MILITARY CONSTRUCTION AND VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2011

THURSDAY, APRIL 15, 2010

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 2:04 p.m., in room SD–124, Dirksen Senate Office Building, Hon. Tim Johnson (chairman) presiding.

Present: Senators Johnson, Murray, Nelson, Pryor, Hutchison, Brownback, Collins, and Murkowski.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY

ACCOMPANIED BY:

HON. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION
MICHAEL WALCOFF, ACTING UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION
STEVE L. MURO, ACTING UNDER SECRETARY FOR MEMORIAL AFFAIRS, NATIONAL CEMETERY ADMINISTRATION
W. TODD GRAMS, ACTING ASSISTANT SECRETARY FOR MANAGEMENT AND CHIEF FINANCIAL OFFICER
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OPENING STATEMENT OF SENATOR TIM JOHNSON

Senator JOHNSON. This hearing will come to order.

We meet today to review the fiscal year 2011 budget request and the fiscal year 2012 advance appropriations request for the Department of Veterans Affairs.

Secretary Shinseki, I welcome you and your colleagues and I thank you for appearing before our subcommittee.

I will remind my colleagues that in order to reserve time for questions, our procedure is to have opening statements by the chairman and ranking member, followed by an opening statement from the Secretary. We will limit the first round of questions to 6 minutes per member, but we can have additional rounds should we need them.

The fiscal year 2011 discretionary budget request for the VA totals $56.9 billion, an increase of 7.4 percent over the fiscal year 2010 enacted level. Additionally, the request includes $50.6 billion in fiscal year 2012 advance appropriations for medical care.

The budget submission also includes a separate supplemental request of $13.4 billion to expand Agent Orange benefits.

I am especially pleased to see that the request includes an increase of $460 million over fiscal year 2010 for the Veterans Benefits Administration (VBA) to hire additional claims processors. Delays in claims processing are probably the most common complaint I hear from South Dakota vets.

Mr. Secretary, I have read your testimony and I am happy to see that reducing the current claims backlog is your highest priority. It is my highest priority as well, and I will continue to work to provide the sufficient resources to the Department to increase the number of claims processors and to streamline and expedite the process.

Before I turn to my ranking member, I want to commend you, Mr. Secretary, for your passion and commitment to ending homelessness among the vets population.

I am also pleased to see a continued commitment in the budget to improve mental healthcare among vets and to strengthen and expand rural healthcare.

Mr. Secretary, I look forward to hearing your opening statement, but before you begin, Senator Hutchison, would you care to make an opening statement?

STATEMENT OF SENATOR KAY BAILEY HUTCHISON

Senator HUTCHISON. Thank you, Mr. Chairman. I will be brief. Let me just make a couple of points. I think the chairman has stated the facts.

I want to say that I commend the Department for the decision on the Agent Orange diseases, and I think that is the right thing to do. I also commend you for putting into the rulemaking process gulf war syndrome and the diseases that have come from that that have heretofore not been acknowledged, and I think that is a step in the right direction.

However, I will say that I also agree with the chairman that it means that you are going to have more claims and claims processing has been an issue, and I know you know that. But certainly the Agent Orange ones will come first and 150,000 are expected. That is information that I know you have and I know that you will make that a high priority. But it is the right decision for our veterans, and I commend you for it.

The only other thing that I will mention in the big picture—and I will have a question or two—is also the emphasis on mental health services. As we have all discussed, post traumatic stress disorder, substance abuse problems, suicides, and illnesses that have increased in our active duty population, which also moves into our veterans population and retirees—I think that the increase in the budget proposed, $5.2 billion for mental health treatment, is an increase from last year that is very warranted. I think that we have begun in the last few years to acknowledge more the mental health issues and I think the treatment that is to follow coming from that is the right thing.

With that, Mr. Chairman, I will submit the rest of my statement for the record and look forward to asking a few questions.

[The statement follows:]

PREPARED STATEMENT OF SENATOR KAY BAILEY HUTCHISON

Thank you, Mr. Chairman. I am pleased to welcome Secretary Shinseki and our other witnesses and guests to discuss the President's 2011 budget request.

Mr. Chairman, the Department of Veterans Affairs has one of the most important missions in our government, and this subcommittee has always worked hard to provide the Department with the resources it needs to give our veterans the very best care this Nation can provide. In my home State of Texas, I am proud to say the VA operates 11 major medical centers, more than 40 outpatient clinics, 14 vet centers, and 6 national cemeteries to care for our State's 1.7 million veterans.

Today we will examine the budget request that provides for our veterans nationwide, including their benefits and healthcare. The VA's 2011 budget request proposes an $11.4 billion increase above last year's level—a robust 10 percent increase for our veterans. In addition to the $121 billion requested in 2011, the Department has recommended $13.4 billion in the 2010 supplemental appropriations bill for new Agent Orange-related presumptions, and $50.6 billion in advance appropriations to fund veterans' healthcare in 2012. That is a total of $185 billion in VA spending before us today—a tremendous amount of funds—and I want us all to work together to ensure this money is spent is the most fiscally efficient way possible.

In addition to its 2011 request, the Department is requesting $13.4 billion in the 2010 supplemental appropriations bill to fund the VA's recent decision to add ischemic heart disease, Parkinson's disease, and B cell leukemia to its list of automatic service-connected disabilities for Vietnam veterans exposed to Agent Orange. This presents a considerable challenge to the VA's claims processing system, which already has an unacceptably large disability claims backlog. The Department anticipates the total number of disability claims it receives to increase by 30 percent in 2010, with approximately 150,000 of these claims Agent Orange-related. I am pleased to see that this budget adds another 2,100 claims processors to the VA's current staff level, because I am concerned that our veterans already wait too long for their disability claims to be processed. Mr. Secretary, you have a significant challenge in front of you on how to handle a 30 percent increase in your claims workload, in addition to such a large influx into your workforce that will require specialized training, without causing a major disruption to other veterans' disability claims. I look forward to your comments on how we can assist you in this matter.

Mr. Secretary, the Army and the VA currently share a joint facility in El Paso, Texas. The Army has requested a significant amount of money in its 2011 budget request to begin design of a new facility in June of this year. As I understand it, the VA will need to commit funds towards a joint design by June, or the Army will award a contract based only on its own requirements. I look forward to discussing your plans on how to match the Army's accelerated timetable for this facility during the question and answer portion of our hearing today.

In its 2011 budget request, the VA recommends $1.15 billion for major construction projects, slightly below last year's level of $1.2 billion. A significant portion of this funding shows an effort to accelerate the schedules for two of the VA's longest-running projects—hospitals in New Orleans and Denver that have been partially funded for several years.

However, I am concerned that we are not obligating construction funds as quickly and efficiently as we could, and that the VA does not have a prioritized long-range capital plan to present to Congress. As you know, Mr. Secretary, for military construction projects we appropriate funds that have to be spent within 5 years to ensure efficient planning and execution. And, we also receive a Future-Year Defense Program (FYDP) from each service to understand and budget for long-range capital needs. As a former Army Chief of Staff, I am interested to hear your thoughts on whether you think having the VA construction program abide by some of these parameters, such as 5-year funding and a prioritized Five-Year Capital Plan, would be beneficial to the process.

Mr. Secretary, nearly all the efforts to modernize the VA hinge upon the Department's ability to leverage information technology to improve services to our veterans. Some of the projects we've funded in past budgets include a paperless solution to the disability claims backlog, a new electronic medical record, and a lifetime service record to follow service members through the Departments of Defense and Veterans Affairs. However, government agencies have a poor track record developing and implementing costly IT programs, and an internal audit by the VA last year resulted in 45 of the Department's 282 ongoing projects being halted because they were either significantly behind schedule or over budget. I want to be sure we are spending our taxpayer dollars efficiently, and I look forward to hearing your thoughts on what steps we can take to ensure more efficiency and transparency for these projects.

I am pleased to see the emphasis that the Medical Services request places on mental health and rehabilitation, especially for our soldiers returning with delayed Post-Traumatic Stress Disorder and substance abuse problems. The VA's budget proposes $5.2 billion for mental health treatment, a $410 million increase above last year. The VA now has PTSD specialists or treatment teams in all of its medical centers.

As our men and women return from war, we want to be certain they receive the very best medical care our Nation can provide. Your budget request keeps us on that track. I know it is difficult to anticipate every need, but this subcommittee will certainly make every effort to provide you the resources you need.

Mr. Secretary, I am extremely pleased with the VA's decision to build its fifth polytrauma center in San Antonio. I can't wait to see this project complete and operational, and I'm thrilled that contracts have been awarded and construction has begun. This new center will care for our most severely injured veterans and will be a great complement to the other medical facilities in the San Antonio area, where cutting-edge technology will be shared between the VA and the military services.

The VA manages the only nationwide network to care for polytrauma patients and has become the world's leader in traumatic brain injury rehabilitation. As more of our soldiers return home with multiple traumatic injuries, I am confident we can leverage the VA's experiences at the other four Level 1 polytrauma centers to make this new facility the VA's flagship for our Nation's most seriously wounded veterans.

Mr. Secretary, this subcommittee has always put our Nation's veterans first, and I can say with great assurance that we will do whatever it takes, in a bipartisan manner, to work with you to make sure the VA has all of the necessary resources to take care of our Nation's veterans. At the same time, it is our joint responsibility to ensure these funds are spent in the most fiscally responsible and efficient manner possible. I look forward to working with you on these and other issues in the coming months.

Thank you, Mr. Chairman.

Senator JOHNSON. Thank you, Senator Hutchison.

Mr. Secretary, again I welcome you to the subcommittee. I understand that yours will be the only opening statement. Your full statement will be included in the record. So please feel free to summarize your remarks. Mr. Secretary.

Secretary SHINSEKI. Thank you very much, Chairman Johnson. To you and Ranking Member Hutchison, other distinguished members of this subcommittee, thanks. I always say that sincerely. Thank you for this opportunity to present the President's 2011 budget and the 2012 advance appropriations request for VA.

I am able to report a good start in 2009, and I would just take a moment to remind that the 2009 budget was a congressionally enhanced budget. So there was a great foundation for this Secretary upon arrival to put in place a good foundation for the year that we are now having with the 2010 budget. VA had a good start in 2009 with a tremendous opportunity this year in 2010. We are happy to talk about what we are doing, and the President's continued strong support for veterans and veterans needs into the 2011 budget request, which is before Congress, with the 2012 advance appropriations.

I appreciate the generosity of time shared by members of this subcommittee with me as I made my rounds. I regret that I was not able to call on everyone, but I thank the members that I was able to meet. Those opportunities are always invaluable to me in getting insights.

I would like to acknowledge in our audience today representatives from some of our veterans service organizations. Their insights have been helpful to me in understanding our obligation and how to frame our actions to better meet the needs of veterans.

By way of introduction, Mr. Chairman, let me introduce the members of my team from my left here. Mike Walcoff is the Acting Under Secretary for Benefits. Todd Grams is our new Principal Deputy and Acting Assistant Secretary for Management. Dr. Randy Petzel to my right, recently confirmed Under Secretary for Health. Steve Muro, Acting Under Secretary for Memorial Affairs. And on my extreme right, Roger Baker, our Assistant Secretary for Information and Technology, who also serves as our Chief Information Officer.

This subcommittee's longstanding commitment to our Nation's veterans has always been unequivocal and unwavering, and such commitment and the President's own steadfast support of veterans resulted in a 2010 budget that provides this Department the resources to begin renewing itself in fundamental and comprehensive ways, not in spots but as an entire organization, fundamental and comprehensive ways.

We are well launched on that effort and determined to continue that transformation into 2011 with this budget and 2012.

For over a year now, we have promoted a new strategic framework organized around three governing principles, and I have mentioned them before in prior testimonies, and I will just repeat them again. It is about transforming VA into being more people-centric, results-oriented or results-driven, and forward-looking. And in our effort, our strategic goals are several: improve the quality of, and increase access to, care and benefits while optimizing value; heighten readiness to protect our people, clients as well as our workforce, and our resources each day, as well in times of crisis; enhance veteran satisfaction with our health, education, training, counseling, financial, and burial benefits and services; and finally, invest in our human capital both in their well-being, our workforce, and in their development as leaders so that over time we have this irreversible drive toward excellence in everything we do, from management, to IT systems, to support services.

This last goal is vital to mission performance if we are to attain being a model of governance in the next 4 years, which is our goal. These goals will guide our people daily and focus them on producing the outcomes veterans expect and have earned through their service to the Nation. We will advocate for veterans we serve.

To support our pursuit of these goals, the President's budget provides $125 billion in 2011, $60.3 billion in discretionary resources and $64.7 billion in mandatory funding. Our discretionary budget request represents an increase of $4.2 billion over the President's 2010 enacted budget.

VA's 2011 budget focuses primarily on three critical concerns that are of significant importance to veterans, and I get this in feedback as I travel and I am sure members of the subcommittee do as well. First, increase access to benefits and services now. Eliminate the disability claims backlog by 2015. And finally, end veteran homelessness in the next 5 years. The three goals we have set for ourselves.

Access. This budget provides the resources required to increase access to our healthcare system and our national cemeteries. We will expand access to healthcare by activating new and improved facilities, by honoring the President's commitment to veterans who

were exposed to Agent Orange 40 years ago, by delivering on President Obama's promise to provide healthcare eligibility to more priority group 8 veterans, by making greater investments in telehealth and extending our delivery of care into the most remote rural communities and, where warranted, even into veterans' homes. And finally, we will increase access to our national shrines by establishing five new national cemeteries.

The backlog. We are requesting an unprecedented 27 percent increase in funding for our Veterans Benefits Administration, primarily for staffing to address the growing increase in disability claims receipts, even as we continue to reengineer our processes and develop a paperless system integrated with VLER, the Virtual Lifetime Electronic Record. That is the joint project between DOD and VA.

Our goal in processing: no claim that is longer than 125 days. So it is not an average. No claim longer than 125 days, and a processing accuracy of 98 percent. Today we are at the 84 percent mark. So this is a stretch goal.

Ending homelessness. We are requesting substantial investment in our homelessness program as part of our plan to eliminate homelessness in 5 years. Ending the downward spiral that often enough leads to veterans' homelessness mandates that we aggressively and simultaneously address housing, education, jobs, and healthcare.

In this effort, we partner with other Departments. The Department of Housing and Urban Development is probably our closest collaborator, but we collaborate as well with Labor, Education, Health and Human Services, Small Business Administration, among others.

Now, taken together, these initiatives are intended to meet veterans' expectations in each of these three mission-focused areas. I mentioned them earlier. Increasing their access, eliminating the backlog, ending homelessness. We will achieve these objectives by developing innovative business processes, some of them already underway, and delivery systems that not only better serve veterans and families' needs for many years to come, but which also dramatically improve our efficiency and control our costs.

While our budget and advance appropriations request provide the resources to continue our pursuit of the President's two overarching goals for this Department—transform this Department and ensure veteran access—we still have much work to accomplish.

We appreciate the chairman's and ranking member's leadership and the support of all the members of the subcommittee especially in some of the areas that we have given attention to, areas like rural health and healthcare for women veterans. We are determined to build on the progress you have enabled, especially with the provision of a significant first-year funding for rural initiatives. So our efforts are well begun, but there is more work to be done in meeting our obligations here.

PREPARED STATEMENT

Again, Mr. Chairman, members of the subcommittee, thanks for this opportunity to appear here today. I look forward to your questions.

[The statement follows:]

PREPARED STATEMENT OF HON. ERIC K. SHINSEKI

Chairman Johnson, Ranking Member Hutchison, Distinguished Members of the Senate Appropriations Committee, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies:

Thank you for this opportunity to present the President's Fiscal Year 2011 Budget and Fiscal Year 2012 Advance Appropriations request for the Department of Veterans Affairs (VA). Our budget provides the resources necessary to continue our aggressive pursuit of the President's two overarching goals for the Department—to transform VA into a 21st century organization and to ensure that we provide timely access to benefits and high quality care to our Veterans over their lifetimes, from the day they first take their oaths of allegiance until the day they are laid to rest.

We recently completed development of a new strategic framework that is people-centric, results-driven, and forward-looking. The path we will follow to achieve the President's vision for VA will be presented in our new strategic plan, which is currently in the final stages of review. The strategic goals we have established in our plan are designed to produce better outcomes for all generations of Veterans:

—Improve the quality and accessibility of healthcare, benefits, and memorial services while optimizing value;
—Increase Veteran client satisfaction with health, education, training, counseling, financial, and burial benefits and services;
—Protect people and assets continuously and in time of crisis; and,
—Improve internal customer satisfaction with management systems and support services to achieve mission performance and make VA an employer of choice by investing in human capital.

The strategies in our plan will guide our workforce to ensure we remain focused on producing the outcomes Veterans expect and have earned through their service to our country.

To support VA's efforts, the President's budget provides $125 billion in 2011—almost $60.3 billion in discretionary resources and nearly $64.7 billion in mandatory funding. Our discretionary budget request represents an increase of $4.3 billion, or 7.6 percent, over the 2010 enacted level.

VA's 2011 budget also focuses on three concerns that are of critical importance to our Veterans—easier access to benefits and services; reducing the disability claims backlog and the time Veterans wait before receiving earned benefits; and ending the downward spiral that results in Veterans' homelessness.

This budget provides the resources required to enhance access in our healthcare system and our national cemeteries. We will expand access to healthcare through the activations of new or improved facilities, by expanding healthcare eligibility to more Veterans, and by making greater investments in telehealth. Access to our national cemeteries will be increased through the implementation of new policy for the establishment of additional facilities.

We are requesting an unprecedented increase for staffing in the Veterans Benefits Administration (VBA) to address the dramatic increase in disability claim receipts while continuing our process-reengineering efforts, our development of a paperless claims processing system, and the creation of a Virtual Lifetime Electronic Record.

We are also requesting a substantial investment for our homelessness programs as part of our plan to ultimately eliminate Veterans' homelessness through an aggressive approach that includes housing, education, jobs, and healthcare.

VA will be successful in resolving these three concerns by maintaining a clear focus on developing innovative business processes and delivery systems that will not only serve Veterans and their families for many years to come, but will also dramatically improve the efficiency of our operations by better controlling long-term costs. By making appropriate investments today, we can ensure higher value and better outcomes for our Veterans. The 2011 budget also supports many key investments in VA's six high priority performance goals (HPPGs).

