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Chair

Mr. Rob Anders

Standing Committee on Veterans Affairs

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● (1530)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): I now call to order the Standing Committee on Veterans Affairs.

We have some guests by video conference. I will introduce them. From the United States Department of Veterans Affairs, we have as witnesses Susan McCrea, liaison officer for intergovernmental affairs; Keith Pedigo, associate deputy undersecretary of benefits for policy and program management; Steve Muro, director of field programs; Gail Graham, director of health data and informatics, veterans health administration; and Linda Fischetti, acting chief of the health information office. Thank you very much.

Usually the way we work is that our witnesses....

Sorry, Mr. Sweet.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): Just before you address the witnesses and they give their testimony, I wanted to commend the staff for their great job in making this meeting look very appropriate and official, with our witnesses having the flag of the United States of America directly behind them and our chairman the flag of Canada directly behind him. I just wanted to commend them for the great set-up of this.

Thank you very much.

The Chair: There we go. Mr. Sweet has noticed the wonderful official protocol being noted. And yes, it is well done.

Generally the way it works is that witnesses have about 20 minutes, but I understand that the arrangement today is for 10 minutes each. Fair enough.

The floor is yours. I turn it over now to our American witness friends.

Ms. Susan McCrea (Liaison Officer, Intergovernmental Affairs, United States Department of Veterans Affairs): Good afternoon.

As you said, my name is Susan McCrea. I am going to do introductions, but before I do that, I want to give you a few statistics about the VA.

First, we have 24 million veterans in the United States. Our budget for fiscal year 2008 is about $90 billion; and for the next year, the President has asked for $94 billion. We're the second-largest government agency, with 264,000 employees. We partner with our veteran service organizations, such as the American Legion, the VFW, and Disabled American Veterans, who help prepare claims for veterans. They also partner with state veterans affairs agencies in claims preparation, provide long-term care to veterans, and provide burial benefits also.

We have three administrations: health, benefits, and cemetery.

As you've already said, Keith Pedigo will talk to you about veterans benefits; Steve Muro will talk about the cemetery benefits; and Gail Graham and Linda Fischetti will talk about veterans health care benefits.

Keith.

● (1535)

Mr. Keith Pedigo (Associate Deputy Under Secretary, Benefits for Policy and Program Management, United States Department of Veterans Affairs): Good afternoon, committee members. It's a pleasure to be with you this afternoon. I'm going to give you a quick run-through of the five benefit programs administered by the veterans benefits administration.

Let me start by telling you that we have 57 regional offices around the country involved in providing these benefits to our 24 million veterans.

I'm going to start with the largest of our benefit programs, which is our compensation and pension program. That program has five major elements, the largest of which is the disability compensation program. Veterans who incur injury in military service, or have an injury or illness that was aggravated by military service, can apply for disability compensation. The veteran makes his or her contentions. The VA then gets involved in a very protracted process of developing medical information and other evidence to try to support the veteran's contentions.

If we are able to do so, then we award disability compensation. That compensation amount is based on the severity of the injury, and it ranges from 10% up to 100%. So a veteran who is approved for 10% disability compensation would receive $117 a month. A veteran at the 100% level would receive $2,527 per month. There is a possibility for veterans with more traumatic injuries to go to as high as $7,500.

We also have a disability pension program. This program is designed to assist veterans who have a total and permanent disability, but a disability that is not in any way related to their military service. The veterans who qualify for this must have served during a wartime period. This is a means-tested program, and we check all of a veteran's countable income in an effort to determine whether or not he or she deserves a payment under this benefit.

We then have another program that we call the dependency and indemnity compensation program, which is designed to provide monetary assistance to the survivors of a veteran who has died as a result of his or her service-connected disability. This is both for the spouse any minor children the service member may have had, and we can pay up to $1,091 a month under this program.

The fourth program is yet another pension program. This we call our death pension, which is designed to provide pension payments to the survivors of a veteran who served during a wartime period. This, like the other pension programs, is means-tested, so we look very closely at the level of income the veteran had before we make a determination.

Last year we paid disability compensation to 2.84 million veterans. We paid out $27 billion. We had 323,000 veterans in receipt of pensions and we paid almost $3 billion to those veterans.

The second benefit program that I want to talk about is our education program. Back in 1944, Congress provided us with the GI Bill, which began the education program for veterans.

