veterans; our ability to process claims efficiently; and our ability to provide Veterans' benefits and services. In 2013, VA IT systems supported nearly 1,750 VA points of healthcare: 151 medical centers, 135 community living centers, 103 domiciliary rehabilitation treatment programs, 820 community-based outpatient clinics, 300 Vet Centers, and 70 mobile Vet Centers. The corresponding increase we have seen in the medical care spending for these facilities directly translates to new and increased services provided to Veterans. To provide Veterans access and benefits, we must make the necessary investments in IT innovations and deployments.

Our 2015 Budget requests \$3.9 billion for IT, consisting of \$531 million for development; \$2.3 billion for sustainment; and \$1 billion for more than 7,400 staff, most of whom serve in VA hospitals and regional offices. The request will sustain our infrastructure while making necessary investments in critical business processes, such as modernizing healthcare scheduling, streamlining benefits processing, enhancing and modernizing VA's electronic health record, enhancing data security, and achieving health data interoperability with DoD.

Information security is a top priority at VA. The 2015 Budget requests \$156 million for information protection and cyber security, an increase of \$33 million (27 percent) over 2014. VA is constantly strengthening information security and improving technology and processes to ensure Veteran data and VA's network are secure. Like any organization, public or private, we must continue to adapt. Our security posture is based on a "defense-in-depth" approach, which includes our partners at the Department of Homeland Security who maintain an over watch on our exterior perimeter. Working inward from our firewalls, VA has additional layers and protections that are constantly monitoring potential threats.

Technology is also a critical component for achieving our goal to eliminate the disability claims backlog in 2015. The 2015 Budget requests \$137 million in IT funding for the Veterans Benefits Management System (VBMS), including \$44.5 million for development and \$92.5 million for sustainment. The 2015 development funds will allow VA to electronically process disability compensation claims in VBMS, from establishment to award. Planned enhancements and increased automation will allow end-users to focus on more difficult disability compensation claims by reducing the time required to process less complex claims. Sustainment funds will support the

infrastructure behind VBMS as well as the deployment of additional new functionality features.

The 2015 Budget continues our progress toward evolving VA's VistA electronic health record (EHR) and achieving seamless integration of health data with the DoD by 2017. The budget requests \$269 million to help achieve our shared goal of providing the best possible support for Servicemembers and Veterans. In the near term, we are working to create seamless integration of DoD, VA, and private provider health data. In the mid-term, we are working to modernize the software supporting DoD and VA clinicians. Together, these two goals will help to create an environment in which clinicians and patients from both Departments are able to share current and future healthcare information for continuity of care and improved treatment. As we strive to build on our successful history of health data sharing and collaboration, we understand our EHR modernization efforts are complicated, dynamic, and multi-faceted.

Improving and Expanding Access to Benefits and Services

The number of Veterans receiving VA benefits and services has grown steadily and will continue to rise as overseas conflicts end and more Servicemembers transition to Veteran status. In 2015, the number of patients treated within VA's healthcare system is projected to reach 6.7 million, an increase of nearly one million patients (17.4 percent) since 2009. Within VBA, the number of Veterans and survivors receiving Compensation and Pension benefits will approach 5 million in 2015, while the number of Education and Vocational Rehabilitation beneficiaries will exceed 1.1 million.

We continue to improve access to VA services by opening new, and improving current, facilities closer to where Veterans live. Since January 2009, we have added approximately 55 community-based outpatient clinics (CBOCs), for a total of 820 CBOCs, and the number of mobile outpatient clinics and Mobile Vet Centers, serving rural Veterans, has increased by 21, to the current level of 78. In addition, while opening new and improved facilities is essential for VA to provide world-class healthcare to Veterans, so too is enhancing the use of ground breaking new technologies to reach countless other Veterans. We continue to invest in "taking the facility to the Veteran" - through expanded access to telehealth, sending Mobile Vet Centers to reach Veterans in rural areas where certain services are limited or difficult to reach, and by deploying social media to connect with Veterans to share information on the VA benefits they have earned.

The Affordable Care Act (ACA) expands access to coverage, provides new ways to bring down healthcare costs, improves the Nation's healthcare delivery system, and has important implications for VA. VA is ensuring a coordinated and collaborative approach to ACA implementation. We estimate that there are approximately 1.3 million uninsured Veterans, of which 1 million may be eligible for, but not enrolled in VA healthcare. We will continue our education and outreach efforts so Veterans know the healthcare law does not affect their VA health benefits or out-of-pocket costs, and that

Veterans enrolled in VA healthcare do not need to take additional steps to meet ACA's new coverage standards. We will also encourage Veterans' family members not enrolled in a VA healthcare program to obtain coverage through the Health Insurance Marketplaces.

A large part of our Veteran population hails from the small towns of rural America. Some 3.1 million Veterans enrolled in VA's healthcare system live in rural or highly rural areas, about 36 percent of all enrolled Veterans. In total, more than \$17.36 billion were obligated in 2013 for the health care needs of rural Veterans. As technology advances and broadband access expands across rural America, we have been able to extend the availability of VA healthcare through telemedicine, web-based networking tools, and the use of mobile devices -- all of which help improve access to care and support economic development for people in rural areas. Telehealth is a transformative breakthrough in healthcare delivery in 21st century medicine, allowing care to reach Veterans who otherwise may not have access, especially those who live in rural and extremely remote areas. VA has made a significant investment in telehealth, which translates to a nearly seven-fold increase in funding since 2009. The 2015 Budget requests \$567 million for telehealth, including \$72 million for Rural telehealth.

Changing demographics are driving transformation at VA. Women now comprise nearly 15 and 18 percent of today's active duty military forces and Reserve component, respectively. Women are the fastest growing segment of our Veteran population. Since 2009, the number of women Veterans enrolled in VA healthcare increased by almost 29 percent, to 629,683. The 2015 Budget includes \$403 million for gender-specific healthcare services for women Veterans. Today, nearly 49 percent of our facilities have comprehensive women's clinics, and every VA healthcare system has designated women's health primary care providers and a women Veterans' program manager on staff.

The Caregivers and Veterans Omnibus Health Services Act (Caregivers Act) marked a major step forward in America's commitment to those who provide daily care for wounded warriors, who have borne the battle for us all. The sustainment phase of the Caregivers program began in 2013, and includes application processing; stipends; travel and healthcare coverage; education, training, and competency; and IT support. The 2015 Budget includes \$306 million for the Caregivers program, including \$235 million for caregiver stipends.

Since VA began implementation of the Honoring America's Veterans and Caring for Camp Lejeune Families Act in August 2012, more than 10,100 Veterans have contacted VA concerning Camp Lejeune-related treatment, as of February 27, 2014. Of these, roughly 8,300 were already enrolled in VA healthcare. Veterans who are eligible for care under the Camp Lejeune authority, regardless of current enrollment status with VA, will not be charged a co-payment for healthcare related to the 15 illnesses or conditions recognized, nor will a third-party insurance company be billed for these services. VA continues a robust outreach campaign to these Veterans and family

members while we press forward with implementing this law. The 2015 Budget includes \$51 million to provide healthcare for Veterans and family members who were potentially exposed to contaminated drinking water at Camp Lejeune.

The Grants for Construction of State Extended Care Facilities program provides grants to States to acquire or construct State home facilities; furnish domiciliary or nursing home care to Veterans; and expand, remodel, or alter existing buildings for furnishing domiciliary or nursing home care to Veterans in State homes. VA's funds are leveraged by State matching funds, which provide 35 percent of project costs. The 2015 budget is requesting \$80.0 million for this program. The 2015 budget request will support life-safety projects, new construction, and renovation projects.

The 2015 Budget requests \$99.6 million in IT funding for the Veterans Relationship Management (VRM) initiative, which is transforming Veterans' access to VA benefits and services by empowering Veterans with new self-service tools. In addition, VRM is essential to achieving our access goals. We are transforming VA's national call centers into service centers by delivering enhanced, integrated, system-wide telephone capabilities. VBA is also implementing the Client Relationship Management Unified Desktop that provides Veterans or beneficiary contact history and a consolidated view of benefit programs for our employees to enhance the customer's experience and provide responsive and complete information.

As part of this experience, VBA aggressively promoted eBenefits and improved Veterans ability to enroll in and access VA benefits and services. The joint VA-DoD eBenefits Web portal is a personalized central location for Veterans, Servicemembers, and their families to research, access, and manage their benefits and personal information. More than 3.2 million Servicemembers and Veterans are enrolled in eBenefits, and our goal is to expand enrollment to 5 million users in 2015. Over 50 self-service features, including online filing of claims, online uploading of evidence, and claim status tracking are now available in eBenefits; VA and DoD continue to expand functionality with each quarterly release.

VA also continues to increase access to burial services for Veterans and their families through the largest expansion of its national cemetery system since the Civil War. At present, approximately 90 percent of the Veteran population - about 20 million Veterans - has access to a burial option in a national, state, or tribal Veterans cemetery within 75 miles of their homes. In 2004, only 75 percent of Veterans had such access. This dramatic increase is the result of a comprehensive strategic planning process that efficiently uses resources to serve the greatest number of Veterans.

Improving Access to Mental Health Services

We have been a Nation at war for more than a decade, and the state of Servicemembers' and Veterans' mental health is a National priority. At VA, meeting the individual mental health needs of Veterans is more than a system of comprehensive treatments and services; it is a philosophy of ensuring that Veterans receive the best mental healthcare possible, while focusing on the overall mental well-being of each Veteran. VA remains committed to doing all we can to meet this challenge.

Through the strong leadership of the President and the support of Congress, Veterans' access to mental healthcare has significantly improved. Some of the stigma associated with seeking help has diminished. We proactively screen all Veterans for PTSD, depression, TBI, problem drinking, substance abuse, and military sexual trauma (MST) to identify issues early and provide treatments and intervention opportunities. We know that when we diagnose and treat people, they get better. Rates of suicide among those who use VHA services have not shown increases similar to those observed in all Veterans and the general U.S. population. Since 2006, the number of Veterans receiving specialized mental health treatment has risen each year from 927,000 to more than 1.3 million in 2013. In addition, Outpatient visits and encounters will increase to 12.8 million in 2015, from 12.1 million in 2013. Vet Centers are another avenue for mental healthcare access, providing services to 195,913 Veterans and their families in 2013.

While we made significant progress in serving the growing number of Veterans seeking mental healthcare, our work is not done. The 2015 Budget includes \$7.2 billion for mental healthcare, an increase of \$309 million (4.5 percent). VA efforts are crucial to dispel the lingering stigma surrounding treatment, and help Veterans regain their dignity and the ability to hold meaningful employment and maintain a home, which helps, in turn, strengthen our Nation's economy.

In response to the growing demand for mental health services, VA enhanced capacity and improved the system of care so that services are more readily accessible. In 2012, VA completed a comprehensive assessment of the mental health program at every VA medical center and is using the results of that assessment to improve programs and share best practices across VISNs and facilities. VA also held mental health summits at each of our 151 medical centers, broadening the community dialogue between clinicians and stakeholders.

We are developing new measures to gauge mental healthcare performance, including timeliness, patient satisfaction, capacity, and availability of evidence-based therapies. Evidence-based staffing guidelines are being written for specialty and general mental health. In addition, VA is working with the National Academy of Sciences to develop and implement measures and corresponding guidelines to improve the quality of mental healthcare. To help VA clinicians better manage Veteran patients' mental health needs, VA is developing innovative electronic tools. For example, Clinical Reminders give clinicians timely information about patient health maintenance

schedules, and the High-Risk Mental Health National Reminder and Flag system allows VA clinicians to flag patients who are at-risk for suicide. When an at-risk patient does not keep an appointment, Clinical Reminders prompt the clinician to follow up with the Veteran.

Since its inception in 2007, the VA's Veterans' Crisis Line in Canandaigua, New York, answered nearly 1,000,000 and responded to more than 143,000 texts and chat sessions from Veterans in need. The Veterans' Crisis line provides 24/7 crisis intervention services and personalized contact between VA staff, peers, and at-risk Veterans, which may be the difference between life and death. In the most serious calls, approximately 35,000 men and women have been rescued from a suicide in progress because of our intervention - the rough equivalent of two Army divisions.

Eliminating the Claims Backlog

VA has no greater responsibility than ensuring Veterans and their survivors receive timely, accurate decisions on their disability compensation and pension claims. Too many Veterans have waited too long to receive their benefits – and this has never been acceptable to VA, including the employees of VBA, over half of whom are Veterans. To attack this longstanding problem, we launched a historic plan to transform our people, processes, and technology. Our strategy advances VBA's tools, streamlines claims processes, trains its workforce, improves workload management, and meaningfully enhances interaction with Veterans and stakeholders to deliver more timely and accurate benefit decisions and services to Veterans and their families. Despite an escalating workload brought about by the correct decisions for Veterans on Agent Orange, Gulf War, and combat PTSD presumptions -- and successful outreach to Veterans informing them of their benefits -- we are making steady progress toward our goal of eliminating the disability claims backlog in 2015.

The 2015 Budget requests \$2.5 billion for VBA, an increase of \$28.8 million from 2014. VBA projects a beneficiary caseload of 5.1 million in 2015, with more than \$78.7 billion in disability compensation and pension benefits obligations. We expect to process 1.5 million compensation and pension claims in 2015, up from 1.25 million claims in 2014, an increase of nearly 17 percent over 2014.

Through our claims transformation initiatives, the use of mandatory overtime, and other innovative strategies, we are making real progress in reducing the disability claims backlog. As of March 8, 2014, the backlog stood at 368,829 claims, down 242,244 (40 percent) from its highest point on March 25th, 2013. Additionally, under its Oldest Claims Initiative that began in April 2013, VA provided decisions to over 500,000 Veterans whose claims had been pending the longest. VA continues to work closely with DoD, the Internal Revenue Service, the Social Security Administration, and our other Federal partners to identify electronic data-sharing opportunities and process reforms to streamline workflows and limit paper claims filing.

VBMS is key to VBA's transformation and success in meeting our 2015 goal. In June 2013, VBA completed national deployment of VBMS -- six months ahead of schedule -- providing access to over 25,000 end-users. Approximately 80 percent of VA's pending disability claims are in a digital format for electronic processing in VBMS. Moving to a digital environment is critical. VA anticipates there will be approximately 250,000 new Servicemembers transitioning to Veteran status each of the next 4 years, for a total of one million new Veterans added during the next four years. As a result of our increased efforts to enable more Veterans to access the benefits they have earned and deserved, many of these Veterans are likely to file a claim with VBA within the first year of separation.

The 2015 Budget includes \$138.7 million for continued investment in the Veterans Claims Intake Program (VCIP), which converts paper claims into an electronic format and enables electronic transfer of medical and personnel records. This electronic transfer is critical to creating the necessary digital environment for populating the eFolders and supporting end-to-end electronic claims processing for each stage of the claims lifecycle. Although VA continues to accept paper claims from Veterans who are not familiar with or cannot access computer technology, VBA is working with stakeholders to increase the number of claims submitted electronically. VBA now converts paper claims to electronic format as we receive them, saving time and effort and improving accuracy. As of December 2013, over 25,000 VBMS users could access 424 million electronic images converted from paper.

The 2015 Budget includes \$94.3 million for the Board of Veterans' Appeals (the Board), which we are requesting as a new appropriation separate from the General Administration appropriation. The Board provides direct service to Veterans and their families by conducting hearings and issuing final appeals decisions. VA is actively pursuing initiatives to improve the appeals process and reduce wait times for Veterans, including a Board-led initiative that pre-screens appeals to ensure that the record is fully developed and ready for adjudication. The Board is also streamlining decision writing to increase output and efficiency. Expanded use of VBMS and the eventual incorporation of appeals functionality in VBMS will save resources currently spent handling, accessing, storing, and transporting paper claims files between the Board and VBA Regional Offices. The Board completed major technological upgrades to its video teleconference (VTC) equipment and the Board now conducts slightly over half of their hearings by video teleconference, a significant increase from 29 percent in 2009. We project appeals will increase to 72,786 cases in 2015, an increase of 12 percent from 2014's 64,941 cases.

Ending Veteran Homelessness

Every Veteran who has served America ought to have a home in America. We made great progress toward achieving our goal to end Veteran homelessness in 2015. VA will use knowledge gained over the past four years to ensure robust prevention programs are in place for future years. The 2015 Budget request is essential for VA to

successfully achieve an end-to-the-rescue phase, and prevent future homelessness among Veterans at-risk in the years to come.

Since 2009, VA, together with our Federal, state, and local partners, has reduced the estimated number of homeless Veterans by 24 percent. We have conducted over six million clinical visits with over 600,000 Veterans who were homeless, at-risk of homelessness (including formerly homeless). In 2013 alone, VA served more than 240,000 Veterans who were homeless or at-risk of becoming homeless – 21 percent more than the year before. Over the past four years, the Point-in-Time (PIT) count of homeless Veterans declined steadily, despite challenging economic times. The PIT count estimate of the number of homeless Veterans dropped from 75,609 in January 2009, to 57,849 in January 2013, a 24 percent decrease.

VA's programs constitute the largest integrated network of programs with components of homeless assistance in the Nation. They provide homeless Veterans with nearly 80,000 beds or units, including permanent supportive housing through the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program; link Veterans with needed mental health and other medical care; and provide supportive services and opportunities to reintegrate Veterans back into the community and workforce. VA's cost-effective, evidence-based homeless programs produce large savings and cost avoidance in budgetary, social, and economic terms. Using a Housing First strategy, VA relies on research that shows that placing homeless Veterans into Housing First reduces emergency room visits, other forms of intensive hospitalization, and substance overdose. Medical care costs are roughly three times as expensive for homeless compared to Veterans who are not homeless.

Despite significant progress and important accomplishments, much work remains. We estimate that between 2013 and 2015, approximately 200,000 Veterans will experience homelessness at some point in time. To reach our goal of ending Veteran homelessness in 2015, the Budget requests \$1.6 billion for VA homeless-related programs, including case management support for the HUD-VASH voucher program, the Grant and Per Diem Program, the Supportive Services for Veteran Families (SSVF) program, and VA justice programs. This represents an increase of \$248 million (17.8 percent) over the 2014 Budget level. This budget supports VA's long-range plan to end Veteran homelessness by emphasizing rescue for those who are homeless today, and prevention for those at risk of homelessness.

HUD-VASH provides permanent supportive housing to the most vulnerable of our homeless Veterans. The 2015 Budget requests \$374 million for HUD-VASH, an increase of \$47 million (14 percent) over the 2014 Budget level. This funding will support nearly 3,500 case managers to provide intensive wraparound services to nearly 80,000 Veterans. These case managers provide an average number of 12 clinical visits per year to these Veterans to ensure that they remain in housing and do not become homelessness again. Veterans in HUD-VASH are vulnerable; the majority meets criteria for chronic homelessness, and suffers from serious mental illness, substance use disorders, and chronic medical conditions. This partnership remains the most

responsive housing option available to VA and is a critical component of our strategy to move homeless Veterans from the streets to a safe and stable home.

The Grant and Per Diem Program helps fund community agencies providing services to homeless Veterans with the goal of helping them achieve residential stability, increase their skill levels and/or income, obtain greater self-determination, independent living, and employment as soon as possible. The 2015 Budget requests \$253 million for the Grant and Per Diem Program, an increase of \$3 million (1.1 percent) over the 2014 Budget level. In 2015, the program will provide over 15,500 transitional housing beds to Veterans through partnerships with more than 650 projects.

VA's SSVF is a critical aspect of our strategy to prevent and end Veteran homelessness. This program provides both prevention and rapid rehousing services to Veterans and family members. In 2013, SSVF successfully prevented over 60,000 at-risk Veterans and family members from falling into homelessness, and successfully placed over 84 percent of homeless Veterans and family members into permanent housing. In the last three years, VA awarded grants totaling \$459.6 million to 324 community agencies in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. SSVF grants to private non-profit organizations and consumer cooperatives provide a range of supportive services to include outreach, case management, assistance in obtaining VA benefits, and assistance in obtaining and coordinating other public benefits. In 2015, VA will deploy SSVF grants strategically to target resources to communities with concentrations of homeless Veterans.

In addition, VA's Justice Programs, which facilitate access to needed VA treatment for Veterans in criminal justice settings such as Veterans Treatment Courts, are an important prevention effort for homeless and at-risk Veterans. The goal of these Courts is to divert those with mental health issues and homelessness risk from the traditional justice system and give them treatment and tools for rehabilitation and readjustment. The first Veterans court was established in 2008 in Buffalo, N.Y. By the end of 2013, there were 257 courts nationwide, positively affecting the lives of 7,724 Veterans; VA serves Veterans in each of these courts. Many of the participating Veterans have avoided incarceration and the cycle of homelessness, that often follows incarceration. The 2015 Budget requests \$35 million for Veterans Justice Programs, an increase of \$1.5 million (4 percent) over the 2014 Budget level.

To increase homeless Veterans' access to benefits, care, and services, VA established the National Call Center for Homeless Veterans (NCCHV). The NCCHV provides homeless Veterans and Veterans at-risk for homelessness free, 24/7 access to trained counselors. The call center is intended to assist homeless Veterans and their families; VA medical centers; Federal, state, and local partners; community agencies; service providers; and others in the community. In 2013, the National Call Center for Homeless Veterans received 111,096 calls (38 percent increase over 2012) and made 78,622 referrals to VA Medical Centers (55 percent increase over 2012). The 2015 Budget requests \$5.6 million for NCCHV, an increase of \$1.7 million (45 percent)

over the 2014 Budget level. VA has established 28 Community Resource and Referral Centers (CRRC) to provide rapid assistance to homeless Veterans.

Multi-Year Budget for Medical Care

Due to Congress's foresight, under the Veterans Health Care Budget Reform and Transparency Act of 2009, VA includes a request for an advance appropriation for its medical care budget. The legislation requires VA to plan its medical care budget using a multi-year approach, which ensures that VA requirements are reviewed and updated based on the most recent data available and actual program experience. The 2015 medical care budget of \$59.1 billion, including collections, will fund treatment to over 6.7 million unique patients, an increase of 4 percent over the 2013 estimate. Of those unique patients, 4.7 million Veterans are in Priority Groups 1-6, an increase of more than 204,836 (4.5 percent). Additionally, VA anticipates treating over 757,600 Veterans from the conflicts in Iraq and Afghanistan, an increase of over 141,100 patients (23 percent) over the 2013 level. VA also provides medical care to non-Veterans through programs such as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and the Spina Bifida Health Care Program; we expect this population to increase by over 42,600 patients (6.3 percent), during the same period.

Based on updated 2015 estimates largely derived from the Enrollee Health Care Projection Model, the 2015 Budget will allow VA to increase funding for programs to end Veteran homelessness; continue implementation of the Caregivers and Veterans Omnibus Health Services Act; fulfill multiple responsibilities under the ACA; provide for activation requirements for new or replacement medical facilities; and invest in strategic initiatives to improve the quality and accessibility of VA healthcare programs. The 2015 appropriations request includes an additional \$368 million above the enacted 2015 advance appropriations level. Our multi-year budget plan assumes that VHA will carry over a small percentage of unobligated balances from 2014 into 2015 to ensure that funds are available at the beginning of the fiscal year to cover any unforeseen costs.

The 2016 medical care budget of \$61.9 billion, including collections, provides for healthcare services to treat over 6.8 million unique patients, an increase of 1.5 percent over the 2015 estimate. The 2016 request for medical care advance appropriations is an increase of \$2.9 billion, or 4.9 percent, over the 2015 budget request. Medical care funding levels for 2016, including funding for activations, non-recurring maintenance, and initiatives, will be revisited during the 2016 budget process, and could be revised to reflect updated information on known funding requirements and unobligated balances.

Medical and Prosthetic Research

VA supports the President's national action plan to guide mental health research across government, industry and academia, and develop more effective ways to

prevent, diagnose, and treat mental health conditions like TBI and PTSD. VA's medical research programs demonstrate the creativity and ingenuity of our Nation's greatest minds to help save Veterans' lives, limit their incapacitation, and build a better world for their families. Projects funded in 2015 will focus on identifying or developing new treatments for Gulf War Veterans, improving social reintegration following traumatic brain injury, reducing suicide, evaluating the effectiveness of complementary and alternative medicine, developing blood tests to assist in the diagnosis of PTSD and mild traumatic brain injury, and advancing genomic medicine.

In 2015, Medical Research will be supported through a \$589 million direct appropriation, and an additional \$1.3 billion from VA's medical care program, Federal grants, and non-Federal grants. Including Medical Care support, other Federal resources, and private resources, total funding for Medical and Prosthetic Research will be nearly \$1.9 billion in 2015. VA's research program benefits Veterans, their families, and the Nation.