HPPG I: REDUCING THE CLAIMS BACKLOG

The volume of compensation and pension rating-related claims has been steadily increasing. In 2009, for the first time, we received over 1 million claims during the course of a single year. The volume of claims received has increased from 578,773 in 2000 to 1,013,712 in 2009 (a 75 percent increase). Original disability compensation claims with eight or more claimed issues have increased from 22,776 in 2001 to 67,175 in 2009 (nearly a 200 percent increase). Not only is VA receiving substantially more claims, but the claims have also increased in complexity. We expect this level of growth in the number of claims received to continue in 2010 and 2011 (in-

creases of 13 percent and 11 percent were projected respectively even without claims expected under new presumptions related to Agent Orange exposure), which is driven by improved access to benefits through initiatives such as the Benefits Delivery at Discharge Program, increased demand as a result of nearly 10 years of war, and the impact of a difficult economy prompting America's Veterans to pursue access to the benefits they earned during their military service.

While the volume and complexity of claims has increased, so too has the productivity of our claims processing workforce. In 2009, the number of claims processed was 977,219, an increase of 8.6 percent over the 2008 level of 899,863. The average time to process a rating-related claim fell from 179 to 161 days in 2009, an improvement of 11 percent.

The progress made in 2009 is a step in the right direction, but it is not nearly enough. My goal is to process claims so no Veteran has to wait more than 125 days. Reaching this goal will become even more challenging because of additional claims we expect to receive related to Veterans' exposure to Agent Orange. Adding Parkinson's disease, ischemic heart disease, and B-cell leukemias to the list of presumptive disabilities is projected to significantly increase claims inventories in the near term, even while we make fundamental improvements to the way we process disability compensation claims.

We expect the number of compensation and pension claims received to increase from 1,013,712 in 2009 to 1,318,753 in 2011 (a 30 percent increase). Without the significant investment requested for staffing in this budget, the inventory of claims pending would grow from 416,335 to 1,018,343 and the average time to process a claim would increase from 161 to 250 days. If Congress provides the funding requested in our budget, these increases are projected to be 804,460 claims pending with an average processing time of 190 days. Through 2011, we expect over 228,000 claims related to the new presumptions and are dedicated to processing this near-term surge in claims as efficiently as possible.

This budget is based on our plan to improve claims processing by using a three-pronged approach involving improved business processes, expanded technology, and hiring staff to bridge the gap until we fully implement our long-range plan. We will explore process and policy simplification and contracted service support in addition to the traditional approach of hiring new employees to address this spike in demand. We expect these transformational approaches to begin yielding significant performance improvements in fiscal year 2012 and beyond; however, it is important to mitigate the impact of the increased workload until that time.

The largest increase in our 2011 budget request, in percentage terms, is directed to the Veterans Benefits Administration as part of our mitigation of the increased workload. The President's 2011 budget request for VBA is $2.149 billion, an increase of $460 million, or 27 percent, over the 2010 enacted level of $1.689 billion. The 2011 budget supports an increase of 4,048 FTEs, including maintaining temporary FTE funded through ARRA. In addition, the budget also includes $145.3 million in information technology (IT) funds in 2011 to support the ongoing development of a paperless claims processing system.

HPPG II: ELIMINATING VETERAN HOMELESSNESS

Our Nation's Veterans experience higher than average rates of homelessness, depression, substance abuse, and suicides; many also suffer from joblessness. On any given night, there are about 107,000 Veterans who live on the streets, representing every war and generation, including those who served in Iraq and Afghanistan. VA's major homeless-specific programs constitute the largest integrated network of homeless treatment and assistance services in the country. These programs provide a continuum of care for homeless Veterans, providing treatment, rehabilitation, and supportive services that assist homeless Veterans in addressing health, mental health and psychosocial issues. VA also offers a full range of support necessary to end the cycle of homelessness by providing education, jobs, and healthcare, in addition to safe housing. We will increase the number and variety of housing options available to homeless Veterans and those at risk of homelessness with permanent, transitional, contracted, community-operated, HUD–VASH provided, and VA-operated housing.

Homelessness is primarily a healthcare issue, heavily burdened with depression and substance abuse. VA's budget includes $4.2 billion in 2011 to prevent and reduce homelessness among Veterans—over $3.4 billion for core medical services and $799 million for specific homeless programs and expanded medical programs. Our budget includes an additional investment of $294 million in programs and new initiatives to reduce the cycle of homelessness, which is almost 55 percent higher than the resources provided for homelessness programs in 2010.

VA's healthcare costs for homeless Veterans can drop in the future as the Department emphasizes education, jobs, and prevention and treatment programs that can result in greater residential stability, gainful employment, and improved health status.

HPPG III: AUTOMATING THE GI BILL BENEFITS SYSTEM

The Post 9/11 GI Bill creates a robust enhancement of VA's education benefits, evoking the World War II Era GI Bill. Because of the significant opportunities the Act provides to Veterans in recognition of their service, and the value of the program in the current economic environment, we must deliver the benefits in this Act effectively and efficiently, and with a client-centered approach. In August 2009, the new Post-9/11 GI Bill program was launched. We received more than 496,000 original applications, 578,000 enrollment certifications, and 237,000 changes to enrollment certifications since the inception of this program.

The 2011 budget provides $44.1 million to complete the automated solution for processing Post-9/11 GI Bill claims and to begin the development and implementation of electronic systems to process claims associated with other education programs. The automated solution for the Post 9/11 GI Bill education program will be implemented by December 2010.

In 2011, we expect the total number of all types of education claims to grow by 32.3 percent over 2009, from 1.70 million to 2.25 million. To meet this increasing workload and complete education claims in a timely manner, VA has established a comprehensive strategy to develop an end-to-end solution that utilizes rules-based, industry-standard technologies to modernize the delivery of education benefits.

HPPG IV: ESTABLISHING A VIRTUAL LIFETIME ELECTRONIC RECORD

Each year, more than 150,000 active and reserve component service members leave the military. Currently, this transition is heavily reliant on the transfer of paper-based administrative and medical records from the Department of Defense (DOD) to the Veteran, the VA or other non-VA healthcare providers. A paper-based transfer carries risks of errors or oversights and delays the claim process.

In April 2009, the President charged me and Defense Secretary Gates with building a fully interoperable electronic records system that will provide each member of our armed forces a Virtual Lifetime Electronic Record (VLER). This virtual record will enhance the timely delivery of high-quality benefits and services by capturing key information from the day they put on the uniform, through their time as Veterans, until the day they are laid to rest. The VLER is the centerpiece of our strategy to better coordinate the user-friendly transition of service members from their service component into VA, and to produce better, more timely outcomes for Veterans in providing their benefits and services.

In December 2009, VA successfully exchanged electronic health record (EHR) information in a pilot program between the VA Medical Center in San Diego and a local Kaiser Permanente hospital. We exchanged EHR information using the Nationwide Health Information Network (NHIN) created by the Department of Health and Human Services. Interoperability is key to sharing critical health information. Utilizing the NHIN standards allows VA to partner with private sector healthcare providers and other Federal agencies to promote better, faster, and safer care for Veterans. During the second quarter of 2010, the DOD will join this pilot and we will announce additional VLER health community sites.

VA has $52 million in IT funds in 2011 to continue the development and implementation of this Presidential priority.

HPPG V: IMPROVING MENTAL HEALTH CARE

The 2011 budget continues the Department's keen focus on improving the quality, access, and value of mental healthcare provided to Veterans. VA's budget provides over $5.2 billion for mental health, an increase of $410 million, or 8.5 percent, over the 2010 enacted level. We will expand inpatient, residential, and outpatient mental health programs with an emphasis on integrating mental health services with primary and specialty care.

Post-Traumatic Stress Disorder (PTSD) is the mental health condition most commonly associated with combat, and treating Veterans who suffer from this debilitating disorder is central to VA's mission. Screening for PTSD is the first and most essential step. It is crucial that VA be proactive in identifying PTSD and intervening early in order to prevent chronic problems that could lead to more complex disorders and functional problems.

VA will also expand its screening program for other mental health conditions, most notably traumatic brain injury (TBI), depression, and substance use disorders.

We will enhance our suicide prevention advertising campaign to raise awareness among Veterans and their families of the services available to them.

More than one-fifth of the Veterans seen last year had a mental health diagnosis. In order to address this challenge, VA has significantly invested in our mental health workforce, hiring more than 6,000 new workers since 2005.

In October 2009, VA and DOD held a mental health summit with mental health experts from both departments, and representatives from Congress and more than 57 non-government organizations. We convened the summit to discuss an innovative, wide-ranging public health model for enhancing mental health for returning service members, Veterans, and their families. VA will use the results to devise new innovative strategies for improving the health and quality of life for Veterans suffering from mental health problems.

HPPG VI: DEPLOYING A VETERANS RELATIONSHIP MANAGEMENT SYSTEM

A key component of VA's transformation is to employ technology to dramatically improve service and outreach to Veterans by adopting a comprehensive Veterans' Relationship Management System to serve as the primary interface between Veterans and the Department. This system will include a framework that provides Veterans with the ability to:

—Access VA through multiple methods;
—Uniformly find information about VA's benefits and services;
—Complete multiple business processes within VA without having to re-enter identifying information; and
—Seamlessly access VA across multiple lines of business.

This system will allow Veterans to access comprehensive online information anytime and anywhere via a single consistent entry point. Our goal is to deploy the Veterans Relationship Management System in 2011. Our budget provides $51.6 million for this project.

In addition to resources supporting these high-priority performance goals, the President's budget enhances and improves services across the full spectrum of the Department. The following highlights funding requirements for selected programs along with the outcomes we will achieve for Veterans and their families.

DELIVERING WORLD-CLASS MEDICAL CARE

The Budget provides $51.5 billion for medical care in 2011, an increase of $4 billion, or 8.5 percent, over the 2010 level. This level will allow us to continue providing timely, high-quality care to all enrolled veterans. Our total medical care level is comprised of funding for medical services ($37.1 billion), medical support and compliance ($5.3 billion), medical facilities ($5.7 billion), and resources from medical care collections ($3.4 billion). In addition to reducing the number of homeless Veterans and expanding access to mental healthcare, our 2011 budget will also achieve numerous other outcomes that improve Veterans' quality of life, including:

—Providing extended care and rural health services in clinically appropriate settings;
—Expanding the use of home telehealth;
—Enhancing access to healthcare services by offering enrollment to more Priority Group 8 Veterans and activating new facilities; and
—Meeting the medical needs of women Veterans.

During 2011, we expect to treat nearly 6.1 million unique patients, a 2.9 percent increase over 2010. Among this total are over 439,000 Veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom, an increase of almost 57,000 (or 14.8 percent) above the number of Veterans from these two campaigns that we anticipate will come to VA for healthcare in 2010.

In 2011, the budget provides $2.6 billion to meet the healthcare needs of Veterans who served in Iraq and Afghanistan. This is an increase of $597 million (or 30.2 percent) over our medical resource requirements to care for these Veterans in 2010. This increase also reflects the impact of the recent decision to increase troop size in Afghanistan. The treatment of this newest generation of Veterans has allowed us to focus on, and improve treatment for, PTSD as well as TBI, including new programs to reach Veterans at the earliest stages of these conditions.

The fiscal year 2011 Budget also includes funding for new patients resulting from the recent decision to add Parkinson's disease, ischemic heart disease, and B-cell leukemias to the list of presumptive conditions for Veterans with service in Vietnam.

Extended Care and Rural Health

VA's budget for 2011 contains $6.8 billion for long-term care, an increase of 858.8 million (or 14.4 percent) over the 2010 level. In addition, $1.5 billion is included for non-institutional long-term care, an increase of $276 million (or 22.9 percent) over 2010. By enhancing Veterans' access to non-institutional long-term care, VA can provide extended care services to Veterans in a more clinically appropriate setting, closer to where they live, and in the comfort and familiar settings of their homes.

VA's 2011 budget also includes $250 million to continue strengthening access to healthcare for 3.2 million enrolled Veterans living in rural and highly rural areas through a variety of avenues. These include new rural health outreach and delivery initiatives and expanded use of home-based primary care, mental health, and telehealth services. VA intends to expand use of cutting edge telehealth technology to broaden access to care while at the same time improve the quality of our healthcare services.

Home Telehealth

Our increasing reliance on non-institutional long-term care includes an investment in 2011 of $163 million in home telehealth. Taking greater advantage of the latest technological advancements in healthcare delivery will allow us to more closely monitor the health status of Veterans and will greatly improve access to care for Veterans in rural and highly rural areas. Telehealth will place specialized healthcare professionals in direct contact with patients using modern IT tools. VA's home telehealth program cares for 35,000 patients and is the largest of its kind in the world. A recent study found patients enrolled in home telehealth programs experienced a 25 percent reduction in the average number of days hospitalized and a 19 percent reduction in hospitalizations. Telehealth and telemedicine improve healthcare by increasing access, eliminating travel, reducing costs, and producing better patient outcomes.

Expanding Access to Health Care

In 2009 VA opened enrollment to Priority 8 Veterans whose incomes exceed last year's geographic and VA means-test thresholds by no more than 10 percent. Our most recent estimate is that 193,000 more Veterans will enroll for care by the end of 2010 due to this policy change.

In 2011 VA will further expand healthcare eligibility for Priority 8 Veterans to those whose incomes exceed the geographic and VA means-test thresholds by no more than 15 percent compared to the levels in effect prior to expanding enrollment in 2009. This additional expansion of eligibility for care will result in an estimated 99,000 more enrollees in 2011 alone, bringing the total number of new enrollees from 2009 to the end of 2011 to 292,000.

Meeting the Medical Needs of Women Veterans

The 2011 budget provides $217.6 million to meet the gender-specific healthcare needs of women Veterans, an increase of $18.6 million (or 9.4 percent) over the 2010 level. The delivery of enhanced primary care for women Veterans remains one of the Department's top priorities. The number of women Veterans is growing rapidly and women are increasingly reliant upon VA for their healthcare.

Our investment in healthcare for women Veterans will lead to higher quality of care, increased coordination of care, enhanced privacy and dignity, and a greater sense of security among our women patients. We will accomplish this through expanding healthcare services provided in our Vet Centers, increasing training for our healthcare providers to advance their knowledge and understanding of women's health issues, and implementing a peer call center and social networking site for women combat Veterans. This call center will be open 24 hours a day, 7 days a week.

ADVANCE APPROPRIATIONS FOR MEDICAL CARE IN 2012

VA is requesting advance appropriations in 2012 of $50.6 billion for the three medical care appropriations to support the healthcare needs of 6.2 million patients. The total is comprised of $39.6 billion for Medical Services, $5.5 billion for Medical Support and Compliance, and $5.4 billion for Medical Facilities. In addition, $3.7 billion is estimated in medical care collections, resulting in a total resource level of $54.3 billion. It does not include additional resources for any new initiatives that would begin in 2012.

Our 2012 advance appropriations request is based largely on our actuarial model using 2008 data as the base year. The request continues funding for programs that we will continue in 2012 but which are not accounted for in the actuarial model. These initiatives address homelessness and expanded access to non-institutional

long-term care and rural healthcare services through telehealth. In addition, the 2012 advance appropriations request includes resources for several programs not captured by the actuarial model, including long-term care, the Civilian Health and Medical Program of the Department of Veterans Affairs, Vet Centers, and the state home per diem program. Overall, the 2012 requested level, based on the information available at this point in time, is sufficient to enable us to provide timely and high-quality care for the estimated patient population. We will continue to monitor cost and workload data throughout the year and, if needed, we will revise our request during the normal 2012 budget cycle.

After a cumulative increase of 26.4 percent in the medical care budget since 2009, we will be working to reduce the rate of increase in the cost of the provision of healthcare by focusing on areas such as better leveraging acquisitions and contracting, enhancing use of referral agreements, strengthening DOD/VA joint ventures, and expanding applications of medical technology (e.g. telehome health).

INVESTMENTS IN MEDICAL RESEARCH

VA's budget request for 2011 includes $590 million for medical and prosthetic research, an increase of $9 million over the 2010 level. These research funds will help VA sustain its long track record of success in conducting research projects that lead to clinically useful interventions that improve the health and quality of life for Veterans as well as the general population.

This budget contains funds to continue our aggressive research program aimed at improving the lives of Veterans returning from service in Iraq and Afghanistan. This focuses on prevention, treatment, and rehabilitation research, including TBI and polytrauma, burn injury research, pain research, and post-deployment mental health research.

SUSTAINING HIGH QUALITY BURIAL AND MEMORIAL PROGRAMS

VA remains steadfastly committed to providing access to a dignified and respectful burial for Veterans choosing to be buried in a VA national cemetery. This promise to Veterans and their families also requires that we maintain national cemeteries as shrines dedicated to the memory of those who honorably served this Nation in uniform. This budget implements new policy to expand access by lowering the Veteran population threshold for establishing new national cemeteries and developing additional columbaria to better serve large urban areas.

VA expects to perform 114,300 interments in 2011 or 3.8 percent more than in 2010. The number of developed acres (8,441) that must be maintained in 2011 is 4.6 percent greater than the 2010 estimate, while the number of gravesites (3,147,000) that will be maintained is 2.6 percent higher. VA will also process more than 617,000 Presidential Memorial Certificates in recognition of Veterans' honorable military service.

Our 2011 budget request includes $251 million in operations and maintenance funding for the National Cemetery Administration. The 2011 budget request provides $36.9 million for national shrine projects to raise, realign, and clean an estimated 668,000 headstones and markers, and repair 100,000 sunken graves. This is critical to maintaining our extremely high client satisfaction scores that set the national standard of excellence in government and private sector services as measured by the American Customer Satisfaction Index. The share of our clients who rate the quality of the memorial services we provide as excellent will rise to 98 percent in 2011. The proportion of clients who rate the appearance of our national cemeteries as excellent will grow to 99 percent. And we will mark 95 percent of graves within 60 days of interment.

The 2011 budget includes $3 million for solar and wind power projects at three cemeteries to make greater use of renewable energy and to improve the efficiency of our program operations. It also provides $1.25 million to conduct independent Facility Condition Assessments at national cemeteries and $2 million for projects to correct safety and other deficiencies identified in those assessments.

LEVERAGING INFORMATION TECHNOLOGY

We cannot achieve the transformation of VA into a 21st century organization capable of meeting Veterans' needs today and in the years to come without leveraging the power of IT. The Department's IT program is absolutely integral to everything we do, and it is vital we continue the development of IT systems that will meet new service delivery demands and modernize or replace increasingly fragile systems that are no longer adequate in today's healthcare and benefits delivery environment. Simply put, IT is indispensable to achieving VA's mission.

The Department's IT operations and maintenance program supports 334,000 users, including VA employees, contractors, volunteers, and researchers situated in 1,400 healthcare facilities, 57 regional offices, and 158 national cemeteries around the country. Our IT program protects and maintains 8.5 million vital health and benefits records for Veterans with the level of privacy and security mandated by both statutes and directives.