Presently we have four major programs that Congress has provided for us. Each of these programs has been designed to serve a particular segment of the veterans population, based on the type of military service they had.

The largest of these programs is what we call the Montgomery GI Bill for active duty. This means that active duty service members who have served at least three years in the military and have contributed $1,200 of their own money can become vested in this program, and they can then receive 36 months of educational benefits, most of which are generally used to seek a four-year college degree.

We have a second program, the Montgomery GI Bill for the selected reserve. This is designed for those service members or veterans whose only military service was either in a reserve component of our military or the National Guard. This program does not pay as much as the active duty program, but it does pay $317 a month while that veteran is in school.

The third program is our reserve education assistance program. This is the newest of our programs, and it was designed to address the increasing incidence of our service members being called up, either from the reserves or the National Guard, to serve on active duty, either in Iraq or Afghanistan. This program allows these veterans to qualify for some amount of money very similar to what those on active duty would normally receive.

The final education program is designed to provide educational assistance to the survivors of a veteran who died as a result of a service-connected disability, or for the minor children and spouse of a veteran who was 100% service-connected disabled.

Since 1944 we have served 21 million veterans under the education program. This past year we had over half a million veterans receiving benefits and we paid out $3 billion for education.

● (1540)

The third benefit program is our vocational rehabilitation and employment program. This program is designed to allow disabled veterans who have an employment handicap to undergo training that the VA pays for to receive rehabilitation counselling provided by VA, with the ultimate goal of helping that disabled veteran find suitable employment. In essence, this is an employment program.

We recognize that there are a number of veterans whose disabilities are so serious they cannot reasonably be expected to qualify for employment, so we're able to provide services to them under this rehab program to help them learn to live independently.

Last year we served 89,000 veterans under this program, and we paid out $802 million.

The next program is our home loan guarantee program. This program has been with us since 1944. It is designed to allow veterans to purchase a home without the need to make a down payment. The program is structured so that the loans are actually made by private lending institutions, and VA provides a guarantee that can be as high as $104,250. That level of guarantee would allow a veteran to obtain a no-down-payment VA loan of up to $417,000. We've made a little over 18 million loans, and at present we have guarantees outstanding amounting to $209 billion.

The final program that I will talk about is the VA insurance program. The VA has a large insurance program. If it were in the private sector in the United States, it would be the fifth-largest life insurance program in our country. There are five insurance programs that we administer in VA.

The most popular and probably the best known is the service members' group life insurance. This is the insurance that those on active duty military service can take advantage of. In the event of their death, it would pay their beneficiaries up to $400,000.

When service members get out of military service they can take advantage of the second program that we administer, which is the veterans' group life insurance. This enables them to make an easy transition from one insurance program for members in active duty to an insurance program for veterans.

The newest of our insurance programs, the third one that I will talk about, is our traumatic service members' group life insurance. Our Congress gave us the authority to administer this program in 2005. The purpose of this program is to provide financial assistance to service members who have been seriously injured in combat, as well as their families, in a effort to help them meet their financial needs during the long period of recovery. So this is not technically a life insurance program, simply an insurance program that provides assistance to the veteran who is still living.

The fourth program that we administer is for veterans who have a service-connected disability. It's difficult to get insurance in the private sector if you're disabled, so the VA steps in and provides this insurance for those individuals.

Finally, we have a fifth program that is designed to provide insurance for seriously injured members of the military and the veteran community who have received a grant from the VA to build an accessible home that would be suitable for wheelchair use. In the event of that veteran's death, this insurance program would pay down the mortgage that they obtained in order to buy or build a home.

Members of the committee, that's a very quick run-through on some of the benefits in the veterans benefits administration.

● (1545)

At the appropriate time, I will be happy to take any questions that you might have.

The Chair: You have 10 minutes each, so I think we're moving to the next witness, are we?

Mr. Steve Muro (Director of Field Programs, United States Department of Veterans Affairs): Yes, thank you, Chairman, and thank you committee members for the opportunity to present the goals of the national cemetery administration.

We are the smallest of the three within the Department of Veterans Affairs, yet our mission is an extremely important one. We maintain and provide dignified burial space for veterans and their dependants, and we maintain our cemeteries as national shrines.

We also administer the federal grants program, which helps states develop state-run veterans cemeteries. We actually pay 100% of the cost to develop the cemetery. They just need to own the land.

We're also responsible for headstones and markers that we ship all over the world to private cemeteries and also to all the national cemeteries that are federally administered as well as state cemeteries.