Increasing Employment Opportunities for Veterans

Under the President's leadership, VA, the Department of Labor, DoD, and the entire Federal government made Veterans' employment one of their highest priorities. At VA, we led by example. We made great strides during the last five years and remain committed to meeting our goal of 40 percent of VA employees being Veterans, compared to 32.4 percent currently. During 2013, 33.8 percent of all new hires at VA were Veterans, including an impressive 78.5 percent of all new employees in our National Cemetery Administration (NCA).

We continue to work to ensure that all of America's Veterans have the support they need and deserve when they leave the military, look for a job, and enter the civilian workforce. The interagency Employment Initiative Task Force, co-led by VA and DOD, developed a new training and services delivery model to help strengthen the transition of our Veteran Servicemembers from military to civilian life. Accordingly, the 2015 Budget includes \$106 million to meet VA's responsibilities under the President's Veterans Employment Initiative and the VOW to Hire Heroes Act. In addition, the 2015 Budget includes \$1 billion in mandatory funding over 5 years to develop a *Veterans Job Corps* conservation program that will put up to 20,000 Veterans back to work over the next 5 years protecting and rebuilding America. Jobs will include park maintenance projects, patrolling public lands, rehabilitating natural and recreational areas, and law enforcement-related activities. Additionally, Veterans will help make a significant dent in the deferred maintenance of our Federal, state, local, and tribal lands, including jobs that will repair and rehabilitate trails, roads, levees, recreation facilities, and other assets. The program will serve all Veterans, but have a particular focus on post-9/11 Veterans.

Since 2009, VA provided over \$31.8 billion in Post-9/11 GI Bill benefits in the form of tuition and other education-related payments to cover the education and training

of more than 1 million Servicemembers, Veterans, family members, and survivors. As part of this effort VBA launched an online GI Bill Comparison Tool to make it easier for Veterans, Servicemembers, and dependents to calculate their Post-9/11 GI Bill benefits and learn more about VA's approved colleges, universities, and other education and training programs across the country. The GI Bill Comparison Tool provides key information about college affordability and brings together information from more than 17 online sources and 3 Federal agencies, including the number of students receiving VA education benefits at each school.

VA is also now working with Student Veterans of America to track graduation and training completion rates, and we expect a draft report by the end of 2014 to quantify program outcomes. The Post-9/11 GI Bill continues to be a focus of VBA transformation, as it implements the automated Long-Term Solution (LTS), VA's end-to-end claims processing solution that utilizes rules-based, industry-standard technologies for the delivery of education benefits. At the end of January 2014, we had 68,215 education claims pending, 21 percent lower than the total claims pending the same time last year. The average days to process Post-9/11 GI Bill supplemental claims decreased by 9.1 days, from 16.1 days in September 2012 to 7 days in January 2014. The average time to process initial Post-9/11 GI Bill original education benefit decreased by 15.3 days in the same period, from 32.5 days to 17.2 days.

Capital Infrastructure

The 2015 Budget requests \$1.06 billion for VA's major and minor construction programs, the same as the 2014 Budget level. The capital asset budget demonstrates VA's commitment to address critical major construction projects that directly impact patient safety and seismic issues and reflects VA's ongoing promise to provide safe, secure, sustainable, and accessible facilities for Veterans. The request also reflects the current fiscal climate and the great challenges VA faces in order to close the gaps identified in our Strategic Capital Investment Planning (SCIP) process.

Major Construction

The major construction request in 2015 is \$561.8 million. The request provides funding for four on-going major medical facility projects. They include: (1) seismic corrections to renovate building 205 for homeless programs at the West Los Angeles, CA VA Medical Center; (2) seismic corrections and construction of a new mental health facility and parking structure at the Long Beach Healthcare System; (3) construction of a new community living center (CLC), domiciliary and outpatient facility in Canandaigua, NY; and (4) construction of a new spinal cord injury/CLC facility, hospice nursing unit, and upgrades to a high-risk seismic building in San Diego, CA. These projects represent VA's most critical major construction projects and correct critical safety and seismic deficiencies that are currently putting Veterans, VA staff, and the public at risk. Once the projects are completed, Veterans seeking care will be served in more modern and safer facilities.

The 2015 Budget also includes \$2.5 million for NCA for advance planning activities and \$7.5 million for land acquisition to support the establishment of 5 additional national cemeteries in Cape Canaveral and Tallahassee Florida; Omaha, Nebraska; southern Colorado; and western New York to meet the burial access policies included in the 2011 budget.

Minor Construction

The 2015 Budget includes a minor construction request of \$495.2 million. The requested amount would provide funding for ongoing and newly identified projects that renovate, expand, and improve VA facilities. This year's focus is a balance between continuing to fund minor construction projects that we can implement quickly to maintain and repair our aging infrastructure, while using major construction funding to address life-threatening safety and seismic issues that currently exist at multiple VA medical facilities.

Opportunity, Growth and Security Initiative

The Budget also includes a separate \$56 billion Opportunity, Growth, and Security Initiative to spur economic progress, promote opportunity, and strengthen national security. This Initiative would increase employment, while achieving important economic outcomes in areas from education to research to manufacturing and public health and safety. Moreover, the Opportunity, Growth, and Security Initiative is fully paid for with a balanced package of spending cuts and tax loophole closers.

At the Department of Veterans Affairs (VA), the Opportunity, Growth, and Security Initiative will support capital investments essential to expanding and protecting Veterans' access to quality care and benefits. By providing an additional \$400 million for the VA capital program, enactment of the Initiative will allow additional progress in addressing the Department's highest priority capital needs, including a major construction project to replace a seismically deficient research facility in San Francisco, California.

National Cemetery Administration

The NCA has the solemn duty to honor Veterans and their families with final resting places in national shrines and with lasting tributes that commemorate their service and sacrifice to our Nation. We honor those individuals' service through our 133 national cemeteries, which includes two national cemeteries scheduled to open in 2015, 33 Soldiers' lots and monuments, the Presidential Memorial Certificate program, and through the markers and medallions that we place on the graves of Veterans around the world. The 2015 Budget includes \$256.8 million for operations and maintenance to uphold NCA's responsibility for this mission, including funds to open two new national cemeteries and to begin preparations for opening two National Veterans Burial Grounds.

NCA projects its workload will continue to increase. For 2015, we anticipate conducting approximately 128,100 interments of Veterans or their family members, and maintaining and providing perpetual care for approximately 3.5 million gravesites. NCA will also maintain 8,882 developed acres and process approximately 362,900 headstone and marker applications.

NCA maintains a strong commitment to hiring Veterans. Currently, Veterans comprise over 74 percent of its workforce. Since 2009, NCA hired over 450 returning Iraq and Afghanistan Veterans. In addition, NCA awarded 66.5 percent of contract awards in 2013 to Veteran-owned and service-disabled, Veteran-owned small businesses. NCA's committed, Veteran-centric workforce is the main reason it is able to provide a world-class level of customer service. NCA participated for the 5th time in the American Customer Satisfaction Index (ACSI), sponsored by the Federal Consulting Group and Claes Fornell International (CFI) Group. In the 2013 review, NCA received a score of 96 out of a possible 100, the highest score to date for any organization in the public or private sector.

NCA continues to leverage its partnerships to increase service for Veterans and their families. As a complement to the national cemetery system, NCA administers the Veterans Cemetery Grant Service (VCGS), which provides grants to establish, expand, or improve state and tribal Veterans' cemeteries. There are currently 90 operational state and tribal cemeteries in 45 states, Guam, and Saipan, with five more under construction. Since 1980, VCGS awarded grants totaling more than \$566 million to establish, expand, or improve these Veterans' cemeteries. In 2013, these cemeteries conducted over 32,000 burials for Veterans and family members.

Legislation

In addition to presenting VA's resource requirements, the 2015 President's Budget also proposes legislative action that will benefit Veterans. These proposals build on VA's legislative agenda transmitted in the First Session of the 113th Congress, as part of the 2014 President's Budget. Let me highlight a few provisions: VA proposes a measure that will allow better coordination of care when a Veteran also receives other care at a non-VA hospital, by streamlining the exchange of patient information. Additionally, we propose allowing the CHAMPVA to cover children up to age 26, to make that program consistent with benefits conferred under the ACA. We also are submitting a proposal that would modernize our domiciliary care program by removing income-based eligibility restrictions.

To continue our priority to end Veteran homelessness, VA proposes increased flexibility in the Grant and Per Diem program to focus on the transition to permanent housing. Also among our proposals is a measure that would allow VA to speed payment of Dependency and Indemnity Compensation and other benefits to surviving spouses by eliminating the need for a formal claim when there already is sufficient

evidence for VA to act. We greatly appreciate consideration of these and other legislative proposals included in the 2015 Budget and look forward to working with Congress to enact them.

Summary

Since the founding of our great Nation, Veterans helped our country meet all challenges; this remains true today as Veterans help rebuild the American middle class. At VA, we continue to implement the President's vision and transform VA into a 21st century leader of efficiency, effectiveness, and innovation within the Federal government. Our 2015 Budget supports Presidential priorities to always add value to the Nation, boost economic growth, strengthen the middle class, and work side-by-side with Federal partners to eliminate unnecessary overlaps or redundancies.

Given today's challenging fiscal environment, this Budget focuses VA resources, policies, and strategies on the most urgent issues facing Veterans and provides the resources critical to expand access, eliminate the disability claims backlog in 2015, and end Veteran homelessness in 2015. There is no greater mission than serving Veterans. Again, thank you for the opportunity to appear before you today and for your unwavering support of Veterans.



The Honorable Eric K. Shinseki

Department of Veterans Affairs

Washington, D.C.

Retired U.S. Army General Eric K. Shinseki was nominated by President Barack Obama on Dec. 7, 2008 to serve as Secretary for the United States Department of Veterans Affairs. His nomination was confirmed by the Senate January 20, 2009, and he was sworn in as the seventh Secretary of Veterans Affairs on January 21, 2009.

General Shinseki served as Chief of Staff, United States Army, from 1999 until June 11, 2003, and retired from active duty on August 1, 2003. During his tenure, he initiated the Army Transformation Campaign to address both the emerging strategic challenges of the early 21st century and the need for cultural and technological change in the United States Army.

Following the Sept. 11, 2001 terrorist attacks, he led the Army during Operations Enduring Freedom and Iraqi Freedom and integrated the pursuit of the Global War on Terrorism with Army Transformation, enabling the Army to continue to transform while at war.

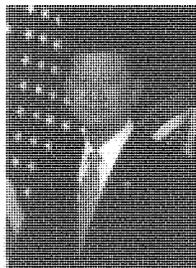
Prior to becoming the Army's Chief of Staff, General Shinseki served as the Vice Chief of Staff from 1998 to 1999, after serving simultaneously as Commanding General, United States Army, Europe and Seventh Army; Commanding General, NATO Land Forces, Central Europe, both headquartered in Heidelberg, Germany; and Commander of the NATO-led Stabilization Force, Bosnia-Herzegovina, headquartered in Sarajevo.

He was commissioned a second lieutenant of Artillery upon graduation from the United States Military Academy in June 1965, and was attached to Company A, 1st Battalion, 14th Infantry Regiment, 25th Infantry Division as a forward observer from December 1965 to September 1966, when he was wounded in combat in the Republic of Vietnam. He was returned to Tripler Army Medical Center, Honolulu, Hawaii to recuperate, following which he was assigned as Assistant Secretary, then Secretary to the General Staff, U.S. Army, Hawaii, Schofield Barracks, from 1967-1968. He transferred to Armor Branch and attended the Armor Officer Advanced Course at Fort Knox, Ky, before returning to Vietnam a second time in 1969. While serving as Commander, Troop A, 3d Squadron, 5th Cavalry Regiment, he was wounded in action a second time in 1970.

Other assignments include Commander, 3rd Squadron, 7th Cavalry, 3rd Infantry Division; Commander, 2nd Brigade, 3rd Infantry Division; Deputy Chief of Staff, Support for Allied Land Forces Southern Europe; Assistant Division Commander-Maneuver, 3rd Infantry Division; Commander, 1st Cavalry Division, as well as G-3, 3rd Infantry Division, 1984-1985; G-3, VII US Corps, 1989-1990; and Deputy Chief of Staff for Operations and Plans, Headquarters, Department of the Army, 1996-1997.

Shinseki holds a Bachelor of Science degree from the U.S. Military Academy at West Point; a Master of Arts degree from Duke University, and is a graduate of the National War College. General Shinseki has been awarded the Defense Distinguished Service Medal, Distinguished Service Medal, Legion of Merit (with Oak Leaf Clusters), Bronze Star Medal with "V" Device (with 2 Oak Leaf Clusters), Purple Heart (with Oak Leaf Cluster), Defense Meritorious Service Medal, Meritorious Service Medal (with 2 Oak Leaf Clusters), Air Medal, Parachutist Badge, Ranger Tab, Joint Chiefs of Staff Identification Badge, and the Army Staff Identification Badge.

January 2009



**Secretary
of Veterans Affairs**



Robert A. Petzel, M.D.

**Department of
Veterans Affairs**

Washington, D.C.

Robert A. Petzel, M.D., was appointed Under Secretary for Health in the Department of Veterans Affairs (VA) on Feb. 18, 2010. Prior to this appointment, Dr. Petzel had served as VA's Acting Principal Deputy Under Secretary for Health since May 2009.

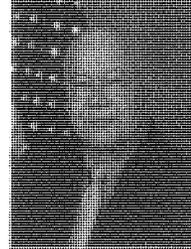
As Under Secretary for Health, Dr. Petzel oversees the health care needs of millions of veterans enrolled in the Veterans Health Administration (VHA), the nation's largest integrated health care system. With a medical care appropriation of more than \$48 billion, VHA employs more than 262,000 staff at over 1,400 sites, including hospitals, clinics, nursing homes, domiciliaries, and Readjustment Counseling Centers. In addition, VHA is the nation's largest provider of graduate medical education and a major contributor to medical research. More than eight million veterans are enrolled in the VA's health care system, which is growing in the wake of its eligibility expansion. This year, VA expects to treat nearly six million patients during 78 million outpatient visits and 906,000 inpatient admissions.

Previously, Dr. Petzel served as Network Director of the VA Midwest Health Care Network (VISN 23) based in Minneapolis, Minn. In that position, Dr. Petzel was responsible for the executive leadership, strategic planning and budget for eight medical centers and 42 community-based outpatient clinics, serving veterans in Iowa, Minnesota, Nebraska, North Dakota, South Dakota, western Illinois and western Wisconsin.

Dr. Petzel was appointed Director of Network 23 (the merger of Networks 13 and 14) in October 2002. From October 1995 to September 2002, he served as the Director of Network 13. Prior to that position, he served as Chief of Staff at the Minneapolis VA Medical Center.

Dr. Petzel is particularly interested in data-based performance management, organization by care lines, and empowering employees to continuously improve the way we serve our veterans. He is involved in a collaborative partnership with the British National Health Services Strategic Health Authority. In addition, he co-chairs the National VHA Strategic Planning Committee and the VHA System Redesign Steering Committee.

Dr. Petzel graduated from St. Olaf College, Northfield, Minn., in 1965 and from Northwestern University Medical School in 1969. He is Board Certified in Internal Medicine and on the faculty of the University of Minnesota Medical School.



**Under Secretary for
Health**

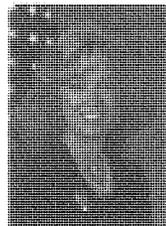


Department of Veterans Affairs Washington, DC

Allison A. Hickey
Under Secretary for Benefits

Retired Brig. Gen. Allison A. Hickey assumed the duties of Under Secretary for Benefits at the Department of Veterans Affairs (VA) on June 6, 2011.

As Under Secretary for Benefits, Hickey leads more than 20,000 employees in the delivery of a wide range of integrated programs of non-medical benefits and services to Veterans, their dependents and survivors. Through a nationwide network of 56 regional offices, special processing centers, and VBA Headquarters, she directs the administration of VA's disability compensation, pension, education, home loan guaranty, vocational rehabilitation and employment, and life insurance programs, and an annual budget of \$76.3 billion.



Prior to her appointment, Hickey led Human Capital Management for the consulting company Accenture in their work for the National Geospatial-Intelligence Agency – supporting operational business processes for intelligence community organizations in the areas of customer relationship management, call center practices and 21st Century information technology systems.

As the Director of the Air Force's Future Total Force office at the Pentagon, she provided leadership and oversight for four divisions in the areas of strategic planning, mission development, public and congressional affairs and program and resource implementation for more than 140 new Air Force units. Hickey was responsible for shifting billions of dollars towards new capabilities across the Air Force portfolio and directing new organizational models for a world-wide 500,000 person organization including active duty, Air National Guard and Air Force Reserve units and personnel to create a common Air Force policy, mission, and culture – known in the Department as the Total Force Perspective.

Prior to that assignment, Hickey served as the assistant deputy director of Strategic Planning, where she provided leadership and oversight for five divisions. She also served as chief of the Air Force Future Concepts and Transformation Division focused on the integration of technologies, organizations and concepts of operation to model for the Air Force of 2025.

Hickey is a 27-year Veteran of the Air Force having served on active duty, in the Air National Guard and the Air Force Reserves. Her Air Force career began in 1980 as a graduate of the U.S. Air Force Academy's first class to include women. As a pilot and aircraft commander, she accumulated more than

1,500 hours of flight time in KC-10A, KC-135A, T-38 and T-37 aircraft. She is the daughter of retired Lt Gen William J. Hilsman, a Vietnam Army Veteran, and Jean Hilsman, who served as a director and past-president of the National Military Family Association and as the first Department of Defense Family Policy Office director.

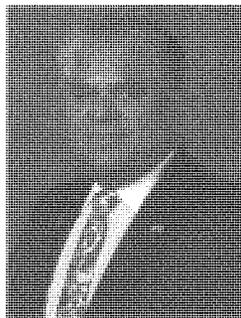
Hickey is married to retired Col. Robert Hickey, a 30-year Veteran and former A-10 and C-130 pilot. She and her husband have three children.



**Department of
Veterans Affairs**

NATIONAL CEMETERY ADMINISTRATION

**STEVE L. MURO
ACTING UNDER SECRETARY
FOR MEMORIAL AFFAIRS
CENTRAL OFFICE
WASHINGTON, D.C.**



Steve L. Muro was named Acting Under Secretary for Memorial Affairs Jan. 21, 2009. As Acting Under Secretary, he is responsible for overseeing 128 National Cemeteries that provide dignified burial services for military veterans and eligible family members, and maintaining the cemeteries as national shrines; for land acquisition, design, construction, and other activities relating to the establishment of new national cemeteries; overseeing other memorial programs for veterans, including the provision of headstones, markers and Presidential Memorial Certificates to honor the service of deceased veterans; and for administering federal grants to help states, territories and tribal governments establish veterans' cemeteries.

Prior to this appointment, Mr. Muro was named Deputy Under Secretary for Memorial Affairs on Oct. 20, 2008. He served as director of the Office of Field Programs from February 2003 to October 2008, providing leadership and direction for the Administration's field offices and facilities supporting a system of 128 national shrine cemeteries. Under his guidance, a new NCA Training Center was established that graduated its first class of Cemetery Director Trainees in April 2005 and NCA created a nationwide National Cemetery Scheduling Office. From February to November 2005, Mr. Muro served as the Acting Deputy Under Secretary for Memorial Affairs and as such was integral to the organization at several Senate hearings regarding future land acquisitions and fiscal planning.

Mr. Muro's life's work is linked with the mission of the National Cemetery Administration. He began his career in 1979 as an automotive mechanic at Los Angeles National Cemetery. While there, he was promoted to Maintenance Foreman and in 1981 was selected to attend the Cemetery Director Trainee Program. Mr. Muro completed this intensive training program at Riverside National Cemetery and upon his graduation he was assigned as Assistant to the Director, Los Angeles National Cemetery. He has held positions of increasing responsibility to include Director, Baton Rouge and Port Hudson National Cemeteries; Assistant Director and Director, Long Island National Cemetery; Assistant Director, Riverside National Cemetery; Director, Fort Snelling National Cemetery; and Acting Director, Golden Gate and San Francisco National Cemeteries. Mr. Muro was assigned to the newly formed Memorial Service Network V, where he served as its Director from 2001 through 2002.

Mr. Muro served in the U.S. Navy from 1968 to 1972, including two tours of duty in Vietnam: one on board the USS Benjamin Stoddert (DDG-22) and one with a mobile construction (Seabee) battalion.

Mr. Muro graduated from Mt. San Antonio Junior College with an associate's degree. He is a graduate of Leadership VA Class of 1996 and graduated from the Senior Executive Service Candidate Development Program in August 2004.



Department of Veterans Affairs Washington, DC

Stephen W. Warren

Executive in Charge for Information and Technology



Stephen Warren joined the Department of Veterans Affairs in May 2007 as the first Principal Deputy Assistant Secretary in the Office of Information and Technology (PDAS/IT) and serves as the Deputy Chief Information Officer for the Department. As the PDAS, Stephen is the Chief Operating Officer of the \$3.3 billion, 8,000-employee IT organization, overseeing its day-to-day activities to ensure VA employees have the IT tools and services needed to support our Nation's Veterans. He successfully led the integration of VA's vast IT network into one of the largest

consolidated IT organizations in the world.

Prior to assuming his current role, Warren served as Chief Information Officer (CIO) for the Federal Trade Commission and previously as CIO for the Office of Environmental Management, Department of Energy. Beginning in 1982, Warren served nine years of active duty in the U.S. Air Force, where he was involved in a broad range of activities, to include: research in support of the Strategic Defense Initiative (SDI), support for nuclear treaty monitoring efforts, and service in Korea as a transportation squadron section commander.

Warren has received a number of awards and honors, to include: Federal Computer Week Federal 100 award winner, 2004 and 2012; Presidential Rank Award of Distinguished Executive, 2008; Government Information Security Leadership Award (GISLA), 2006; Service to America Social Services Medal, 2004; AFFIRM (Association for Federal Information Resources Management) Leadership Award for Innovative Applications, 2004; and American Council for Technology Intergovernmental Solutions Awards, 2004. Warren has been widely published on subjects involving nuclear facilities, radioactivity, and related issues. He holds a Master's in Systems Management from the Florida Institute of Technology and a Bachelor's in Nuclear Engineering from the University of Michigan.



**Department of
Veterans Affairs**

Helen Tierney

**Executive in Charge, Office of Management,
and Chief Financial Officer**

Washington, D.C.

Ms. Helen Tierney was designated as the Executive in Charge for the Office of Management, and VA Chief Financial Officer, on June 6, 2013. As the Executive in Charge, she is responsible for the overall budget and financial management of VA's \$160+ billion budget as well as the Department's performance management, business oversight, enterprise risk management, and asset enterprise management programs. Ms. Tierney joined VA in March 2011 as the Executive Director for Operations in the Office of Management. In this position she served as the deputy to the Executive in Charge.

From 2008 to 2011, Ms. Tierney served in the Department of Homeland Security (DHS) as the Executive Director for Planning, Program Analysis, and Evaluation for the Office of Field Operations (OFO) in the U.S. Customs and Border Protection Agency. In this position she was responsible for OFO strategic planning, enterprise performance measures, national program analysis and evaluation, internal policy process management, manpower modeling, and the coordination of the self-inspection program and responses to audits. Additionally, she pioneered an innovative informatics program that identified real time performance issues at U.S. Ports of Entry.

Before her appointment in DHS, Ms. Tierney served in key Army civilian positions, culminating in leading business transformation programs on the Army Financial Management and Comptroller (FM&C) Secretariat staff. She started her career as an Army civilian in Heidelberg, Germany.

Ms. Tierney holds a BA degree in Government from Cornell University and a Master of Policy Management from Georgetown University. She is a 2007 Distinguished Graduate of the National Defense University, Industrial College of the Armed Forces, where she earned a Master of Science in National Resource Strategy.

She is the daughter of a WWII Veteran and the wife of an Army Veteran. Ms. Tierney is a member of the Association of the U.S. Army, the American Society of Military Comptrollers, the National Defense University Foundation, the Association for Federal Enterprise Risk Management, and the Senior Executive Association.

August 2013

ENDING THE BACKLOG BY 2015

Mr. CULBERSON. Thank you very much, Mr. Secretary.

We realize you have responded to the concerns of the Congress and the veterans service organizations in doing what you can to deal with the continuing backlog, but it is, as everyone in the Committee has said, inexcusable, a deep source of concern. And I want to focus first on that.

I know that you have increased automation. You have done additional training, overtime, shifting staff from other areas to claims processing, brokering of claims, et cetera.

But even with all this effort, it is difficult to see how it is going to be possible for you to make your target of ending the backlog by the end of 2015 because, at the end of fiscal year 2013, September 30, you still had 59 percent of the disability claims inventory in backlog.

And we note that that 59 percent number is virtually unchanged in this week's Monday morning report. Nearly 6 months have gone by and you are still at about 59 percent.