VA's 2011 budget provides $3.3 billion for IT, the same level of funding provided in 2010. We have prioritized potential IT projects to ensure that the most mission-critical projects for improving service to Veterans are funded. For example, the resources we are requesting will fund the development and implementation of an automated solution for processing education claims ($44.1 million), the Financial and Logistics Integrated Technology Enterprise project to replace our outdated, non-compliant core accounting system ($120.2 million), development and deployment of the paperless claims processing system ($145.3 million), and continued development of HealtheVet, VA's electronic health record system ($346.2 million). In addition, the 2011 budget request includes $52 million for the advancement of the Virtual Lifetime Electronic Record, a Presidential priority that involves our close collaboration with DOD.

ENHANCING OUR MANAGEMENT INFRASTRUCTURE

A critical component of our transformation is to create a reliable management infrastructure that expands or enhances corporate transparency at VA, centralizes leadership and decentralizes execution, and invests in leadership training. This includes increasing investment in training and career development for our career civil service and employing a suitable financial management system to track expenditures. The Department's 2011 budget provides $463 million in General Administration to support these vital corporate management activities. This includes $23.6 million in support of the President's initiative to strengthen the acquisition workforce.

We will place particular emphasis on increasing our investment in training and career development—helping to ensure that VA's workforce remain leaders and standard-setters in their fields, skilled, motivated, and client-oriented. Training and development (including a leadership development program), communications and team building, and continuous learning will all be components of reaching this objective.

CAPITAL INFRASTRUCTURE

VA must provide timely, high-quality healthcare in medical infrastructure which is, on average, over 60 years old. In the 2011 budget, we are requesting $1.6 billion to invest in our major and minor construction programs to accomplish projects that are crucial to right sizing and modernizing VA's healthcare infrastructure, providing greater access to benefits and services for more Veterans, closer to where they live, and adequately addressing patient safety and other critical facility deficiencies.

Major Construction

The 2011 budget request for VA major construction is $1.151 billion. This includes funding for five medical facility projects in New Orleans, Louisiana; Denver, Colorado; Palo Alto and Alameda, California; and Omaha, Nebraska.

This request provides $106.9 million to support the Department's burial program, including gravesite expansion and cemetery improvement projects at three national cemeteries—Indiantown Gap, Pennsylvania; Los Angeles, California; and Tahoma, Washington.

Our major construction request includes $51.4 million to begin implementation of a new policy to expand and improve access to burial in a national cemetery. Most significantly, this new policy lowers the Veteran population threshold to build a new national cemetery from 170,000 to 80,000 Veterans living within 75 miles of a cemetery. This will provide access to about 500,000 additional Veterans. Moreover, it will increase our strategic target for the percent of Veterans served by a burial option in a national or state Veterans cemetery within 75 miles of their residence from 90 percent to 94 percent.

VA's major construction request also includes $24 million for resident engineers that support medical facility and national cemetery projects. This represents a new source of funding for the resident engineer program, which was previously funded under General Operating Expenses.

Minor Construction

The $467.7 million request for 2011 for minor construction is an integral component of our overall capital program. In support of the medical care and medical research programs, minor construction funds permit VA to realign critical services;

make seismic corrections; improve patient safety; enhance access to healthcare; increase capacity for dental care; enhance patient privacy; improve treatment of special emphasis programs; and expand our research capability. Minor construction funds are also used to improve the appearance of our national cemeteries. Further, minor construction resources will be used to comply with energy efficiency and sustainability design requirements.

SUMMARY

Our job at the VA is to serve Veterans by increasing their access to VA benefits and services, to provide them the highest quality of healthcare available, and to control costs to the best of our ability. Doing so will make VA a model of good governance. The resources provided in the 2011 President's budget will permit us to fulfill our obligation to those who have bravely served our country.

The 298,000 employees of the VA are committed to providing the quality of service needed to serve our Veterans and their families. They are our most valuable resource. I am especially proud of several VA employees that have been singled out for special recognition this year.

First, let me recognize Dr. Janet Kemp, who received the "2009 Federal Employee of the Year" award from the Partnership for Public Service. Under Dr. Kemp's leadership, VA created the Veterans National Suicide Prevention Hotline to help Veterans in crisis. To date, the Hotline has received almost 256,000 calls and rescued about 8,100 people judged to be at imminent risk of suicide since its inception.

Second, we are also very proud of Nancy Fichtner, an employee at the Grand Junction Colorado Medical Center, for being the winner of the President's first-ever SAVE (Securing Americans Value and Efficiency) award. Ms. Fichtner's winning idea is for Veterans leaving VA hospitals to be able to take medication they have been using home with them instead of it being discarded upon discharge.

And third, we are proud of the VA employees at our Albuquerque, New Mexico Clinical Research Pharmacy Coordinating Center, including the Center Director, Mike R. Sather, for excellence in supporting clinical trials targeting current Veteran health issues. Their exceptional and important work garnered the center's recognition as the 2009 Malcolm Baldrige National Quality Award Recipient in the nonprofit category.

The VA is fortunate to have public servants that are not only creative thinkers, but also able to put good ideas into practice. With such a workforce, and the continuing support of Congress, I am confident we can achieve our shared goal of accessible, high-quality and timely care and benefits for Veterans.

CLAIMS BACKLOG

Senator JOHNSON. Thank you, Secretary Shinseki.

In the 4 years that I have chaired this subcommittee, we have provided a total of $427 million above what the VA requested to hire additional claims processors to reduce the claims backlog. I am pleased to see that this year's budget request reflects a significant increase over last year to hire claims processors. However, the average claims time still hovers around 161 days and is expected to increase, given the new decision regarding Agent Orange.

I know that the task of transforming the VA is daunting, but the level of frustration that vets expressed to me is growing.

When can we expect to see some tangible results from the investments that we are making into the VBA claims process?

Secretary SHINSEKI. Mr. Chairman, if there is frustration to go around, I share a good bit of it.

I wanted to put a little more of my attention into the claims backlog last year. I got diverted a little bit. I spent some time making sure that the 9/11 G.I. bill was up and running properly, and now that it is, this year for me and for VA is about breaking the back in the backlog, getting to the root causes of what creates this as a never-ending challenge. Last year, we produced 977,000 decisions on claims, and then we got a million new claims in return. So this is a big numbers issue.

Today we have probably 11,400 claims adjudicators, and this number of workforce, good people who come to work every day, takes a while to get them trained up. They provide us the ability to take that average processing time from, at one point, 190 days, and we have worked our way down to about 160 days now, headed toward that 125 goal as an average.

With this budget for 2011, we have increased VBA's budget by 27 percent. A good portion of that resources initiatives underway, but also adds 4,000 people to the workforce. And right now, if we want to go faster, the solution is to hire more people because we lack the automation tools that should have helped us break the code some time ago. We are working on developing those tools, and I will turn to Secretary Baker in a second to give you an assessment of where we are.

I will also tell you that we created four pilots to take this process apart and look at those pieces individually and we intend to put them back together in a way that makes greater sense, simpler, less complex, and then try to get momentum here at the same time we are developing these tools.

This year, 2010, I am happy to report that we have the resources in the right place, and we have the leadership focused on how to do this correctly.

So let me turn to Secretary Baker and then I will turn to Mike Walcoff here for any other comments he might like to provide.

Mr. BAKER. Thank you, Mr. Secretary. Just quickly recapping where we are on the paperless system, the Veterans Benefits Management System. There are a number of pilots in place right now looking at different processes and different technologies to move VBA forward, one in Baltimore that we are particularly proud of, the Virtual Regional Office, that ties together process changes with technology to demonstrate what can be done inside of VBA. We will be letting contracts in the spring and the summer to get that fully implemented into pilots during 2011 at VBA regional offices and then full rollout starting in late 2011 and 2012 of the paperless system across the entire VBA enterprise.

Now, the paperless system does two things for us. One clearly is moving the system away from being paper-bound and into electronic. But the second is making it much more flexible for the VBA to look at their processes and make changes in their processes that will speed the way the work is done on top of the electronic system. So we are making good progress in that area at this point, primarily driven by our Chief Technology Officer, Peter Levin, and I think we have substantial progress to this point and you will see substantial progress through the rest of 2010 and 2011.

Mr. WALCOFF. Thank you, Mr. Secretary.

Just a couple of things that I want to add. The Secretary mentioned that we are going to be hiring more people. Secretary Baker talked about the technology. And we also mentioned the pilots that we are doing that are looking at the business process itself to determine what can we do to improve the process so that when we have the new tools, it will not be just adding the tools to the old process.

In addition to that, we recently brought all of our leadership together about a month ago and laid out for them what the challenge

was. The Secretary has set some very, very ambitious goals for us. We always used to talk about time limits in terms of average. So when we said our goal was 125 days, it was that the average case would take 125 days. This goal is a lot more ambitious where he is saying that he is eliminating any cases over 125 days and, at the same time, doing it with a 98 percent accuracy rate. That is really putting the challenge to us and saying we have to change the basic way we do business in order to accomplish that.

We talked with our directors. We got a lot of really good ideas. We have some things that we are going to implement immediately. Just to give you an example, we are looking at doing what we call interim ratings where, for instance, on Agent Orange, if a veteran applies, is able to establish Vietnam service, has a diagnosis of, say, ischemic heart disease, but we do not have an exam to determine how disabling is the condition, we would pay him immediately at a minimum rate so he at least starts getting benefits and starts getting entitlement to things like voc rehab and treatment at VA hospitals while we go and do the exam to determine what his permanent rating would be. Those are the kinds of things that we believe we need to do to improve the service that we are providing to veterans.

Senator JOHNSON. My time has expired.

Senator Hutchison.

PRESUMPTIVE DISEASES

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

On the gulf war illness issue, your task force recommended nine new conditions to be automatic presumptions, and I am very pleased because these young men and women have been really in never-never land for a long time. I think that hitting it now rather than waiting so long, as was done in Agent Orange, it is still late, but I am glad we are doing it.

This is my question. What is the timetable that you have after you have your rulemaking and you go through all of the required processes, that you think you will make the final determination on the gulf war syndrome presumptions? And then after learning the timetable, then I am wondering on the budget what you will expect, if it is going to be able to be covered this year, or will you have to accommodate that next year.

Secretary SHINSEKI. I am going to turn to Dr. Petzel on this.

Dr. PETZEL. Thank you, Mr. Secretary.

The process by which presumption is established is that there is a gulf war task force that will look at information such as the IOM report that recently came out regarding the gulf war. They will then make a recommendation to the Secretary as to illnesses that ought to be considered presumptive. The decision then is his as to what illnesses will be presumptive and what illnesses will not. And then there is a rulemaking process that occurs after the Secretary's decision has been made. As an example, I believe that the decision and the rules regarding Agent Orange, where the decision was made this early spring/late winter, will be finished, Michael, sometime——

Mr. WALCOFF. Early July.

Dr. PETZEL. In the late summer.

Mr. WALCOFF. Correct.

Dr. PETZEL. So, Senator, that would be the process by which we establish presumption.

Senator HUTCHISON. So give me a guesstimate then. Is it 9 months you are talking about after you get the recommendation and then there is the rulemaking and then the publication? I am just getting just a general idea. I am not asking for some blood oath, but just a general idea of what are we looking at in a timetable?

Secretary SHINSEKI. I believe we will begin and will have the rulemaking done this summer, and then we will begin processing claims. It will be late summer timeframe.

FORT BLISS JOINT FACILITIES

Senator HUTCHISON. Okay. That is what I needed. Thank you.

So we will probably need—I know it is not in this year's budget. So we will probably need to address that at some point in the future.

The other question that I have—General, you and I have talked about this, but the VA and the Army currently share joint facilities at Fort Bliss, and as we all know, Fort Bliss is in the process of being plused-up by about 30,000 troops. And that is going to affect the retiree population as well. Once the Army leaves the facility, the VA is going to be in a problem situation if the VA does not move with the Army.

This is my question. The funding for the new hospital that is, at this stage, planned to be a joint facility, Army and VA, is in the Army's 2011 budget request and in the 2009 stimulus and then the 2009 war supplemental. The Army is ready to move and it is not in your budget this year because you were planning for all of this to be 1 year out.

My question is, what are your plans? A, are you committed to the joint facility with the Army at Fort Bliss? And B, what are you thinking in updating your timetable to go along with the Army?

Secretary SHINSEKI. Senator, we are committed to an integrated effort with the Army. We are a bit mid-stride right now because we planned on and were programmed for a 2012 start. So this acceleration to 2011 leaves us in a position where we do not have the resources to do that. We are looking at what options might be available to us. It also requires about a $20 million design investment this year, 2010. So we are looking at that as well.

And while we may be successful in being able to find those dollars, 2011 still remains an issue. I do not have the resources for it right now. It is not in my budget, and there are a number of longstanding projects that are on execution for us, and I would prefer to keep that priority because there have been veterans waiting for those assets to be provided. But we are interested in staying abreast of the Army's move here. We think it is important for it to be an integrated facility, and so we are looking at this hard.

Senator HUTCHISON. You believe that you can have the $20 million that would work with the Army to start the planning process in June. Is that correct?

Secretary SHINSEKI. We are locating those dollars. I think there is a good chance we will do that, but I am hesitant to put $20 mil-

lion up without understanding how we take care of 2011, and right now I do not have resources.

Senator HUTCHISON. Well, I will look forward to having you come to us with your suggestions, and then we certainly will be helpful because it would not make sense not to be joint and it would leave a big void if the Army moved and you did not. And it also would not be a wise use of taxpayer dollars when a joint effort would be so much more efficient. So I will look forward to hearing from you and helping as well. Thank you.

Secretary SHINSEKI. Thank you.

Senator JOHNSON. Senator Nelson.

OMAHA VAMC

Senator NELSON. Thank you, Mr. Chairman.

Thank you, Secretary Shinseki for testifying today. I am particularly pleased with your budget this year. I know the increases are there and there will be those who ask questions about why during these difficult times are we having increases. But the various causes that you are addressing in your budget are the kinds of things that I think, in spite of difficult times, we still have to identify and help.

And I was especially pleased to see in your fiscal year 2011 budget request that it addresses the needs of the Omaha VA Hospital. As we have discussed, this institution provides very good care for veterans, and I know Dr. Petzel knows that. But the physical facility is stuck back in the 20th century. Built back in the 1950s, upgrades to the facility and its equipment have served well, but now it is in need of a major overhaul. And working with your predecessor, Secretary Peake, and you, we have pushed to see that the hospital shortcomings are being addressed. You personally are well aware of these shortcomings, but for the record, I think they bear noting.

A study by the VA, released last summer, found a number of critical functional deficiencies. I will not name all of them, but I will address a few. Significant space deficiencies. Forty-two out of 52 departments will need additional space. Surgical capacity is based on 1948 design. Present space does not meet room size, privacy requirements. A deteriorating building envelope, including problems with windows, walls, and the roof. Air handling and HVAC system beyond useful life, and overall refrigeration systems rated an F.

In addition, the hospital has a unitary heating and cooling system and health officials have shared serious concerns about a virus such as the recent H1N1 virus being spread by this HVAC throughout the entire hospital, providing less than adequate health safety for the patients.

So for these reasons, I am very pleased to see that your 2011 budget calls for $56 million for planning and design toward substantial modernization of this hospital. It is a necessary first step toward what we expect will be a 21st century healthcare facility. And, Secretary Shinseki, this commitment is extremely good news for the thousands of veterans both in Nebraska and western Iowa.

I have often said that I hope we some day become—and I think you are in the process of doing that—as good at taking care of our veterans as we are creating them. And your commitment to im-

proving the Omaha VA Hospital is just one more example that caring for American veterans remains one of the Nation's highest priorities and clearly is one of yours.

So, Mr. Secretary, from your perspective, perhaps you could give us your idea why this is a high priority for the Veterans Administration to see an improved facility in Nebraska.

Secretary SHINSEKI. There is a great tradition in the VA, Senator. When we have problems, we do not blame our predecessors. When something comes out right, we give credit to them as well. Jim Peake is an old friend. He and I soldiered together for many years. In fact, I selected him to be the Surgeon General when I was on my last service in uniform. He was my predecessor in 2008, I think. Because he was apprised of some shortfalls in the service, primarily the safety aspects of the hospital in Omaha, he initiated an independent study, not a VA study, but an independent study, to go in and make their own assessment to provide him some idea of what the conditions were. As things turned out, I inherited that study which came in the spring of last year, as I recall. We put it into our annual scoring process. I think the Omaha hospital at one point was 15 or 16 on a priority list. Seven of the projects in that list were funded in the previous year's budget. So it moved up, and so all of the projects moved up, at least moved up accordingly. One project was removed from the list, as I recall, for some reason, but then with this new independent study, the rescoring just put Omaha within the range to get the ranking it did.

I think it came out well. It came out right. It was the right thing to do for veterans in that part of the country. But understand, Omaha is just the location of the hospital. It serves Iowa. It serves lots of adjacent States. So veterans in many locations are serviced by this hospital. Location is only one issue.

So that is my take on it, Senator.

VETERANS CEMETERY

Senator NELSON. Well, I appreciate that.

I also want to commend you for the VA budget having design funds for a new national veterans cemetery in Sarpy County, Nebraska, also eastern Nebraska adjacent to the Omaha area, which will serve a number of veterans from a region. The location of that cemetery, as the location of the hospital, will catch not only some South Dakota residents, veterans, but Iowa and northern Missouri, as well as perhaps some of Kansas' as well. So we appreciate your focus on it. You are doing an outstanding job, and we appreciate the opportunity to work with you.

And we want to compliment former Secretary Peake for his wisdom in stepping in and seeing that we get an independent study so that it is some outside thoughts, as well as our inside thoughts.

Thank you very much.

Thank you, Mr. Chairman.

Senator JOHNSON. Senator Murkowski.

RURAL ACCESS

Senator MURKOWSKI. Mr. Chairman, thank you.

Secretary Shinseki, good to see you. Thank you for our conversation earlier in the week. Not only did we have a chance earlier this

week to discuss the issue of access to care to so many of our veterans who live in very rural parts of the country, we talked about it last year and the challenges that particularly our Alaska Native veterans face in accessing their earned healthcare benefits when they come back to their villages and they are hundreds of miles from the nearest VA facility, the challenges that they face. And we have talked a little bit about the effort that has gone into the rural Alaska pilot project and the need to make sure that we make that pilot function a little more efficiently.