We also administer the Presidential Memorial Certificate. Any veteran with an honourable discharge can and will receive a Presidential Memorial Certificate. We normally send it out if they've been buried at a national cemetery or if they requested a headstone or a marker in a private cemetery. The program also allows that if the family members would like to have more, they can request it. It's a certificate that has the President's signature embossed on it.

We have 125 national cemeteries throughout the United States and including Puerto Rico. We have five memorial service network offices that administer these cemeteries and provide them financial support and guidance as they operate the cemeteries.

In 2007 we conducted over 100,000 burials of veterans and their dependants in our national cemeteries. We have 1,600 employees who manage these cemeteries, and we maintain 2.8 million gravesites. One thing that's unique about national cemetery administration is that 70% of our employees are veterans. We actually have a higher percentage of veterans than any other federal agency, including DOD. They're at 34% veterans, and the VA as a whole is at 33% veterans. We're proud that most of our employees—at least 70% of them—are veterans who have served this nation.

Regarding burial in a national cemetery, there is a long list of eligibility. I'll just go over some short ones really quickly. Anyone who served in the armed forces of the United States and died on active duty or was discharged from the military, for any reason other than dishonourable, may be eligible for burial in a national cemetery—to include their dependants.

Any National Guard member or reservist who has served 20 years and is eligible for retirement from the National Guard or reserves and has reached the age of 60 would be eligible. Spouses and minor children are eligible. The term “children” refers to anyone under the age of 21 unless they are going to an accredited college, in which case it goes up to the age of 23 or if they become physically or mentally disabled prior to reaching the age of 21, in which case they would become adult dependant children and would be eligible for burial in our national cemeteries.

The responsibilities we have are to provide gravesites, open and close the grave, provide an outside container—what we call a grave liner, which is normally concrete—headstones and markers, perpetual care, a U.S. flag that drapes the casket at the time of the veteran being brought to the cemetery for the service, and the Presidential Memorial Certificate.

Unfortunately, you don't have the pictures, but hopefully you'll get some pictures of the headstones that we provide and the Presidential Memorial Certificate that we also provide. We have marble, granite, or bronze headstones that we provide at the national cemeteries and in private cemeteries. Last year we provided over 360,000 headstones throughout the world and over 420,000 Presidential Memorial Certificates.

The median age of the World War II veteran is 84. We have over 16 million who participated. In Korea there were five million-plus, and their median age is 77. In Vietnam it was eight million, with a median age of 61. Currently there are five million who have served in the Gulf War, with a median age of 38.

● (1550)

The death rate for our population from World War II is dropping off, but from Korea and Vietnam it's picking up, and our workload actually peaked this year in terms of our burial rate. It has not and will not drop off fast. It's dropping off slowly, and then it will increase because of what we call second interments. Once there's an individual buried there, either the veteran or the spouse can come at their time of need.

As to our strategy for the future, we're developing new cemeteries. We've recently opened six new cemeteries, and we are in the planning and construction stage of opening six more throughout the United States. We're expanding our existing cemeteries. Our goal is to continue to have services at national cemeteries, so we'll try to find land, whether we buy it or it gets donated or transferred from DOD, to keep our existing cemeteries open.

Right now, the six new cemeteries that are in the construction phase and planning phase are at Bakersfield, California; Washington Crossing, Pennsylvania; the District of Columbia area; Alabama; Jacksonville, Florida; and this Sunday we're going to dedicate a cemetery in Sarasota, Florida, which will be our 126th cemetery to come online.

With the straight grant program, as I said before, we pay 100% of the cost to develop the cemetery, from designing it to building it to providing the equipment. The states then hire the employees and run the cemetery. As it needs expansion, we help them expand it by spending the dollars in funding so that they can pay for the construction. Since 1980 we've spent over $300 million in 162 grants to states to develop state cemeteries. Our goal is to maintain the cemeteries as shrines to commemorate veterans' service to our country.

Thank you.

The Chair: Thank you.

Ms. Gail Graham (Director, Health Data and Informatics, Veterans Health Administration, United States Department of Veterans Affairs): Thank you.

Good afternoon. I'm Gail Graham from the veterans health administration, the last of the three administrations we'll discuss. We were specifically asked to talk about digitization of medical records. We have an electronic health record that we've been using for about 20 years. I'm going to tell you just a little bit about the eligibility for health care.