But the goal you have set is to reach 50 percent of ending the backlog for fiscal year 2014, and that is just a short time away, the end of fiscal year 2014.

And then to have no backlog by the end of 2015.

But at that rate, I don't see how that can happen when you have got a slow creep downward in that measure. It just seems unrealistic.

How do you expect to be able to drop from half the cases being in the backlog to no backlog in the course of a year when the progress so far has been so slow and so halting? What is going to be done differently?

Secretary SHINSEKI. Mr. Chairman, let me begin by saying no veteran should have to wait for the benefits they have earned, and that has been our commitment now for my 5 years here. And 5 years ago we committed to ending the backlog in 2015.

We have briefed the Congress on our plan to do that, and you have been very generous in supporting us. At the same time that we committed to ending the backlog, we also looked at unfinished business from previous wars.

48 years ago, Vietnam, we had veterans who had never been given eligibility to file a claim. 20 years ago, Desert Storm, again, veterans who were not eligible to file a claim because service connection was not granted.

Combat PTSD. For as long as we have had combat, PTSD has been a fact of life. We called it by different names. Today we recognize it and we discuss it openly, where in times past we weren't willing to do that.

For those veterans who have been dealing with PTSD for decades, we took the step of granting them service connection if they had been in combat and they had medically verifiable PTSD. This is called the access. So when you grant those opportunities, you expect the claims will be submitted, and they were.

For Agent Orange alone, almost overnight 260,000 claims were added to the inventory. All told, as we look back, over a million vet-

erans were able to submit disability claims, where 5 years ago they were not eligible.

When we briefed our plan to do this and said that we would expect that this growth and increase would occur up to 2013, the high-water mark would be hit in 2013, we couldn't predict exactly when in 2013 it would occur. But, in fact, we were pretty sure that we were going to hit a high-water mark and things would then begin to recede.

We also knew that it gave us 3 years to develop an automation tool that we did not have 3 years ago. It is called the Veterans Benefits Management System. It took us 3 years to design, develop, test, pilot, and then field it.

We committed to fielding that automation tool before 31 December 2013 and, in fact, finished fielding it 6 months ahead of schedule, a large program. In June 2013, all 56 of Secretary Hickey's regional offices were fielded with this program.

The high-water mark occurred on 25 March 2013, 611,000 claims. That has dropped by 43 percent in the last 12 months. And we have essentially 18 months to go. And I understand your concerns. I would also tell you I think we are in a good position to deliver on our promise.

Mr. CULBERSON. My question is, sir we all agree with you in your commitment. We know your service to the country, and God bless you for it and to the veterans.

We know about the surge where that has come from. And as Ms. Lowey and Mr. Bishop pointed out, you are going to see even more of an increase as folks leave the military.

My question really is: What are you going to do differently in the months ahead? The Committee will probably be thinking about some creative techniques to help you reach your goal because we are deeply concerned. It is only 20 months until December 31, 2015. What are you going to do differently?

Secretary SHINSEKI. I would like to check numbers with you here. But we have, by our count, 43 percent reduction in the last 12 months, and we think we have enough time.

Now, I would also agree that very recently DOD has announced this plan to downsize. We work with DOD, and we are looking forward to having a plan from them that shows rate, time, and date at which they will be downsizing.

Mr. CULBERSON. So you got a whole new surge of folks coming into the VA system.

Secretary SHINSEKI. And we will have to calculate that. 5 years ago, when we put out our plan—the downsizing aspect of this is rather recent. We will have to adjust.

Mr. CULBERSON. What will you do differently in the future to make sure that you hit your target?

Secretary SHINSEKI. We expect that VBMS, the automation tool that has been fielded—and we are in this transition year going from paper to digits—that we are going to get significant lift from that investment this year.

Mr. CULBERSON. What kind of lift?

Secretary SHINSEKI. We have some estimates that I am happy to share with you. I will provide that for the record.

[The information follows:]

VA anticipates a 3-5 percent increase in production in FY 2014 over FY 2013 based on technology improvements. VBMS is the largest single technology initiative in VBA in FY 2014.

Mr. CULBERSON. I am just looking for you to give us some encouragement because, truly, we are going to need to come up with some creative mechanisms, this year to help encourage the VA to hit your mark. Thank you very much.

I am going turn to Mr. Bishop.

Mr. BISHOP. I yield to Mrs. Lowey.

Mr. CULBERSON. I am quite sorry about that, Mrs. Lowey.

Mrs. LOWEY. You don't have to be sorry at all, and I appreciate your consideration.

I have been very concerned for a long time about our veterans who come home and have real issues with mental health. It is such a serious issue. There have been numerous articles detailing the escalating problems for those veterans, to include an increased number of suicides.

VA HELPING VETERANS WITH MENTAL ILLNESS

If you could share with us how the VA is helping veterans who are suffering from mental illness, how many cases of post-traumatic stress have been reported among women. And are there any special programs tailored towards our female veterans?

We are well aware that the treatment of PTSD can take a substantial amount of time and support by the family members. And what programs are available for family members of veterans who are diagnosed with PTSD? And how many veterans who committed suicide in 2013 can be traced to PTSD?

Thank you.

Secretary SHINSEKI. Congresswoman, let me begin with just talking about mental health in particular. And then I will call on Dr. Petzel to address the suicide-PTSD-specific issues.

I agree we have a large and growing set of responsibilities here in the mental health arena. We have been at war for 10 years. That is the longest war in our history. We are also conducting these operations with a small professional force which requires repeated redeployments.

We ought to all be very proud of the youngsters who have out carried these missions. We have asked a lot of them. They haven't wobbled. They haven't complained. And now it is our obligation to make sure we take care of them. So I share those concerns with you.

I would also say, between 2009 and 2014, our mental health budget was increased by 61 percent through the support of this Committee. This year alone for mental health overall, there is about \$7 billion that we are putting into this.

We are sensitive to this and watching. And where we are not having the access numbers that we would like to see, then we adjust and hire more people. And we just went through that here last year. So I would offer to you that we are sensitive to this.

And in the specific areas of suicides and PTSD, let me call on Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Congresswoman Lowey, the prevalence of suicide is a national tragedy. The fact that there is one individual who served our country, was in conflict, and then finds themselves unable to continue living their life and takes their life is a tragedy. And we believe strongly that we have an obligation to provide the kinds of services that will prevent this from happening in the future.

As the Secretary said, we are spending almost \$7 billion in 2015 on mental health services, much of it devoted to suicide. We have suicide prevention coordinators at each one of our medical centers and large clinics. We case-manage every individual that we identify as being at risk for suicide.

All patients that come to us for health care are screened for suicidal ideation and for the antecedents of suicide: Depression, substance misuse, chemical dependency, PTSD, sleep disorders, and pain management. Those are things that we frequently find in our population preceded an attempt to take one's life.

There is good evidence that, when people are under our care and we are able to reach them, that we can reduce the rates of self-harm, the rates of repeated attempts at suicide are decreased, the rates of suicide in that population of people are reduced.

So our biggest obligation to these veterans is to reach out to them and to bring them into our system. We are not seeing everybody that is eligible. We are not seeing everybody that needs our care.

So we are spending a tremendous amount of effort to reach out to these veterans and to their families to bring them under care because there is, again, just to reiterate it, evidence that, when we treat, people do get better.

The other thing that you mentioned was PTSD. And, as I said before, it is an antecedent of suicide. There is a tremendous amount of research money being devoted to looking at, again, the causes, being able to identify, again, the antecedents of PTSD.

VA and DOD have combined to put \$25 million apiece into a PTSD research consortium, as well as a TBI research consortium. We are going to be spending probably \$30 million in our own research budget looking at issues related to PTSD in 2015.

We are absolutely committed. This is something that we are international experts in, and we are determined to get better at identifying it and at treating it.

Mrs. LOWEY. Thank you, Mr. Chairman.

Mr. CULBERSON. Thank you very much.

We are going to do our best. Normally, I allow folks plenty of extra time, but let's try, if we could, to stick to the 5-minute rule today so we can get everybody out in time to catch their airplanes.

At this time we go to Mr. Fortenberry.

Mr. FORTENBERRY. Thank you, Mr. Chairman.

Mr. Secretary, welcome and thank you for your commitment and service to our Nation's veterans. We all obviously agree that they deserve all of our highest commitment and highest level of quality services, given the extraordinary sacrifices that they and their families have made. So I want to thank you and welcome you all.

CREATIVE OPTIONS FOR CONSTRUCTION

Let me turn quickly to some questions I have, the first regarding construction. We use lease-back arrangements for the construction of clinics, but why not hospitals?

Why can we use a finance program with a lease-back arrangement—effectively, a finance program through lease-back for the construction of smaller clinics, but not large construction projects?

If we don't do this, the problem is the opportunity cost of waiting—for instance, in Omaha, as you are quite aware, we are on the list for a new hospital. The operating rooms were shut down a little while back because of problems. So, thankfully, we are on the list for new construction, but the potential for that to come in the near term is more and more limited.

There are other creative options out there for getting this done quicker, which we do use on a smaller scale. Somebody has made a decision along the way—and I would like to understand why—why we do not apply the same finance model to larger construction projects.

Secretary SHINSEKI. That is a fair question, Congressman.

And on this particular point, why we couldn't use the same model for major construction, I think it is in the law, and I would have to do a little more research.

But this is a key significant difference, that for major construction, we are required to set the money aside up front and fund the entire project.

Our challenge has been that there is—you know, the amount of resources available. We prioritize what we go to work on, and we put safety at the very top. We put security in the next spot.

And I would say the third place goes to taking care of what we have. So wherever veterans are being seen, they are being seen in an environment that is, you know, respectful.

And then new construction where we don't have a capability becomes part of that discussion. Now, these are not absolutes. I mean, there is some blending here. But, overall, those are the general priorities.

Mr. FORTENBERRY. Of course, you are sharing the goal of getting highest quality level of service to veterans as quickly as possible. And somewhere along the way a distinction was made between a smaller construction project, which, apparently, qualifies for creative financing, versus larger types of projects.

I am just trying to figure out if that is somebody else's decision a long time ago that no longer makes sense, that can we potentially set up new forms of financing arrangement that would allow the private sector to develop this with a guarantee of payment from the government, again, like the clinic model or smaller institutional models, and rapidly clear out the building of inventory of need that you have for new construction facilities without exposing the budget in the long term to significant increases because of the potential problems with the client.

Obviously, the government is a stable client and is going to be in a pretty good position to guarantee lease payment. So it makes sense to me—well, given our time is short, tell me a pathway in which we can explore changing this, potentially.

Secretary SHINSEKI. I will be happy to work with you on that. In a previous life, in a similar situation, when one of the services had family housing issues and, similarly, not enough funding to cover it, we created an opportunity. So there is some history here.

Mr. FORTENBERRY. That is another precedent out there. That is exactly right. Military housing. Same issue.

CONSEQUENCES OF CLAIMS WORKLOAD SHIFTS

The second question is: Regarding the backlog of VA claims, as you are potentially aware, Nebraska has done an extraordinary job. In fact, I think we are one of the best outcomes in the Nation. So what that has meant is that more and more work is shifting to Nebraska.

So there is some concerns that—obviously, we have the magnanimity of spirit to want to help out, but don't want to be penalized, our own veterans from our own state, by being forced further back in the line because we are trying to bail out other systems that aren't operating as effectively as ours. So I want to bring that concern to you.

I'm done. I've got the hook.

Thank you, Mr. Secretary.

Mr. CULBERSON. We will get back to you, if we can, but we have got folks trying to catch airplanes. Forgive me.

Mr. Bishop.

Mr. BISHOP. Thank you very much.

SEGMENTED LANES CONCEPT

Mr. Secretary, the VA's strategic plan to eliminate the compensation claims backlog talks about teams working together on one of three segmented lanes: Express, special ops or core.

In the plan, it states that the VBA projects that segmented lanes can accelerate 350,000 express claims from 262 days to completion to 80 days, a reduction of 182 days, reducing the average days to complete for all claims by 54 days.

How many of the regional offices are currently using the segmented lanes structure? And what results are you seeing from utilizing this initiative?

Secretary SHINSEKI. Under Secretary Hickey.

Ms. HICKEY. Thank you, Congressman Bishop.

100 percent is the quick and simple answer. In fact, we went into those segmented lanes a full 9 months ahead of schedule because we had done it in about six stations and we saw immediate results with those segmented work lanes.

I have subsequently taken and put fully developed claims as another way to speed up our claims. And those are also now going into express lanes and getting some priority because they take less time to do.

I acknowledge the help of our Veterans Service Organizations in this: We have gone from 3 percent this time last year of fully developed claims in our system to now more than 28 percent fully developed claims in our system.

And they are going substantially faster. The average days to complete those is 140 days, and they are getting done quicker at a high-quality answer.

I can tell you that the people who are working in those segmented claims lanes are hardworking VBA employees, 52 percent of whom are veterans themselves, many more a direct family member of a veteran, and more are service member family members who come to work with us every day.

They really do care about doing a great job, and they have. We did 1.17 million claims last year, the highest ever in our history at VBA, and we are on track to meet the 1.3 million claims that we will do this year. So that is part of how we will make the 2015 numbers in the future.

We are producing more and we are producing them at a higher quality as well, a full 7 percent age points higher than 2011 at the claim level, meaning above 90 percent now in our accuracy rates at the claim level, and 96.7 percent at the medical issue level as well.

So many things are going on, but, most important, is continued IT support.

Mr. BISHOP. Thank you.

THE VBMS SYSTEM

Last year we also discussed the benefits of the VBMS system, which you believe will transition the VA from paper to electronic claims.

I just want to confirm that the VBMS is currently in every regional office. Is that correct?

Ms. HICKEY. Yes, Congressman. VBMS is fully deployed 6 months early. We just this weekend did another release of a new enhancement, new upgrades, that we are doing on an every-12-week cycle. And we are adding more and more functionality every 12 weeks.

Mr. BISHOP. What is the current percentage of claims that are filed on paper? How many have been processed using the VBMS? And how long will it take for us to see the tangible progress on reducing the backlog using the VBMS?

Ms. HICKEY. Congressman, we have 84.5 percent of our claims that are now electronically scanned into VBMS, nearly a billion pieces of mail that have been turned into digits that are now in the system that we are avoiding having to move—

Mr. BISHOP. You say a “billion” or a “million”?

Ms. HICKEY. A “billion.” Nearly a billion pieces of paper we have turned into digits.

Mr. BISHOP. With a “B.” All right.

Ms. HICKEY. We have, of our inventory, less than 100,000 claims in the entire system of the 623,000 that are still in paper.

So we are predominantly now moving more and more into the electronic environment, leveraging the tools and the IT.

Mr. BISHOP. You are making substantial progress.

Ms. HICKEY. We are making substantial progress.

INCREMENTAL VERIFICATION OF CLAIMS

Mr. BISHOP. The average number of claimed conditions for recently separated service members is now in the 12 to 16 range, which is an increase in the number of disabilities claimed by veterans from earlier eras.

Do claims processors have to have all of the claimed conditions verified before a claim can be processed or do you now—as conditions are verified, you work on that claim as the conditions are verified and approve the various individual claims within a veteran's package?

Ms. HICKEY. Congressman, that is our intention in 2015 and beyond, to have the functionality to be able to do that, hence the reason our IT budget is so critical for this budget, because that will help us do some of the rules.

Now, I will tell you, if you are watching a very specific number in a backlog and you don't do every medical condition in that claim, it will not come out of backlog. So we will have to have a different discussion around how we measure the metrics.

Mr. BISHOP. I am sorry. But I thought I understood from some earlier conversations that, because of the multiple claims, in order to accelerate the backlog and to service the veterans, that if you had all of the information for one of the claims, although you didn't have it for the other nine or ten, that you would go ahead and process that one.

Ms. HICKEY. We do about 10 percent of those today, and we try to if we need to move that forward. But we need to get fully through all the paper and fully into the electronic system with all the automation to really leverage that strongly. But that is our intention. That is our vision.

Mr. BISHOP. Okay. I thought I was giving you a softball question.

Mr. CULBERSON. Mr. Graves. We are just working out who got here first and who's got airplanes.

Mr. GRAVES. Spirit of cooperation.

Thank you, Mr. Chairman.

And thank each of you for being here. And I want to thank you for the undertaking that you have committed to take on. And I know it has got to be difficult. And I see the progress that has been made with the backlog issue.

And I know your history and service to our country, Secretary, and I want to thank you for that.

And I imagine there is no one at that table that more desires to serve our veterans than you, and I want to thank you for that and your commitment over the many budget cycles to come back each time and address this very, very important issue.

HOLDING EMPLOYEES ACCOUNTABLE

Before I ask you about the backlogs, I wanted to address a question that was asked to Mr. Petzel previously in another hearing, and it was at the Veterans Affairs Subcommittee on Health hearing.

And it was Dr. Dan Benishek, you might remember, who asked you a question about—to provide a list of everything that the VA has done to hold employees accountable in response to the preventable veterans' deaths in Pittsburgh, Augusta, Memphis and Atlanta.

Has that report been provided to Dr. Benishek yet or the committee?

Dr. PETZEL. Congressman Graves, I can't tell you. I don't know whether it has or not, and I will certainly find out as soon as I get back.

Mr. GRAVES. Okay. That would be great. And, one, if it hasn't, I hope that you provide that report soon. And maybe you could include this Committee as well.

I know there are many members of this Committee that would have an interest in the progress that has been—or the report, what it provides.

But maybe you could tell the Committee a little bit what has been done, if you know some of it, prior to the report being released.

Dr. PETZEL. Yes, I would, Congressman.

The VA takes this issue of accountability very seriously. We hire people. We train them. We tell them what they are accountable to do. And when they don't perform as they are supposed to or when they complete criminal acts or malfeasance, we do indeed hold them accountable.

Last year over 3,000 employees were released from the VA, fired, in your terms. And in the previous year, more than 3,000 were.

In addition to that, over the last 2 years, six senior executives have been removed from Federal service, as well as a number that have been seriously disciplined.

There is, I think, good evidence that the VA does take the problem of holding people accountable very seriously and has demonstrated in the past that they indeed do that.

Mr. GRAVES. And we can wait on the report. And I know that there is going to be limited time. Thank you for that brief synopsis. It is good to hear that accountability is taking place there, and we will look forward to a more full and thorough analysis.

PERFORMANCE RATINGS

Along those lines, Mr. Secretary, it was reported that all but one of the VA senior executive service employees received a high performance rating in the fiscal year 2012. I am hearing some of the conversation today about the backlog and other concerns.

Do you see that that was appropriate? Is that something that you are going to look to do?

Secretary SHINSEKI. I am not familiar with that number. But I would reiterate, if we are talking about the backlog, Congressman, three decisions created this growth in claims. And the very people that you are asking me about are the people that are delivering, solving a problem.

And the problem was, for years, since Vietnam, there are people who haven't been recognized. We have now recognized them. We have to work it down. But veterans have been served.

Mr. GRAVES. And that is a fair explanation. You are right. There has been tremendous progress made.

Secretary SHINSEKI. In those cases where we have evidence that someone has not performed to our standards—and I come from a background where the institution has the responsibility to set very clear standards so people know what is expected of them—we have the responsibility to train them to those standards.

If we haven't done either one of those, it is hard to hold someone accountable. We are doing that now. We probably were not as strong in these areas as we should have been.

We now have a formal training program, set clear standards, expect the leadership to motivate people to come to work and do their best every day.

And when we have evidence that people are not meeting the standards or are doing things that are wrong, we have tools to take them out of position, and evidenced from Dr. Petzel, we do use them.

Mr. GRAVES. Thank you.

And you have set a laudable goal as well, and we might point out 2015 to have the backlog cleared.

DEFINITION OF BACKLOG

And, Mr. Chairman, if I could just ask the Secretary to maybe define what—I guess the backlog.

When does that begin? What does that mean? Because maybe we are not clear on exactly what that definition is.

Secretary SHINSEKI. This is an excellent question, Congressman.

Five years ago we didn't have a definition for a backlog. We had a large inventory of claims and our mission was to just do more claims better and reduce the numbers. It wasn't good enough.

So we defined the backlog as any claim over 125 days. It was a number that we picked because it was a stretch goal. We weren't anywhere near meeting it. 125 days. No claim over 125 days. Not an average.

So you don't do 250 days and 1 day and you get the average of 125. No claim over 125 days. And all of it done at 98 percent accuracy so we didn't turn into a paper mill just ginning decisions.

With those two factors, we took a look at how long it would take us to deal with the inventory we had then, knowing that we were going to make those three big decisions I talked about that would grow this. And then we set our target on 2015. Very ambitious.

We didn't have an automation tool then. We had to design and develop it. And we thought we could do that. We have done it. We are on track so that, in 2015, when we say we have ended the backlog, there should be no claim over 125 days. And we track our accuracy here.

I would also offer, Congressman, that when we hit 125/98 in 2015 and we know that we can do that without fail, we can hit that number regularly, Secretary Hickey won't want to hear this, but my push is going to be, "What is wrong with 110?"

I mean, our mission is to get, as I said earlier, high-quality decisions on benefits and services veterans have earned. So we have a requirement to do that as quickly as possible.

The minute I say 100 days, there is going to be another backlog, and you'll be asking me why. I will tell you it is because we will have made the right decisions. Our business here is to take care of veterans.

And I don't want VA to be in a position sometime down the road to shy from making those decisions that benefit veterans because we are afraid of dealing with the backlog. Our job is to take care of veterans.

Mr. CULBERSON. Thank you, Mr. Secretary. If I could recognize Dr. Price.

MOTIVATING THE WORKFORCE

Mr. PRICE. Thank you, Mr. Chairman.

Mr. Secretary, I want to ask you what may seem like an unusual question, but it is one I have been thinking about for quite a while. And, actually, you set it up somewhat in your answer to the last question.

I want to ask you to reflect a bit on how to motivate a workforce, how to bring forth their best performance. You have a lot of background in that. You have spent a career motivating the men and women in the military, and now you are doing the same thing in a large Federal department.

As I understand the tools of management, they are both positive and negative, high expectations, pressures, accountability, but, also, appreciation for hard work, rewards for a job well done. It is a familiar mix, although not always skillfully applied.

I have to tell you I have watched with some dismay and puzzlement at how we have handled this backlog from the congressional side. I sometimes wonder what view my colleagues have of human psychology. How do they think management works?

It has just been so relentlessly negative. How can you bring forth good results in dealing with a complicated backbreaking task?

There has certainly been a lot of criticism, even berating of personnel, usually referred to as bureaucrats. There is much talk of demands and pressures and all of this in a context that arguably has denigrated public service.

I am talking about repeated pay freezes. I am talking about benefit reductions for Federal employees. And then I am talking about the shutdown. That damaged government performance in so many ways, but especially on a critical crash program like reducing the backlog.

You haven't complained a lot about what the shutdown did to you, but I can't imagine it helped. In fact, I can't imagine that it wasn't a major factor that you had to overcome.

So under the circumstances, I don't think it is too surprising that the VA has a morale challenge. You rank 14th, as you know, out of 19 Federal departments and agencies. Honestly, I am surprised it is not lower.

But it does raise the question with which I began: How, as an experienced and skilled administrator, do you develop the mix of pressures and rewards, blame and praise, to get optimal performance out of your workforce? How do you do it? How do you raise morale? How do you sustain a sense of positive engagement, teamwork, to get this job done?

I assume that is more effective than constantly berating people. But I think maybe we all need a lesson in human psychology here. How do you get the most out of a workforce to get a complicated job done?

Mr. CULBERSON. Superb question, and I would like to second.

Do you have the authority to give bonuses where somebody exceeds expectations, for example?

Secretary SHINSEKI. We do have the authority to provide performance awards. And I think, as the chairman knows, performance awards are part of the compensation plan for all Federal workers. It begins for us with hiring the right person to begin with; so, we are very diligent.

We do ask a lot of our workforce. And right now the hardest working folks, perhaps, are in the benefits administration, where they are working overtime—and I do mean overtime—to drive those backlog numbers down.

And then the responsibility is to grow a sense of teamwork in an organization. And that begins with growing trust amongst all of the participants, trust, worker to worker, trust between leader and led, and trust within the administrations of this organization.

5 years ago we were very siloed, very stove piped. Today we are much more a single department because of the work that goes on, without any effort on my part, across the department.

Day to day it is assuring people that success in leadership is about making them successful, and part of making them successful is making sure they understand what it is we expect them to do, so it is clear, there are no question marks, and then training them to do those tasks and then expecting them to come to work every day to excel at doing that.

Leadership has to be involved. You can't sit in your office. You have to walk the hallways. You have to make corrections as well as compliment people who are doing good work. It is all the tasks of hands-on leadership that comes with this. At the end of the day, you say thank you to folks.