I understand—and I thank you for your offer to visit with the folks over at Indian Health Service (IHS) to see how we cannot iron out some of those issues, but again, find an easier path for those veterans who are in some of our most rural communities and have access to an IHS facility, that we might be able to partner with some of that care. But we know that that is just one part of the problem in Alaska.

The other dimension of access to our veterans in my State is we have got concerns that those that actually have access to the VA facilities there cannot access the facilities with their particular healthcare conditions. Sometimes demand exceeds the capacity. Sometimes our veterans are told that they have to travel to Seattle because the procedures are not available in Alaska, just not available within the facilities that we have. It is our understanding that these veterans are told, well, the regulations require us to send you outside to Seattle rather than purchase care within the community. I had asked whether or not you felt that the VA was being a little overly rigid in interpreting these regulations.

But essentially what I am looking for and what I am hoping that we can work with you on is how we ensure that the commitment made to these Alaskans is kept without having to send them outside to care, a 2,000-mile trip, for some even more than 2,000 miles, to access care when it could be made available through purchased care within the State.

Secretary SHINSEKI. Well, Senator, I appreciate those insights. I am reminded that in our geographical descriptions of our system, we have urban, rural, highly rural. So two-thirds of our definitions have the word "rural" in it, and then I am told that even highly rural may not describe some parts of the country and Alaska is one of them.

We are going to look at very closely why we would send a veteran on a 2,000-mile journey if there is competent, safe healthcare available close by. We will take a look at that.

This also behooves us to have a better working relationship, although we have already started this with the Indian Health Service, but a better relationship of sharing assets and capabilities so that we reach out into these areas. Even as hard as we are working at it, it is not still good enough. Telehealth is another capability we have invested in heavily. If there is any place we ought to be demonstrating the power of a microprocessor it would be in places like remote tribal lands in Alaska.

Let me just turn to our senior medical officer, Dr. Petzel, and ask him for his insights here.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Murkowski, I share your concern about the distance that some of these people have had to travel. We looked back and 685 veterans were asked to travel from Alaska down to a medical center in the Lower 48, usually Seattle, but it may have been other places. The question that I have when I heard that is what sorts of things are they being referred for. It is one thing to come down for open heart surgery, which may be a super-special kind of thing to do. But, on the other hand, routine surgery that we could be performing in Anchorage on a contract or on a fee basis probably ought to be looked at. So it is my intention to look at why those cases were sent, what kinds of cases were sent, and see if we can find out some sort of an arrangement that provides better, more community-level access for those veterans.

Senator MURKOWSKI. Well, Dr. Petzel, I appreciate that. In speaking with constituents that are expressing their concerns and their frustrations, what we are hearing is that a 6-week chemotherapy treatment—an individual lives in Fairbanks, our second-largest community, fine medical facilities, and yet they are being sent outside down to Seattle for treatment. I would like to think that that is one of those that should absolutely not be necessary for something as routine as chemotherapy treatment. So we would like to work with you on that. I would certainly like a better understanding myself. So much of what we know is anecdotal, but when we hear these anecdotes, this is something that for these families that have to make these transitions and spend 6 weeks down in a hotel in Seattle with no family members, the expense that is involved, but also the separation is something that is not the kind of care that I think our veterans certainly deserve and that we owe to them. So we want to work with you on this.

Dr. PETZEL. We would share your concern, Senator.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Senator JOHNSON. Senator Murray.

VETERANS EMPLOYMENT

Senator MURRAY. Thank you very much, Mr. Chairman. And I would tell my colleague from Alaska that we would happily take care of your veterans in Seattle. But I think most people do not realize it is a 3½ hour flight from Alaska to Seattle. It is a long way for those people to go. So I appreciate your concern.

Mr. Secretary, thank you for you and your team being here today.

I wanted to talk with you about an issue that is really weighing heavily on our veterans today and that is that they are coming home from serving us so honorably overseas and cannot find a job. The unemployment rate for our young veterans returning from Iraq and Afghanistan is now over 21 percent.

When I was out in my State for the last 2 weeks, I sat down with a number of young veterans to talk to them about what was keeping them from finding work when they came home. And frankly, it was really shocking what a lot of them said to me. Some of them told me that they actually leave off the fact on their résumé, when they are giving it to an employer, that they are a veteran. And I asked them why and they said it was because it went to the bottom of the stack. They did not know if it was because of the stigma of

the invisible wounds of war, but they were finding that from many employers.

Many of them told me that the Pentagon and VA transition programs do not work for the jobs and types of opportunities that could be available today.

Many of them told me that they completely struggle to get civilian employers to understand what their experience was in the military that translates to what a civilian employer might need.

They basically told me that their peer group either chose to get a job and had good experience or went to college or some kind of apprenticeship school and had that experience. They chose to go to the military and their experience does not count when they come home to get a job.

I just find that completely unacceptable. I found that it often triggers a lot of mental and emotional issues that we are seeing among our veterans today as well. These people serve our country honorably. They are great workers. They are skilled. They come to work on time. They should not be facing these kind of barriers when they come home.

So I wanted to ask you today, while you are here, if you are hearing the same kinds of concerns from our returning veterans and if there is anything the VA is doing today to try and make the transition work better.

Secretary SHINSEKI. Thank you, Senator.

I hear some of the same things, perhaps not the same anecdotes, but it feeds a couple of images I carry around and I tend to refer to them in speeches. This will take a few minutes, so I hope I do not take up too much time here.

The first image is the one we are most familiar with. Every year about 60 percent of high school graduates go on to universities or some higher institution of learning. The remaining 40 percent go to vocational training or right into the workforce, and as you indicate, a very small percentage join the less than 1 percent of Americans serving in uniform doing the Nation's bidding. Good folks. They go through the train of experience, prepare for life with discipline and accountability. When they arrive in their first unit, good leadership puts them on missions that are complex, dangerous, sometimes near impossible. And yet, they outperform all our expectations. Great youngsters.

The second image is a smaller population, but it says veterans are a disproportionate share of the Nation's homeless, jobless, mental health, depressed patients, substance abusers, and suicides.

So the issue is what happened here. They are the same kids in both images. Something happened, and that is what we are about, is to try to figure this out, how to keep the kids in image one going on to do great things and then reach into image two and get those youngsters the help they need. That is what we are about.

Senator, I would tell you that in all of our Departments of the Federal Government we have a goal of hiring veterans as part of the workforce. Right now, VA is at about 30 percent. It may be a point or two less. We intend to raise that. I am happy to serve as the Vice Chair to Secretary Solis who chairs the interagency task force on hiring veterans in the Federal Government. All of us are working toward this to try to increase the opportunities for them.

At the VA, we have a Veterans First project which is better known. Small businesses are given the opportunity to compete for our contracts, and if competent, we level the playing field and they have a good shot at that.

An example of this is last year in the stimulus funding, we were given $1 billion, lots of money for VA, and we competed 98 percent of those dollars. As a result, our contracts came in lower than usual, and so we were able to have 20 percent more buying power.

So just by the way we run these things, we feel good about the processes we have in place. In that process, 82 percent of our contracts went to veteran-owned small businesses, important for us because veterans hire other veterans. So that creates the churn of jobs, and we are looking for any opportunity we might have to repeat that.

But I do share your concern. The G.I. bill is important because it gives some opportunity for youngsters to have constructive work for the next 4 years, but 4 years from now, they will be looking for jobs, and we need to have in place——

Senator MURRAY. Well, I very much appreciate that response. I think there are a number of things we need to do. The TAPS program, National Guard, their skills and the way we treat them today cannot be the way we treated them 20 years ago.

I am going to be introducing actually legislation next week on a veterans' employment legislation. I would love to have anybody join me on that that is interested. But looking at how we can help them transition their skills better so that civilian employees actually hear the skills that they have, opening up opportunities for apprenticeship programs that they currently do not have under the G.I. bill in an online school which often works for them, and helping them actually establish small businesses, not just have veterans on preference, but actually helping them do that. I think there are a number of things we have really got to aggressively work on so that as we are recruiting today and telling young people to come into the military, it is great experience, it is actually an experience that will help them get a job some day and they do not feel left behind.

So, Mr. Chairman, I thank you for the extra time here.

Mr. Secretary, I hope I get your help and support on my legislation as well. Thank you.

Senator JOHNSON. Senator Collins.

VETERAN SUICIDES

Senator COLLINS. Thank you, Mr. Chairman.

Mr. Secretary, welcome. I was pleased to have an opportunity to talk with you recently in my office and to thank you for coming to the great State of Maine to tour our veterans hospital, which I would inform my colleagues is the oldest in the Nation, the very first veterans hospital.

A recent article in Time magazine noted that between 2001 and the summer of 2009, our military lost 761 soldiers in combat in Afghanistan. During that exact same period, the military lost more soldiers to suicide, 817 of our men and women in uniform. Last year, 160 active duty soldiers took their lives, and just this week

the Army announced that in the first 3 months of this year, 71 more soldiers took their own lives.

I know that this news is heartbreaking to you personally, as it is to all of the members of this subcommittee. I have talked with the active duty leaders in our military about what the Pentagon is doing to address the mental health needs of the active duty force, but I would like to know from you whether you feel the VA's budget is adequate to address the same kind of needs for mental health services and counseling that face so many of our returning veterans.

Secretary SHINSEKI. Well, Senator, thank you very much for that question.

We have resourced this properly, but there is so much more to be done in this area. First of all, none of us are experts in how to deal with the phenomena that results in great young people who do such wonderful things for us ending up feeling that there is no other choice but to have to take this step and hurt themselves.

We have, in the last 4 years, hired probably an additional 5,000 to 6,000 mental health staff to bolster our capabilities here in dealing with this issue. We probably number 20,000 or 19,000 mental health staff today. We have made mental health part of our primary care facilities so that having someone think about having to go to the mental health clinic and the stigma associated with that is eliminated, especially amongst 20-year-olds. We are trying to help them not have to deal with that. So we provide mental healthcare inside the primary care facility.

We have created a suicide hotline that is well recognized nationally out of Canandaigua, New York. They handle probably 10,000 calls each month and each day something on the order of 10 rescues online of individuals who are under such great duress that they are thinking about hurting themselves. Over the several years since we have started this, we have had probably 3,000 intercessions that stop the act of self-destruction in progress while the phone call is being made. When the phone is picked up, it is a mental health professional on the line. It is not just an operator. There are two of them. They work in a pair, one of them speaking to the individual and getting as much information and the other is helping to try to locate the individual so we can get help there. So these are actual online rescues that are occurring.

We advertise this hotline in most of the major cities in the country so that people have some understanding of this, at bus stops, on buses, on the metro.

More work needs to be done in terms of research, and so we are putting some energy there as well.

Let me turn to the Chief Medical Officer here, Dr. Petzel, and see if he has got anything to add to this.

Dr. PETZEL. Thank you, Mr. Secretary. That was really quite thorough. Just a couple of things, Senator, that I would add.

One is that we have a suicide prevention team at every one of our facilities. These teams include experts in PTSD, substance abuse, and those other mental illnesses that are often associated with suicide.

In addition to that, all of the veterans returning from combat who seek care with us are screened for traumatic brain injury, sub-

stance abuse, PTSD, and depression: again, those things which we often have associated with suicide. Any suicide death is a tragedy. Any suicide death is a tragedy.

I think that we have the resources, as the Secretary pointed out, and the programs to have an impact on veterans' suicide. I would not want to say we can eliminate this, but I think we will be able to see the fact that we are having an impact.

The Secretary mentioned at the end of his remarks, research. One of the things that we need, that the Nation needs to do is a better job of, is being able to identify those people who are really at risk. I mean, there is a suicide assessment that could be done, but it does not really hone in on those people who are very seriously at risk and I think we need to be at the forefront of doing that kind of research.

Secretary SHINSEKI. May I just provide just some data here to answer your question, Senator? The 2011 budget request includes an 8.5 percent increase, or $400 million, over the 2010 budget for mental healthcare, and then in terms of mental health research, the 2011 budget request is a 15 percent increase above the 2009. Eighty-three million dollars is the research number.

G.I. BILL

Senator COLLINS. Thank you. That is very encouraging.

Mr. Chairman, I have another question that I would like to just submit for the record. It has to do—and the Secretary was the one who brought this to my attention, the fact that when we updated the G.I. bill to help provide more educational assistance, we narrowed the kind of training program that is available, and we left out a lot of vocational, community college kinds of programs. And that is something I think we need to take a second look at. So I have a couple of questions on that that, with your consent, I would like to submit for the record. Thank you, Mr. Chairman.

Senator JOHNSON. It will be received.

Senator Pryor.

RURAL ACCESS

Senator PRYOR. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being here.

I do want to echo Senator Collins' concerns about the suicide rates. I agree with what you have said, that any suicide is a tragedy. I know you are working on it. You are very attentive to it, and I would just encourage you to continue on that track and even put more resources there if that is what you need to do. But it is very important.

Let me ask a question. I do not want this to sound like a parochial question because I am going to talk about Arkansas here for just a minute. I am sure every other State in the Union has these same type of concerns because even the most urban States have some type of rural area in them.

But in our rural areas of my State, I hear from a lot of our veterans about the difficulties they have in accessing medical care that meets their needs. The VA outreach initiatives have been good in a lot of ways and there have been good attempts and steps in the right direction. I know you have the community-based out-

patient clinic program. But have you done any sort of top-down review of the community-based outpatient programs and looking for ways that they can provide greater oversight and guidance so that the best possible care and access is available to these veterans who live in these rural areas? I know you mentioned some of the most rural areas in the country, Alaska, but our State has a lot of hard-to-access areas with not much healthcare in there.

Secretary SHINSEKI. I am going to turn to Dr. Petzel in a second.

Again, Senator, this is a great reminder. Several years ago, very bright people, well before my time, decided that having 153 premier flagship medical centers was not good enough, that there is so much expanse to our country that we had to find a different solution in delivering healthcare, not just welcoming people to come get it but delivering healthcare. So we created a community-based outpatient clinic system, which you have asked me whether or not we are taking a look at. Outreach clinics in places that do not have a veteran population to support a full-time clinic will go lease a piece of real estate, stand a clinic up for 3 days, shut it down, and move it, mobile, on wheels, and do the same thing.

Telehealth, telemedicine. Right now, we have 40,000 veterans who are receiving telehealth monitoring because they are chronically ill in their own homes. They do not have to go anywhere. The technology is there. So this is part of the structure.

Yes, we are looking down to make sure that we have the right capabilities, the right services to meet the needs out there, and that is a constant look. There are looks underway right now. In fact, I would just offer to everyone that this is a look and we are trying to ensure that we have a good understanding where the needs are.

With that, let me turn to Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Pryor, I heard two questions or two concerns. Let me just add a little bit to the first one to what the Secretary had to say.

Each year we assess the needs for community-based outpatient clinics. It starts at the medical center level, moves up through the network, and eventually we come to a national understanding of what the needs are for additional community-based outpatient clinics. We will be opening a number of new ones during 2010. We hope to have about 862 clinics opened with the completion of fiscal year 2010.

But as the Secretary mentioned, there are much more mobile, if you will, modalities that we can use. Home-based primary care where we send visitors into the home. Telehome health where we actually have tools for monitoring in the home. A case manager, from the veterans' perspective, is probably the most desirable way to provide care in the rural community. They do not have to travel very frequently to a clinic or to a medical center. And then we have telemedicine where we can provide in the community telemedicine access to specialists at various places.

I think we are going to be doing a better job in these next 2 years of reaching rural America. I think the Secretary mentioned there are 40,000 patients on telehome health. I think that the number who need that modality is probably hundreds of thousands, and we

are moving aggressively to increase the number using telehome health.

The second question, though, that I thought I heard in what you said was, what about the quality of the care that we receive in our community-based outpatient clinics. And we do hold them to the same standards and do assess them in the same ways for the quality of care that they are receiving, and that is whether it is a clinic that we staff ourselves or whether it is a clinic where we contract for care.

ELECTRONIC HEALTH RECORD

Senator PRYOR. Great. I appreciate that and I appreciate your attention to that. It is important to pretty much every Senator in the Senate because we all have some rural areas and some challenges out in those rural areas.

Mr. Secretary, I would like to ask you about the joint lifetime electronic record. I know that this is something that the DOD and the VA have been working on together. I think it is very important that we do it and do it right. Could you give us a very brief status report on that?

Secretary SHINSEKI. Let me turn to the expert, Senator. Let me turn to Roger Baker here who handles that for us.

Mr. BAKER. Thank you, Mr. Secretary. I will give you a quick update. We have a lot of detail on this one.

As you know, we have probably the best interoperability right now with the Department of Defense, exchanging information between our electronic health records. As we moved to expand that, we have moved to a national standard for information exchange so that we can bring the private sector into that electronic health record. Roughly 50 percent of the care provided to veterans is done by the private sector, and in the past we have not shared those health records. So we are moving that forward.

We have had a pilot live in San Diego with Kaiser Permanente on that project for several months. We have announced that we will be doing another pilot in the Hampton Roads area and moving forward with pilots there toward a 2012 general availability of that for private sector folks to hook in with.

On the benefits side, we have also made substantial progress in achieving what the Secretary terms the "seamless transition" and doing things along the lines of putting all of our benefits information and the DOD's benefit information on a common Web site so that a service member goes to the e-benefits portal while they are in the service and sees what their benefits are. They have the same log-in, exactly the same Web site, when they move to VA so all the information is the same there.

We really have moved a long ways forward in a global approach to sharing that information. It is a long process. There are a lot of systems involved and a lot of information involved, but we feel very good about the progress.

Senator PRYOR. Good.

Thank you, Mr. Chairman.

Senator JOHNSON. Senator Brownback.

JOINT VENTURES

Senator BROWNBACK. Thank you, Mr. Chairman.

Mr. Secretary, welcome, and gentlemen, good to have you here.

I want to raise two quick issues with you. One is the joint VA/DOD ventures that you have around the country, Mr. Secretary. I understand you have eight joint ventures between DOD and the Veterans Administration as far as healthcare facilities that serve both active duty members and veterans.

I just want to put out for you that at Leavenworth one of the things that I have been talking about with the local base and the Veterans Administration in Leavenworth is that as they look to move forward, I think there are some real synergies and possibilities of a joint facility in Leavenworth. You have a small VA hospital that is there. You have got a major Army base. We have the disciplinary barracks from the DOD also there. And then the Bureau of Prisons (BOP) has a major facility. And yet, no hospital healthcare facility for the entire complex.

It is expensive care that is taking place now. The Bureau of Prisons is building a kidney care center for dialysis just for older people that are in prison. To get dialysis, they are going to move all their prisoners from around the country to Leavenworth to get dialysis care. Probably a good idea, but I am looking at this and thinking you have a VA, a major military base, disciplinary barracks, and BOP, and it is all the same Government and we are short of taxpayer money.