Currently, as was discussed under benefits administration, health care is provided to those who are service-connected veterans, those who have a financial need determined by a means test, or those who, by virtue of serving in combat, are provided a five-year eligibility for health care services. We deliver health care directly through over 1,800 sites of care, including hospitals, nursing homes, domiciliaries, and clinics. We also administer a large purchase program for health care that runs in excess of $2 billion. We have a foreign medical program through which we pay for health care services provided to veterans living in foreign countries. We have a lot of rural areas, common with your country, and we are using telemedicine quite broadly in those areas.

Ms. Fischetti and I both represent the office of information within the veterans health administration.

So who are the veterans? We've talked about the different populations that each of us treat. Last year veterans health administration treated about 5.6 million veterans, and 209,000 of those came from current conflicts, what we refer to as Operation Enduring Freedom and Operation Iraqi Freedom. We do see the number of women veterans increasing, and it's projected to double in the next five years. The median age today of the veterans to whom we provide health care is 60 years. We have a large population of veterans of 85 years and older; we have about one million of those, compared to only 164,000 of that same age group in 1990. It's projected that the number of veterans over age 85 will grow to 1.3 million by 2011.

We spend a lot of time preparing for a different veteran of the future. We see the veterans who are coming out of current conflicts as Internet-savvy. They use that as their primary source of information, and we've had to move along to support that need. They're also convenience oriented—not quite as patient as our World War II veteran to wait for appointments or tolerate appointments and diagnostic services that aren't performed together, for example, or that aren't conveniently located. So we've opened a lot of clinics in the last few years that are located in small rural communities, and then we use referrals to larger medical centres.

We also find a more highly educated population, for example.

In certain segments, such as the Vietnam veterans, we see a population that is aging with disabilities, both a high rate of mental illness as well as physical ailments, which complicates treatment and broadens it to many areas and increases the need for geriatric intervention. We see projected needs higher in the area of mental health, for example, for post-traumatic stress disorder, substance abuse, and other mental illnesses, and a higher need for long-term care, which we are trying to satisfy in ways other than institutional long-term care.

As I said at the opening, VA has had an electronic health record, with components of it over about 20 years and full implementation over about the past 10 years. This enables us to have records that are available to practitioners wherever the patient may seek care. For example, with the population we have who are over 65, it's common that they would receive care in the northern part of the United States in the summer, and in the southern part of the United States in the winter. Our providers can look at these records regardless of where the patient presents for care. This also spans over different clinic settings and health care settings. For example, the records are available in acute settings, long-term care, and clinics, in the home health arena, and in telemedicine.

As I said, the most recent capabilities are really the ability to share these records, both the clinical information and the images from information such as diagnostic images. This is also an area where we're expanding our use due to shortages, for example, in radiologists. We're developing centralized reading centres, so the digital films are taken at the site where the veteran is located but are read elsewhere.

● (1555)

We try to make this data more easily accessible to the providers, but it's also accessible to our partners and the veterans benefits administration. As Mr. Pedigo mentioned, when they're processing claims, they also have access to this information as needed to adjudicate a claim for a veteran, and it may be at times used to do presumptive adjudication—for example, if there's been a presumption of connection between Vietnam service exposures and diabetes.

We've seen this adoption of the electronic health record help us in controlling health care costs in many aspects, from not repeating diagnostic tests because the results are available regardless of the location of the veteran to just being able to control our resources in a more equitable manner—using tertiary facilities as needed, but treating patients in a local setting whenever possible.

Thank you.

● (1600)

The Chair: Thank you.

Ms. Linda Fischetti (Acting Chief, Health Information Office, United States Department of Veterans Affairs): Mr. Chairman, members of the committee, good afternoon.

My name is Linda Fischetti. I'm going to be talking about two programs and one workforce issue. "My Health*e*Vet" is a personal health record that we offer to our veterans. We also have an interoperability program with the Department of Defense, which I'll mention. I'll also speak to the informatics workforce.

My Health*e*Vet is a personal health record. It is accessible to the veterans from home. There is a three-tiered level of access to this. The first tier is that anyone can go and look at a limited amount of information online.

The second tier of access is that a veteran will go in and register himself or herself, and at that point in time the veteran is able to see information that is educational and targeted directly to our veterans. This information has been vetted by a content-matter expert team of both clinicians and other veterans, so we're making sure that the veterans are receiving information from trusted sources to educate them about their health care issues.