My great challenge—and this is something we focus on every day in this leadership team—the big challenge for us, as Congressman Price has indicated, is making sure people—their morale is such that they do come to work every day. At times, we ask a lot of them, and they never fail to deliver.

These numbers, the 40 percent decrease, Mr. Chairman, is why I am so confident that they are going to deliver for us in 2015.

This is not about technology, although they deserve the best tools that we can provide. And they didn't have them 5 years ago. They have got them now.

About these tools, as powerful as they are—I come from a background where I had something to do with a great tank called the M1, best tank in the world. Even my Russian counterpart admitted that. The best attack helicopter in the world, I have some familiarity with that.

But the fact is not one of those pieces of equipment turned itself on. That helicopter never lifted itself off the ground. That tank never shot itself in qualification gunnery.

There was always some youngster at the controls who we trained to do what we expected, and then they outperformed all of our expectations. They shot better, farther, faster than even our books, firing tables, had asked. And that is why it was a great Army.

And we intend to do the same kind of thing here. We have given the people in VBA a great tool, and we expect that they are going to turn this tool around and perform in a way that will make all of us proud.

Mr. PRICE. Thank you. Thank you very much.

Thank you, Mr. Chairman.

Mr. CULBERSON. Mr. Rooney.

Mr. ROONEY. Thank you, Mr. Chairman.

General, again, I spoke with you last year. I am not really sure what the last questioner was referring to when he was alluding to what our responsibility here on this Committee is and your responsibility and the people that work for you's responsibility is when it comes to serving our veterans.

I can speak for myself. I am accountable every two years for a whole lot of veterans in South Central Florida that know that I am on this Committee and they are not always very happy with the results that we are all providing, collectively, we.

So when it comes to how you do your job, I think you were hired—as I think I said before, I am probably the only person up here that actually served under you in the Army—I think that you were hired because the administration believed that you could do this job, as I do.

And, you know, with the things that you have said today, I mean, obviously, that is bearing out. But let's make no mistake. Our constituents, my constituents, are not collectively happy with the job that we are all doing as a group here trying to serve them, yet.

I think that we are moving in the right direction, so much so that we are kind of the butt of the jokes. We are repeatedly on the Daily Show and, believe me, people use that as a news source. So if you could go back on there, by the way, and revisit some of the things that he said, that would be helpful.

CONTINUITY OF SERVICES BETWEEN DOD AND VA

But I want to talk about something else that I hear a lot back home, and that deals with the continuity of services between DOD and the VA, as you have been somebody who has served in both. And I talked a little bit about this last year.

What is the status when it comes to somebody who enlists or is commissioned, gets out of the military, gets a disability in the VA? What is the breakdown? Why is there a breakdown?

Because I can't keep going home saying, you know, "When you all get out of the Army and then you have a disability and you go in the VA, it is like a different system. There are different computer systems or something like that." That is just maddening. Are we any closer to making that a more seamless transition?

Secretary SHINSEKI. Congressman, a lot has been done and a lot more needs to be done. I would say today and 5 years ago, we have two separate electronic health records, both of them with varying qualities.

We happen to be very proud of ours. We feel that, in 1997—and you hear often that technology turns every 18 months and, in some cases, some of it turns even faster, 9 months.

So here you have an electronic health record that has been in place since 1997 and it is still considered one of the best in the country, and we intend to upgrade it.

DOD has its own electronic health record, but they also have a mission to deploy medical capability overseas, life-saving procedures, medical evacuation. So the missions are slightly different.

But today we have created a joint viewer that is able to pull data out of both databases and allow clinicians, whether VA or DOD clinician to be able to see the entire record and make decisions. Much better than 5 years ago, but still not good enough.

Mr. ROONEY. Is it an ego thing between the two agencies? Or is there something we can try to do to change that? I mean, when we give these budget requests—or these appropriation requests, is there some kind of force of those requests that we can make either to DOD or to you to say this has got to be—this can't—it has got to continue to keep getting better, but it has to be the same or similar enough that it is—

Secretary SHINSEKI. Sure.

Mr. ROONEY [continuing]. Easily read.

Secretary SHINSEKI. We started out a discussion with Secretary Gates, to see if we could get to a single, joint, common, integrated electronic health record. And that is what he and I pursued. We did this for several years with Secretary Panetta as well.

When Secretary Hagel arrived, he looked at how he was structured to deliver on his half of this, and he wasn't satisfied. And so he asked to take a pause, which he did. And then decided to pursue an acquisition strategy.

We, on the other hand, have what we have. It is a great electronic health record. And we are evolving it from where it is today to a much more capable system. And that is what part of this budget request is about to unencumber some funds here that have been held from 2013 and 2014 budgets.

We are on a complementary path. We are watching what he is doing in acquisition. And this is a discussion, ongoing discussion. As he declares requirements, if we don't have the capability, we are going to include it in our electronic health record. So that as we get down to where they are ready to make a decision, 3, maybe 4 years from now, we want our electronic health record to be competitive. And I have been assured by Secretary Hagel that we will be in the hunt. And that is why I need to get us moving. However it turns out, even if we get to the point they decide to select another commercial vendor, we have put our code, the MUMPS code from Vista, we put it in the commercial marketplace. Contractors are picking up on it, using it, and providing it as solutions in the competition for the DOD acquisition.

I am hoping that we are good enough to win the competition. But even if we don't, we are going to be so very close in interoperability it would be entirely seamless, and that is where we are both headed.

Mr. ROONEY. General, my time has expired, but I can tell you, this is a huge issue for people in my district when it comes to them leaving DOD and going into the VA. It doesn't seem to be the same right now. And it has to be able to help with backlogs and everything if you can just basically log in the same Social Security number and have it all right there. So I appreciate your work on that. And I hope I have impressed upon you that it is an important—

Secretary SHINSEKI. You have. And I would add just one thing. So this is not just waiting for technology to deliver. Between DOD and VA, and Department of Labor as well, we have created a transition assistance program. You may be familiar with it. It is that

last phase before the uniform comes off. It is a DOD program. VA and our benefits opportunities, the school opportunities for entrepreneurship for veterans who want to start their own businesses. We are integrated into that week. So we are doing the warm hand-off, if you will, which is relatively new. We weren't doing that 3 years ago. We are doing it now. Just started in the last year.

And part of that is an exit physical exam so that we have a baseline read on everyone's medical condition, everyone, 100 percent of the folks leaving the military now. That is what we are doing between the two departments. We are underwriting a good portion of that.

Mr. ROONEY. Thank you, sir.

Mr. CULBERSON. Thank you very much.

I recognize the gentleman from Philadelphia, Mr. Fattah.

Mr. FATTAH. General, good to see you again. And I want to thank you for your extraordinary public service. I also want to thank the President for all that has been done to help veterans. Every time I turn on the news, we see one of these young people coming home. And so the first thing that the administration has done is ended this war in Iraq so that our young people, rather than being killed and maimed, are coming home. And we see these celebrations all over the country. That adds to your caseload.

But I think when we talk about the backlog, I want the public to know that every single veteran gets 5 years of health care while you are working through these various claims. There is nobody that is not being treated. Or not being helped. Is that correct?

Secretary SHINSEKI. That is correct.

Mr. FATTAH. So I think it is very important that the public understand what is going on here.

BRAIN DISEASES

I met with your team around all of the brain-related diseases and disorders. And we got an extraordinary briefing about the great work that is being done. I want to say this is an area that I am very interested in and focused on. I know that the VA has been part of the interagency working group that I created with the language out of my other job as Ranking Member on Commerce, Justice, Science. The VA has played an extraordinary part with the recommendations about how we might deal with some of these brain-related diseases and disorders is very important.

EPILEPSY CENTERS OF EXCELLENCE

And I am working with the Chairman of this subcommittee to make sure that the VA's work—and that is why I want to focus my question—is as robust as possible. You are doing a lot of great work for over 6 million veterans. I just want to focus in just for the day on one area, that is the Epilepsy Centers of Excellence. This is something that has been remarkable inside the VA. There is an issue in the 2014 spend plan about whether we meant \$6 or whether we meant \$8 million. And there have been some efforts, particularly in the Chairman's State, to expand in San Antonio on the epilepsy front.

So it is my intention, General, to see that in 2015 that we are clear that we mean \$8 million, not \$6 million. I think that the

staffing view of this is a little different. But I am going to work with the Chairman, because I would hate for us to have to retrench those efforts in Texas. This is very important.

Epilepsy is not just an issue for the VA, it is an issue for the entire country. And the work you are doing is at the very cutting edge. So we don't want any retreat, we don't want to equivocate. I could talk to you about 100 other brain-related diseases and challenges. I just want to put this one on your mind. And remind you that, in addition to that, we are going to have the basketball, wheelchair championships in Philadelphia. I was at the VA on Valentine's Day. I spent Valentine's Day with our veterans at the VA Hospital in Philly. A lot of happy veterans. I didn't find any complaints. And I know I talked to the veterans. And they believe they were getting excellent service at the hospital from your team. And, I also want to make sure you know that you are welcome to come and toss that ball up.

Secretary SHINSEKI. Let me just ask Dr. Petzel to make a comment on the Epilepsy Centers.

Dr. PETZEL. Thank you, Mr. Secretary, Congressman Fattah. I am familiar, very familiar with the specific example that you mentioned, broad epilepsy.

Our veterans are really getting a particularly good deal, if you will, from the investments that have been made in neurosciences. I don't think there is anybody in the country that invested as much research money particularly, but also patient care money in these specific Centers of Excellence. Amyotrophic lateral sclerosis, epilepsy, a number of other—

Mr. FATTAH. And you have got an MS process going on. You have a lot of great things going on.

Dr. PETZEL. We do.

Mr. FATTAH. The Chairman and I are going to work together. We are going to beef these up even more robustly. But go ahead.

Dr. PETZEL. We think it is extremely important the veterans, again, that were returning with these neurologic injuries from conflicts, are presented with absolute best care that is available. And we do that in these Centers of Excellence.

I would be happy to talk to you about epilepsy particularly.

Mr. FATTAH. I thank you. Sam said that I was making sure that the chairman heard me. I know that the ranking member and Chairman are going to make these decisions. But there is one thing I am interested in is making sure that we get from \$6 to \$8 million on the Epilepsy Centers. So I am going to be aggressive and interested in this matter. Thank you.

Mr. CULBERSON. What a privilege it is to work with you on the National Science Foundation, the CJS Subcommittee, to make sure we are also making those investments in the sciences end in addition to the work that you all are doing.

Thank you.

Mr. BISHOP. Would the gentleman yield?

Mr. CULBERSON. Yes.

Mr. BISHOP. I am certain all of us appreciate the great work that the gentleman from Pennsylvania does on behalf of veterans and for brain—

Mr. FATTAH. Thank you.

Mr. BISHOP. Thank you, sir.

Mr. CULBERSON. At this time, we recognize Ms. Roby.

Mrs. ROBY. Thank you, Chairman. And thank you, Secretary Shinseki, for being here today, all of your support staff. We appreciate all of your service to our country and all the hard work and challenges that you have that clearly we all have recognized here today. But thank you again for your service.

PATIENT CENTERED COMMUNITY CARE PROGRAM

I have been looking forward to this hearing for a while now. I am the newest member, one of the newest members of the Appropriations Committee. And it has been something that I have really been looking forward to have the opportunity to hear from you, Mr. Secretary, regarding the Patient Centered Community Care program, also known as PC3.

This program is of great importance to me. And it is a new national program operated by the Veterans Health Administration that would allow veteran patients to seek care from community providers when the local VA medical center is not capable of providing timely care or adequate care.

I have almost 70,000 veterans in my district, and I am all too familiar with the challenges and the frustrations our veterans face while seeking treatment from the VA. And so that is why I am cautiously optimistic that the PC3 program might mitigate some of the challenges inhibiting our veterans from receiving timely treatment.

In recent conversations with veterans in my district, they are hopeful that the PC3 program will be successful. That being said, I think there needs to be more effort to ensure that veterans are aware of the program so that they can take advantage of it.

Mr. Secretary, I have been tracking this program for some time, the last couple of months. And it has come to my attention that there may be some reluctance by some VA personnel to fully embrace the program. Would you please share with the committee what efforts are in place to ensure that all personnel representing all aspects of the VA are dutifully embracing this program so that it has a chance to succeed?

Secretary SHINSEKI. I am going to ask Dr. Petzel to comment on the implementation of PC3.

PC3 is fact. We are going to do this. And Dr. Petzel is implementing it, and he can give you an update of where we are.

Mrs. ROBY. That is great. Thank you.

Dr. PETZEL. Thank you, Congresswoman Roby. The PC3 is designed to provide veterans, particularly in rural areas but veterans in other areas as well, with specialty care particularly in their communities when we are not able to, either in a timely fashion or a distance fashion—

Mrs. ROBY. Right.

Dr. PETZEL [continuing]. To provide that.

We have two contracts with two large networks, TriWest and Health Net, around the country. They have, in kind, developed networks of providers in the areas where they are responsible. Done this quite successfully, actually.

Mrs. ROBY. And I—just because we have—we are so limited on time today. And I understand the successes. That is why I am ask-

ing this question, because I think that this program could really mitigate—we have talked about backlog and all of this. But veterans' opportunities to have the appropriate treatment.

What I want to know is what you guys are doing to help VA personnel embrace this, because we feel like there is some real pushback from those that are on VA's payroll that are not embracing this, and it is going to prohibit this program from being the success that we think it can be.

Secretary SHINSEKI. Congresswoman, I think anytime you initiate a new program, there is this, what you are referring to. Your insights are helpful. We will go redouble our efforts to make sure this decision is, in fact reinforced all the way down. We are going to do this. And it makes great sense. Earlier we had discussions about construction and—

Mrs. ROBY. Absolutely. This plays right into that. So.

Secretary SHINSEKI. When we talk about access, we are talking brick and mortar because that is access. We are also talking about fee for non-VA care, having it available in the community. And PC3 is part of that effort.

We are also talking about State veterans homes. We finance 65 percent of the cost of those. And I think we are putting about \$1 billion into maintaining the veterans who are in those State veterans' homes. So it is another aspect of access. But this PC3 is an important part of this.

Mrs. ROBY. And you know the importance of leadership and that all these things start from the top. So I would just encourage you guys in your positions. And again, I appreciate the great challenges that you have. To the extent that I can. But just really want to encourage you to continue to push this program, because—

Secretary SHINSEKI. We will do that.

Mrs. ROBY [continuing]. Representing very rural areas in my district and seeing how this program can be successful, I think it could be a really huge benefit to our veterans.

RECRUITING PHYSICIANS

It appears to me that one of the contributing factors preventing veterans from receiving timely medical treatment is the VA's inability to recruit and retain physicians. We have seen this again right in Alabama's second district. Not only primary care physicians, but dentists as well. And one veteran recently said he loved his dentist at the VA but typically had to wait months for an appointment.

I am going to—my time—the red light is on, and there are others that are waiting to ask you questions. But I really would like to also address this issue. I think it is multifaceted in what some of the problems are in recruitment and retention. But, again, I will submit this to you in writing. But would like to continue to have this conversation. Again, thank you all for your service.

And, Under Secretary Hickey, I appreciate your willingness to come and help brief the entire Alabama delegation in a couple of weeks. So I just appreciate all of your service. So thank you.

Mr. CULBERSON. Thank you, Ms. Roby.

I recognize my friend from California, Mr. Farr.

Mr. FARR. Thank you very much, Mr. Chairman.

Mr. Secretary, my army fellow is sitting behind you, engineering, not armament. But he is still appreciative of your remarks about the armament and capability of the soldiers and likes to see—we are both proud to see you here.

I want to start off with some really thank you's. First of all, I am grateful for your personal attention and hard work you have done in creating this joint VA–DOD clinic at the former Fort Ord. And it wouldn't have happened without your personal involvement.

I think you, better than anybody else, understand, the link between VA and DoD. It appears to me that Veterans' Department is really standing up to its responsibility. And in this integration of records and everything has been more of a letdown by DOD.

I think they care about the soldier up to the day they leave. And then, they have to realize that there is a big responsibility for them to also help with the transition in the VA.

You know, we have also had workings with your department. State of California finally submitted a grant application for a State cemetery. And it is very complicated. California is a complicated State. But if it hadn't been for your staff members and George Eisenbach and Tom Paquelet would have just—they really stepped in. And would you please give them my appreciation for their hard work? Been a great resource to us.

VETERAN SUICIDE

If you average it out, over 1,000 people a day will transition from DOD to the VA. And it is a huge responsibility. And obviously with those that aren't even transitioned, but coming home, we have a huge issue with suicides.

And I just wondered. We have 22 veterans a day that are committing suicide. And we are going to be here for a couple hours. So just the time we are here, we will lose some lives. I know we all care about this. And I think we have a lot of reactive treatment and care. And probably not enough proactive treatment and analysis.

And I just wanted to share with you that the Army has set up a group in Monterey, with all the DOD data manpower, historically, not just presently, but historically that power is there. And this is the Army Analytics Group Research Facilitation Team. And essentially what they are is big data; smart people.

And I wonder if they—if there might be ability for you to reach out with them as they analyze the ability to identify potential traits, both mental and physical, that could indicate a higher risk for suicide. They are doing this by analyzing all the DOD databases, following all the compliance with privacy regulations.

So if you could just look at whether there might be an opportunity to develop a memorandum of understanding with DOD so the VA can utilize the Army Analytics Group Research Facilitation Team in Monterey to identify suicidal behavior and characteristics and trends in veterans, it might be helpful.

Secretary SHINSEKI. Congressman, we will pick up on that. We have worked this very hard. And any opportunity for us to understand this complex issue better, we will pick up on that.

Mr. FARR. I know how sincere you are about that, and I appreciate that very much.

SERVICES TO RURAL VETERANS

You know, I have been doing a lot to focus services for veterans in rural areas. Most of my district is very rural. And even though we have got the clinic coming in, the major hospitals in Palo Alto, veterans have to go up there. It is far away, especially some of the towns in the rural part. Veterans feel like that is too far away, particularly trying to deal with the services.

And one of the things that we asked you to do was give us a report on how you could better help veterans in rural areas, kind of underserved or not well served, or not best served. And I don't know where the status of that report is. But I think there is also a question in there, a timeline for implementation of five new burial sites in rural locations.

You know, the VA has established a 75-mile, I don't know if you know this, Mr. Chairman, but 75-mile distance as a guidance that will not create any new cemeteries that are not—where there is an existing cemetery within a 75-mile circumference, as the crow flies. It is not a statutory provision. Congress didn't order it. It is an administrative position. It can be waived. And the VA has waived the 75-mile radius by creating urban columbarium programs in fiscal year 2011. That program was created. They didn't come to Congress for that. They just did it. It serves the veterans in urban areas even though as we now know it, they still had an access to a cemetery served them within a 75-mile radius.

So the question is, how can we use either waiver or ability to get more veterans cemetery services in the rural areas of America? I would like it if you could look into that.

Mr. CULBERSON. We need to keep it as short as we can. Mr. Nunnelee needs to leave at 3:00.

Mr. FARR. That is the end on that. I have other questions. If you have time, I will take them.

Mr. CULBERSON. Mr. Nunnelee.

Mr. NUNNELEE. Thank you, Mr. Chairman. I want to thank Mr. Valadao for yielding time.

RELIGIOUS FREEDOM IN VA

Mr. Secretary, I know you are very much aware that your Department deals with individuals on some of the most difficult days of their life. You are dealing with teenagers, 20 year olds that have suffered very serious injuries trying to figure out how to go on with their lives, as well as 70-, 80-, 90-year-old World War II, Korean, Vietnam veterans that are dealing with serious illnesses at the end of their life.

And for so many of these Americans and their families, their faith is an important part of their ability to deal with the situation in life that they found themselves. And I continue to see an outright hostile attitude, whether it is in the military or in the VA toward religion and religious freedom in general, and Christianity in particular.

I will just cite a couple of examples in the interest of time. I could cite more. Major Steven Firtko, U.S. Army, and Navy Lieutenant Commander Dan Klender filed a lawsuit against the VA. They claimed that their religious beliefs—they weren't allowed to

practice their religious beliefs or pray or read scripture at a San Diego clinic.

The Alleluia Community School Choral group was told by administrators at the Charlie Norwood VA Medical Center Augusta, they couldn't sing Christmas carols or religious songs when they visited the hospital.

The Central Alabama Veterans Healthcare System in Montgomery refused to allow a young woman to distribute her hand-made Christmas cards for veterans.

And so I need to know, what are you and what is the administration doing to foster an atmosphere that allows people to exercise their constitutionally guaranteed right of freedom of religion?

Secretary SHINSEKI. Congressman, what I would tell you is, Christmas is a Federal holiday. And we in VA observe it. There is no prohibition in VA for any of the things that you have described. Christmas cards, caroling.

Mr. NUNNELEE. But these people were prohibited.

Secretary SHINSEKI. Sometimes the actions of a few on the ground aren't what we would like. And so then we get in there and make sure we take corrective action.

I regret these things happened. But what I would tell you is there is no policy that denies this.

What we do need to be better at is for all these volunteers, Veteran Service Organizations, individuals, other communities that want to support veterans, we need to be sure we accept their gifts and then distribute them in the appropriate manner.

I think you would also understand we try to be sensitive to the fact that there are varying religious beliefs. And we try to get the right gifts to the right people, the right cards to the right people. And I think sometimes our execution of that gets a little fuzzy. We need to be better at it. We will.

Mr. NUNNELEE. I will be submitting questions for the record. Because what we see time and time again when we ask about these issues in Committee, the answer we get from the various agencies, oh, that was an isolated incident, it won't happen again. And it does happen again. And so I need to know what is being done, once these incidents happen, what is being done with the employees that cause them? And, secondly, what is being done to make sure they don't happen again when you are back here this time next year.

Secretary SHINSEKI. I am happy to provide that for the record. [The information follows:]

VA regrets any misunderstandings that occurred at these facilities. VA staff has been retrained on the official policies to try and help avoid isolated incidents like these in the future. VA works closely with Veterans Service Organizations, community groups, and volunteers concerning visits and donations during the holiday season. VA is extremely grateful for volunteers who take time to remember, visit, and support our Nation's heroes, especially during a holiday season.

There is no VA policy that prohibits accepting Christmas cards or gifts from the public that are for the benefit of our Veteran patients. The VA policy on accepting gifts by Veterans Health Administration (VHA) officials is addressed in VHA Directive and Handbook 4721, and VA facilities have also been referred to VA Directive 0022, "Religious Symbols in Holiday Displays in VA Facilities," and VHA Handbook 1111.02, "Spiritual and Pastoral Care Procedures," in regards to these issues. Out of respect for the diverse religious beliefs of our Veterans, organizations are asked to work with local facility staff to ensure materials of a religious nature are available for those Veterans who would like to receive them. We will continue to work to ensure that VA staff members are familiar with and appropriately trained on the proper procedures.

The incidents in January 2014, in which Veterans Affairs Medical Center (VAMC's) declined to accept Christmas cards or gifts for Veterans with religious messages, were isolated instances. In all three cases, the medical center declined the items without consulting with the VA Chaplain Service. The Chaplain Service would have accepted the gifts and cards and distributed them to patients based on the chaplains' knowledge of patients' religious preferences. Only the VA chaplains at the medical center are aware of the religious affiliation of the patients.

Regarding the incident of a community organization's desire to sing religious songs at a VAMC in 2013, VA incorrectly told the organization that they would need to sing non-religious songs if they wanted to sing in the public area, even though they had sung religious songs in that same area in 2011 and 2012. VA offered to allow the organization to sing religious songs in a specific location in the medical center that was accessible to all interested individuals; however, the organization declined to visit when VA identified the location in which the group could sing.

Although VA cannot comment on any pending litigation, it is important to note that the Chaplain Service follows specific curriculum from the Association for Clinical Pastoral Education (ACPE). There are guidelines of certain work and research that must be completed in order to receive a passing grade; and acceptance into the program does not guarantee a position as a VA Chaplain.

The National Chaplain Center (NCC) takes continuing action to educate the medical center chaplains about policy, including:

- Reminders about policy on monthly national Chaplain Service conference calls;
- Mandatory orientation for all new chaplains;
- Regular email messages to the field chaplains;
- Every VAMC must submit an annual report signed by its Director that certifies; VAMC compliance with spiritual and pastoral care policies;

- Associate Directors of the National Chaplain Center are assigned to each VISN to provide advice and consultation; and
- Site visits, when possible.

A Field Advisory Board of chaplains is designated to provide additional liaison between NCC and the field. Field Chaplains will also be asked to address other local employees prior to the 2014 holiday season, to ensure that all employees (who are likely to receive gifts) understand the appropriate process for donations of a religious nature. In addition, the NCC will request, from the National Director of Voluntary Service, an opportunity to speak to this issue on a Voluntary Service national hotline call during the Fall of 2014.

Mr. NUNNELEE. Thank you.