I think this is a prime place to look at something of that nature, and I would just urge your folks to take a look at that. I know the base commander at Leavenworth would be interested in doing this because he does not have a healthcare facility at all, and it is a substantial base. I think it is the largest base in the country without a healthcare facility, and it would be nice to do this in the most economical way we could.

A second issue I just want to raise with you—and Senator Collins raised it. It was on Senator Pryor's mind as well—is on the suicide, PTSD, traumatic brain injury issue. I think we are doing a lot better job this time around on this than after the Vietnam era. When I first came into Congress, I would see a number of Vietnam veterans come into our office that just had not—there was not any recognition that there was a PTSD syndrome at the time, and then they did not get any care and it just got worse for neglect. I think you are doing a better job this time around.

One issue I would offer to you on that and I hope you do is to engage more of the private sector community on it, particularly the not-for-profit, faith-based community that would really like to engage because in my experience, these guys have difficulties that in many cases they are not willing to express or talk about or it is not tough if I do, and yet the longer it goes on, the worse it is going to dig in. And they need to really just build relationships. They need somebody that just sits there and says I care about you. Look, we have a problem and let us go get it taken care of.

And I have seen some interesting models around the country of where the private sector is stepping in. There is a group that just came into my office—I think they are from Kentucky—that is

working doing this—and this seemed to me to be really classically built for a private, faith-based community engagement because really what you need is somebody to build a relationship that can see the signs coming on this. And many of these guys either do not have that level of relationship or have already blown through their relationships, their close ones, because of PTSD or traumatic brain injury and then the steps on down the road are drugs or alcohol or suicide at the worst case. This one seemed to me to be really made for that sort of issue because you are going to need a lot of hands on deck to pick these sort of problems up as they come along.

I would urge you to look at that and I would hope you could look at this possible joint facility at Leavenworth.

Secretary SHINSEKI. Senator, I am going to turn to the Chief Medical Officer here for his insights.

But I would tell you we look for any opportunity to partner, especially with DOD. Very little of what we do in VA originates here. We are joined by the one key link between us and that is the individual who wears a uniform one day and takes the uniform off the next. And the VA then has responsibility to care for them for a long period of time.

You may be interested to know that today we still have two children of Civil War veterans on our rolls as beneficiaries.

Senator BROWNBACK. Is that right?

Secretary SHINSEKI. One hundred and fifty-one Spanish-American War beneficiaries. So our responsibilities go on for a long time, and this effort to partner with DOD makes good sense, makes good business sense, and it takes great care of these youngsters.

Let me just turn to Dr. Petzel here for a few seconds.

Dr. PETZEL. Just to elaborate a bit on the Secretary's comment—thank you, Mr. Secretary. In Kansas, we are actually engaged already with Leavenworth. The VHA leadership has been in discussions with the Leavenworth military community about how we can cooperate.

Senator BROWNBACK. Good.

Dr. PETZEL. I think that is an excellent suggestion, Senator.

Senator BROWNBACK. I have been pushing them to do this. It really makes a lot of sense to do it.

Dr. PETZEL. We are actually also looking at another place in Kansas, in Wichita at McConnell Air Force Base. We have engaged McConnell in discussions about how we can share jointly. We are one Federal Government and there ought to be ways that we can share our expenses.

Senator BROWNBACK. This would be unusual, but if you could even think about involving the disciplinary barracks which is part of the military that is in Leavenworth and the BOP. I know that is really outside of the box, and we may be pushing it to get two stovepipes together, and three or four may be just a bridge too far. But they are all within 3 miles of each other—4. And you would impress a lot of people if you are able to get that many stovepipes in the same chimney.

Dr. PETZEL. We will certainly look into that.

Senator BROWNBACK. Thank you.

Secretary SHINSEKI. Senator, I will just add to this. Forty thousand veterans come out of prisons every year, and so out of our medical care system—out of VA for both benefits and healthcare, we have already been in touch with prisons. I think there are something on the order of 1,300 Federal prisons. We have visited maybe 800 of them and made contact with about 15,000 prisoners in the effort to prepare them so they leave to be on track with a good phase in the next phase of their lives. Much of that has to do with treatment to begin with and then stability in jobs and other things. But already there is this requirement to work together with the Bureau of Prisons.

Senator BROWNBACK. Good.

Thank you, Chairman.

Senator JOHNSON. Thank you, Senator Brownback.

I would like to thank the Secretary and those accompanying him for appearing before this subcommittee. I look forward to working with you this year.

ADDITIONAL COMMITTEE QUESTIONS

For the information of members, questions for the record should be submitted to the subcommittee staff by close of business on April 21.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR TIM JOHNSON

Question. Mr. Secretary, on March 18, the VA published a Proposed Rule in the Federal Register that would establish a presumption of service connection for nine diseases for veterans who served in the Persian Gulf and Afghanistan. I am pleased that the VA is taking steps to recognize diseases that afflict vets that served in the Gulf. As the VA moves to implement this proposed rule, have you developed any budget estimates, both for compensation payments and healthcare costs, for the cost of implementing this new policy?

Answer. The compensation benefit costs associated with this proposed rule are estimated to be $1.5 million during the first year, $11.5 million for 5 years, and $36.4 million over 10 years. This proposal would amend section 3.317 of title 38 C.F.R. to establish a presumption of service connection for the nine diseases (brucellosis infection, campylobacter jejuni infection, coxiella burnetti infection, malaria infection, mycobacterium tuberculosis infection, nontyphoid salmonella infection, shigella infection, viseceral leishmaniasis and west nile virus infection). However, the costs associated with this regulation are based only on compensation for tuberculosis due to insufficient data available on the other rare diseases. Because of the small number of veterans and survivors affected by this rule annually, the additional caseload and cost of implementing this new rule will be absorbed in existing resources.

Question. Collaboration between the VA and the Indian Health Service needs to improve. Many Native Americans who are veterans often get conflicting information regarding benefits that they are entitled to. What plans does the VA have to improve the coordination of benefits between the two Departments?

Answer. VA has a robust program with the Indian Health Service (IHS) as is reflected in Attachment A, which provides details regarding specific Native American/Alaska Native veteran outreach and healthcare activities.

In addition, on May 24, 2010, VA Secretary Shinseki met with Dr. Yvette Roubideaux, Director of Indian Health Service. During this meeting, it was agreed the Memorandum of Understanding between VA/IHS would be updated by September 30, 2010, to reflect the expansion of collaborative activities, as well as the enhancement of communications. Both organizations agreed that working together in partnership will enhance the delivery of benefits to our Native American and Alaska Native veterans.

Question. Mr. Secretary, the budget includes a supplemental request to implement the Agent Orange decision. The entire request is for VBA disability claims. How-

ever, this decision is likely to have an important impact on demand for VHA medical care as well. Has VHA projected the likely effects on its medical expenditures?

Answer. VHA projects Agent Orange expenditures of $165 million and $171 million in fiscal year 2011 and 2012, respectively. These costs are included in the budget request.

Question. The denial of On-the-Job Training (OJT) benefits under the GI Bill for the State workers who work in State Veterans Affairs' State Approving Agencies (SAA) is inconsistent with the policy regarding Federal VA workers and OJT. There have been several incidents where the VA has denied OJT programs with the South Dakota SAA. The VA has deemed employees to be "fully qualified" due to the fact that they were hired to their positions, but being fully qualified is not the same as being fully trained. VA employees, such as a VA Veterans Claims Representative, or an Education Liaison Representative can use their GI Bill benefits for an OJT program with the VA, but those in State Approving Agencies are denied approval to use their GI Bill benefits for OJT Programs. The VA's argument for denying the claims of SAA employees is that they don't need training because they are already qualified, and yet, the VA employees who are in positions of authority over the SAA employees are generally approved to use OJT benefits.

Why does the VA deny the use of the GI Bill for OJT programs for SAA employees while approving them for the education liaison representatives (and others) who would generally be considered more qualified, trained, and knowledgeable?

Answer. SAAs are charged with approving education courses in accordance with the provisions of chapters 33, 34, 35 and 36 of title 38 U.S.C. Under contracts with VA, SAAs ensure that education and training programs meet Federal VA standards through a variety of approval activities, such as evaluating course quality, assessing school financial stability, and monitoring student progress. SAAs also promote the development of apprenticeship and on-the-job training programs and approve tests used for licensing and certification. The Federal Acquisition Regulations (FAR) require SAAs to be qualified to perform the required duties before they can be awarded a contract. Therefore, VA has denied the requests of current SAA employees for on-the-job training programs.

VA's General Counsel is currently reviewing the law and regulation as it applies to this matter and will issue a formal opinion by mid-July 2010.

The Veterans Benefits Administration does hire employees in entry-level trainee positions. Work completed by trainees is reviewed and approved by experienced supervisors. These supervisors are required to have the necessary knowledge and skills to perform the duties of the job prior to being selected for the position, much like the requirements for SAAs. Therefore, they would not be approved for an on-the-job training program.

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

Question. Mr. Secretary, it is my understanding that the Department of Veterans Affairs has done an extremely good job when it comes to both hiring veterans, and utilizing service-disabled veterans small businesses to execute contracts. Would you please elaborate on some of the goals that VA would like to meet with regard to both hiring and small businesses in fiscal year 2011?

Answer. The average employment of veterans across the Federal workforce is 25.8 percent according to OPM, as of September 30, 2009. Today, approximately 30 percent of the Department of Veterans Affairs workforce (over 90,000 of 300,000 employees) is comprised of veterans. We've set a strategic target of 35 percent veteran employment. Our target for fiscal year 2011 is to obtain 31 percent veteran employment.

VA is proud to lead the Federal Government in small business contracts to service-disabled and other veteran-owned small businesses. Preliminary VA data for fiscal year 2009 indicate that service-disabled and other veteran-owned small business interests respectively received 16.3 percent and 19.3 percent of VA's total procurement dollars. We are on a similar performance track to exceed our goals in fiscal year 2010. Our employees worked especially hard to exceed these ambitious goals for implementing ARRA funds. Of the over $1 billion in ARRA funding for VA approximately 80 percent have so far been awarded to Veteran Owned Small Businesses (VOSB). Our goal for fiscal year 2011 for service-disabled VSOB is 10 percent, and for VSOB is 12 percent.

Question. Mr. Secretary, there are many pressing issues that face our veterans, and the fiscal year 2011 VA budget was crafted to seek the greatest degree of balance. The VA is the agency charged with caring for the needs of our veterans for the long-term. As you looking forward and anticipate the greater demands that will

fall upon VA, in terms of healthcare and benefits, what actions are you taking to prepare the Department for the expected influx? Given the constraints we are all facing during these economically difficult times, how do you see the Department meeting the requirements this preparation requires?

Answer. We recently completed development of a new strategic framework that is people-centric, results-driven, and forward-looking. The path we will follow to achieve the President's vision for VA will be presented in our new strategic plan, which is currently in the final stages of review. The strategic goals we have established in our plan are designed to produce better outcomes for all generations of veterans:

—Improve the quality and accessibility of healthcare, benefits, and memorial services while optimizing value;
—Increase veteran client satisfaction with health, education, training, counseling, financial, and burial benefits and services;
—Protect people and assets continuously and in time of crisis; and
—Improve internal customer satisfaction with management systems and support services to achieve mission performance and make VA an employer of choice by investing in human capital.

VA's 2011 budget focuses on three concerns that are of critical importance to our veterans—easier access to benefits and services; reducing the disability claims backlog and the time veterans wait before receiving earned benefits; and ending the downward spiral that results in veterans' homelessness.

This budget provides the resources required to enhance access in our healthcare system and our national cemeteries. We will expand access to healthcare through the activations of new or improved facilities, by expanding healthcare eligibility to more veterans, and by making greater investments in telehealth. Access to our national cemeteries will be increased through new burial policies that lower the veteran population threshold required to build a national cemetery from 170,000 to 80,000 within a 75-mile radius and that allow for the establishment of urban satellite cemeteries.

We are also requesting a substantial investment for our homelessness programs as part of our plan to ultimately eliminate veterans' homelessness through an aggressive approach that includes housing, education, jobs, and healthcare.

The Veterans Benefits Administration now employs more than 11,600 full-time claims processors and plans to add 3,000 additional decisionmakers in fiscal year 2011. However, continuing to increase the size of our workforce is neither a long-term nor scalable solution; we need to do a much better job of leveraging network automation and software productivity tools to more effectively manage our workload and serve our clients. Bold and comprehensive changes are needed to transform VA into a high-performing 21st century organization that provides high quality services to our Nation's veterans and their families.

VA's transformation strategy leverages the power of 21st century technologies applied to redesigned business processes. Pilot programs are underway at four of our regional offices to support our business transformation plan to reduce the claims backlog, improve service delivery, and increase efficiencies. Each pilot functions as a building block to the development of an efficient and flexible paperless claims process. The results of all four pilots will be incorporated into the nationwide deployment of the Veterans Benefits Management System (VBMS) in 2012. VBMS will be built upon a service-oriented architecture, enabling electronic claims processing by providing a shared set of service components derived from business functions. Initially, VBMS will focus on scanned documents to facilitate the transition to a paperless process. Ultimately, it will provide end-to-end electronic claims workflow and data storage.

VA is also seeking contractor support to develop a system to support evidentiary assembly and case development of the new Agent Orange presumptive claims. The system will enable veterans to proactively assist in the development of their claims through a series of guided questions and will automate many development functions such as Veterans Claims Assistance Act notification and follow up.

In addition to an electronic claims processing system, VA is committed to improving the speed, accuracy, and efficiency with which information is exchanged between veterans and VA, regardless of the communications method. The Veterans Relationship Management Program (VRM) will provide the capabilities to achieve on-demand access to comprehensive VA services and benefits in a consistent, user-centric manner to enhance veterans', their families' and their agents' self-service experience.

In summary, VA will be successful in resolving these three concerns by maintaining a clear focus on developing innovative business processes and delivery systems that will not only serve veterans and their families for many years to come, but will

also dramatically improve the efficiency of our operations by better controlling long-term costs. By making appropriate investments today, we can ensure higher value and better outcomes for our veterans.

Question. Mr. Secretary, would you please discuss some of VA's long-term plans to meet the healthcare needs of our veterans that live in remote areas? For example, the State of Hawaii is home to many brave men and women that have served this country in uniform. Remote and rural areas in the State as well as the territories in the Pacific create unique demands on the VA's system. There has been discussion of allowing existing Federal healthcare providers in the area to provide care for veterans. Could you please elaborate on the plans to address these unique needs through partnerships, telehealth, or other initiatives, and how these goals may be met through the VA's budget?

Answer. It is VA's intention to continue aggressively pursuing a strategy designed to reach veterans in remote areas, no matter where they live. Veterans Integrated Service Network (VISN) and local facility leadership are also exploring opportunities to extend the reach of VA's benefits into more remote areas. As a result, a comprehensive strategy for addressing the needs of rural and highly rural veterans, including those in the Hawaiian and other Pacific Islands, is based on the establishment of community-based outpatient clinics, rural health outreach clinics, telehealth and telemental health initiatives, as well as partnering with other Federal, State and local healthcare providers.

In Hawaii, VA closely partners with the Department of Defense and is exploring opportunities to partner with Papa Ola Lokahi, a non-profit organization which addresses native Hawaiian healthcare needs, and other healthcare systems and practitioners located in the Islands. This partnership is seeking to improve the availability of and access to VA enrollment materials for Native Hawaiian veterans, and is considering the potential use of Native Hawaiian Clinics where veterans can access traditional and complementary medical care, where feasible.

QUESTIONS SUBMITTED BY SENATOR MARY L. LANDRIEU

Question. General Shinseki, as you are aware, VA is in the process of improving its human capital capabilities through the Human Capital Investment Plan and Human Resources Lines of Business initiative. These are important efforts and I applaud VA's efforts to both improve its efficiency and look after its people. With respect to the HR Line of Business initiative, there are a number of Federal shared service centers capable of providing these services, one of which is located in East New Orleans at USDA's National Finance Center. In February, I wrote you asking that you consider the merits of utilizing NFC for your department's line-of-business needs. Utilizing a Federal agency like the National Finance Center would allow VA to avoid a lengthy and costly procurement process—and there are certainly other benefits.

I would be interested to know where VA is in the process of selecting a line-of-business provider, and whether your staff has met with NFC personnel to discuss this matter.

Answer. VA has been working with the Office of Personnel Management and other Executive Branch Departments and agencies on the overall Human Resources Line of Business Initiative. Using our current selection process guidelines, VA will consider NFC as our human resources services provider along with all interested and approved providers.

NFC will be afforded the full opportunity to demonstrate to key members of my staff the full range of products and services they desire to provide VA in this regard, and we will look forward to that process.

Question. I would also like to ask about an issue that I am sure is very much on your mind—the implementation of the Post 9/11 GI Bill. There has been a great deal of effort to make sure this goes as smoothly as possible—a difficult task under the best of circumstances, but made all the more difficult given the complexity of the law and the short amount of time to get the system up and running. And indeed, there have been delays and backlogs that have frustrated veterans, but I know the VA is moving aggressively to address these issues.

A significant amount of the work to develop the long term solution for the Post 9/11 GI Bill is being done by SPAWAR in New Orleans. It seems to me that given the concentration of subject matter expertise in both the implementation of the law and development of the supporting IT system, VA would be wise to examine an ongoing relationship between VA and SPAWAR with respect to GI Bill benefits.

Once the planned releases of the Long Term Solution (LTS) system are complete, what are VA's plans with respect to the LTS system?

Answer. As of today, VA intends to continue to house the Long Term Solution at the Terremark Data Center in Culpepper, Virginia. No decision has been made to date on whether or when to transition LTS back into a VA data center.

Question. It is my understanding correct that the system will be housed at a VA data center and that claims will be processed in regional centers? Given the complexity of this undertaking, would it not be wise to examine a centralized processing center to handle claims and eliminate any existing backlog?

Answer. All VA education benefit claims are currently processed at one of four Regional Processing Offices (RPOs) nationwide using systems housed in various locations throughout the country. VA has substantial experience in processing claims through off-site systems and is prepared to continue this procedure for the Long Term Solution (LTS). The creation of a centralized processing center would add complexity to the process by requiring that VA build out a centralized location, transition all relevant IT systems to this center, and relocate the trained claims processing staff currently spread throughout the four RPOs. VA has developed staffing and IT strategies to address any backlog of education claims that may occur and is confident that these strategies will be sufficient to achieve timely processing and payment of claims.