The third level of access is that a veteran can choose to go to a local VA medical centre and, through the health information management professional, be in-person authenticated. At the point in time that a veteran is in-person authenticated, they are then able to actually import information from our electronic health record, which Ms. Graham just spoke about, into the personal health record.

We're rolling out at a number of sites. We have not completed our national rollout. That will be finished by the end of this year.

The feedback we've received from the veterans on this ability to import their own electronic health record information is very empowering. They feel that they're able to be more of a partner in their care. They're also able to journal their own information. For example, they can import information from the electronic health record related to lab results, and then, on the other hand, journal some of the personal choices, lifestyle choices, that might influence those lab results. Therefore, they'd be able to see a trend in their personal journal of salt intake and weight changes related to blood pressures that were recorded when they were at the medical centre at their different visits. So we partner with our veterans for this ability to give them their own personal health record.

Our typical veteran who chooses to participate is a Vietnam War veteran who is between 51 and 70 years old, actually changing the paradigm of the assumption that it's the younger generation that has a greater affinity for IT.

The frequency at which this veteran comes and visits us is about once a month. The reason for this is that the veterans who choose to use the personal health record are able to reorder their prescriptions online. No longer do they have to go into the medical centre or pick up the phone and call someone during the times they're open and reorder their medicine, in person or by phone. They're able to go online and reorder their medicines. We believe this is what drives the majority of our veterans coming in once a month.

We currently have 590,000 users, who have racked up 18 million visits, and we have refilled six million prescriptions. We have found also that as we bring new functionality online, the number of people who participate in the use of it increases.

One of the things we also do is use a web survey tool, called the American consumer satisfaction index, to make sure that we are capturing veterans' level of confidence in the information on the website and their opinion on the look and feel of the website. As well, we ask them what future functionality they would like us to put into the personal health record. Based on this, we're able to prioritize our future development efforts.

We know, for example, that the very next thing the veterans would like to see are all of their upcoming appointments. We know this because we asked them in this web-based survey that takes place when they're in the personal health record online, at which point in time we can float that to the top of our development priority.

The next program that I want to speak about is the interoperability that we have with the Department of Defense. There are different levels of interoperability. For example, you can just move text from one electronic health record system to another in such a way that the text is then displayed to the clinician. It's human-readable text. You're not able to sort it or parse it or to compute any logic against it, such as with clinical reminders. We have that as our first effort of interoperability.

The second level of interoperability is the ability to recognize that different parts of the electronic health information coming from a foreign electronic health record is in fact a lab value, or a pharmacy order, or a progress note that has been entered by a clinician, at which point in time you're able to put those appropriately where they belong within your electronic health record.

● (1605)

The highest level of interoperability that we're speaking about today has to do with information that's semantically interoperable, against which in fact you would be able to do pharmacy checks.

Within our DOD-VA interoperability, we started with the first type, the ability to just view the information from DOD in 2002. At this point in time, we have moved information on four million patients from DOD over to VA. This is a one-way interface called a federal health information exchange. It is only the big chunk of human-readable text information that comes across at the lower level of interoperability.

As our systems have become more sophisticated, we have been able to move information in both directions—from VA over to DOD and from DOD over to VA—and we're able to do this in real time, at the time the clinician asks for it. We've been able to move approximately three million patients' records this way. This information is also sorted. We call this our bidirectional health information exchange.

In response to the severely wounded warriors, since the beginning of the current engagement we have realized the value of moving all of the veterans information that has been collected at every point at which they've been seen within DOD. So not only the lab results but also the X-rays and the pathology results, and everything related to the patients who are severely wounded, needs to be moved into the VA polytrauma centres. With that, we were able to quickly set up an exchange that involved collecting and moving all of that information to a single point.

We continue to explore the highest level of interoperability in a project that we call the clinical health data repository. With that, we have mapped common terms for pharmacies, allergies, and a few other domains so that we are able to actually do an order check to see, for example, if two orders have been written for the same medication.

Lastly, I want to talk about a workforce issue. You've heard a great deal from Ms. Graham in terms of the use of IT within the health environment. What VA has done is impressive. The level of saturation at which clinical and business processes within the health care environment are supported by IT is pretty unprecedented, when you look at our size and the number of processes we support.