Thank you, Mr. Chairman.

Mr. CULBERSON. A really important question, and I appreciate it.

Mr. Farr, go back to you? Or Mr. Valadao.

Mr. VALADAO. I would like to go if possible.

Mr. CULBERSON. Thank you very much. Thank you for letting Mr. Nunnelee go first too.

Thank you, Sam.

UNDERPERFORMANCE AT OAKLAND REGIONAL OFFICE

Mr. VALADAO. Thank you, Mr. Chairman. Thank you Mr. Farr, for allowing me to cut in line a little bit.

Mr. Shinseki, as you stated, one of the VA's top goals is to eliminate the disability claims backlog by 2015. As I am sure you are aware, the problem with this backlog is particularly severe at the Oakland Regional Office, which serves the constituents in my district. One means to reduce the backlog that is being utilized by the VA is brokering the claims to other offices. By doing so, it seems as though we are shifting work off of underperforming services without addressing the underlying problem. What is the VA doing to address the underperformance of these offices? Or is there something different about these offices to make their claims backlog worse than other regional offices?

Secretary SHINSEKI. We have done considerable work here, particularly with Oakland.

Let me call on Under Secretary Hickey to review that with you.

Mr. HICKEY. Congressman Valadao, thank you for the question.

Let me just tell you very quickly, conditions have significantly improved in Oakland. The backlog is down 76 percent, a very significant number, from 28,000 down to 6,900. How did we do that? The same way that we are training every person who joins VA to do this very important work, many of them are veterans.

We have a challenge training. Part of our budget, an important part of our budget, is a new training process over the last 3 years. We take and put every new person through that, where they are doing live cases, where they are doing it in a way that we have found, time and time and time again, is improving the both production and the quality of the outcome of those individuals.

We went specifically into Oakland. And specifically at Oakland we took and stood, as you well know, the entire station down here about 2 years ago now, and retrained every single person there. And I can tell you, you can see that in the production by Oakland alone. Even without brokering, they have exceeded their claims production by 3,000 claims this year. Their quality is much higher than it has been. They are up over 90 percent, both claims and issues.

Mr. VALADAO. In January, the Oakland VA director, Douglas Bragg, retired. It is important to select a qualified director that is capable of addressing this issue. Where is the VA process of hiring a new director for the Oakland Regional Office?

Ms. HICKEY. Congressman, I can tell you that the proposed candidate has gone through the initial hiring board selection process, is going through the approval processes, and then he will have to go through OPM for final approval.

Mr. VALADAO. Okay. Well, I think that is all I have got. Thank you. I yield back.

Mr. CULBERSON. Thank you, Mr. Valadao.

INTEROPERABILITY OF THE ELECTRONIC HEALTH RECORDS

I wanted to ask, if I could, Mr. Secretary, about the electronic health record. In answer to a question from one of the other members, I thought I heard you say that in 3 to 5 years, you are going to be in the hunt to get a seamless transition. I hope I misunderstood.

Secretary SHINSEKI. I am speaking roughly here. Because DOD is following an acquisition path. And I am just guessing that in about 3 to 4 years, they will be making their decision on the record that they are going to select as theirs.

In about 2 years, maybe 2½ years, I think we can be at level 4, which would put us in a position to compete. That is what I would like to do. And try to keep us on track with getting a high degree of interoperability, if not a single record.

Mr. CULBERSON. Well, if you could tell us a little bit more. I am happy for you to turn to the executive team, because a lot of the discussion of the VA budget describes how VistA will improve patient care, but neither the budget documents or the testimony today really gives us a whole lot of information on interoperability. Could you reassure the Committee that you guys will be able to be completely interoperable and get as seamless a transition as you can for these young men and women as they leave the Armed Forces to go into civilian life?

Let me call on Mr. Warren, who is our technical expert here.

Mr. WARREN. Thank you, Mr. Secretary, Mr. Culberson. Broad questions about interoperability and electronic record—

Mr. CULBERSON. Yes. And what we will be doing differently in the future to give us assurance that you will actually hit these targets.

Mr. WARREN. Glad to, sir. And if I could hit three key areas.

One of the key goals we had set out, the Secretary had set out for us, was to take that electronic health record, and make it a veterans'. And so we talked about the Blue Button program, which allowed a veteran to download their electronic record, their personal health record, and take it to their physician and be able to take the information and use it. Done that as a single thing that they could take, the interoperability program, not just with DOD, also with third-party providers, is how do we do that securely, electronically?

So as an example, Walgreen's this year, if a veteran went in to get a flu shot, we now pick that information up in the VistA system so we can see that and continue driving those types of programs.

We also have an exchange with the Indian Health Service, in terms of care given at their locations. The information flows into the VistA system, so we have that complete electronic health record.

On the DOD side, there is a lot of information that moved in the back office systems. But the Secretary already talked about the joint viewer, Janus, which allows the clinicians to see veteran data and service member data in the same view. So when they are in a care situation, the clinician can see VA data and DOD data in

a way that is actionable. Same units, the ability to fire off opportunities. Yes, the blood level is this, we need to do something here. As well as starting to look at drug-drug interactions, third party, DOD, and VA. So how do we do that today? Janus does that. So the focus has been seamless interoperability of data.

You had also touched on another area with my colleague, Under Secretary Hickey, in terms of moving that electronic health record through the Haims system. So now we are able to bring the data over electronically from our partners in DOD so it is part of the benefits determination process.

A lot of work to move data, a lot of work to work together with our partners in DOD. That personal health record that the veteran can take, make that electronic and do it not just with DOD but third-party providers. Making sure the data is seen real-time, in the clinical setting, DOD data and VA data.

As we continue to expand that, we need to evolve the VistA system. The more data that we share, the more stress we put on our back-end systems. Which is why your support to continue to evolve VistA so we can continue to support that high quality care that we give.

Hopefully, that answered your question, sir.

Mr. CULBERSON. Yes, sir. Thank you. And we will have more follow-up for the record in detail.

Mr. Farr.

ADEQUATE IT FUNDING

Mr. FARR. Thank you very much, Mr. Chairman. I have just sort of a general question on all of this improvement of medical records and the Veterans Benefits Management System, the paperless system. And the question is, did OMB allow you sufficient funding in this year to make your goal? I think your goal is to have your IT capability operational, fully paperless by 2015. And you have indicated that if you do that, you can reduce the claim process to less than 125 days per claim. So it would meet those goals that you talked about.

But do you have enough money to get there from here, for IT?

Secretary SHINSEKI. Our 2015 budget request for IT, \$3.9 billion, will cover that. But that was created before the DOD downsizing decision. So we are working closely with DOD, as we have been for 3 years. Show us a plan so that we can ensure that we have both capability in terms of hardware and automation assets as well as people to be able to support them as they draw their forces down.

They have a requirement to flow forces out. They have a set deadline when their strength levels must be at a certain number.

If we are not able to process people out, they have trouble meeting that. So this is important for them from a readiness standpoint and important to us to get veterans into our system and being cared for.

Mr. FARR. So I would imagine that today's records, modern records, are much more complete for your purposes than the old records. So if these 1,000-plus people are going to be out every day, coming to you, isn't this going to happen quickly in the next couple years? Are they listening to you? It sounds like you are way ahead,

and we ought to do more in Congress to push DOD to help you because you can't do anything without them having stuff ready.

Secretary SHINSEKI. I worked this personally with both Secretary Hagel and Chairman Dempsey. They have been very supportive.

They have had to wait to see what their budget numbers are going to be, and then write the plan to get their force structure to fit that budget. We are now in contact with them as they develop those numbers, that flow. We are to be able to tie ourselves into that plan.

Mr. FARR. I am sure the chair would appreciate, and committee would appreciate, if tis anything we can do to push them a little bit more. Because essentially, they have got to pack the suitcase. And if it is not properly packed, the burden then falls on you.

Secretary SHINSEKI. It has been an ongoing discussion for 3 years. And they have been very cooperative. Now we are at the point wwe have got to put together hard plans.

Mr. FARR. We have heard in the past that it hasn't been the fact—I mean, that all the Secretaries have gotten together and made these agreements have been great. But it has been the trickle-down effect of that wthave been people in DOD who don't want this to happen. Because they have got their vendors, they have got their way of doing it. And they are slowing down the change. So if tis anything we can do to help that our—in this Appropriations Committee and our other—you know, the defense side of it, let us know. We would be glad to push.

Secretary SHINSEKI. Thank you.

Mr. FARR. I don't have any other questions. I would just like to say I am really proud of this Department. And I think, you know, we need to, in our whole discussion of military budgets, I think we need to start thinking about how VA and DOD are really one and the same and not—because those are big budgets. And we have got to run them just administratively smarter. And technology is probably the way to do it. But it also takes, intuition.

Thank you for your service.

Mr. CULBERSON. Thank you, Mr. Farr.

You do indeed lead a wonderful team of people. And it is important for everyone in the VA that is listening and tracking this hearing to know how deeply we appreciate them. I do agree very much with Dr. Price, Mr. Farr's statement that it is too often our concern about how our tax dollars are spent. I don't want them to feel like we are being critical of the hard work that all those men and women that you lead do to make sure that those veterans that they represent are getting everything that they earned as soon as humanly possible. And we will do everything we can, as we have in previous years, sir, to make sure that you get funding you need, the support you need, the language that is necessary in the bill, whatever changes we can do to help make your job easier and to be able to reward those and your agency that are exceeding expectations and to give you the tools that you had in the Army, I hope, to be able to take care of those that are not meeting their standards.

But, above all, we want to thank you for your service to the country. We will have additional questions for the record. Deeply appre-

ciate all the hard work that you all do. And we will look forward to working with you, sir.

And at this point, we will adjourn the hearing. We will submit our additional questions for the record.

Thank you, sir.

Secretary SHINSEKI. I would just say, Mr. Chairman, thank you for your leadership and great support for me for all these many years here.

Mr. CULBERSON. It is a real privilege.

Hearing is adjourned. Thank you.

[Questions for the Record submitted by Congressman Nunnelee for the Honorable Eric K. Shinseki follows:]

Question 1: What is the VA doing to recruit and retain qualified medical personnel and physicians?

Answer: As a principal resource, the Veterans Health Administration (VHA) National Recruitment Program (NRP) provides VA with an in-house team of skilled professional recruiters employing private sector best practices to recruit for the agency's most critical clinical and executive positions. NRP works directly with Veterans Integrated Service Network (VISN) Directors, Medical Center Directors, and clinical leadership in the development of comprehensive, client-centered recruitment strategies that address both current and future openings in all medical specialties. Since fiscal year (FY) 2011, 90.2 percent of annual NRP placements have been physicians. NRP annual production consistently exceeds the national private industry average. NRP continues its success with recruiting primary care and mental health physicians, Veterans, and providers for rural and highly rural communities. To successfully compete for top talent in the health care arena, VHA incorporates social media technology and targeted advertising to strategically drive qualified health care professionals to VACareers.va.gov. Full integration of social media resources include Facebook, Twitter, LinkedIn, Public Service Announcements, Live Chat, and a VHA blog to complement an aggressive marketing initiative tailored to meet VHA's current and future recruiting needs.

National Recruiters that are also assigned near military installations participate, when invited, in Department of Defense Transition Assistance Program seminars and brief separating service members on VHA employment opportunities.

Media Outreach: To successfully compete for top talent in the health care arena, VHA incorporates social media technology and targeted advertising to strategically drive qualified health care professionals to VACareers.va.gov. Full integration of social media resources include Facebook, Twitter, LinkedIn, Public Service Announcements, Live Chat, and a VHA blog to complement an aggressive marketing initiative tailored to meet VHA's current and future recruiting needs.

DoD/VHA Partnership: VHA is an active member of the DoD Chief Human Capital Officer Healthcare Executive Council through the Assistant Deputy Under Secretary for Health (ADUSH) for Workforce Services. As a member, the ADUSH actively partners with DoD Health Affairs, Army, Navy, and Air Force to improve recruitment of recently or soon to be discharged health care professionals. This collaboration has resulted in data exchanges that identified the pipeline and can serve to increase the supply of Veteran Physicians and Nurses to help meet VHA demand at all 1,700 sites of care.

VHA National Scholarships Programs: VHA has a number of education and loan repayment programs, which include providing education/tuition assistance, education debt reduction and loan repayment programs, to recruit and retain Title 38 medical professionals. Through the Education Debt Reduction Program (EDRP), VHA reimburses educational loan debt for hard-to-

recruit and retain health care professionals in VHA. VHA uses EDRP as a recruitment and retention incentive to assist health care employees pay down their qualifying education loans. This program targets individuals who would likely decline an opportunity to work for VHA, or who would otherwise leave VHA employment without this incentive. EDRP, is designed to assist individuals in reducing their qualifying loan balances by reimbursing loan payments over 5 years. Local facilities have the flexibility to prioritize hard-to-recruit occupations based on facility needs. Rather than using a service obligation period, employees receive reimbursements while they remain employed by VHA in the position that was approved for EDRP. Since EDRP's inception in July 2002, over 9,000 employees have received this incentive.

The Employee Incentive Scholarship Program (EISP) authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. The National Nursing Education Initiative (NNEI) and VA's National Education for Employees Program (VANEPP) are programs which originated from the legislative authority of EISP. EISP covers tuition and related expenses such as registration, fees, and books. NNEI exclusively targets Registered Nurses (RN) pursuing associate, baccalaureate, and advanced nursing degrees. VANEPP provides replacement salary dollars to VA facilities for scholarship participants to accelerate their degree completion by attending school full-time. Participants incur a 1 to 3-year service obligation following completion of their program.

Clinical Training and Development: As an employer of choice, VHA is committed to providing clinical training and educational support for clinicians to enhance recruitment and retention. Additionally, VHA researchers participate in scientific conferences and meetings to advance practices that improve health outcomes for Veterans and enhance the care provided by VA and community partners. VHA has flexibilities in place that ensure the provision of time off, direct funding or reimbursement and broad organizational latitude offered to employees to pursue their educational needs. Externally-sponsored training developed and delivered by professional associations is the primary source for occupational-specific clinical training required to meet licensure and certification requirements. 38 U.S.C. § 7411 (1991) requires VHA to reimburse board certified physicians and dentists up to \$1,000 for the costs of continuing education units. VHA supports employees by subsidizing a portion of the overall costs incurred through a combination tuition reimbursement, travel reimbursement, and authorized absence. In addition to recruitment, external events present unique opportunities for clinicians and researchers to share knowledge and build professional and research partnerships.

VHA Academic Affiliations: VHA's academic affiliations serve as a pipeline for recruiting VHA physicians and dentists. Approximately 70 percent of current VA optometrists and psychologists and 60 percent of VA physicians participated in VA training programs prior to employment. Over the last 5 years, VA has expanded the mental health pipeline through targeted increases in training positions and approval of additional sites for mental health training, expanded the VA Nursing Academy, developed new residency programs in nursing and other associated health disciplines, and assumed a national leadership role in interprofessional education and collaborative practice.

Additionally, the VHA Office of Academic Affiliations has partnered with the VHA National Recruitment Program to directly target recruitment messages to clinical trainees. In Spring 2014, a series of messages went out to education officials in VA, as well as their external contacts at academic institutions, to deliver a VA-specific recruitment message. The message, "Take a Closer Look", markets the attractiveness of a VA career for new health professionals.

Question 2: Doctors are subject to less liability within the VA system, but in your opinion, does this contribute or lead to a less-than desirable outcome?

Answer: While a direct comparison between VHA and the private sector with respect to liability is not possible due to the lack of comparable data, VHA's longstanding policies and practices to promote patient safety contribute to improved outcomes, a safer system for Veterans, and a better value for taxpayers. When patients experience avoidable harms, VA strives to prevent recurrences by sharing lessons learned throughout the system. Our National Center for Patient Safety works with patient safety managers at each of the 151 medical centers to conduct root cause analyses of serious adverse events or near misses. The combination of a robust electronic health record, standard policies for disclosure to Veterans and families when avoidable harms occur, and communication of lessons learned support our commitment to continuous improvement in the care we provide the Veterans we serve. Finally, VHA has one of the strongest peer review systems in the Nation.

Question 3: What within the FY15 budget request will help you continue the much needed scrutiny, but also support the VA's health care delivery mission?

Answer: The Department of Veterans Affairs (VA) will continue to hold employees accountable and ensure the delivery of high quality health care to our Nation's Veterans. Oversight and information gathering are accomplished through various inspections and reviews, including those of the Office of Special Counsel, Office of Inspector General (OIG), Government Accountability Office, and Office of Medical Inspector. VA also conducts Administrative Investigative Board reviews, organizational assessments, and fact finding reviews and audits.

With respect to assuring that Veterans receive safe, high quality care, ongoing Joint Commission and other accreditation body reviews and OIG Combined Assessment Program reviews provide valuable independent external assessments to help ensure that our Nation's Veterans receive high quality VA health care services.

Question 4: Are you on schedule to submit the report to the committee detailing the Department's career counseling services provided to veterans by April 17 as instructed by the FY14 omnibus?

Answer: Yes, the Veterans Benefits Administration (VBA) submitted the career counseling report to Congress on December 31, 2013. The report is attached for your use.

Question 5: What kind of training programs is the VA implementing in addition to regular testing and monitoring of poorly performing regional offices to identify and remediate performance problems and ensure quality and accuracy to reduce claims appeals? The omnibus directed VA to provide quality review teams and to conduct spot audits at regional offices to

assess the performance of claims processing operations and flag any management or operational weaknesses. Are these audits currently occurring?

Answer: VBA instituted Quality Review Teams (QRT) in 2012 to improve decision accuracy while decreasing rework time. QRTs focus on fixing the most common sources of errors in the claims-processing cycle. QRTs at all 56 regional offices (RO) evaluate local quality and identify error trends through in-process reviews and individual quality reviews early in the claims process, where high error categories exist. Based on error trends, QRTs make specific training recommendations. In FY 2013, QRTs conducted more than 145,000 in-process reviews, prevented errors before they could impact Veterans, and provided specialized re-training to claims processors to prevent future errors.

VBA instituted national-level Challenge Training in 2011 to improve the quality and effectiveness of its employee training. Challenge Training is focused on building the overall skills and readiness of the workforce through an 8-week curriculum. Approximately 3,100 claims processors have graduated from Challenge training since 2011. In FY 2013, rating accuracy for claims completed in Challenge Training was 95.5 percent. VBA also created Station Enhancement Training (SET), a Challenge course focused on improving the low performing ROs. Three ROs have completed SET, resulting in improvements in both quality and production.

In addition, VBA is developing a curriculum that addresses key elements in the claims process that have been identified as performance problems. Advanced Rating Training (ART) will address these issues, identified by each RO's QRT, and direct Rating Veterans Service Representatives (RVSRS) to specific training to enhance their skill sets and correct problems. RVSRSs will take an assessment test prior to starting the training to identify individual knowledge gaps and direct them to the appropriate training classes.

Question 6: The FY14 omnibus requires the VA "to provide rigorous, publicly available Web-based monthly reports to the Committees on performance measures for each regional office, including the number of backlogged claims, the average number of days to complete a claim, and error rates". I understand the Committees are receiving the reports, but I am curious as to how you are making them publicly available. Where could I find this?

Answer: VA has been providing these monthly reports to the Committees as required. In terms of public reporting, similar information is available on our Web sites, specifically through the ASPIRE (www.vba.va.gov/reports/aspiremap.asp) and Monday Morning Workload Reports (MMWR). Individuals can view the current inventory of claims, backlog, and other workload measures for both the national level and the officer-level by visiting <http://www.vba.va.gov/reports/>. The MMWR provides workload indicators reported by VBA ROs and is updated weekly. The home page for MMWR contains current and historical information, as well as definitions for data provided in the reports. The ASPIRE Dashboard provides monthly information on how VBA and ROs are performing in relation to 2015 aspirational goals. To find specific RO data in ASPIRE:

- Find the specific state on the map, place cursor within the state, and click.
- This will open the VBA ASPIRE Benefits site; click “enter.”
- There will be a split table; on the left table, click on “compensation.”
- This will expand the table.
- Follow the table to the right until the specific RO column is located.

Question 7: The VA was required to submit a report describing the number of active prime contractors that, despite alleged review by VA, do not have a satisfactory performance record; do not have a satisfactory record of integrity and business ethics; or have a pending civil lawsuit or have had a lawsuit brought by subcontractors and material suppliers for failure to make timely payments? Has this report been completed? If so, could you provide and update us on the findings and if not, where are we on timing of this report?

Answer: The requested report requires that information be gathered from several sources external to VA. This information is in the process of being gathered and reviewed at this time. The delivery date of this report is currently unknown, but an update on the timing can be provided in late June.

Question 8: Has the VA conducted a review of the variation in the length of time it takes veterans service organizations to assist veterans in their appeals? If this review has been completed, what were some of the findings? If not, could you provide when will this review be complete?

Answer: VSOs assist Veterans with their appeals in a number of ways at both VBA and the Board of Veterans' Appeals level, to include representation at hearings, submission of written brief materials, and other matters. VA has not undertaken a study of the variation in the length of time it takes VSOs to complete these actions, but VA and VSOs collaborate closely to provide the best service to our Nation's Veterans.

[Questions for the Record submitted by Congresswoman Roby for the Honorable Eric K. Shinseki follows:]

Question 1: Secretary Shinseki, it appears to me that one of the contributing factors preventing veterans from receiving timely medical treatment is the VA's inability to recruit and retain physicians. This is especially true in Alabama's Second District where the Central Alabama Veterans Health Care System struggles to recruit not only primary care doctors but dentists too. Would you please share with the committee what specific programs you have in place to recruit and retain such healthcare providers?

Answer: Through the Education Debt Reduction Program (EDRP) VHA reimburses educational loan debt for hard-to-recruit and retain health care professionals in VHA. VHA uses EDRP as a recruitment and retention incentive to assist health care employees pay down their qualifying education loans. This program targets individuals who would likely decline an opportunity to work for VHA, or who would otherwise leave VHA employment without this incentive. EDRP, used as an effective retention incentive, is designed to assist individuals in reducing their qualifying loan balances and to aid in retaining employees by reimbursing loan payments over a 5-year service period. Local facilities have the flexibility to prioritize hard-to-recruit occupations based on facility needs. Rather than using a service obligation period, employees receive reimbursements while they remain employed by VHA in the position that was approved for EDRP for up to 5 years. Since EDRP's inception in July 2002, over 9,000 employees have received this incentive.

The Employee Incentive Scholarship Program (EISP) authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. The National Nursing Education Initiative (NNEI) and VA's National Education for Employees Program (VANEEP) are policy-derived programs which originated from the legislative authority of EISP. EISP awards cover tuition and related expenses such as registration, fees, and books. NNEI is limited to funding Registered Nurses (RN) pursuing associate, baccalaureate, and advanced nursing degrees. VANEEP provides replacement salary dollars to VA facilities for scholarship participants to accelerate their degree completion by attending school full-time. Participants incur a 1 to 3-year service obligation following completion of their program.

Finally, the VHA National Recruitment Program (NRP) provides VA with an in-house team of skilled professional recruiters employing private sector best practices to recruit for the agency's most critical clinical and executive positions. NRP works directly with Veterans Integrated Service Network Directors, Medical Center Directors, and clinical leadership in the development of comprehensive, client-centered recruitment strategies that address both current and future openings in all medical specialties.

Question 2: Secretary Shinseki, I understand that the VA updated its estimates of what resources are required for long term care in 2015 which includes intent to reallocate this money to other initiatives on top of a request for supplemental funding for FY 2015. Please explain why

the VA requested its 2015 advance for medical care yet funding for those initiatives did not represent what VA believed the actual requirement to be?

Answer: VA develops the Advance Appropriation request 3 years before the start of that fiscal year. Specifically in this case, VA developed its original estimates for the 2015 Advance Appropriation in September 2012, based primarily on FY 2011 data representing the most recent full year of budget execution. VA's 2015 budget request reflects an update to the long-term care cost estimates as a result of more sophisticated modeling, the latest Veteran population data, and program data from another year of budget execution. Also, VA's original FY 2015 estimate for VA Community Living Centers had a higher estimate of workload and unit costs than the current estimate. This allowed VA to refocus those resources on the Secretary's highest goals – such as eliminating Veteran homelessness and ensuring adequate funding for facility activations to improve access for Veterans. In this constrained fiscal environment, VA must be able to update program estimates and reprioritize resources to highly critical programs that support Veterans' care.

Question 3: Secretary Shinseki, we have heard from some veterans' organizations that in an effort to reduce the backlog, resources are being pulled from other areas and as a result these areas are suffering.

Please explain what resources have been pulled or reallocated from the appellate process? Additionally, please explain when said resources will be restored? Also, provide specifics as to the number of appellate claims for 2012, 2013, and 2014 to include the average length of time for complete resolution of appellate claims for each of those years.