Lastly, the LTS will both reduce the number of people needed to process claims and allow VA to move work electronically to available resources. Therefore, once VA gains experience with the new claims processing system, a review of the best model for claims processing locations will routinely occur as we maintain the best efficiency in our system while accounting for workload and available resources.

Question. Will VA consider a Project Labor Agreement for the construction of the New Orleans VA Hospital?

Answer. The Executive Order which relates to Project Labor Agreements encourages Federal agencies to consider the use of a PLA on construction projects valued at greater than $25 million. The final change to the Federal Acquisition Regulation was recently issued. The Department is finalizing an acquisition instruction letter that will establish policy on evaluating the use of PLAs for projects over $25 million, including New Orleans. This will include evaluating factors such as the positive or negative impacts of a PLA on project cost, schedule, labor availability, competition, and labor unrest. The developed business cases and final decisions will become part of the contract file.

Question. Where is VA in its decision for VA/DOD centers of excellence for blind veterans?

Answer. VA is assisting the Department of Defense (DOD) in establishing the Vision Center of Excellence (VCE). VA is responsible for providing staff support for the VCE based on a Joint DOD/VA Memorandum of Understanding signed on October 16, 2009. VA has successfully recruited a Deputy Director, Chief of Staff, and Vision Rehabilitation Specialist. A Research Optometrist and Administrative Assistant are in the selection process and the Biostatistician position will be released for recruitment before the end of the 3rd Quarter of fiscal year 2010. VA personnel are currently occupying DOD space in Falls Church, VA.

DOD has the lead on developing the Joint Defense and Veterans Eye Injury and Vision Registry (DVEIVR) to provide capability for analyzing longitudinal outcomes, assessing intervention strategies, enhancing performance improvement, and developing a common user/provider interface across DOD and VA. VA provided $1.7 million for use in developing a data store to capture information to populate the DVEIVR. Initial testing for VA's data store was completed in March 2010. VA estimates that by the end of the first quarter of fiscal year 2011, it will begin data abstraction efforts for the VA functional data store. Data abstractors will take clinical information from medical records and enter it into a computable database for analysis to improve medical care and conduct research. Development of the DVEIVR is projected to begin in the first quarter of fiscal year 2011.

QUESTIONS SUBMITTED BY SENATOR ROBERT C. BYRD

Question. Secretary Shinseki, Congress has continued to fund Department of Defense and the Department of Veterans Affairs' efforts to integrate record keeping for over two and a half decades. As a result of departmental failures in both agencies, wounded soldiers often languish between the systems and receive inadequate care. Last April, President Obama joined you and Secretary Gates in announcing a combined DOD-VA electronic health record system development effort. Since that announcement over a year ago, what concrete progress has been made towards making the system a reality? What role have you played in accomplishing this goal? What are the milestones and timelines for completion of this effort? What will the system

look like when completed? Will it be one seamless system, an integrated system, or an interoperable system?

Answer. The Department is fully committed to meeting the needs of our service members and veterans, especially those who have given so much for their country. The Virtual Lifetime Electronic Record (VLER) is one of VA's highest priorities. VA's dedicated VLER team quickly explored new opportunities for exchanges of health information between not only VA and the Department of Defense (DOD), but also with private healthcare providers who also care for our veterans. The information obtained from this group is critical to the Department's efforts to ensure a complete treatment record is available. VA and DOD capitalized on the work being done by the Department of Health and Human Services to create the Nationwide Health Information Network (NHIN). VA conducted a proof of concept in September 2009 by exchanging very limited information over the NHIN on two patients who consented to be a part of this exchange. The test was conducted in San Diego, California, with two veterans who were seen by both the VA Medical Center and by Kaiser Permanente (KP). After the test, VA completed more work to be able to begin exchanging a limited set of health data for approximately 400 veterans who have consented to be part of a production pilot in San Diego between the VA and KP. That effort commenced mid-December 2009 and continues today. VA plans a second pilot in the Virginia Tidewater area that is expected to go into production during the summer of this year. Following the guidelines of the Chief Information Officer's Program Manager Accountability System (PMAS), development and deployment of additional health data elements and additional functionalities will occur in 6-month phases.

However, as VLER builds upon this health data exchange, the VA's Enterprise Program Management Office (EPMO), which was established to oversee the efforts of both the health and benefits lines of business teams and coordinate those requirements with the information technology development teams, will begin exploring additional means of creating the framework for information interoperability necessary for all of VA's service providers to seamlessly have secure access to the information needed. This data liquidity will significantly reduce the burden on service members and veterans to repeatedly provide information that should and will be made available to our service providers.

The next step in this approach will be to engage in discussions throughout VA and with the Social Security Administration (SSA) to identify those health data elements required for a disability claim that can be exchanged via the NHIN, and to determine the remaining data elements and design the framework for those exchanges. This approach will build on the lessons learned from the NHIN work and rely on HHS standards and protocols where applicable for health data exchanges.

The approach VA is taking leverages the work being done by HHS and allows exchange of health data information over the NHIN. Utilizing the NHIN by creating an adapter from each Electronic Health Record (EHR) to the NHIN gateway allows each Department to modernize on their own schedule and meet their individual needs but still share health information.

The VA's approach to VLER will accomplish the following:

—Create the data liquidity required for service providers to access and use the information needed;

—Reduce the burden on the service member and veteran of repeatedly providing information;

—Deliver new functionalities and capabilities every 6 months, to the NIHN adapter for information interoperability; and

—Position the Department to have laid the framework for the lifetime electronic record by 2012.

Question. Secretary Shinseki, many wounded, disabled, and homeless veterans live in rural areas. Conversely, Department of Veterans' Affairs facilities tend to be aggregated in more densely populated areas to achieve maximum efficiencies. Southern West Virginia disabled veterans often have to travel to facilities as far away as Richmond, Virginia, to receive certain types of medical care. For some services, these veterans may have to travel 6–8 hours each way in order to receive care. For homeless veterans living in these areas, services are often completely unavailable. Last year, I asked what could be done to accommodate some of these services closer to home. What new initiatives have been undertaken since then, in West Virginia and nationwide, to accommodate some of these services closer to rural veterans?

Answer. A significant number of initiatives have been developed and are providing services to veterans in remote areas, including West Virginia. Partnering with local community providers, community and outreach clinics, and telehealth initiatives are all methods VA is utilizing to provide care closer to the veterans' home.

Attachment B provides details on a variety of programs that benefit all veterans who reside in the Appalachian region.

Question. Secretary Shinseki, many VA community-based treatment centers are being collocated with large VA hospitals. These hospitals, in turn, are near large community or general hospitals. In part, this is because collocation affords cost-savings and staff-sharing relationships. Unfortunately, community-based centers are most needed in underserved areas where VA hospitals are far away. What are some of your thoughts on how we can best serve veterans living in these rural areas and what have you done to accomplish this in the last year?

Answer. VA has long recognized that veterans who reside in more remote communities or geographic areas require the same level of services and healthcare as those living in more accessible areas. Providing care away from a VA medical center is a concept that VA began using in the early 1990s. Initially, community-based outpatient clinics (CBOCs) were located in areas with large concentrations of veterans and were reasonably accessible to a VA medical center or community hospital. As the number of CBOCs has increased and technology has improved, VA has recognized that veterans who reside in more remote communities or geographic areas require the same level of services and healthcare as those living in more accessible areas. As a result, in fiscal year 2008, the Office of Rural Health (ORH) funded the establishment of 10 part-time outreach clinics and 4 rural mobile healthcare clinics to target areas where there is not sufficient demand (or it is not feasible) to establish a full-time CBOC. These clinics extend access to primary care, case management and mental health services to rural veterans.

Building upon these initiatives, an additional 30 rural outreach clinics and 51 CBOCs were approved in fiscal year 2009 and fiscal year 2010, respectively. The primary requirement in determining the location of the outreach clinics was based on drive time and percentage of rural and highly rural veterans who receive care.

In addition to the establishment of CBOCs and outreach clinics, a number of telehealth and Home-Based Primary Care (HBPC) teams have been activated.

In fiscal year 2009, VA allocated $80 million for telehealth, augmented by an additional $67 million in fiscal year 2010 for a total of $147 million. Telehealth care is now provided from 144 VA medical centers to 500 other sites of care and supports care to more than 260,000 veterans.

The outcomes of this funding through the end of September 2009, when compared to the September 2008 baseline, has shown an 18 percent growth in the average daily census of rural and highly rural veteran patients receiving care in their homes via care coordination home telehealth (CCHT); a 41 percent growth in the number of clinical video telehealth (CTV) visits provided to rural and highly rural veteran patients; and a 77 percent increase in the number of care coordination store-and-forward telehealth (CCSF) visits provided to rural and highly rural veteran patients.

The fiscal year 2010 initiatives are also showing positive growth over the prior year achievements by increasing access to care for veterans who reside in rural/highly rural area and who use telehealth care.

Question. Secretary Shinseki, with an aging Vietnam veteran population, my office is receiving an increasing number of complaints about the lack of adequate VA nursing home and extended care facilities for veterans in West Virginia. Many facilities scheduled for construction years ago have experienced repeated delays. Last year, I asked you to look into this and get back to me on what we can do to accelerate and increase the construction of these facilities. Has anything been done to accelerate the construction of nursing home facilities during the last year and when can we expect to see additional Administration efforts in this area?

Answer. The Beckley VA medical center submitted a 90-bed Community Living Center (CLC) Major Construction project application that ranked 50 out of 61 in the fiscal year 2011 budget consideration. Projects ranking higher in priority focused on several sub-criteria, such as special emphasis, safety or seismic deficiencies. However, this project only supported the access sub-criteria; therefore, it ranked in the lower echelon.

VA CLCs offer modern nursing home care units focusing on a home-like environment to foster healing. These are primarily constructed in pods of 10–12 home-like units. Due to this new concept, the current CLC design offers a unique opportunity to construct pods within the Minor Construction threshold. In the fiscal year 2010 Minor Construction program, for example, VA started approximately $261.3 million worth of design or construction projects across the country. VA will analyze the opportunities for Beckley's CLC to use an approach that considers Minor Construction while continuing to evaluate the project under Major Construction.

Question. The Conference Report associated with the fiscal year 2010 Military Construction, VA and Related Agencies Appropriations Act encouraged the VA to expand its partnership with accredited nonprofit service dog organizations where vet-

erans with PTSD help to train service dogs. What is the current status of this effort, and to what degree has the Department of Veterans Affairs expanded its partnership with accredited nonprofit service dog organizations where veterans with PTSD help to train service dogs?

Answer. VA has developed an excellent working relationship with nationally recognized organizations in the service dog community. VA has provided information to these organizations to assist with veteran education about the benefits of service dogs, and the veterans they interact with are provided an invitation to contact VA with questions. VA is partnering with the certification agency, Assistance Dogs International, Inc., for assistance with the development of educational materials for our veterans and clinicians, including a brochure and a video.

VA Rehabilitation Service has a pilot program at the Palo Alto Veterans Healthcare System (Menlo Park Division) called the "Paws for Purple Hearts Service Dog Training Program," which began in July 2008. VA has found that patients with PTSD assigned to the Men and Women's Trauma Recovery Program have benefited from this program. These patients are training dogs to become service dogs for persons with mobility impairments. Under this program, the service dogs are the property of the Assistance Dog Institute, with the Bergin University of Canine Studies, and return there for placement after the dogs are trained. The program has made the following clinical observations, finding that participants who train service dogs for mobility impairment have, on average:

—Increased patience, impulse control, and emotional regulation;
—Improved ability to display affection with less emotional numbness;
—Increased positive social interactions and reduced isolation;
—Improved sleep patterns and decreased use of pain medication;
—Decreased number of startled responses and lowered stress levels; and
—Improved parenting skills and family dynamics.

The pilot program is ongoing. Its outcomes and the demand for its services will continue to be assessed to determine if expansion of the program to other VA medical centers is warranted.

Question. Secretary Shinseki, the Department of Veterans Affairs receives funding for research. Historically, this funding has been restricted by the Department to research performed by, or in conjunction with, VA researchers. This practice has sometimes resulted in policy-based rather than science-based research. The VA's own Gulf War Veterans Illness Research Advisory Committee has been forced to approach Congress directly, year after year, to get funding for independent peer-reviewed scientific research. Last year, we had some indications that the Administration would request this independent research funding in the fiscal year 2011 budget request; however, it did not. This research has been funded through the Department of Defense, and again in fiscal year 2011, Congress will have to directly provide these funds. Some of this research has been groundbreaking and very productive. Last year, I asked you what could be done to bring this type of research back into the VA budget process. What has been done in this regard since our last meeting, and when will the VA's own Gulf War Research Advisory Committee be able to say that they no longer need Congressional assistance to fund the best and brightest proposals and scientists to conduct research into the causes and treatments for gulf war related illnesses?

Answer. VA's plans for its gulf war research portfolio include a multi-pronged approach that balances the urgency of understanding and finding new diagnostic tests and treatments for ill veterans of the 1990–1991 gulf war (short-term) with the need to do new studies on a national group of gulf war veterans (long-term). VA's goal is to maintain funding levels for gulf war research as close as possible to $15 million per year.

VA's Office of Research and Development (ORD) issued three new requests for applications (RFA) specific to gulf war veterans research on November 10, 2009. RFA CX–09–013 is specifically aimed at identifying potential new treatments (clinical trials, including complementary medicine approaches) for ill gulf war veterans. RFA CX–09–014 and BX–09–014 are aimed at increasing our understanding of gulf war veterans' illnesses and identifying new diagnostic markers of disease and potential therapeutic targets to develop new therapies. The lists of topics of interest in CX–09–014 and BX–09–014 incorporate over 80 percent of the research recommendations contained in the 2008 report from the VA Research Advisory Committee on Gulf War Veterans' Illnesses (RAC) and direct RAC input to ORD. The three RFAs described above will be re-issued twice a year to regularly request submission of new proposals and revisions of previously reviewed, but unfunded, applications.

ORD's long-term plans include the design and implementation of a new study of a national group of gulf war veterans under the auspices of the VA Cooperative Studies Program, which has extensive experience in developing multi-site VA clin-

ical trials and clinical studies. The design of this new study will include a Genome Wide Association Study (GWAS) and other elements, based on evaluating the existing body of scientific and clinical knowledge about the illnesses affecting gulf war veterans and recommendations received from the RAC. VA has targeted September 2010 for completion of the study design and implementation. This study was discussed with the RAC at their November 2–3, 2009, meeting to gather input on what additional elements could be included in the study. A planning committee has been established to define the elements to be included in the final study.

The expiring authority found at 38 U.S.C. § 1117(c)(2) will not result in the loss of compensation benefits or medical care for gulf war veterans currently receiving benefits for disabilities that are categorized as "undiagnosed illnesses" and for which service connection has been properly decided. Those veterans will continue to receive benefits after the date of the expiring authority on September 30, 2011.

Question. Secretary Shinseki, the Persian Gulf War Veterans Act of 1998, passed as part of the fiscal year 1999 Omnibus Appropriations Act (Public Law 105–277), is scheduled to expire this year, 10 years after the last day of the fiscal year in which the National Academy of Sciences submitted its first report. Will any veterans lose priority care or benefits as a result of the expiration of the law, such as those who remain classified as having an "undiagnosed illness," and will Congress have to pass additional legislation to ensure that these veterans will continue to receive priority healthcare, disability payments and other benefits? If so, what efforts are you aware of within your department or the Congress to draft this legislation?

Answer. No veterans will lose priority care or benefits as a result of expiration of Public Law 105–277. Section 513 of the recently enacted Public Law 111–163, the "Caregivers and Veterans Omnibus Health Services Act of 2010," gives both certain Vietnam-era veterans exposed to herbicides, as well as veterans of the gulf war, special priority care for treatment.

Benefit determinations and payments initiated under Public Law 105–277 will continue to be made. For future reference, 2 of the 3 expiring sections of Public Law 105–277, including the one affecting benefit decisions, actually expired on the first day of fiscal year 2010 per Public Law 105–277, 122 STAT 2681–744 and 745.

Question. Secretary Shinseki, given the importance of the care we give to veterans, and knowing that not all needs can be adequately reflected in a budget document, what do you feel are critical or important needs at the Department of Veterans Affairs that are not well reflected in the fiscal year 2011 budget request?

Answer. The 2011 VA budget continues the strong commitment of the President with an increase in discretionary funding of almost 20 percent since 2009. The budget reflects a balanced and prioritized program that addresses the most critical and important needs of the Department. It allows VA to improve services for veterans and continue transformation of the VA. VA's 2011 budget focuses on three concerns that are of critical importance to our veterans—easier access to benefits and services; reducing the disability claims backlog and the time veterans wait before receiving earned benefits; and ending the downward spiral that results in veterans' homelessness. The budget includes $799 million in specific programs to eliminate homelessness and $250 million for Rural Health Initiatives. It also provides a $42 million increase in telehealth funding in VHA and an unprecedented increase of 27 percent in funding for VBA to address the disability claims backlog. Funding is also provided to continue improving the condition of VA's capital infrastructure.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. Secretary Shinseki, I was deeply disturbed by the news reports in January stating the VA's preliminary data show a dramatic increase in veterans suicide between 2005 and 2007. The fact that our veterans have sacrificed for our Nation only to spiral into depression and suicide is appalling. The preliminary data did suggest that access to VA services makes a difference in suicide prevention. The VA needs a more comprehensive effort and these numbers show that the duty of providing mental health services and outreach to our returning veterans is still a challenge.

Answer. VA shares your concern regarding veteran suicide. Each is a tragedy for the veteran, his family, the community and the Nation. The rates of suicide among veterans in the 16 States monitored by the Center for Disease Control and Prevention's (CDC) National Violent Death Reporting System increased from 2005 to 2007. The increases were greatest among those veterans aged 18–29, with only a slight increase among those aged 30–64, and a slight decrease among those 65 and older. However, among those aged 18–29, suicide rates decreased significantly in those veterans who came to VA for services. VA interprets these findings as an early indi-

cation that VA's mental health enhancements and its suicide prevention programs are working for those who come to us for care. As a result of these statistics, as well as other factors, VA is transforming its mental health system to follow a public health model, providing more programs and resources to veterans in the community and the Nation as a whole, as well as to those seen in our medical centers, clinics, and Vet Centers. These efforts will focus on outreach and education to returning service members and veterans, and to veterans of all eras in their communities. The goal is to encourage as many eligible veterans as possible to seek care within VA, and to support help-seeking for all veterans when they need it. Specific plans are being developed as components of VA's Operating Plan for Mental Health for 2011–2013, and the Department of Defense (DOD)-VA Integrated Strategy for Mental Health.