Yes, this is an IT issue in terms of how we protect the information, keep it secure, and move it to wherever the patient is and where the clinicians need that information, but there is also a culture change. So we work with a workforce called “informaticists”. Informaticists are a group of people who focus specifically on the area between the IT domain knowledge and the clinical domain knowledge.

● (1610)

These are people who work on things such as what I just spoke about—semantic interoperability. How do you make systems sophisticated enough and normalize the information to the point that you can do this? It takes a great deal of effort. How do you take IT and insert it into a physician's process of writing an order and do it in a way that's effective so that the physician will continue to use the IT and actually feel a level of trust and safety that in fact there's a value added in having the IT there?

Within our environment operationally, informaticists are at the elbow of the clinicians who are using the system. They're also involved in system development. In fact, with the system development, they continue to work with the development teams to give iterative direction. For example, if you display a serum sodium that way, the clinician is not going to know what it means. A software developer would not know that. The clinician and the informaticist at the elbow of the software developer can help improve product that comes out.

In terms of research, we have a large research community here within the veterans health administration. We partner with them to do things such as human factors engineering software before it's put into the clinical space, or look at whether we have in fact improved clinical outcome with the insertion of a new technology into the health care environment.

Very important is the health information management professional. One of the most important things when you are moving from the paper record and you're changing the media of that health record to now become an electronic record is to preserve all of the policies and guidelines that have been in place to assure the integrity and legal accountability of that paper record. The health information management professional is the one who has to rewrite all of the policies or continue to enforce the policy and is a very important check-off for any IT that's going out into the clinical space to make sure that in fact you're capturing information that will have the integrity of the previous paper medical record.

That ends my comments. I'm going to hand it back to Susan.

Ms. Susan McCrea: We're open for questions now.

The Chair: Thank you very much.

I've made a number of notes myself. However, I'm going to turn it over to other committee members, because that's the nature of things when you're the chair.

It now goes to the Liberal Party of Canada, to Mr. Roger Valley for seven minutes.

Mr. Roger Valley (Kenora, Lib.): Thank you very much.

Thank you for trying to help us as we deliver some of the changes that we make to our Veterans Affairs.

You may not know, but this is a fairly new committee brought in by this government. Before it was attached to the Department of National Defence, but now it's a stand-alone committee in our Parliament, which gives it a lot more say.

We're looking for areas in which we can improve. We know our cousins to the south have a lot of experience in this.

Somebody mentioned that many of your departments are quite proud of the number of veterans who are serving in them. Are any of you veterans...?

Well, it's nice to see some of the brass at the top.

Voices: Oh, oh!

Mr. Roger Valley: I have a question that we've struggled with in committee. We don't have a definition, or one that I'm comfortable with myself, of what a veteran is. I'd like to ask anyone at the table if they have a definition in the United States of what a veteran is.

While you're thinking of an answer, I'll give an example. Right now in Canada we say that a veteran is someone who has served in the forces and has left the uniform. But at the same time, we have many people in uniform receiving pensions from Veterans Affairs.

So I'm wondering if you could elaborate on your definition of a veteran in the United States.

Mr. Keith Pedigo: Sir, I will take a shot at that, and I'm sure my colleagues might want to weigh in.

The simple definition is that anyone who has served in the military for any period of time is a veteran, but that doesn't necessarily mean they qualify for the various benefits that we administer in the Department of Veterans Affairs. Because our benefit programs, our health care programs, and our national cemetery administration programs were developed over time in a piecemeal fashion based on statutory changes provided by our Congress, there is not even uniformity within our own Department of Veterans Affairs.

For example, if you serve during a period of war, you can qualify for many benefits after 90 days of service. But if you are disabled on your first day of military service, you can also become qualified for most VA benefits based on one day of service. If you served in peacetime, sometimes you require two years of military service or the full term for which you are called to active duty to qualify for the benefit.

I think you can see that there is no simple definition of what a veteran is for the purposes of qualifying for the benefits that we administer.

● (1615)

Mr. Roger Valley: Thank you for that.

If anybody else wants to join in, please feel free.

I'm trying to make the definition of a veteran up here that when you put on the uniform you're our responsibility, not when you drop the uniform. We're having ongoing discussions on that. I think it's something we have to continue to work on so they're clear on where they stand.

I have many questions, but I'm going to go right to the bottom of the page—and this goes to what you mentioned, Keith, at the very start—that you have so many offices and branches reaching out into small areas. The area I serve in Canada is northern Ontario, where there's lots of land—a huge piece of real estate—and no people, and almost no levels of service.