Answer: The VA appeals process has multiple steps established in law and divides responsibility between the Veterans Benefits Administration (VBA) and the Board of Veterans' Appeals (the Board). VBA allocates significant resources to appeals in its ROs (735 employees) and at the Appeals Management Center (AMC) (222 employees). Resources have not been reallocated from the appellate process. The number of VBA employees processing appeals remained consistent from FY 2012 through FY 2014. Although RO employees assigned to appeals are required to focus on prioritized claims during mandatory overtime, they continue to process appeals during regular work hours. Employees at the AMC process appeals during both regular work hours and overtime.

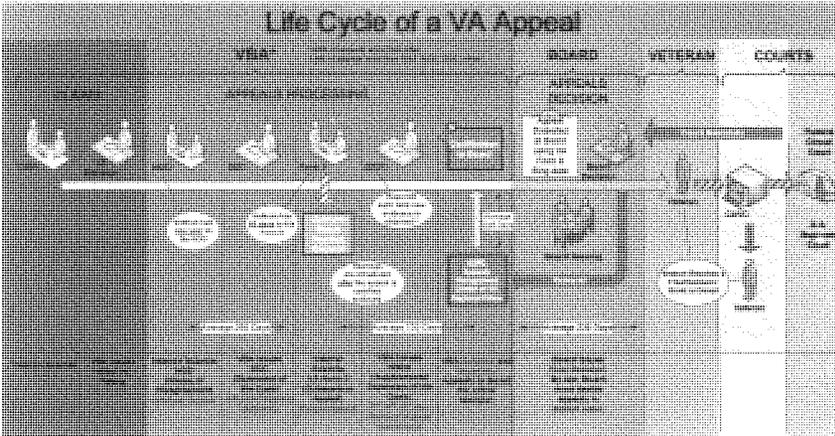
The exclusive mission of the Board is to conduct hearings and dispose of appeals properly before the Board in a timely manner. All Board staff are devoted to processing appeals as efficiently as possible, and the Board had 627 full-time equivalent employees at the end of March 2014. The table below reflects appeals receipts at the various stages of the multi-step VA appeals process, which spans VBA and the Board, as well as the average length of time it takes the Department to process an appeal from the date a claimant files a Notice of Disagreement (NOD) until a case is *finally resolved*, whether the appeal is resolved at the VBA RO level or at the Board. *See* Lifecycle of a VA Appeal Pictorial.

VA Appeal Receipts and Resolution Time, 2012-2014

	FY 2012	FY 2013	FY 2014 (through March)
NOD Receipts (Informal Appeal)*	111,641	118,053	61,305
Substantive Appeal (VA Form 9) Receipts (Formal Appeal)	37,326	41,612	18,769
Appeals Resolution Time (ART)**	903 days	912 days	973 days

*Appeals are initiated at the Agency of Original Jurisdiction, which includes VBA ROs, Veterans Health Administration medical facilities, the National Cemetery Administration, and the Office of General Counsel. Approximately 96 percent of appeals considered by the Board involve claims for disability compensation from VBA.

** ART is a joint measure (i.e., VBA/the Board) that represents the average length of time it takes the Department to process an appeal from the date a claimant files a NOD until a case is *finally resolved*, whether the appeal is resolved at the VBA RO level or at the Board.



Question 4: Secretary Shinseki, in last year's budget submission it was stated that savings from six operational improvements dealing with acquisition, fee care, energy, and other administrative savings were now "embedded" in VA's baseline estimates of resources. For 2015, VA has new operational improvements it states will result in an additional \$515 million in savings. However, some of those improvements look the same as the savings VA says are now embedded in its baseline, for example, moving to national contracts for certain medical items. Please confirm the VA is not double counting estimated savings. Also, when will the savings for the new operational improvements be "embedded" in VA's baseline estimate going forward?

Answer: VA is not double counting estimated savings. VA is continuing to identify savings that will result in more efficient operations in VA's health care system. VHA is proposing \$416 million in acquisition savings in 2015, \$384 million in 2016, together with improved operational savings of \$99 million in 2015 and \$132 million in 2016. Acquisition savings will be embedded in VA's baseline in the FY 2016 Congressional submission. Improved operational savings will be embedded in VA's baseline in the FY 2017 Congressional submission except, the Financial Service Center (FSC) software savings which will be embedded in the 2018 Congressional Submission. The best way to think about embedded savings is as follows: acquisition savings from these efforts were achieved in FY 2013. FY 2013 will serve as the base year for the update to the Enrollee Health Care Projection Model that will inform the FY 2016 budget request. Therefore, savings from these acquisition efforts will be embedded in VA's baseline estimates for the first time with the FY 2016 Congressional submission.

Question 5: Secretary Shinseki, most of VBA's process initiatives outlined in the budget center around the concept of centralization; including the national work queue and centralized mail operations. Although the Department asserts that VBA's brokering and centralization strategies help to balance inventory of pending claims and better serve veterans, what this strategy does not do is fix underlying systemic issues in poorly performing regional offices. On the contrary, it appears that this strategy merely shifts work away from poorly performing regional offices and re-distributes the work amongst higher performing offices.

As the VA continues to move toward further centralizing its processes, how does the Department plan to fix ongoing issues at poorly performing offices?

Answer: The performance of every RO is evaluated against national and RO-specific targets that are based on VBA's strategic goals. These targets are established at the beginning of each fiscal year, across all the business lines and for a variety of measures, including quality, timeliness, production, and inventory. Challenging performance expectations are established at each RO that build on the previous year's performance, giving consideration to current staffing levels and anticipating that each RO is working to ensure the most efficient utilization of those resources. RO directors are held accountable for their performance, which is reflected in their end-of-year evaluations. As appropriate, performance improvement plans are put in place for employees and closely monitored by the area director.

In the initial release of the National Work Queue (NWQ), VBA is matching its inventory with claims processing capacity at the RO level, moving claims electronically from a centralized queue to an office identified as having capacity to complete the work. With this national

workload approach, VA will continue to focus on the improvement of its traditional performance metrics, with an emphasis on improving quality and consistency of claims processing nationwide to ensure Veterans and their families receive timely benefits, regardless of where they reside. Individual RO employees and managers continue to be held accountable for both production and quality.

Future iterations of NWQ will include more robust workload management capabilities to automate portions of the claims process and metrics to direct work based on national priorities. VA has established a work group that includes VA field and headquarters staff to develop and refine logic that will drive the electronic routing of work through NWQ and establish appropriate metrics.

VBA has also made significant investments in training to improve performance. VBA instituted national-level Challenge Training in 2011 to improve the quality and effectiveness of its employee training. Challenge Training is focused on building the overall skills and readiness of the workforce through an 8-week curriculum. Approximately 3,100 claims processors have graduated from Challenge training since 2011. In FY 2013, rating accuracy for claims completed in Challenge Training was 95.5 percent. VBA also created Station Enhancement Training (SET), a Challenge course focused on improving the low performing ROs. Three ROs have completed SET, resulting in improvements in both quality and production.

VBA instituted Quality Review Teams (QRT) in 2012 to improve decision accuracy while decreasing rework time. QRTs focus on fixing the most common sources of error in the claims-processing cycle. QRTs at all ROs evaluate local quality and identify error trends through in-process reviews and individual quality reviews early in the claims process, where high error categories exist. Based on error trends, the QRTs make specific training recommendations. In FY 2013, QRTs conducted more than 145,000 in-process reviews, preventing errors before they can impact Veterans and providing specialized re-training to claims processors to prevent future errors.

In addition, VA is developing a curriculum that addresses key elements in the claims process that have been identified as performance problems. Advanced Rating Training (ART) will address these issues, identified by each RO's QRT, and direct Rating Veterans Service Representatives (RVSRs) to specific training to enhance their skill sets and correct problems. RVSRs will take an assessment test prior to starting the training to identify individual knowledge gaps and direct them to the appropriate training classes.

Question 6: Mr. Secretary, it is my understanding that the development of a VA Nursing Handbook has been an ongoing effort for nearly four years. It is also my understanding that this handbook may contain a new policy that will result in certified registered nurse anesthetists (CRNAs) becoming licensed independent providers (LIPs) throughout the VA system. I have heard from several constituents in the medical field that have unanswered questions about this proposed policy. Please update me on the status of implementation of the VA Nursing Handbook? Also, please discuss the methodology used and industry leaders consulted in order to support this proposed change with regard to CRNAs becoming LIPs. Additionally, what

impact is anticipated with regard to staffing levels in the VA system once this proposed change is implemented?

Answer: VHA's Office of Nursing Services began the development of a Nursing Handbook in 2009 to establish policy for the process of care delivery and the elements of nursing practice in VHA.

The 2010 Institute of Medicine (IOM) landmark report, *The Future of Nursing: Leading Change, Advancing Health* recommended removal of scope-of-practice barriers to allow APRNs to practice to the full extent of their education and training. This evidenced-based recommendation prompted VHA to propose FPA for APRNs in its upcoming Nursing Handbook revision. The proposal would remove the variation in APRN practice that exists across VHA as a result of disparate state regulations. As an integrated Federal health care system, VA is proposing policy that would parallel current policies in the Department of Defense and the Indian Health Service. A significant number of states have approved full practice authority for CNPs and CRNAs, with many VA Medical Centers successfully utilizing APRNs to the full extent of their education and training. The recognition of APRNs as full-practice providers is a licensing and privileging matter that would not affect the current VA team model of care. Team-based care is a systems approach to care that integrates multiple providers, often from different disciplines, across settings, around the specific needs of the patient.

At present, the proposed new policy to allow FPA for APRNs is under review. Prior to finalizing a change in policy, VA is seeking input from internal VA program offices and from external stakeholders through a variety of means. VHA is conducting a robust literature review focusing on the quality and safety of patient care by APRNs. A variety of meetings have occurred with professional medical organizations, including those from the field of anesthesiology, as well as professional nursing organizations. Meetings with additional stakeholders are being scheduled. Finally, the proposed policy will be published in the Federal Register for notice and comment. VHA aims to be transparent with regard to health care delivery decisions and to discuss policy concerns and answer questions. VHA believes ongoing collaboration with stakeholders is one of the most effective ways to ensure the continuation of high quality care for Veterans. The future success of health care delivery within VHA depends on all health care providers practicing to the full extent of their education, training, and certification. VHA does not anticipate any changes occurring in staffing levels throughout VA's health care system, should this policy change be implemented.

[Questions for the Record submitted by Congresswoman Lowey for the Honorable Eric K. Shinseki follows:]

Claims Backlog

Question 1: What steps are you taking to make sure we don't see another surge in the claims backlog as the Army draws down, and how are you planning to take care of all of these new veterans in the future?

Answer: In partnership with the Department of Defense (DoD) and Veterans Service Organizations (VSO), VA is working to ensure that as the military draws down, we are still able to reach the Secretary's goal of eliminating the disability claims backlog in 2015 with 98-percent accuracy. A critical step in the claims process is receiving complete and electronic service treatment records (STR), including Tricare, contract medical, and inpatient summaries. DoD has committed to providing VA with 100 percent of separating Servicemembers' complete and certified STRs electronically. On January 1, 2014, DoD ceased sending VA paper STRs for separating Servicemembers, making certified STRs available to VA electronically within 45 days of separation from the military.

As Servicemembers separate, they are informed of the full range of VA benefits and services through the revamped Transition Assistance Program, now known as Transition GPS (Goals, Plans, Success). Individuals who submit disability claims to VA are encouraged to work with VSOs and expedite their claims by participating in the following initiatives:

- *eBenefits* is a joint VA-DoD client-services portal with 58 self-service options that allow users to file claims online in an easy-to-use, prompt-based system. Veterans can also: upload supporting claims information that feeds into VA's paperless claims process; check the status of claims or appeals; review their VA payment history; and obtain military documents, among other actions.
- *Fully Developed Claims (FDC)* are submitted together with the claim-specific information and evidence needed to substantiate the claim at the time of application. Veterans certify they have no further evidence to give VA, eliminating the need for VA to undertake a lengthy search for missing information or evidence needed to decide the claim.
- *Disability Benefits Questionnaires (DBQ)* capture all the needed medical information relevant to a specific condition at once and up front. Veterans can have their private physician complete one or more of 71 different DBQs that are designed to efficiently gather the specific medical evidence needed to evaluate their claim.

Question 2: Are recently separated soldier's Service Treatment Records being delivered to the VA electronically, or are they on paper as well?

Answer: On January 1, 2014, DoD ceased sending VA paper STRs. An interface was implemented between the departments to transmit certified STRs, including Tricare, contract medical, and inpatient summaries, between DoD's Healthcare Artifact and Image Management System and VA's Veterans Benefits Management System in an electronic format.

Electronic Health Records (EHR)

Question 1: You have decided that VistA will be the VA's core system, but have you been given any indication of what core system the Department of Defense will choose or how long it will take for them to choose a system?

Answer: The Department of Defense (DoD) is pursuing an acquisition strategy for the selection of a comprehensive electronic health record (not only a separate core system). DoD is following its standard acquisition process and can best address questions regarding the timeline for the process. VA expects vendors specializing in Veterans Health Information Systems and Technology Architecture (VistA) variant products to compete in DoD's process. VA is working in close collaboration with DoD to ensure that whatever system is chosen will share health data seamlessly with VA's VistA evolved system and will conform to open standards.

Question 2: What steps is your Department taking to make sure that VistA will be compatible with whatever system DoD chooses to use?

Answer: The VA/DoD Interagency Program Office (IPO) is charged with setting the standards that both Departments are required to follow. The IPO is responsible for establishing, monitoring, and approving the clinical and technical standards profile and processes to create seamless integration of health data between DoD and VA electronic health record (EHR) systems. It represents and leads VA and DoD efforts with the Office of the National Coordinator and other national and international standards organizations. The VA/DoD Target Health Standards Profile (HSP) contains the agreed-upon, cross-agency standards that both VA and DoD will adhere to, at the direction of the IPO. The VistA Evolution Program data standards will conform to the HSP; as new standards are added, the VistA Evolution Program will proactively respond to and adopt the new standards.

Additionally, joint testing between VA and DoD, as defined by the designated joint working group, comprised of Defense Medical Information Exchange Integrated Quality Assurance and VA Enterprise Testing Services personnel, will ensure that the systems are compatible.

Question 3: Your FY 2015 budget request includes \$326 million for VistA Evolution and EHR, which is a decrease of \$17 million from FY 2014. Can you explain why this funding request is decreased if your Department is currently developing an EHR?

Answer: In his March 25, 2014, testimony before the Senate Appropriations Committee, on the fiscal year (FY) 2015 budget hearing, Secretary Shinseki outlined the funding request for the

VistA electronic health record and how this line item will continue the Department's progress toward evolving VistA:

"The 2015 Budget continues our progress toward evolving VA's VistA electronic health record (EHR) and achieving seamless integration of health data with the DoD by 2017. The budget requests \$269 million to help achieve our shared goal of providing the best possible support for Service members and Veterans. In the near term, we are working to create seamless integration of DoD, VA, and private provider health data. In the mid-term, we are working to modernize the software supporting DoD and VA clinicians. Together, these two goals will help to create an environment in which clinicians and patients from both Departments are able to share current and future healthcare information for continuity of care and improved treatment. As we strive to build on our successful history of health data sharing and collaboration, we understand our EHR modernization efforts are complicated, dynamic, and multi-faceted."

VA is confident its FY 2015 budget request for the VistA EHR will allow for continued progress in evolution, modernization, and interoperability efforts associated with the EHR. The budget request is a "requirements-based" budget, aligned to the VistA Program Plan. As such, FY 2015 has less development requirements than in future years.

The \$326 million FY 2015 budget number referenced by Ranking Member Lowey consists of VistA Evolution, EHR Interoperability, and Virtual Lifetime Electronic Record (VLER) Health funds. The budget chart depicting those numbers is listed below (in thousands):

	Development	Operations and Maintenance	Total
VistA Evolution	\$179,922	\$89,484	\$269,406
EHR Interoperability/VLER Health	\$32,000	\$25,000	\$57,000
TOTAL	\$211,922	\$114,484	\$326,406

Jobs

Question 1: What courses of action are you taking to tackle this particular issue?

Answer: Connecting America's Veterans to meaningful civilian employment is one of the Administration's highest priorities. Veterans are an asset to our Nation and building their skills, funding their education, and providing them with training and counseling all contribute to their economic competitiveness.

At the core of developing a strategy to address the challenges associated with Veteran employment, is data-driven decisions. The Veterans Benefits Administration (VBA) is working on detailed data collection and analysis that will improve VA-provided services, to serve many cohorts of at-risk or underserved Veterans, including the Post-9/11 era, Vietnam era, homeless,

and women Veterans. This also facilitates further understanding of the Veteran profile and challenges at the local level. This encourages the engagement of local community-level resources and interested parties.

VBA works closely with the private sector and engages in partnerships with other Federal agencies to offer Veterans meaningful employment opportunities. We leverage these partnerships to provide better, more coordinated services for Veterans. Also, a recently deployed employment portal called the Employment Center, located in eBenefits, incorporates the best tools and consolidates requirements from Federal agencies in order to provide resources to assist Servicemembers transitioning to the civilian workforce and Veterans looking for employment opportunities. This employment portal includes a job-search tool, military skills translator, and resume builder, along with other valuable resources, information, and advice. Further, the employment portal provides a platform for employers seeking Veterans to join their industry and help to establish connections.

VBA is also promoting underutilized, existing services, such as Chapter 36 educational and career counseling. VBA also administers the Vocational Rehabilitation and Employment (VR&E) program for Veterans with service-connected disabilities and an employment handicap. The VR&E program helps Veterans with service-connected disabilities prepare for, find, and maintain suitable careers.

Question 2: What kinds of transition assistance programs are you working on to assist service members moving from military to civilian life?

Answer: As of March 31, 2014, 100 percent of separating Servicemembers worldwide have been receiving VA's newly enhanced transition briefing as a result of the revamped Transition Assistance Program now known as Transition GPS (Goals, Plans, Success). The ultimate goal of Transition GPS is to ensure every transitioning Servicemember successfully meets career readiness standards when leaving the military, decreasing their chances of becoming unemployed. VA's partner agencies, including DoD, the Department of Labor, and the Department of Homeland Security, are moving to adopt a Military Lifecycle Transition Model, in which career readiness preparation will be embedded throughout the span of the military career. As this transition model continues to develop, VA will be there to support Servicemembers, Veterans, and family members from initial enlistment to final honors.

VA's courses in Transition GPS are designed to provide Servicemembers and spouses with a set of value-added training and services, equipping them with the tools and resources needed to proactively pursue their post-military goals. VA's enhanced briefings include 6 hours of interactive instruction and are aimed to better connect Servicemembers with the benefits and resources available to them as Veterans. The VA Benefits I Briefing is a 4-hour module. This course informs Servicemembers about the full range of VA benefits and services. Servicemembers leave with actionable steps to help them make informed choices about which benefits to use while transitioning to Veteran life. The briefing also provides Servicemembers with information on VA topics, such as disability compensation (including Pre-Discharge programs), education, health care, home loans, life insurance, pension, and vocational rehabilitation and employment. The VA Benefits II Briefing is a 2-hour module that provides

supplementary information to expand and reinforce what is covered in the VA Benefits I Briefing. It addresses how to gain access and navigate the eBenefits portal and MyHealthVet. Servicemembers are afforded detailed information about health care eligibility and enrollment, as well as an in-depth overview of the disability compensation claim process.

The Career Technical Training Track in Transition GPS offered by VA is a two-day workshop for Servicemembers and spouses and assists them in navigating through the myriad of choices and decisions involved when selecting a civilian technical career, such as electrician, plumber, welder, nurse, or emergency medical technician. Participants receive assistance in identifying required credentials and investigating training options to pursue those qualifications. The outcome is a customized plan for success to make it easier for the Servicemember's transition to a technical career once he/she leaves the military. VA is in the process of placing the entire Transition GPS curriculum on the eBenefits Web site to make it available to Veterans and family members.

In addition to supporting mandatory Transition GPS, VA provides educational and career counseling services to eligible Veterans and Servicemembers, to include Servicemembers who are within 6 months of being discharged and 12 months post-discharge.

Question 3: How will educational opportunities be incorporated? Do you see these as helping the jobless rate for younger veterans?

VA Response: VBA, through its Office of Economic Opportunity (OEO), helps build the foundations for Veterans to succeed through development of policies and programs that promote successful Veteran outcomes. OEO oversees VA's home loan, education, and vocational rehabilitation and employment benefits. The office's mission has evolved over time to also include Veteran employment initiatives. Through this level of organization and oversight, VBA is able to ensure alignment of education and employment programs so they are dedicated to empowering Veterans with the knowledge, skills, and opportunities they need to succeed in the 21st century. VBA also ensures that transitioning Servicemembers are aware that they may be eligible for the Post-9/11 GI Bill. Our GI Bill Web site (gibill.va.gov) provides tools to assist Servicemembers and Veterans in selecting the appropriate career path and school based on their individual circumstances and interests. The Post-9/11 GI Bill can be used for formal education and training, as well as apprenticeship and on-the-job training programs with employers.

Women Veterans

Question 1: How are female veterans' services prioritized at the VA, and what kind of female specific services can we expect to see in the future?

Answer: VA recognizes the increase in the number of women Veterans enrolling in VHA for health care services and how these shifting demographics have placed new demands on VHA's health care system, which had previously treated mostly men. The population of women Veterans has doubled in the past 10 years. Currently, there are over 2.2 million women Veterans in the United States, and over 390,000 utilized VHA health care services in FY 2013. VA is

continuing to enhance services and access to ensure that women Veterans receive, and are satisfied with, the high-quality care they have earned and deserve.

VA successfully invested in comprehensive primary care for women Veterans in all VA health care systems. Comprehensive care for women Veterans is defined as care by a designated women's health provider who is proficient in women's health and can provide primary care and gender-specific care in the context of a continuous patient-clinician relationship. Designated Women's Health providers are now available in 100 percent of VA health care systems, 95 percent of VA medical centers, and 84 percent of community-based outpatient clinics.

VA provides maternity care (usually off-site through Non-VA medical care or contract). VHA has a national policy that describes requirements for providing high quality maternity care and care coordination for women Veterans. The policy includes preventive health visits with a woman Veteran's primary care provider at the beginning and end of pregnancy to ensure continuity of care and a maternity care coordinator at each VA medical center, who remains in contact with pregnant women Veterans to ensure they have access to needed resources and services throughout pregnancy. Through this policy, VHA has decreased fragmentation of care during and after pregnancy, which enhances the health of women Veterans and their children.

In FY 2013, the Reproductive Mental Health Steering Committee conducted a needs assessment that led to the development of multiple live and virtual trainings on reproductive mental health topics as well as a core curriculum that will be piloted in FY 2014. This interdisciplinary partnership enhances the quality of mental health care for women Veterans by raising awareness of the intersections between and interdependencies of reproductive life events, mental health, and well-being.

Through face-to-face trainings and virtual modalities, VHA has successfully developed and implemented curriculum to train providers in state-of-the-art care for women Veterans. VHA has trained more than 1,850 primary care providers in a comprehensive course (women's health mini-residency) that includes training for breast and pelvic exams and has made available more than 50 accredited, on-demand courses on health issues of women Veterans. In FY 2014, this training has expanded to include primary care nurses as well as emergency medicine providers and nurses.

Over 35 percent of women Veterans live in rural areas and may have to travel distances to receive some VHA services. This increases the challenge for women Veterans to receive timely, needed health care and to play an active role in their health management. Every Veterans Integrated Service Network (VISN) has implemented women Veterans telehealth programs to provide services such as Tele-gynecology, Tele-mental health, Tele-pain management, Tele-pharmacy, and other services utilizing innovative technologies that reduce barriers to accessing care. Women's Health Services (WHS), in collaboration with VA Connected Health, is currently developing six mobile applications that enhance provider and/or patient access to information about women's health topics and VA health services for women Veterans.

To improve specialty care for women Veterans, VHA is collaborating with the American Heart Association's *Go Red for Women* Campaign to raise awareness and improve prevention of heart disease among women Veterans.

VHA has developed a comprehensive Women's Health Research Agenda to inform VA health care policy and services. Understanding of the women Veterans population, health care needs, and utilization is needed to inform VA policy and planning for women Veterans health. The Women's Health Research Agenda has expanded rapidly across VHA to include studies of women Veterans' health outcomes, utilization of services, and implementation of comprehensive women's health policy. A Women's Health Research Consortium and a Women's Health Practice-Based Research Network have been developed.

Mental Health

Question 1: How is the VA helping veterans who are suffering from mental illness?