Additionally, VA created the Veterans National Suicide Prevention Hotline in June 2007 to help veterans in crisis. To date, the hotline has received almost 256,000 calls and rescued about 8,100 people judged to be at imminent risk of suicide since its inception. The center's newest feature is a chat line for those who prefer computer-oriented communication, especially young veterans. Both the hotline and chat line are available 24 hours a day, 7 days a week.

Question. It has been 9 years since our service members have been going to war, often for multiple deployments. What have we done to improve the mental health efforts of those returning veterans?

Answer. VA has made enormous efforts to expand access to care, continuity of care, and quality of care regarding mental health concerns of returning veterans. Those efforts particularly began in 2005, with the implementation of the VA Comprehensive Mental Health Strategic Plan. In each fiscal year from 2005 through 2008, VA funded elements of the Strategic Plan for implementation, with broad national development of innovative programs and overall enhanced staffing of mental health services. In fiscal year 2008, the results of implementation helped VA organize a national model of what mental health services must be made available to all eligible, enrolled veterans seeking VA healthcare. The resulting document, VHA Handbook 1160.01, "Uniform Mental Health Services in VA Medical Centers and Clinics," became VA policy at the start of fiscal year 2009 and is being fully implemented throughout the system nationally, with regular monitoring of implementation showing excellent progress. As of the end of December 2009, VA medical centers and community-based outpatient clinics (CBOC) reported an implementation rate of 98 percent for the more than 200 requirements in the Uniform Mental Health Services Handbook.

We have reported previously on VA mental health efforts—some of the successes include (but are not limited to) the following: increasing mental health staff by over one-third, from 14,000 to over 20,000 nationally and decreasing time to a first appointment for new mental health referrals with a standard of evaluation within 24 hours. This is then followed by urgent care, if needed, or development and implementation of a treatment plan within the next 14 days (with 96 percent success in meeting this standard). VA has also developed the Suicide Prevention Hotline and teams of Suicide Preventions Coordinators at every VA facility. VA integrated mental health into primary care clinics and mandated screening for mental health problems to include: PTSD, depression, problem drinking, military sexual trauma, and suicide risk assessment if PTSD or depression screens are positive. Finally, VA expanded substance use disorder treatment and treatment of co-occurring substance use and PTSD problems.

All of these efforts improved the full system of care for all veterans, but there also have been elements specifically designed to serve returning Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans. These include:

—Development of special mental health staff specifically reaching out to returning veterans, in the system, to ensure mental health issues are fully addressed.

—Integration of these staff into the Post-Deployment OEF/OIF special primary care clinics.

—Collaboration with the case management system for OEF/OIF veterans to ensure mental health needs are always considered.

—Placement of mental health staff in specialty polytrauma care settings for severely wounded returning veterans.

—Training of over 3,000 VA mental health staff in evidence-based psychotherapies for PTSD, depression, family distress, and other mental health disorders that have been shown in research and clinical practice to have the greatest likelihood of resulting in significant improvement in these mental health conditions. Training has been provided with guidance to ensure that initial implementation of these therapies should target OEF/OIF veterans, to provide early intervention as much as possible.

—Expansion of mental health services for women veterans. Female OEF/OIF veterans are more likely to seek VA care than male OEF/OIF veterans, and their increasing numbers require VA to expand services. Specific requirements for serving female veterans are included in the VA Uniform Mental Health Services Handbook mentioned above.
—Collaboration with the Defense Centers of Excellence (DCOE) for Psychological Health and Traumatic Brain Injury, to coordinate efforts.
—Implementation and planning of a joint VA/DOD Mental Health Summit with DCOE and other health components of DOD. This has led to development of an integrated Mental Health Strategic Plan to increase coordination and continuity of care as service members obtain care in DOD, then separate and come to VA for care.

In summary, VA has transformed its overall mental health services in the last 5 years, and that transformation has included focused efforts to ensure enhanced care for currently returning OEF/OIF veterans. These efforts will continue to receive priority.

Question. Why do we still not have the trained mental health professionals in all of our VA facilities?

Answer. VA does have a greatly increased number of mental health staff throughout the system, with mental health professionals in all VA medical facilities. Community living centers, residential rehabilitation treatment programs and domiciliaries have access to mental health resources because they are co-located with other facilities (hospitals or outpatient centers) that have mental health professionals. All large community-based outpatient clinics (CBOC) and all vet centers also have mental health staff who provide outpatient mental health services. Smaller CBOCs must provide mental healthcare through telemental health connections or by contract or fee basis. In addition, all medical facilities have mental health professionals who have been trained in providing various evidence-based psychotherapies and connections to staff with such training are available via telemental health in most CBOCs. VA strongly believes in ensuring that VA mental health staff members have appropriate, high quality training to promote the delivery of high quality, evidence-based and recovery-oriented services. VA qualification standards for employment in mental health positions require that mental health professionals have established levels of education necessary to provide clinical care, with specific competencies required for specific clinical activities and responsibilities.

VA develops and provides extensive training to mental health staff throughout its healthcare system on a broad array of mental health topic areas to ensure that mental health staff can deliver high quality care that is consistent with current clinical science. As part of its commitment to training and high quality patient care, VA has developed national staff training programs in state-of-the-art, evidence-based psychotherapies (EBPs), including cognitive processing therapy and prolonged exposure therapy for posttraumatic stress disorder (PTSD), cognitive behavioral therapy and acceptance and commitment therapy for depression, and social skills training and family psychoeducation for serious mental illness. Training in these programs consists of two key components: (1) participation in an in-person, experientially based workshop of 2–4 days in length, followed by (2) active participation in weekly consultation with an expert in the specific psychotherapy for approximately 6 months. To date, VA has provided training to over 3,000 mental health staff in evidence-based psychotherapy, including providing evidence-based psychotherapy training to staff at all VA medical centers.

In addition, VA annually provides national and regional training to mental health staff on a wide variety of mental health topics through VA's Employee Education System. These trainings are provided through in-person conferences, videoconferences, Web-based trainings, and DVD video trainings. In addition to training provided through these national mechanisms, local VA facilities provide a wide variety of mental health trainings to mental health staff on specific mental health topics.

Question. What can Congress do to assist you? Do you need additional hiring authorities or incentives?

Answer. VA's fiscal year 2011 budget provides for more than $5.2 billion for mental health, an increase of $410 million, or 8.5 percent, over the 2010 enacted level. We will expand inpatient, residential, and outpatient mental health programs with an emphasis on integrating mental health services with primary and specialty care. Recent VA research has demonstrated that the more returning veterans feel supported by their communities and by the Nation as a whole, the less likely they are to develop PTSD and depression. Congress has helped our troops and veterans by continuing to support mental health programs.

VA has significantly invested in our mental health workforce, hiring more than 6,000 new workers since 2005. VA has estimated that the current level of staffing is sufficient to meet the needs of veterans who use VHA for their mental healthcare. There are still a small number of unfilled positions at various VA medical facilities that are supported with mental health enhancement funds. Direction has been sent to all Veterans Integrated Service Networks (VISNs) to use the enhancement funds to fill these positions. In addition, it is essential that this level of staffing be sustained, e.g., positions that are vacated through retirement or other departures are filled in timely fashion.

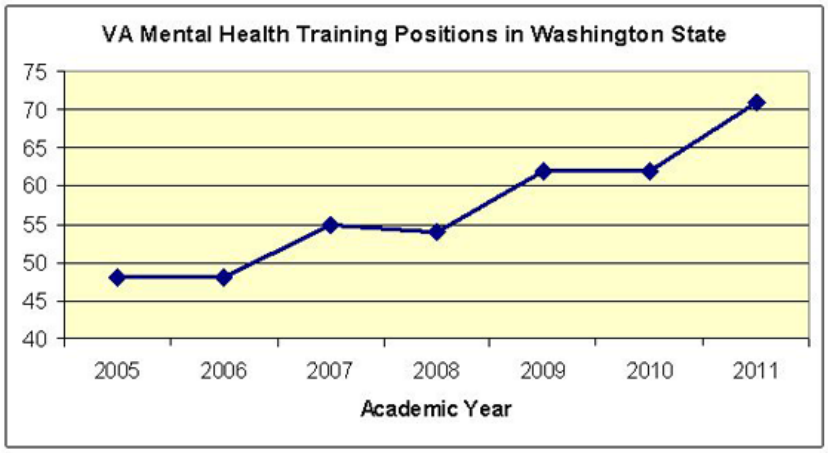
VA has not experienced widespread difficulties in hiring and retaining mental health professionals. However, it has been VA's experience that in certain localities, particularly highly rural regions, there may be a limited number of mental health professionals, especially psychiatrists. Specific incentives have been developed and used in such situations. In addition to opportunities for education debt reduction, VHA has established opportunities for facilities to engage in local advertising and recruitment activities, and to cover interview-related costs, relocation expenses, and provide hiring bonuses for certain applicants. Flexibility is provided to hire providers of other appropriate disciplines or to utilize fee-basis or contract care, when indicated, so that veterans have continuous access to the full continuum of mental health services.

Question. In Washington we are bringing in residents to assist with the manning shortfall. Do we need to expand the program?

Answer. Recognizing the importance of mental health services in the overall care of veterans, VA has expanded training positions in the core mental health disciplines of Psychology, Psychiatry, and Social Work. Within Graduate Medical Education (GME), VA launched the GME Enhancement Initiative in 2006 to expand physician residents in areas of need to attain greater geographic balance in resident allocations, and to foster innovation in the models of training physician residents. The GME Enhancement Initiative created an additional 1,221 physician residents positions, with 123 in psychiatry, and 169 in all mental health related specialties.

In addition, over the last several years, VA has pursued an initiative to increase the number of non-physician mental health practitioners, especially psychologists and social workers. These efforts have been highly successful. Psychology has expanded its national trainee complement by 251 positions, to a total of 683 nationally. Moreover, social work training positions have increased from 588 to 732 for the coming year.

The impact of these initiatives for the State of Washington is shown in the chart below. The overall increase in VA mental health training positions (psychiatry, psychology, and social work) from 2005 to the present is 48 percent.



These data suggest that Washington has benefited greatly from recent expansions in trainee positions. In addition, because of the rural nature of practice in some parts of Washington, it is anticipated that the State will continue to have a high priority for future trainee expansions.

Question. Secretary Shinseki, as you know, women are the fastest growing subsection of veterans and increasingly in need of services from our VA system. Unfortunately the VA has been slow to modernize to meet their unique physical and mental health needs. I recognize the VA is trying to make changes at their facilities to make them more female-friendly, but there appears to lack a coherent, nationwide plan to review and assess the capabilities of all facilities and create a capital plan to start addressing shortfalls in high demand areas.

What is the status of a VA-wide capital plan to evaluate each facility in the VA system and target those that service greater populations of female veterans and veterans with children?

Answer. VA has undertaken an ongoing assessment and improvement process to ensure that VHA facilities meet the healthcare needs of women veterans in a friendly and safe environment that respects their unique needs, dignity, and privacy.

Elements relevant to structural, environmental, and psychosocial patient safety and privacy issues have been incorporated into VHA's monthly environment of care rounds checklist. VA is obtaining monthly assessments from each medical center in order to follow actions taken to address identified issues in the privacy and security of all veterans. Women Veteran Program Managers at each medical center are included in the review process.

In addition, an annual review of structural, environmental, and psychosocial patient safety and privacy issues in VHA patient care settings will be conducted by the Director, Environmental Program Service and incorporated into monthly environment of care rounds.

The Women Veteran's Health Strategic Health Care Group is in the process of performing a comprehensive assessment of facilities' current capacity for providing optimal care of women veterans. The assessment includes site visits and tours of six medical centers in fiscal year 2010 with ongoing assessments in fiscal year 2011. During tours, the site assessment team will review available space, environmental considerations (e.g., signage, privacy), patient and provider flow, and availability of equipment and supplies. The assessment team will also conduct brief interviews with staff in each of these areas. Results of the assessment will be used to address deficiencies and drive future budget allocation requests.

VA's design and construction standards are being enhanced to address the physical and mental healthcare needs of women veterans. Space planning criteria are being adjusted for specific functions to be performed (mammography spaces, outpatient clinics, radiation therapy, etc.).

The national capital plan to address women's healthcare is incorporated into the new Strategic Capital Investment Planning (SCIP) process. With this process, every medical center will identify how it will mitigate service delivery gaps over a 10-year window, including women's privacy deficiencies. As part of the SCIP process, we will create corporate data to support women's privacy needs to ensure a more focused effort is dedicated to mitigating the deficiencies.

QUESTIONS SUBMITTED BY SENATOR KAY BAILEY HUTCHISON

Question. The VA has established a new policy to presume veterans with ischemic heart disease, Parkinson's disease, and B cell leukemia and who served in Vietnam are entitled to compensation benefits as a result of their exposure to Agent Orange. The Department estimates this new policy will result in approximately 150,000 new claims generated in 2010, and for the total number of disability claims to increase from 1 million in 2009 to 1.3 million in 2010. The claims process already takes too long to make decisions on a veteran's disability claim, and I am highly concerned that this new policy will further complicate the already large claims backlog.

I understand that there are funds for 1,800 new claims processing staff in the 2011 budget (excluding term-hire positions included in last year's stimulus bill), and I applaud the effort to handle this influx in claims. But since 2007, this subcommittee has appropriated funding to add nearly 7,000 new positions to the VA's claims processing staff, and there has been no significant decrease in claims processing time. This does not seem to be purely a problem of understaffing.

Does the Department have any estimates on how the 30 percent increase in claims receipts will affect the processing time, and what can we do to help you tackle this problem?

Can you tell me whether the Department is looking at new ways to change the way in which it handles disability claims and what impact the paperless claims IT project will have on both the claims backlog and the average claims processing time?

Answer. Currently, the average time to process a disability compensation claim is about 160 days. Based on the continued growth in claims receipts and the antici-

pated influx of claims related to the new Agent Orange presumptions VA anticipates our inventory will rise to over 700,000 claims in 2011, and the average time to process claims is expected to increase as a result.

The Veterans Benefits Administration now employs more than 11,600 full-time claims processors and plans to add 3,000 more in fiscal year 2011. However, continuing to increase the size of our workforce is neither a long-term nor scalable solution; we need to do a much better job of leveraging network automation and software productivity tools to more effectively manage our workload and serve our clients. Bold and comprehensive changes are needed to transform VA into a high-performing 21st century organization that provides high quality services to our Nation's veterans and their families.

VA's transformation strategy leverages the power of 21st century technologies applied to redesigned business processes. Pilot programs are underway at four of our regional offices to support our business transformation plan to reduce the claims backlog, improve service delivery, and increase efficiencies. Each pilot functions as a building block to the development of an efficient and flexible paperless claims process. The results of all four pilots will be incorporated into the nationwide deployment of the Veterans Benefits Management System (VBMS) in 2012. VBMS will be built upon a service-oriented architecture, enabling electronic claims processing by providing a shared set of service components derived from business functions. Initially, VBMS will focus on scanned documents to facilitate the transition to a paperless process. Ultimately, it will provide end-to-end electronic claims workflow and data storage.

VA is also seeking contractor support in development of a system to support evidentiary assembly and case development of the new Agent Orange presumptive claims. The system will enable veterans to proactively assist in the development of their claims through a series of guided questions and will automate many development functions such as Veterans Claims Assistance Act notification and follow up.

In addition to an electronic claims processing system, VA is committed to improving the speed, accuracy, and efficiency with which information is exchanged between veterans and VA, regardless of the communications method. The Veterans Relationship Management (VRM) transformational initiative will provide the capabilities to achieve on-demand access to comprehensive VA services and benefits in a consistent, user-centric manner to enhance veterans', their families' and their agents' self-service experience.

Question. It is everyone's goal to leverage information technology to improve services to our veterans and to have them seamlessly transition from DOD to the VA. A paperless solution to the disability claims backlog, a lifetime electronic service record that follows a soldier through DOD and VA, a new electronic health record, and a financial management system that provides greater accountability of government resources all have potential to transform the VA. However, the Department has a poor track record in its ability to develop and implement these costly programs. An internal audit by the VA last year temporarily halted 45 of the VA's 282 ongoing IT projects because they were either significantly over budget or behind schedule, and the Department's 2011 budget proposes $3.3 billion for IT, which is identical to the 2010 appropriation, not including the nearly $700 million that was unspent from the 2010 appropriation. I am concerned that this may not be the most efficient use of taxpayer dollars in 2011 without proper oversight and transparency. These projects are of great importance to our veterans, and I want to be sure they succeed.

Mr. Secretary, have you found the certification requirements included in last year's bill to be helpful in your efforts to improve management over IT projects and programs?

Answer. In 2010, VA has fully implemented its Project Management Accountability System (PMAS). This system has put in place the necessary program review and rigor to examine an IT project's chances for success on an ongoing basis. PMAS has been successful in identifying what projects VA should terminate and what projects should continue. Now that the PMAS process is in place, all IT projects must be certified by the Chief Information Officer in order to receive funding and approval to proceed. With PMAS in place, we believe bill language requiring certification may no longer be necessary. The Department is committed to keeping the Committee informed on the PMAS process and the status of IT projects.

Question. Mr. Secretary, we believe there is the potential for more budgetary steps to be taken to improve accountability over IT projects, such as separating the 1-year costs of staff salaries and expenses, and operations and maintenance costs, from the longer-term costs of developing new IT programs. Do you have any thoughts on that idea?

Answer. The Department appreciates the flexibility Congress has provided by making funds appropriated to the Information Technology Systems account available for a 2-year period. This flexibility was a key factor and management tool in VA's successful consolidation of all IT funding into one account over a 3-year period.

The Department would like to retain this management flexibility for administering its IT program. VA continues to refine its accounting for IT costs; this includes better defining which projects are purely new development projects as opposed to operations and maintenance projects. The distinction is not always simple to discern, and there would be some risk in segregating the availability of these funds either by time period or by establishing separate accounts. In addition, the availability of 2-year funding for salaries and administrative costs will enable IT managers to effectively plan for the hiring of additional staff and to adjust to unanticipated changes impacting the workforce.

Currently, VA identifies development, operations and maintenance, and salary/administrative costs separately as part of the annual budget submission and the IT project reprogramming baseline. We will continue to do so to meet the information needs of the Congress.

Question. Can you tell us how many of your project managers are "Project Management" certified by an outside organization (such as Project Management Institute, etc.)?