One of the things that we benefit from in Canada is a very strong system of legions. In many, many small communities, a legion is the heart of the community. It's also the only point of contact for the veterans.

I'm just wondering, do legions play any role in the United States? Is there any involvement from any government departments making sure that legions exist? We know that legions want to be stand-alone entities, so they can feel free to critique the government or some of our programs. They feel they're the speakers for the veterans in our country.

So I'm just wondering if any of you have any comments on how organizations like the legions, or other organizations in the United States, strengthen some of the veterans' positions as they deal with the bureaucracy and the politicians.

Ms. Gail Graham: I'll start and say that we have in excess of 20 different veterans service organizations. They are independent of the VA, but have strong ties to the VA. So, for example, our secretary and our undersecretaries meet with them on a monthly basis. They do frequently speak on behalf of the veterans, whether it be on benefits issues or health issues. For example, they might see genetic issues coming up, and they'd bring it to the forefront relative to the veteran.

We do not fund them, but we work closely with them. I do think that in many cases they see the need for that separation so they can fully serve the veteran and be a separate entity.

Mr. Keith Pedigo: Yes, and with respect to the benefit side of our house, we really couldn't get the job done without the support of these service organizations.

A large percentage of veterans who file claims for disability are using the services of one of our many veterans service organizations, and in many cases the veteran has given these organizations the power of attorney to submit their claim and to pursue that claim to the final step. Literally, there are thousands of veterans service organization employees around the country, who really enhance the level of staffing that we have.

As I said, we really could not provide even a modicum of service if we didn't have the support of these organizations.

Mr. Steve Muro: And one thing with us at the national cemetery administration is that the veterans organizations are our eyes and ears out there in the field and in the cities, where we don't have a cemetery to get the word out.

Also, where we do have cemeteries, many of our cemeteries have grouped together with our rifle squads to provide honours at the end of the funeral services for our veterans. DOD normally sends two individuals on its behalf for honours, but with the veterans organizations, we can have a rifle salute, and they fold and present the flag. It really helps us to give the veteran a nice service when they're there.

Mr. Roger Valley: Thank you.

I'll ask my last question, and I'd like to ask each responder to comment on it as briefly or at length as they'd like.

We have a lot to learn from you. You've had a lot of experience in this and you're covering a lot of areas, especially in the health care records, with the transfers going both ways. All of this is good news for us and we can learn from this.

But I want to ask each one of you—and you know this, because you're in the business and know the answer in some ways—what are the gaps in each of your areas? What have you not been able to deliver that could be a forewarning to us? What is missing from the puzzle that you're all dealing with on how we can better serve veterans? As you build these systems, you're always going to have people who are going to be left behind, whether it's because they are at remote cites, or are in different categories and don't fit into the box.

Please feel free to elaborate on this for each of your responsibilities.

● (1620)

Mr. Steve Muro: I'll go ahead and start. I think that for us, the biggest gap is getting to all the veterans. Of all the veterans there are, we serve about 15% of the veteran population, which means that a lot of veterans who die are being buried in a private cemetery, and it is costly to them. We provide nice cemeteries. We provide perpetual care.

The question for us, and what we constantly work on, is how do we get the word out there to all veterans who have served? Again, a lot of people don't want to hear about their burial benefit, because they think they're never going to need it. Well, we're all going to need it some day, and how do we get to it?

Ms. Gail Graham: I think that one of our gaps on the health side—and this may not translate to you, because of your health care system—is the private sector treatment that the patient receives. For example, our elderly veterans may be using both VA and their Medicare, and there is a gap for us in not knowing that Medicare information or clinical information paid for by Medicare, or for the younger veterans receiving some help outside the VA.

The Chair: Go ahead, sir.

Mr. Keith Pedigo: On the benefit side of the VA, I think our biggest gap is that we have not developed electronic information systems to keep pace with the increasing complexity of the benefits process that our Congress provides to us. Presently our largest program, the disability compensation program, is pretty much paper-driven. Each veteran has a paper C-file that quite literally can be a foot deep, depending on the veteran's situation.

We're desperately and aggressively trying to move forward now to develop electronic records so that we can improve the efficiency with which we handle veterans' claims.

The Chair: Thank you very much for that addition.

[*Translation*]

Now we will move on to Mr. Perron, from the Bloc Québécois.

You have seven minutes.

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Thank you, Mr. Chair.