Answer: VHA is committed to providing the highest quality mental health services that are Veteran-centered, recovery-oriented, and evidence-based that supports personalized, proactive, patient-centered care. VA has many entry points for mental health care, including 151 medical centers, 827 community based outpatient clinics, 300 Vet centers, the Veterans Crisis Line, VA staff on university campuses, and other outreach efforts. VA provides evidence-based specialty mental health care in inpatient, residential, and outpatient settings, with subspecialty care for posttraumatic stress disorder (PTSD), substance abuse, and serious mental illness, as well as general mental health services.

VA provides a wide variety of outpatient mental health services targeted to specific diagnoses (for example, PTSD, substance use disorder (SUD), and psychosis disorders) and to particular sub-populations of Veterans including women, those who have experienced military sexual trauma, those at high risk for suicide, and those who are homeless. In FY 2013, specialty services for PTSD and SUD were provided to 534,000 Veterans with PTSD and almost 190,000 Veterans with SUD. Intensive case management services were provided to more than 15,000 Veterans with serious mental illnesses, such as schizophrenia and bipolar disorder. The Veterans Crisis Line, established in 2007, has had over 1 million calls since its inception, which have led to over 35,000 rescues of people in immediate suicidal crisis.

VA has also been in the forefront of providing mental health services in innovative ways in order to maximize access to care and integrate mental health and other medical services. This has involved the creation of dedicated clinics that provide mental health services in non-mental health settings, embedding mental health clinicians in other clinics throughout the system, and providing services with innovative technology. Mental health clinicians are embedded throughout the VA system. Mental health clinicians can deliver some mental health services through telehealth mechanisms, and the use of Tele-mental health has increased 25-fold in the past 10 years. In FY 2013, there were 278,000 Tele-mental health visits delivered to over 92,000 unique Veterans.

VA has also been in the forefront of disseminating evidence-based clinical practices and monitoring the quality of mental health care to identify opportunities for continuous improvement. A national effort to increase access to evidence-based psychotherapies for PTSD, depression, insomnia, pain, and other conditions has resulted in more than 6,000 mental health staff being trained in at least one evidence-based psychotherapy and significantly positive outcomes for patients.

Question 2: How many cases of post-traumatic stress have been reported among women and are there any special programs tailored towards our female veterans?

Answer: In FY 2013, approximately 50,000 female Veterans seen in VHA (13 percent of the VHA female Veteran patient population) had a diagnosis of PTSD.

VA offers a full continuum of mental health services to women Veterans, including: outpatient assessment; evaluation; psychiatry; individual, group, and family therapy; and, for Veterans in need of more intensive treatment and support, residential and inpatient mental health care. Women Veterans can access PTSD treatment at any VA medical center, all of which offer evidence-based therapies for PTSD, such as prolonged exposure and cognitive processing therapy. Specialty outpatient services are available not only for PTSD but also for common comorbidities such as depression and SUD.

Specific gender-tailored treatment offerings vary from facility to facility, based on local demand and resources. Some facilities have established formal outpatient mental health treatment teams specializing in working with women Veterans. In addition, VA has residential and inpatient programs that provide treatment to women only or programs that have separate tracks for men and women. Some of the women-only programs focus on PTSD, whereas other programs focus on specialized women's care in general. These residential and inpatient programs are considered regional and/or national resources, not just a resource for the local facility.

VA policy requires that mental health services be provided in a manner that recognizes that gender-specific issues can be important components of care. All VA health care facilities must ensure that outpatient and residential programs have environments that can accommodate and support women with safety, privacy, dignity, and respect. All inpatient and residential care facilities must provide separate and secured sleeping and bathroom arrangements including, but not limited to, door locks and proximity to staff for women Veterans. In addition, facilities are strongly encouraged to give Veterans the option of a consultation from a same-sex provider regarding gender-specific issues and to offer Veterans the option of a consultation or treatment from an opposite-sex provider when clinically recommended.

Question 3: We are well aware that the treatment of PTSD can take a substantial amount of time and support by the family members. What programs are available for family members of veterans who are diagnosed with PTSD?

Answer: Since the Vet Center program inception in 1979, the Vet Centers have had the authority to provide readjustment counseling to family members of eligible Veterans. This

counseling is provided in support of the Veteran's readjustment, and the issues addressed must be related to the Veteran's military service. The Vet Center program has always utilized the broadest definition of "family" to include anyone identified by the Veteran as family who is impacted by the issues surrounding the Veteran's military service.

The continuum of family services includes:

- Family Resiliency
- Family Education
- Family Consultation
- Marriage and Family Counseling

In 2010, Congress passed and the President signed the "Caregivers and Veterans Omnibus Health Services Act of 2010." In §401 of this Public Law (PL 111-163) it expanded eligibility of Vet Center services to active duty Service Members (and their families) who served in an area at a time in which hostilities occurred.

VHA offers a graduated continuum of evidence-based mental health services that include family education, family consultation, family psychoeducation, and marriage and family counseling.

Family education provides families with the information necessary to partner with the treatment team and support the Veterans' recovery. VHA's Mental Health Services (MHS) has nationally disseminated two clinician-led family education models for individuals with mental health conditions including PTSD: (1) Support and Family Education (SAFE), which is an 18-session program with an emphasis on PTSD; and (2) Operation Enduring Families, which is a 5-session program that is focused on Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) family members. VA has also partnered with the National Alliance on Mental Illness to offer their Family-to-Family Program at VA Medical Centers.

Family consultation is a service where family members meet with mental health professionals, as needed, to resolve specific issues related to the Veteran's treatment and recovery. Family consultation is often used as part of the treatment plan for Veterans who are diagnosed with PTSD.

Family psychoeducation is a collection of evidence-based interventions to provide family-based education and problem-solving skills for Veterans and their family members to support recovery from serious mental illness. Many of the couples who have received family psychoeducation include a Veteran who has PTSD.

Marriage and Family Counseling is a collection of evidence-based interventions targeted at families and couples in intimate relationships. MHS offers several different models including:

- Integrative Behavioral Couples Therapy focused on reducing relational distress and strengthening family relationships (approximately half of the couples who have received this therapy include a Veteran who has PTSD);

- Behavioral Couples Therapy for Substance Use; and
- Cognitive-Behavioral Couples Therapy for PTSD.

Marriage and Family Counseling training also includes a focus on interpersonal violence, parenting, and same sex couples.

MHS, in collaboration with DoD, has released a new free online self-help course – Parenting for Service Members and Veterans – to help Veterans manage emotional challenges such as reconnecting with their significant others and children and managing stress levels while effectively disciplining their children. The course covers issues relevant to children of all ages. Interactive exercises, videos of real families’ stories, and practical tip sheets make the program both helpful and engaging. It can be accessed at www.VeteranParenting.org.

VA also offers Coaching Into Care, which provides concerned family and friends with a place to call and get information about how to help their Veteran loved one. The goal of this telephone care line is to optimize family involvement in getting the Veteran into care, by helping family members support their Veteran. The VA Call staff provides information about PTSD, reactions to combat trauma, and VA services. Callers who are having difficulty discussing mental health treatment needs with a Veteran are offered a “coaching” service. This coaching service can assist callers over multiple telephone calls to tailor their approach to the Veteran, who may be concerned about stigma or the undue influence of the family member on their treatment decisions. This telephone care line collaborates closely with the Veterans Crisis Line (VCL). Coaching Into Care can be accessed by dialing 1(888) 823-7458 or visiting www.va.gov/coachingintocare for more information.

The VA National Center for PTSD has an extensive Web site with over 450 pages of information on trauma and PTSD, which can be found at www.ptsd.va.gov. The Web site provides information on care for Veterans and the general public, including family members, and information for providers and researchers. Educational materials are accessible via this site. The information provided serves to increase awareness and access to treatment, to educate and train providers who work with Veterans and family members, and to guide further research to improve understanding and care.

Information on the Web site includes the following:

- *Returning from the War Zone Guides* (<http://www.ptsd.va.gov/public/PTSD-overview/reintegration/index.asp>). The Center’s War Zone Guides for family members and military personnel were both revised in 2009. The guides include color photos, graphics, personal stories, and live links to related resources. An award-winning Flash interactive version of the family guide is also available online. A narrator walks the viewer through common readjustment problems, the impact on the family, and available treatments.

The Guide for Families of Military Personnel covers a range of topics for families, including:

- A description of the common reactions that occur following deployment to a war zone;
 - How expectations about homecoming may not be the same for Servicemembers and family members;
 - Ways to talk and listen to one another in order to re-establish trust, closeness, and openness;
 - Information about possible problems to watch out for;
 - How to offer and find assistance for loved ones; and
 - What help is available and what it involves.
- *Fact Sheets* (<http://www.ptsd.va.gov/public/PTSD-overview/reintegration/index.asp>). In addition to more general information on trauma and PTSD, to date, over a dozen printable fact sheets and handouts are directly targeted to provide information about the effects of war on families, children, relationships, and communities. Topics range from “How Deployment Stress Affects Children and Families,” “Coping When a Family Member Has Been Called to War,” and “When a Child’s Parent has PTSD.” Many are available in Spanish.
 - *Videos* (<http://www.ptsd.va.gov/public/videos/list-videos.asp>). The Center has produced a range of videos specific to Veterans and their families, as well as to ethnic minority Veterans and families, including the following:
 - *Combat on Many Fronts: Latino Veterans and Family*: This video helps Veterans and others understand the history and cultural issues of Latino Americans and how VA can best serve these Veterans.
 - *The New Warrior: Combat Stress and Wellness*: This video provides the latest information to help recently deployed Servicemembers and their families.
 - *PTSD Among Asian-American and Pacific Islander Veterans*: This video increases awareness of the cultural aspects experienced by Asian American Veterans with PTSD.
 - *War on Many Fronts: African American Veterans with PTSD*: This video helps viewers understand the cultural aspects of PTSD for African American Veterans.
 - *Women Who Served in Our Military*: This video, released in 2006, discusses the role of women in the military.

- Wounded Spirits, Ailing Hearts (for the general public): PTSD Among American Indian & Alaska Native Veterans: This video educates general audiences about PTSD in American Indian Veterans and the special needs of those belonging to this culture.
- *PTSD Family Coach Mobile Phone Application (app)*. PTSD Family Coach will be released soon for both Apple iOS and Android phones. PTSD Family Coach was designed for family members of individuals with PTSD. This app provides education about PTSD, a self-assessment tool measuring life stress, self-management skills to address acute distress and stress, and a direct connection to support and information about VA and community resources for family members of individuals with PTSD. The app increases intimate partners' knowledge of PTSD, its treatment, and their ability to manage their own life stress, which may in part be the result of living with a Veteran with PTSD.
- *PTSD Coach Application* (<http://www.ptsd.va.gov/public/materials/apps/PTSDCoach.asp>). As with the PTSD Family Coach, PTSD Coach was jointly developed by VA's National Center for PTSD and DoD's National Center for Telehealth and Technology. PTSD Coach was released in the spring of 2011, and lets users track their PTSD symptoms, links them with local sources of support, provides accurate information about PTSD, and teaches helpful individualized strategies for managing PTSD symptoms at any moment. The free PTSD Coach app is available for download for Apple iOS and Android phones. The PTSD Coach is primarily designed to enhance services for individuals who are already receiving mental health care, though it is certainly helpful for those considering entering mental health care and those who just want to learn more about PTSD.
- *PTSD Coach Online* (<http://www.ptsd.va.gov/apps/ptsdecoachonline/default.htm>). PTSD Coach Online is a compilation of 17 stand-alone coping tools for anyone who needs help with upsetting feelings or thoughts, sleep issues, problem solving, relationships, and other issues. Trauma Survivors, their families, or anyone coping with stress can benefit.
- *AboutFace* (<http://www.ptsd.va.gov/apps/AboutFace/>). AboutFace is an online video library collection dedicated to Veterans talking about living with PTSD and how PTSD treatment turned. The Web site now contains a section with clinicians talking about various treatment options and will soon feature a section compiling videos from family members of Veterans with PTSD describing how PTSD affects family members and how family members helped themselves.

Question 4: How many veteran committed suicides in 2013 can be traced to PTSD?

Answer: Data on mortality among Veterans in 2013 is not yet available from the Centers for Disease Control and Prevention and will likely be available in 18-24 months.

[Questions for the Record submitted by Ranking Member Bishop for the Honorable Eric K. Shinseki follows:]

Claims Backlog

Question 1: A year ago the VA began to make provisional decisions on the oldest claims in inventory, what types of results have been seen on this initiative?

Answer: In April 2013, the Veterans Benefits Administration (VBA) launched its Oldest Claims Initiative to expedite decisions for Veterans who had waited more than a year for a decision on their claim. Provisional decisions were issued during this initiative in order to provide benefits more quickly to eligible Veterans who had been waiting the longest for rating decisions, while at the same time giving them an additional 1-year safety net to submit further evidence should it become available. Most Veterans whose claims were processed under this initiative, received final decisions as all relevant evidence was available to VA at the time of the decision. VBA redistributed the oldest claims across the Nation to best utilize the resources of all regional offices (RO). This centralized workload management and redistribution achieved excellent results. Within 2 months, VBA completed more than 97 percent of the 67,000 claims identified for processing under the 2-year phase of the initiative. In June of 2013, the focus turned to completing all claims that had been pending more than 1 year. VBA completed 98.2 percent of the claims that were pending over 1 year by October 31, 2013. Over 500,000 Veterans received decisions on their claims under this initiative, including approximately 14,500 provisional ratings (7,300 for 2-year claims and 7,200 for 1-year claims). Veterans who received provisional decisions were informed that they could obtain and submit evidence within 1 year from the date of notification of the provisional decision to possibly change the rating before it became final after 1 year. The proportion of decisions resulting in benefits being granted under this initiative was consistent with historical averages.

Question 2: As part of the VA's ongoing efforts to get a handle on the backlog in May of 2013 you mandated overtime for claims processors at all 56 regional benefits offices. How successful was this initiative and how long will this mandate continue and how much does this initiative cost?

Answer: Overtime was critical in helping VBA complete a record 1.17 million claims in FY 2013 and reduce the disability claims backlog by 34 percent in FY 2013. Staff at all ROs worked mandatory overtime for 6 months in FY 2013, and October 19 through November 23 in FY 2014. Mandatory overtime was suspended during the holiday season, but employees continued to work optional overtime. VBA resumed mandatory overtime on January 19, 2014, to accelerate the reduction in the backlog. VBA has further reduced the backlog from its peak of 611,000 in March 2013, to 344,000 as of March 31, 2014, a 44-percent reduction. March 2014 was also a month of record-breaking production, with over 135,000 Veterans receiving decisions on their claims. Veterans are now waiting less time for their decisions and benefits. Claims currently in the inventory have been pending an average of 163 days, a 42-percent reduction from the peak of 282 days in February 2013.

Funding for overtime is critical to achieving Secretary Shinseki's goal of eliminating the claims backlog in 2015. In FY 2013, VBA spent \$71 million on overtime to address the claims backlog. Overtime, whether it is optional or mandatory, will continue to be a key management tool. VBA's budget-operating plan for 2014 includes \$100 million in overtime funding specifically to address the claims backlog.

Question 3: The FY 2015 budget request includes \$138 million for the Veterans Claims Intake Program (VCIP), which is a continuation of a scanning program that began scanning on September 10, 2012. How many scanning contracts does the VA have for VCIP and second how many documents are scanned per month? Once a document is scanned how long does it take to get to completed package to a claims processor? What percentage of disability claims are digital?

Answer: VA currently has contracted with two vendors to manage the document conversion of claims folders as claims are received. Based on operational demand, scanning volume under these contracts is approximately 60 million images per month. Images are available to claims processors within hours of successful upload into the Veterans Benefits Management System (VBMS) for electronic claims processing. Although the majority of VA's claimants still file in paper, with scanning support, nearly 90 percent of VBA's current disability claims inventory is electronic.

Question 4: The VA's Strategic Plan to Eliminate the Compensation Claims Backlog talks about teams working together on one of three segmented lanes: express, special operations, or core. In this plan it states that the VBA projects that segmented lanes can accelerate 350K "express" claims from 262 days to complete to 80 days, a reduction of 182 days, reducing average days to complete (for all claims) by 54 days. How many regional offices are currently using the segmented lanes structure? What results are you seeing from this initiative?

Answer: All ROs were in the transformation organizational model, which includes segmented lanes, as of March 2013. Initially planned for deployment throughout FY 2013, VBA accelerated the implementation of its new organizational model by 9 months due to early indications of its positive impact on performance. The new organizational model incorporates a case-management approach to claims processing, by reorganizing the workforce into cross-functional teams that give employees visibility of the entire processing cycle of a Veteran's claim. These cross-functional teams work together on one of three segmented lanes: express, special operations, or core. Lanes were created based on the complexity and priority of the claims, and employees are assigned to the lanes based on their experience and skill levels. An Intake Processing Center serves as a formalized triage process to quickly and accurately route Veterans' claims to the right lane when first received.

The Express Lane was developed to identify those claims with a limited number of medical conditions (i.e., about one to two issues) and subject matter, which could be developed and rated more quickly. The Special Operations Lane applies intense focus and case management on specific categories of claims that require special processing or training (e.g., homeless or terminally-ill Veterans, military sexual trauma, former prisoners of war, seriously injured, etc.). The Core Lane includes claims with three or more medical issues that do not involve special populations of Veterans. Less complex claims move quickly through the system in the Express

Lane, and the quality of our decisions improves by assigning more experienced and skilled employees to the more complex claims in our Special Operations Lane.

Production increased by 10 percent during the first 60 days at ROs using the new model. Processing speed in the Express Lanes has also improved. About 30 percent of claims are routed through Express Lanes and are being processed about 100 days faster than claims routed through Special Operations Lanes (approximately 10 percent of claims) and Core Lanes (approximately 60 percent of claims).

The new organizational model is one key component of VBA's Transformation Plan to improve the delivery of benefits through high-impact people, process, and technology initiatives. Since the implementation of the first phase of our transformation initiatives, which includes nationwide deployment of the new paperless processing system in addition to the new organizational model, the claims backlog has been reduced by 44 percent from its peak of 611,000 claims in March 2013 to 344,000 claims on March 31, 2014.

Question 5: The Army is going to be separating 90,000 troops over the next few years is there a plan to prepare for an uptick in claims due to these separations?

Answer: VA, in partnership with the Department of Defense (DoD) and Veterans Service Organizations (VSO), is working to ensure that as the Army draws down, we are still able to reach the Secretary's goal of eliminating the claims backlog in 2015 with 98-percent accuracy. A critical step in the claims process is receiving complete and electronic service treatment records (STR). DoD has committed to providing VA with 100 percent of separating Servicemembers' complete and certified STRs electronically. On January 1, 2014, DoD ceased sending VA paper STRs for separating Servicemembers, making STRs available to VA electronically within 45 days of separation from the military.

As Servicemembers separate, they are informed of the full range of VA benefits and services through Transition GPS (Goals, Plans, Success). Individuals who submit disability claims to VA are encouraged to work with VSOs and expedite their claims by participating in the following initiatives:

- *eBenefits* is a joint VA-DoD client-services portal with 58 self-service options that allow users to file claims online in an easy-to-use, prompt-based system. Veterans can also: upload supporting claims information that feeds into VA's paperless claims process; check the status of claims or appeals; review their VA payment history; and obtain military documents, among other actions.
- *Fully Developed Claims (FDC's)* are submitted together with the claim-specific information and evidence needed to substantiate the claim at the time of application. Veterans certify they have no further evidence to give VA, eliminating the need for VA to undertake a lengthy search for missing information or evidence needed to decide the claim.
- *Disability Benefits Questionnaires (DBQs)* capture all the needed medical information relevant to a specific condition at once and up front. Veterans can have their private physician complete one or more of 71 different DBQs that are designed to efficiently gather the specific medical evidence needed to evaluate their claim.

Question 6: With the average number of claimed conditions for recently separated Servicemembers is now in the 12 to 16 range which is an increase in the number of disabilities claimed by Veterans of earlier eras. Do claims processors have to have all claimed conditions verified before a claim can be processed or as conditions are verified the claim for that condition is approved?

Answer: As all evidence needed to decide one or more of a Veteran's claimed conditions becomes available, they may be decided and benefits may be paid to eligible Veterans. For reporting purposes, however, the entire claim remains pending until all claimed issues are decided.

VBMS

Question 1: The VBMS is currently at every Regional office correct? What is the current percentage of claims that are filed on paper? How many claims have been processed using the VBMS? How long will it take for us to see tangible progress on reducing the backlog using the VBMS?

Answer: VBMS, VA's Web-based electronic claims processing system, was deployed to all 56 ROs 4 months ahead of schedule in June 2013. This fiscal year through March 31, 2014, 4.5 percent of disability compensation claims have been filed electronically through our eBenefits Web portal. Although the majority of VA's claimants still file in paper, all paper applications and records are now converted to electronic images for paperless processing in VBMS. With scanning support, nearly 90 percent of VBA's current disability claims inventory is electronic. As we continue to focus on completing the remaining paper claims in our inventory, the number of claims processed in VBMS is rapidly growing. In March 2014, 63 percent of the rating claims completed were processed electronically in VBMS. VA has initiated an aggressive outreach campaign to encourage Veterans and their families to enroll in eBenefits and to make them aware of the advantages of filing fully developed claims online.

The tangible results are already evident. Through deployment of electronic processing, together with enhanced training, streamlined business processes, new organizational structures, and other initiatives such as prioritizing the oldest claims, VA's 56 ROs exceeded monthly production records four times in FY 2013 and produced a record-breaking 1.17 million disability claims decisions. We reduced the claims backlog (i.e., claims pending over 125 days) from its peak of 611,000 in March 2013 to 344,000 as of March 31, 2014, a 44-percent reduction. March 2014 was again a month of record-breaking production, with over 135,000 Veterans receiving decisions on their claims. Veterans are now waiting less time for their decisions and benefits. Claims currently in the inventory have been pending an average of 163 days, a 42-percent reduction from the peak of 282 days in February 2013. At the same time, the accuracy of our rating decisions continues to improve. VA's national "claim-level" accuracy rate, determined by dividing the total number of cases that are error-free by the total number of cases reviewed, is currently 91 percent, an eight percentage-point improvement since 2011. When measuring the accuracy of rating individual medical conditions inside each claim, the 3-month accuracy level is 96.5 percent. VBMS is improving access, driving automation, and enabling greater exchange of information and increased

transparency to Veterans, our workforce, and other stakeholders. Using an agile development approach, VA will continue to build new and enhanced VBMS functionalities to further streamline claims processing and ensure we achieve our goal of processing all claims within 125 days at a 98-percent accuracy level in 2015.

Electronic Health Records (EHR)

Question 1: The VA and the DoD were directed to develop an electronic health record system why has this been so difficult to achieve and what guarantees do have that it will be achieved by 2017?

Answer: The Department of Veterans Affairs (VA) and the Department of Defense (DoD) are working together to fundamentally and positively impact the health outcomes of Veterans, Servicemembers, and their dependents. Achieving interoperability of health records between the two Departments is the chief goal motivating the Departments' electronic health record (EHR) efforts. Seamless integration of health data from VA, DoD, and other health care partners enables clinicians and patients to benefit from the availability of a complete longitudinal health record, achieving the goal of developing electronic records that will transition with them from active-duty to retired status.

The Departments are on complementary paths for modernizing their respective EHR systems, or replacing or enhancing existing systems as required to support delivery of the best possible care in their particular environments. VA will enhance and evolve its Veterans Health Information Systems and Technology Architecture (VistA) EHR to achieve its interoperability, clinical, and technical objectives. VA will deliver its VistA enhancements through a series of milestones. The functionality to be delivered in September 2014 will provide the foundational elements of interoperability and clinician-facing enhancements. Interoperability with DoD EHR systems, with an integrated display of data, will be achieved no later than December 31, 2016, (Required by the FY 2014 National Defense Authorization Act, section 713).

Question 2: With both the VA and DOD choosing to go down separate paths what steps are being taken to make sure that whatever system the DOD chooses VistA will be to share information with it?

Answer: The VA/DoD Interagency Program Office (IPO) is charged with setting the standards that both Departments are required to follow. The IPO is responsible for establishing, monitoring, and approving the clinical and technical standards profile and processes to create seamless integration of health data between DoD and VA EHR systems. It represents and leads the VA and DoD efforts with the Office of the National Coordinator and other national and international standards organizations. The VA/DoD Target Health Standards Profile (HSP) contains the agreed-upon, cross-agency standards that both VA and DoD will adhere to, at the direction of the IPO. The VistA Evolution Program data standards will conform to the HSP; as new standards are added, the VistA Evolution Program will proactively respond to and adopt the new standards.

Additionally, joint testing between VA and DoD, as defined by the designated joint working group, consisting of Defense Medical Information Exchange Integrated Quality Assurance (IQA) and VA Enterprise Testing Services (ETS) personnel, will ensure that the systems are compatible.

Question 3: How much it will cost to modernize VistA?