Answer. Trained project management leaders are critical to ensuring IT project success. As an important part of workforce management, all project managers are involved in ongoing project training, training that can be applied towards Project Management certification requirements. At present, 70 percent of IT development project and program managers maintain credentials in Program Management, either through organizations such as the Project Management Institute or VA's rigorous Project Management training programs.

Question. Mr. Secretary, the 2011 budget recommends nearly $2 billion for the VA construction program, including $864 million in site-specific funding for new or replacement hospitals. However, I was concerned to see that there was $2.56 billion in unobligated funds from 2009 into 2010, more than the last 2 years of major construction appropriations, for projects that should be obligated within the fiscal year. I am concerned that our major construction program is not spending its appropriations in a timely and efficient manner, and I want to work with you to resolve this challenge. As I'm sure you know, this is an issue for military construction projects, and we combat it by making projects subject to 5-year funding and by having the services publish a Future Years Defense Program (FYDP) that outlines each service's expected construction needs in the immediate future. This helps us to ensure efficient budgetary planning and that only those projects that are shovel-ready receive funding.

Mr. Secretary, as a former Army Chief of Staff, do you have any thoughts on making new VA construction projects subject to some of these rules? Would you be willing to submit a prioritized "FYDP" for VA construction projects in order to ensure they are shovel-ready and to help us be more fiscally responsible to our veterans and to the taxpayer?

Answer. VA does not support restricting the availability of major construction funding to 5 years. Construction funds should remain as no year money. Once funding is received for a major project, it is obligated over a period of several years for design, construction, contingencies, completion items and contract closeout. VA monitors the progress closely to ensure contracts remain on time and within budget. There are several reasons that project funding remains unobligated including:

—When VA awards a construction contract, a contingency is set aside, 5 percent on new construction and 7.5 percent on renovation. The contingency set-aside is available to address unforeseen conditions. These funds are not obligated until needed and contribute to the unobligated amounts.

—Some projects are phased. Funds required for future phases cannot be awarded until the preceding phase is completed. There are 10 projects with funding of $698.6 million that have future phases. These projects have phases that are currently under construction that must be completed prior to awarding the subsequent phase. Some of these phases will be awarded later this fiscal year. Some of the high visibility projects in this category are polytrauma centers at Palo Alto and Tampa

—When contract claims have been filed or are anticipated, funding is held after completion in case it is needed when a claim is adjudicated.

There are 4 projects with funding of $713.3 million that are currently in design and VA anticipates a construction award later this fiscal year. Some of the high visibility projects in this category are new medical facilities at New Orleans and Denver. Projects like these would be halted until funding could be obtained if funding

is restricted. The major challenge for VA has been in the planning phase for these projects. The current process selects projects for initial budget submission without the benefit of early design. Projects at this stage often have significant unknowns such as constructability issues, incomplete scope definition and the need to complete environmental, historic preservation and often real estate due diligence. The resolution of these issues contributes to delay in making significant obligations on the projects.

VA submits a 5-year Capital Plan annually with the President's budget submission. The current 5-year plan lists approximately 92 major projects. These projects may vary from year to year due to re-prioritization each year—new projects are added, while others are removed as alternative investment strategies (e.g., leases or enhanced-use leases) are utilized to provide the services. Currently the Department is embarking on a Strategic Capital Investment Planning (SCIP) process that will provide a 10-year plan for all capital investments. This plan will help to address where facilities are needed throughout the Department based on demographics, changes in the delivery of care, and the type of care to be provided. The SCIP process will result in a consolidated prioritized list for all capital investments (major/minor construction, non-recurring maintenance, and leases) for 2012–2021. This multiyear planning effort will thus obligate project funding sooner after an appropriation from Congress is received.

Question. Mr. Secretary, I understand that the VA has conducted a comprehensive review of the VA's approach and practices to treat veterans of the 1990–1991 gulf war. This Gulf War Illness Task Force recently released its report and recommended adding nine new conditions as automatic presumptions for service-connected injuries. I applaud your efforts to improve the lives of those veterans suffering from undiagnosed illnesses during this conflict and hope we remain committed to treating those affected and finding a cure. However, as I understand it, this new policy was not in effect when the Department's 2011 budget was formulated.

Assuming these new presumptions go into effect, has the Department made any cost estimates for adding these nine new presumptive conditions for gulf war veterans?

How does the VA expect to pay for these new presumptions if they are not in the Department's 2011 budget request?

Answer. The compensation benefit costs associated with this proposed rule are estimated to be $1.5 million during the first year, $11.5 million for 5 years, and $36.4 million over 10 years. VBA will provide updated fiscal year 2011 projections in the annual Mid Session Review budget submission. This budget submission will include changes in economic assumptions, changing trends based on FYTD experience, and technical adjustments including estimated effects of proposed rules.

The decision to create nine new presumptives based on exposure to infectious agents in the Gulf resulted from the IOM report on Gulf War and Health, Volume 5, Infectious Agents. The Secretary's decision to establish these presumptions was made prior to the formation of the Gulf War Illness Task Force.

QUESTIONS SUBMITTED BY SENATOR MITCH MCCONNELL

Question. Telemedicine is a tool that would seem to have potential to provide improved access to healthcare services for rural veterans, allowing them to get the medical advice they need without undertaking the time and expense of driving to a major VA facility. What measures, if any, are being taken by the VA to expand the use of this technology to help rural veterans?

Answer. VA's 2011 President's budget includes an investment of $163 million in home telehealth. Taking greater advantage of the latest technological advancements in healthcare delivery will allow us to more closely monitor the health status of veterans and will greatly improve access to care for veterans in rural and highly rural areas.

Telehealth is one of the ways in which VA is actively increasing access for veteran patients to healthcare services in rural and remote locations. In fiscal year 2009, 118,000 veterans received healthcare services from VA in rural and remote locations via telehealth. This number represented a 20 percent increase over fiscal year 2008 levels and included 16,000 veterans receiving care in their own homes via home telehealth, 67,000 veterans receiving teleretinal screening and teledermatology services via "store-and-forward" telehealth technologies and 35,000 veterans participating in specialist consultations between community-based outpatient clinics and VA medical centers, predominantly to meet mental health needs. By the end of fiscal year 2010, VA anticipates a further 20 percent increase in telehealth-based care

to veteran patients in rural/remote locations. This will reduce avoidable time and expenses involved in veterans travel to a major VA facility. Telehealth, therefore, continues to be an important capability that VA is utilizing to meet the healthcare needs of veterans we serve in rural and remote locations.

Question. In 2006, there was an alleged homicide that occurred at the Lexington, Kentucky VA Medical Center where the patient died due to an overdose of morphine. In 2009, the nurse involved in the case was arrested and charged with homicide.

Consistent with any restrictions governing the release of information linked to ongoing criminal investigations, what further developments have occurred in this investigation? What actions have been taken by the VA to prevent events like these from happening in the future?

Answer. The investigation was turned over to the VA Office of the Inspector General (OIG) and Federal investigators. A trial for this case is before the U.S. District Court, Eastern District of Kentucky, Central Division at Lexington, KY, and it has been re-set for October 12, 2010. To prevent events like this from happening in the future, VA purchased new intravenous (IV) pumps with additional safety features. These features help prevent the pumps from being set over the maximum dosage or below therapeutic levels. VA used at the time of the event, and continues to use today, tubing sets that prevent the free flow of medication as another safety precaution. VA continues to review monthly dispensing practices to monitor the narcotic administration practices of individual staff.

Question. Of the contract-run Community Based Outpatient Centers in Kentucky, what is the level of patient satisfaction with their care?

Answer. There are two contracted CBOCs in Kentucky. The Bowling Green CBOC received an outpatient score of 62.7 which exceeds the VISN nine goal and makes it the highest satisfaction score for any Tennessee Valley Healthcare System CBOC. The Hopkinsville CBOC does not have a sufficiently large response population for a patient satisfaction score.

Question. What is the VA doing to enhance efforts to locate homeless veterans and to provide resources and programs to help them?

Answer. VA is taking decisive action toward its goal of ending homelessness among our Nation's veterans in 5 years. VA has continued to use and expand its Healthcare for Homeless Veterans (HCHV) efforts, which involve staff making direct searches of environments where homeless veterans are likely to be found and making every effort to gain their trust and bring them in for services. The National Call Center for Homeless Veterans (NCCHV) is a recent initiative in VA's 5-year plan to end homelessness. It can provide homeless veterans with timely and coordinated access to VA and community services, and disseminate information to concerned family members and non-VA providers about all the programs and services available to assist these veterans. There have been callers who have not been previously identified and can now be connected with VA and other services. Callers seeking more details about VA Homeless programs or services can also be referred to the VA Homeless Web site and appropriate VA medical center points of contact for further intervention, referral, or information. As information about the Call Center is more broadly disseminated by local VA facilities and the Homeless Coordinators in all VISNs, more calls are expected. This new outreach effort already is proving very valuable.

In order to better track veterans located through these and other efforts, VA is developing a homeless veterans registry that will track and monitor the expansion of homeless and prevention initiatives and the treatment outcomes for homeless veterans. The registry will be a comprehensive veteran-centric registry (data warehouse) of information about homeless veterans who receive services provided by VA administered programs, as well as services provided by external Federal agencies, and other private and public entities. Additionally, the registry will also be used to identify and collect information about veterans who are at-risk for homelessness. This system will allow VA to analyze mobility among homeless veterans.

Question. What is the VA doing to enhance the privacy of and to increase the resources and programs available for female veterans?

Answer. Following recommendations by a VA workgroup on Veteran Privacy, Security and Dignity, a review of structural, environmental, and psychosocial patient safety and privacy issues has been conducted in VHA outpatient care settings and incorporated into monthly environment of care action plans. The initial review was completed in August 2009 and VA has been conducting monthly status updates since that time. The Women Veteran Program Manager participates as a member of the environment of care team. Each facility must engage in an on-going, continual process to assess and correct physical deficiencies and environmental barriers to care for all veterans, particularly women veterans. In addition, Women Veterans

Program Managers and Deputy Field Directors are conducting on-site visits to monitor compliance with correction of privacy deficiencies. Findings are communicated to local leadership. Other strategies to ensure compliance include unannounced site visits by VISN Environment of Care Teams, random site visits, and records reviews by VHA's Office of Environmental Programs Service, as well as System-wide Ongoing Assessment and Review Strategy (SOARS) site visits. Action plans will be maintained and tracked by the VHA Environmental Programs Service to ensure compliance and assist with construction planning to renovate facilities.

Current initiatives to increase resources and programs available to women veterans include:

—*Redesigning Primary Care for Women.*—Specifically, VHA is redesigning comprehensive women's healthcare delivery within three models of care, which colocate commonly used services and specialties into one care delivery process, ensuring that women can receive all of their primary healthcare (prevention, medical, and routine gynecologic care) by a single primary care provider. Our goal is to decrease fragmentation of care and improve continuity of care.

—*A Full-Time Women Veteran Program Manager at Each Site.*—As of June 28, 2010, 132 of the 144 facilities with a Women Veterans Program Manager has a full-time employee in place; seven other facilities have an acting or interim Women Veterans Program Manager, and four of the remaining five will fill the position by August 2010.

—*National Training Programs for Women's Healthcare Providers.*—Improving primary care clinicians' proficiency, knowledge, and cultural sensitivity in women's health and VA resources available to women veterans through the implementation of mini-residency programs.

—*Evaluation of Primary Care for Women.*—Assessing VA women's health programs through the creation of an assessment tool to identify highly developed women's health programs, their best practices, and better understand successful pathways to implementing comprehensive women's health.

—*Women Veteran Outreach Campaigns.*—Educating women veterans through age and culturally informed communication and outreach initiatives. For example, modifying their cardiovascular risk factors and maintaining their health status in order to delay the onset of complex chronic conditions.

Question. The percentage of female veterans who do not show up for their medical appointments is in many cases greater than the percentage of male veterans that do not show up for theirs. What is the VA doing to better understand why this occurs, and what is being done to reduce this higher percentage?

Answer. Addressing barriers to access for women veterans is a priority. VHA is preparing a report, "Assessment of the Health Care Needs and Barriers to VA Use Experienced by Women Veterans: Findings from the National Survey of Women Veterans." One of the aims of the National Survey of Women Veterans (NSWV) was to determine how healthcare needs and barriers to VA healthcare use differ among women veterans of different periods of military service and assess women veterans' healthcare preferences in order to address VA barriers and healthcare needs. The interim report on barriers to care will be complete by mid-July 2010 with the final report anticipated to be published in 2011.

In addition, several current initiatives will directly improve access to care for women veterans.

—*Redesigning Primary Care for Women.*—Our goal is to decrease fragmentation of care and improve continuity of care. By providing all of a woman veteran's care from one provider, no-show rates will be improved by decreasing the number of appointments a women veteran will have to keep.

—*Patient Centered Medical Home (PCMH).*—VHA recognizes the unique needs of women veterans, specifically the need for after hours care, women's health providers at community based outpatient centers (CBOC) and flexibility in how appointments are scheduled due to demands as the primary caregivers of their families which often include other veterans and inflexible work schedules. The PCMH improves access to care by providing flexibility in when and how women veterans schedule appointment time so complicated schedules can be accommodated. Access to women's health providers in a CBOC means fewer miles traveled to see a provider who can meet women veterans' needs.

In addition, PCMH improves access through direct contact with case managers who will assist veterans with care coordination, facilitates veteran participation with their healthcare with the use of self-management health tools and improves veteran satisfaction by allowing for greater communication with a provider and the veteran through alternative forms of communications such as the Internet through secure messaging.

Question. Following the Wounded Warrior legislation and the Dole-Shalala Commission's recommendations, improvements were to be made to the coordination mechanisms between DOD and VA facilities to better care for our injured troops who are transitioning between the two healthcare systems. What steps have already taken place to improve coordination between the two Departments? What steps remain? Are these provisions sufficient to provide a seamless transition for wounded warriors from the DOD to the VA system? Does DOD or the VA need further legislative authority to improve matters? If so, what?

Answer. To ensure a smooth transition from the Department of Defense (DOD), VA has stationed 33 healthcare liaisons at 18 military treatment facilities to facilitate the transfer of care to VA facilities. This program grew during 2009 with six additional liaisons at five new sites. Altogether these liaisons have assisted more than 20,000 service members in transitioning from DOD to VA since 2004. We continue to work with DOD to identify additional sites that have increasing numbers of wounded warriors who may benefit from these services. VA works closely with DOD to support high quality integrated care for severely injured service members and veterans. The two Departments recently developed revisions to clinical codes to improve identification and tracking of traumatic brain injury (TBI). In 2009, a 5-year pilot project to provide assisted living services for veterans with severe TBI was initiated in collaboration with the Defense and Veterans Brain Injury Center (DVBIC). We have placed three veterans in Virginia, Florida and Wisconsin, and enrollment is pending for two veterans in Texas and Kentucky.

Pursuant to the Dole-Shalala Commission's recommendation, VA and DOD collaborated on development of the eBenefits portal to provide a single and transparent access point to online benefits for wounded, ill, and injured service members, veterans, and their family members and care providers. The eBenefits portal has expanded beyond its original scope and is now intended to be an interactive Web portal for all veterans, service members, and their families. In April 2010, eBenefits launched version 2.3 that provides on-line capability to check the status of disability claims, review payment histories, obtain home loan certificates of eligibility, and obtain military documents.

In November 2007, DOD launched the Disability Evaluation System (DES) Pilot to modernize the process by which potentially unfit wounded, ill, and injured service members are evaluated for retirement, separation, or placement on the temporary disability retirement list. A single medical examination is used by both DOD and VA in determining entitlements. The pilot program began in November 2007 in the National Capitol Region (Walter Reed Army Medical Center, National Naval Medical Center (NNMC) at Bethesda, and Malcolm Grow Air Force Hospital) and has since expanded to 24 additional military installations. Of those separating with a medical disability, approximately 47 percent participate currently in the DES pilot process. VA and DOD are developing a plan to deploy and transform the DES pilot into the integrated DES process worldwide by the end of fiscal year 2011.

VA believes current legislative authority is sufficient to ensure a smooth transition of our injured troops from DOD. VA will work closely with the Committee if further legislative authority is needed in the future.

Question. The Western Kentucky Veterans Center expansion in Hanson, Kentucky is listed as priority #47 in the Fiscal Year 2010 Priority List of Pending State Home Construction Grant Applications subject to 38 CFR part 59. (It involves increasing the number of beds by 40). It is my understanding that an updated priority list for fiscal year 2011 will be submitted sometime in the fall. Although Kentucky is classified as a "limited needs" State by the VA, I want to ensure that expansion of the Hanson facility takes place in the near future and is not permitted to slide down the list of priorities. How can we ensure that even "limited needs" States such as Kentucky are properly looked after in the State Home Construction Grant Application process?

Answer. The Department of Veterans Affairs (VA) may have sufficient funds to participate in a grant for the construction of a 36-bed expansion project at the State Veterans Home in Hanson, Kentucky during fiscal year 2010. A letter was sent to the Honorable Ken Lucas, Commissioner Kentucky Department of Veterans Affairs on May 18, 2010, stating VA participation in the project is contingent upon the State of Kentucky's compliance with the remaining Federal requirements listed in title 38, Code of Federal Regulations, part 59. All projects on the priority list are strictly ranked following the guidelines in the regulation which places life safety projects at the top of the list.

QUESTION SUBMITTED BY SENATOR SUSAN COLLINS

Question. Many of the employees at VA Togus focus specifically on disability claims processing. I was recently was told that the Veterans Benefits Administration at Togus is in the process of hiring 40 new employees that will process disability claims for 8,000 cases related to new Agent Orange and Agent Purple claims. I understand that another 20 employees may be added at Togus to continue to help reduce the disability claims backlogs. Because of the age of some of the buildings and recent storms, as well as the increasing number of claims processing employees, the facility may require additional space and administrative offices. Has the Department reviewed the space requirements at the VBA facility at Togus or can you commit to performing such a review in the near future?

Answer. The Togus Regional Office (RO) received authority to hire 61 additional full-time employees. The RO is actively recruiting, and 32 employees are already on the rolls. The RO plans to use 40 new employees to process Agent Orange claims with the remaining new employees focused on processing the regular disability claims workload. To fully utilize the space at the RO facility, the majority of the new employees will work during a second shift. The RO is on the campus of the Togus VA Medical Center. Although an older building, significant investments were made over the last 2 years to improve the physical space. The improvements include new windows, a new roof, and a new heating, ventilation and cooling system.

SUBCOMMITTEE RECESS

Senator JOHNSON. This hearing is recessed.

[Whereupon, at 3:17 p.m., Thursday, April 15, the subcommittee was recessed, to reconvene subject to the call of the Chair.]