Answer: The VistA 4 Product cost estimate, which is a top-down initial development, deployment, and operations cost estimate for the VistA 4 product, was transmitted to Congress on March 24, 2014. This estimate concludes that the cost to deliver and implement the completed product by FY 2019 will cost \$2.7 billion. The Department is currently working to refine the VistA 4 Product cost estimate, using a bottom-up cost estimate methodology, which is expected to be completed in June 2014.

Question 4: The FY 2015 budget that VistA/EHR is decreasing from the FY 2014 budget level. Can you explain why this is decreasing?

Answer: VA is confident its FY 2015 budget request for the VistA EHR will allow for continued progress in evolution, modernization, and interoperability efforts associated with the EHR. The budget request is a "requirements-based" budget, aligned to the VistA Program Plan. As such, FY 2015 has less development requirements than in future years.

FY 2015 Budget Request

Question 1: The FY 2015 budget request an additional \$368 million for medical care in 2015, can you explain the reason for this additional funding?

Answer: The total net increase of \$367.9 million is due to the following factors:

- Special activities increased by over \$1 billion, primarily due to additional support needed for Ending Veterans Homelessness, including a \$200 million increase for the Supportive Services for Veterans Families (SSVF) program and a \$441 million increase for other homeless programs, including the Housing and Urban Development-VA Supportive Housing Program (HUD-VASH). In addition, estimated activations for new and renovated VA facilities increased by \$404.4 million.
- New programs recently enacted grew by \$35.7 million, and the cost estimates for legislative proposals increased by \$75.0 million, primarily due to the expansion of the CHAMPVA benefit for children of beneficiaries to age 26.
- Offsetting the requested increases, the request for ongoing health care services decreased by \$690.2 million (for health care services, long-term care, CHAMPVA, Caregivers and readjustment counseling services). This reduction is driven largely by revised estimates for VA Community Living Centers, due to a continuing shift from institutional care to non-institutional care based on the preference of many Veterans to live at home in order to maintain a higher quality of life.

- Proposed savings are estimated to be \$33.1 million higher, achieved through additional acquisition savings.
- Additional budgetary resources increased by \$310 million (collections, reimbursements, and unobligated balances). The estimate for the Medical Care Collections Fund decreased by \$125.7 million, while reimbursements decreased by \$14 million. This year's request also assumes \$450 million in start-of-year unobligated balances.

Additional detail on the update to the 2015 advance appropriations request is shown in the attached chart.



Advance Approps
QFR.docx

Dialysis Pilot

Question 1: The VA has undertaken a pilot program to compare VA-run dialysis clinics to contracted clinics. Does the VA plan to move forward with building new sites before it receives the results of the pilot program?

Answer: VHA does not intend to move forward with building new sites before it receives the results of the pilot program. VHA will ensure the committees are briefed on the results of the pilot program, before establishing any new free-standing dialysis centers.

Update to the 2015 Advance Appropriations Request
Dollars in Thousands (\$000)

Description	2015		Increase/ Decrease
	Advance Approp.	Current Estimate	
Health Care Services.....	\$48,016,540	\$48,241,163	\$224,625
Long-Term Care:			
Institutional.....	\$6,096,220	\$5,338,088	(\$758,132)
Non-Institutional.....	\$1,886,747	\$1,708,027	(\$178,720)
Health Care Svcs/Long-Term Care Subtotal.....	\$55,999,507	\$55,287,280	(\$712,227)
Other Health Care Programs:			
CHAMPVA, Spina Bifida, FMP & CWVV.....	\$1,707,642	\$1,716,392	\$8,750
Caregivers (Title 1).....	\$317,414	\$305,716	(\$11,698)
Readjustment Counseling.....	\$212,544	\$237,544	\$25,000
Other Health Care Programs [Subtotal].....	\$2,237,600	\$2,259,652	\$22,052
Congressional Action:			
Affordable Care Act (P.L. 111-148/P.L. 111-152).....	\$85,000	\$105,000	\$20,000
Indian Health Services (P.L. 111-148).....	\$52,000	\$38,649	(\$13,351)
VOW-Exam Costs (P.L. 112-56).....	\$0	\$50,000	\$50,000
Camp Lejeune - Veterans and Family (P.L. 112-154).....	\$72,000	\$51,038	(\$20,962)
Congressional Action [Subtotal].....	\$209,000	\$244,687	\$35,687
Special Activities:			
Activations.....	\$130,000	\$534,416	\$404,416
Ending Veterans Homelessness.....	\$1,000,000	\$1,641,000	\$641,000
Special Activities [Subtotal].....	\$1,130,000	\$2,175,416	\$1,045,416
VA Legislative Proposals.....	(\$28,880)	\$46,102	\$74,982
Proposed Savings.....	(\$482,000)	(\$515,120)	(\$33,120)
Obligations [Total].....	\$59,065,227	\$59,498,017	\$432,790
Funding Availability:			
Appropriation.....	\$55,634,227	\$55,634,227	\$0
Trns to North Chicago Demo. Fund.....	\$0	(\$245,398)	(\$245,398)
Trns to DoD-VA Health Care Sharing Incentive Fund.....	(\$15,000)	(\$15,000)	\$0
Medical Care Collections Fund.....	\$3,174,000	\$3,048,303	(\$125,697)
Reimbursements.....	\$272,000	\$258,000	(\$14,000)
Use of Unobligated Balance.....	\$0	\$450,000	\$450,000
Funding Availability [Total].....	\$59,065,227	\$59,130,132	\$64,905
Annual Appropriation Adjustment.....	\$0	\$367,885	\$367,885

[Questions for the Record submitted by Ranking Member Bishop on behalf of Congresswoman Pingree for the Honorable Eric K. Shinseki follows:]

Homeless Female Veterans

Question 1: I commend the VA for its efforts in reducing homelessness among the veteran population. I remain concerned about the VA's efforts to reduce homelessness among female veterans. Veterans returning from Iraq and Afghanistan have faced a struggling economy and high unemployment rate, resulting in an uptick in homeless veterans. The number of homeless female veterans has also grown. What unique challenges that homeless female veterans face has the VA identified and begun to resolve? How many female veterans has the VA been able to help move into more secure housing under the VA's current initiative? What percentage of VA programs are catered specifically for homeless female veterans? If such programs exist, are they region specific or VA wide?

Answer: VA is taking steps to improve and expand services for women Veterans who are homeless or at risk of becoming homeless. Women Veterans may face challenges when returning to civilian life that are different from those of their male counterparts, including raising children on their own or dealing with the psychological after-effects of events such as military sexual trauma. These issues, without intervention, can put women Veterans at greater risk of becoming homeless. This makes VA's efforts to provide housing and health care support all the more critical. VA's current initiatives and programs to address these challenges are described below.

In fiscal year (FY) 2013, VA served over 260,000 homeless, at-risk, or formerly homeless Veterans in VHA's Specialized Homeless Programs. Of those served, 10 percent were women. The Health Care for Homeless Veterans (HCHV) contract residential treatment services place homeless Veterans in community-based programs that provide quality housing and services. Of the over 13,350 episodes of residential treatment in HCHV contracted community-based facilities in FY 2013, over 4.5 percent of the Veterans served were women.

VA's Homeless Providers Grant and Per Diem (GPD) Program awards grants to community-based agencies to create transitional housing programs funded through per diem payments. More than 200 GPD programs have some capacity to serve women Veterans. Of the more than 200 projects that have some capacity to serve women, approximately 40 of these projects are women-specific. In FY 2013, 7 percent of Veterans served in GPD were women.

The Department of Housing and Urban Development (HUD)-VA Supportive Housing (VASH) Program, a collaboration between HUD and VA, aims to promote maximum Veteran recovery and independence to sustain permanent housing provided through HUD-VASH. As of the end of FY 2013, approximately 13 percent of HUD-VASH recipients were women. VA's Supportive Services for Veteran Families (SSVF) Program provides grants to community-based agencies to provide supportive services to very low-income Veterans families in or transitioning to permanent housing. In FY 2013, SSVF served over 60,000 participants (Veterans and their

family members), close to 40,000 of whom were Veterans. Among Veteran participants in SSVF, 15 percent were women Veterans.

The Homeless Veteran Supported Employment Program (HVSEP) provides a preventive and reparative approach to ending homelessness, offering Veterans improved quality of life, increased self-confidence and independence, and decreased reliance on institutional care. HVSEP provides vocational assistance, job development and placement, and ongoing support to homeless Veterans. Approximately 25 percent of formerly homeless Veterans hired as Vocational Rehabilitation Specialists are female Veterans, and, in FY 2013, approximately 9 percent of the Veterans participating in HVSEP were female Veterans.

The Domiciliary Care for Homeless Veterans (DCHV) program provides time-limited residential treatment to homeless Veterans with health care and social-vocational deficits. In FY 2013, the DCHV program provided services to over 8,400 Veterans, of whom 6 percent were women Veterans.

The Veterans Justice Programs (VJP) provide outreach services to Veterans across the spectrum of the justice system, including at arrest, detention in local jails, in courts, and at re-entry from prison. The goal of VJP is to engage Veterans in needed clinical care that will prevent homelessness, stabilize them in the community, and prevent re-engagement with the justice system. In FY 2013, 4 percent of the close to 52,000 Veterans served in VJP were female Veterans.

Question 2: Military Sexual Trauma Report Claims - A recent VA report detailing all completed MST claims for FY13 was submitted to the committee. The details are troubling. Even though the VA has increased awareness and training for MST related claims, the grant rates for MST claims continue to lag behind other PTSD related claims. According to VA's own numbers, veterans have less than a 50/50 chance of getting their claim approved. We know from Department of Defense data that approximately 90% of assaults go unreported, which makes proving these assaults very difficult, unless of course veterans could rely solely on their mental health diagnosis as evidence in support of the assault. The majority of MST survivors suffer from debilitating mental health conditions and VA's own report stated that 99% of MST claims that are filed are for mental health conditions. Given these numbers and continued inconsistencies across VA Regional Offices after such a rigorous training initiative was implemented, why does the VA continue to resist any improvements in the current regulations that would make it easier for MST survivors to receive disability benefits?

Answer: VA is committed to serving our Nation's Veterans by accurately adjudicating claims based on military sexual trauma (MST) while fully recognizing the unique evidentiary considerations involved in processing these claims. VA's efforts have produced a significant increase in the MST-based posttraumatic stress disorder (PTSD) grant rate. VA developed an aggressive nationwide training initiative in December 2011, and assigned specially trained personnel to handle MST/PTSD claims in all ROs. Because these cases often involve MST stressors that may not be documented in a Veteran's military records, VA's training emphasizes that evidence sources outside of military records are important and that "marker" evidence, i.e., a

wide range of indicators of behavioral changes following the claimed assault, may corroborate occurrence of the assault. To help account for the sensitive nature of MST stressors and the fact that evidence of MST may not be reflected in a Veteran's military records, VA has also promulgated a regulation at 38 Code of Federal Regulations § 3.304(f)(5). Section 3.304(f)(5) of the rule recognizes that evidence from sources other than a Veteran's service records may establish occurrence of the sexual assault, requires notification to the Veteran of the types of evidence that may establish the stressor, and provides for submission of the evidence to an appropriate medical or mental health professional for an opinion about whether it indicates that a sexual assault occurred. In addition, under section 3.304(f)(5), a medical opinion based on a post-service examination of a Veteran may serve as evidence supporting occurrence of an in-service sexual assault.

Within 6 months of launching the VA training and special handling initiatives in December 2011, the percentage of MST/PTSD claims granted service connection rose from 34 percent to 55 percent. At that time, the grant rate for all PTSD claims was approximately 60 percent. Since then, the monthly grant rates for MST/PTSD claims, as well as all PTSD claims, have fluctuated. During FY 2013, VA granted service connection for 3,091 of 6,270 MST/PTSD claims, for an average grant rate of 49 percent. During the same period, the average grant rate for all PTSD claims was 55 percent. The higher rate for all PTSD claims was likely due to the numerous combat-related claims resulting from U.S. military operations in Afghanistan and Iraq. VA is monitoring overall MST/PTSD grant rates closely. Although monthly fluctuations in grant rates occur for all categories of disability claims, overall we believe that the rising MST/PTSD grant rates over the last several years clearly show the benefits of VA's training and special handling initiatives.

The Department recognizes there is some variance in the MST/PTSD grant rates among VA regional offices (RO) that is an area of potential improvement. VA is engaged in additional data analysis and is also evaluating claims processing in ROs with the greatest divergence from the norm. Once this analysis is complete, VA expects to conduct additional training that will address any shortcomings in the medical evaluation or decision-making processes and ensure greater nationwide consistency in MST/PTSD claim decisions.

[Questions for the Record submitted by Congressman Farr for the Honorable Eric K. Shinseki follows:]

Backlog of Benefits

I applaud the Department's efforts on the recent decline in the backlog of benefit claims, but I am still concerned with the number of benefits claims that are being brokered out to other regional offices.

For example, even though the largest bulk of the backlog has been processed, Oakland Regional Office is still "brokering" approximately 19% of its incoming claims to other offices.

What this says to me is that the current Oakland workforce is not large enough to adequately handle the workload.

Question 1: When do you anticipate terminating "brokering" so that each regional office can process their own claims?

Answer: With the 2013 rollout of the Veterans Benefits Management System (VBMS) to all regional offices (RO), the Veterans Benefits Administration (VBA) now has the ability to distribute pending claims electronically to any RO based on claims processing capacity instead of geography. VBA can now improve and normalize processing timeliness at a national level, ensuring Veterans across the country are receiving benefits in a timely manner, and that beneficiaries are neither advantaged nor disadvantaged based on the state in which they reside. VBA is redesigning its workload management approach in this new technology-enabled environment, moving toward a more centralized national approach for workload distribution that optimizes every member of the VBA workforce. This national approach, called the National Work Queue (NWQ), also builds on the success of VBA's Oldest Claims Initiative to expedite decisions for Veterans who were waiting the longest for a decision on their claims. VBA managed the Oldest Claims Initiative from its headquarters and four area offices, redistributing the oldest claims across the nation to utilize the resources of all ROs to better meet the needs of our Veterans. This centralized workload management and redistribution proved effective, helping to drive the claims inventory and backlog to their lowest levels in nearly three years. VBA's success with this initiative demonstrated the potential of a national workload management strategy for improved benefits delivery. VBA's NWQ is designed to route claims to ROs based their productive capacity. Future iterations of the NWQ will include robust workload management capabilities to automate portions of the claims process and metrics in order to direct work based on national priorities. VBA will also analyze the transactional data from VBMS and other corporate systems to assess the complexity of tasks and decisions made by claims processors to determine future skill-based functionality for the NWQ.

Question 2: We know the population of Veterans will continue to grow, so how is the VA planning to align resource requirements, including additional FTE's in the outyears, in anticipation of the influx of benefits claims?

Answer: VBA's Area Directors and the Office of Field Operations will continue to monitor claims inventory levels, distribution of workload, and performance, ensuring accountability for timely and accurate delivery of benefits. As discussed in response to question 1, VBA is also redesigning and

refining its workload management procedures for application in the NWQ electronic environment. Enhanced technology for the NWQ, VBMS, and other initiatives will help VBA increase productivity.

Question 3: What is the back-up plan for the VA to handle the amount of claims if the other Regional Offices can no longer handle the large percentage of claims being brokered?

Answer: VBA has shifted from a brokering strategy, where paper claim files were physically mailed between ROs, to an electronic NWQ strategy. With the 2013 rollout of the VBMS to all ROs, VBA now has the ability to distribute pending claims electronically to any RO based on claims processing capacity instead of geography. Under this new technology-enabled, centralized workload management approach, VBA can improve and normalize processing timeliness at a national level, ensuring Veterans across the country are receiving benefits in a timely manner, and that beneficiaries are neither advantaged nor disadvantaged based on the state in which they reside. Please see the attached fact sheet for more information on NWQ.

Loan Repayment Program for Doctors

Question 1: The VA does not offer a loan repayment program for the doctors it employs, making it incredibly difficult to recruit talented psychiatrists. Has the VA considered requesting resources for a loan repayment programs? Why or why not?

Answer: VA offer a loan repayment program for physicians and other Title 38 and Hybrid Title 38 occupations called the Education Debt Reduction Program (EDRP). It is used as both a recruitment and retention tool. EDRP reimburses employees for loan payments made on qualifying student loans for up to \$60,000 over a 5-year period. In FY 2013, a total of \$16,604,283 in EDRP payments were made to 2,678 EDRP participants. Since EDRP's inception in July 2002, over 9,000 employees have received this incentive.

Medical Research and Innovation

Question 1: The VA's FY 2015 budget submission notes that as of January 31, 2014, the Million Veteran Program (MVP) had enrolled more than 241,000 Veterans. What steps is VA taking to ensure that there is sufficient participation of women and minority veterans in this project?

Answer: Prior to launching this project, VHA worked extensively to develop the Million Veteran Program (MVP) in concert with critical VA offices, such as the Center for Minority Veterans and the Center for Women Veterans, to ensure that the development of MVP appropriately addressed any specific concerns and needs of those groups. MVP staff participated in national calls held by these centers to inform and engage local staff at VA medical centers where MVP would be launched. MVP is engaged with the Women's Health Research Consortium and Practice-Based Research Network. MVP leadership monitors demographics of MVP enrollees on a regular basis to understand levels of participation among various groups. Currently, approximately 8 percent of MVP enrollees are women, and nearly 22 percent of MVP enrollees are non-Caucasian, suggesting that MVP participation is

representative of users of the VA health care system. Specific recruitment efforts to oversample these populations will be considered if enrollment rates begin to decline.

Question 2: In July 2012, the VA released the long-awaited *Final Report of the VA Research Infrastructure Program*, which identified needed repairs and renovations totaling nearly \$774 million. The repairs/renovations were ranked, with those identified as Priority 1 and 2 requiring the most urgent attention. Can you give us an update on what percentage of the Priority 1 and 2 deficiencies have been addressed to date?

Answer: VHA's Office of Research and Development has dedicated funding to address life and safety issues over the last 2 years. Many of the identified deficiencies have appeared in construction and/or renovation projects submitted by VHA for prioritization through the Department's Strategic Capital Investment Planning (SCIP) process.

Approximately 60 percent of the campuses at which assessments were performed have received or are in the pipeline to receive funding for renovation and/or construction projects affecting research space. Not all of these projects were identified based on the research infrastructure assessment. Some of the projects had already been funded prior to the station's assessment.

Question 3: The VA's FY 2015 budget submission notes that VHA supports research and development infrastructure projects by ensuring that the Office of Research and Development (ORD) is involved in the identification of gaps to support the Strategic Capital Investment Planning (SCIP) process. Please explain in more detail how ORD is consulted about its research infrastructure needs?

Answer: The research infrastructure needs data have been incorporated into the Capital Asset Inventory. ORD staff has also been working closely with VA's Office of Construction and Facilities Management to enhance the methodologies for future Facility Condition Assessments with regard to research space and condition. ORD staff serve as subject matter experts to advise the SCIP Board in its periodic evaluation of business plans. ORD staff also participate in the Veterans Integrated Service Network presentations before the SCIP Board.

Question 4: The VA's FY 2015 budget submission notes that \$142 million for non-recurring maintenance projects is included in the Opportunity, Growth, and Security Initiative. Is any of that \$142 million meant to address non-recurring maintenance projects related to the repairs identified in the *Final Report of the VA Research Infrastructure Program*?

Answer: The research non-recurring maintenance projects for FY 2015 total approximately \$19 million, which is within the \$142 million listed above; and are all projects addressing deficiencies identified by ORD.



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Fact Sheet

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Nationwide Electronic Disability Claims Processing: “National Work Queue”

The National Work Queue (NWQ) is a paperless workload management initiative designed to improve VBA’s overall production capacity and assist with reaching the Secretary’s goals of having no claims pending over 125 days and 98 percent accuracy in 2015.

Background

Federal disability benefits are administered by the Veterans Benefits Administration (VBA) through regional offices (ROs) located in every state.

Prior to fielding an electronic claims processing system, each of VA’s 56 ROs focused primarily on processing benefits for Veterans in the state the office was located. The proximity of the beneficiary claimant to the processing RO was important in VA’s legacy paper-based system, where claims records and files were physically stored, processed, and/or mailed between the Veteran, the RO, and the closest supporting VA medical facility. However, this geographically-based approach resulted in variances in RO workloads and processing timeliness due to factors such as multiple National Guard and Reserve Component deployments from certain states, unanticipated staffing losses at ROs, and shifts in the Veteran population in various states.

In April 2013 VBA launched its Oldest Claims Initiative to expedite decisions for Veterans who had been waiting more than one year for a decision on their claims. VBA managed this initiative centrally from its Headquarters and the four Area Offices, redistributing the oldest claims across the nation to utilize the resources of all ROs to better meet the needs of the Nation’s Veterans in an equitable way. As a result of this effort, VBA reduced the inventory of pending claims by 22 percent and the backlog by 36 percent, and completed 98.8 percent of claims older than one year for over 500,000 Veterans who had been waiting the longest – without regard to state borders. VBA’s experience with this initiative demonstrates the potential of a national workload management strategy for improved benefits delivery by optimizing every member of the VBA workforce.

Paperless claims processing

Now that VA has successfully fielded its electronic processing system, the Veterans Benefits Management System (VBMS), there is even greater potential for more streamlined and efficient claims processing. With over 80 percent of its pending claims inventory converted to digital format in VBMS, VBA can now even more efficiently manage the claims workload centrally, prioritizing and distributing the claims electronically across its network of ROs to maximize resources and improve and normalize processing timeliness at the national level. It is important to know that the RO in the state where the Veteran resides will continue to be the first filter for

determining where the claim will be assigned as long as that RO has the capacity to provide the Veteran with a timely decision. In short, the capability VBMS now offers to electronically match workload with RO capacity will minimize wait times for Veterans and bring greater consistency to the delivery of benefits.

National Work Queue Implementation

The NWQ is being implemented in a 3-phased approach. The initial Transition Phase is currently underway and builds upon the success of the workload management strategy employed under VBA's Oldest Claims Initiative. VBA's four Area Directors continue to monitor inventory levels and redistribute RO workload, but now electronically through VBMS. This Transition Phase allows VBA to refine its workload management procedures for application in the electronic environment.

Starting in FY 2015, as workload management functionality is deployed in VBMS, VBA will begin to centrally manage and distribute the claims inventory from the national level. The claims workload will then be distributed from VBA Central Office down to the RO level, taking advantage of RO capacity from a national perspective and ensuring production consistency.

In the final phase, based on additional VBMS automation, claims can be routed nationally down to the individual employee level, based on the nature of claim and the skill set of the claims processor. In all phases and even after full implementation, the first filter for assignment of the claims will remain the geographic proximity to the Veteran's place of residence. In other words, if an appropriately skilled employee is available in the RO to do that next claim, the work queue will assign it to that employee. If there isn't availability, then the claim will be completed by another skilled employee assigned to a different RO.

Under the national workload approach, RO employees will continue to play an important role in supporting local Veterans. Veterans will continue to have real-time access to updated claims information online through their *eBenefits* accounts. Veterans will also still be able to visit regional offices or call VA's National Call Centers for personal assistance with their claims.

Veterans Service Organizations (VSOs) are crucial partners in everything VA does, and their role does not change with the implementation of NWQ. VSOs are instrumental in VA's transformation to paperless claims processing by encouraging Veterans to file claims electronically. VSOs will still be able to bring their questions and concerns on individual cases to the attention of Veterans Service Center supervisors in the local ROs. They will also retain access to claims information on the Veterans they are supporting through VBMS at each RO, and online through the Stakeholder Enterprise Portal.

Congressional staff will have access to VBA RO staff as they do today to check on the status of a constituent's claim. The electronic claims process provides real-time updates, no matter where the claim is assigned for processing, as the claims all exist in the virtual claims system.

Implementation

- Transition Phase -- Electronic Workload Distribution

- Currently underway and builds on the success of the Oldest Claims Initiative
- VBA's 4 Area Offices electronically manage workload distribution to ROs
- NWQ Phase I – VBMS-Supported National Workload Distribution at the RO Level
 - Claims managed by VBA Headquarters and routed electronically to specific ROs based on their capacity to provide timely decisions and national priorities
 - NWQ will first assign claims to the RO in the state where the Veteran resides if that RO has capacity
 - Enables VBA to more easily adjust workload distribution to optimize production
 - Deployment of VBMS software to support NWQ and RO implementation of Phase I NWQ planned for early fiscal year 2015
- NWQ Phase II -- VBMS-Supported Workload Distribution at the Employee Skill Level
 - Assignment of claims to ROs includes filter for claim-specific medical issues
 - Employees are assigned claims based on specific characteristics of the claims and their grade and skill set.
 - Additional VBMS functionality to support medical-issue and skill-based workload distribution planned for delivery later in fiscal year 2015.