Ladies and gentlemen, thank you for your assistance. All the members of the committee around this table know my concerns very well. I am particularly interested in what I call psychological wounds, that is, post-traumatic stress. For Canadians, this is a new affliction, a new kind of wound. But you in America have a little more experience because, if I remember correctly, you began studying the issue and developing your expertise during the Vietnam War.

What kinds of services do you provide to those young people?

[*English*]

Ms. Gail Graham: We provide a full range of mental health services. The big thing that we do now is a more proactive screening. For example, problems within our electronic health records are presented to the providers, who see a veteran depending on where that veteran served, when they served, or the conditions, and they really walk them through a screening for things like post-traumatic stress disorder, depression, and suicidal ideation. They'll be screened for these things so they can be referred for broader treatment. So we have extensive mental health services.

Most recently, there's been a lot of publicity about the whole issue of suicide. So we have set up a national suicide hotline that's connected to the country's suicide hotline, but it's specifically for veterans. They are referred from this national line, and there are screening techniques for the possibility of suicidal ideation.

This is an area where we thought you might possibly need a whole other session, if you will, with our mental health professionals. As you indicated, there have been a lot of studies done by both the Department of Defense and the VA, and we can certainly accumulate those materials for you.

In the past few years, as Ms. Fischetti alluded to, we have had a large research contingent. Plus we've also developed a war-related illnesses centre, which looks not only at physical ailments due to combat-related exposure but also at mental health issues.

But you're exactly right that we are very cognizant of these and make sure that these services are available both to our newer and existing veterans.

● (1625)

[*Translation*]

Mr. Gilles-A. Perron: When a young person is diagnosed with post-traumatic stress, how long does he have to wait before receiving treatment, a pension, and all the other veterans' benefits?

[*English*]

Ms. Gail Graham: I'll speak to that.

On the health care side, the practitioner who identified this would make the referral immediately and it would be a clinical judgment as to whether they needed immediate hospitalization or immediate referral to a psychologist or psychiatrist or their mental health professional or whether they could use a future appointment. It would be completely dependent on their need at that time. So they would not necessarily go into a queue if they had an immediate need for treatment.

Mr. Keith Pedigo: For the benefits, veterans can get disability compensation for PTSD. It requires an application from the veteran, a medical examination, psychological examinations, a gathering of evidence, and then a final determination as to whether the veteran's condition were service connected. If the answer is yes to all those, we can pay disability compensation.

[*Translation*]

Mr. Gilles-A. Perron: Psychologists and psychiatrists all say that it is extremely difficult to determine the extent of the wound for compensation purposes. Do your young people with psychological wounds receive the same compensation as they would for a physical wound, like a bullet in the shoulder or the knee?

[*English*]

Mr. Keith Pedigo: That's an excellent question and one that we're currently struggling with.

We rely to a great extent on the clinical expertise of the veterans health administration to advise us on many of the claims that we receive from veterans. Yes, it is much easier to award disability compensation based on a bullet wound or an amputation. We are continuing to try to get ahead of the curve on gaining an understanding of PTSD and providing training to our veteran service representatives who process disability claims. But this is an ever-evolving area of focus. Right now we think we're doing a reasonably good job, but we know that we still have a lot to learn.

[*Translation*]

Mr. Gilles-A. Perron: I have one more question. What is the success rate of your treatment of young people with post-traumatic stress?

[*English*]

Ms. Gail Graham: I think on that we'll have to get back to you—with Dr. Katz or our mental health providers—on the statistics and the reporting they have on that specific question.

[*Translation*]

Mr. Gilles-A. Perron: I would like to talk about post-traumatic stress all day, but unfortunately, my chair is cutting me off.

[*English*]

Ms. Gail Graham: That actually could be an entire session, in my personal opinion.

The Chair: Thank you very much.

Normally we now go to the next order of opposition parties in the House, but the member is not able to be here today. Normally this five minutes would go to them, but I am going to step into the prerogative of the chair to take up those five minutes. Perhaps the clerk can start the clock so that I don't go over my own time.

First off, I was very impressed and humbled to hear about, in your presentation, all the various things. I think Canada has some way to go. I was impressed with the guarantees and loans for homes, life insurance policies, your education components, etc.

One that I wish to follow up particularly with the questioning is this aspect of your national cemeteries and their designation, in a sense. You mentioned the term “shrines”. I visited your Arlington National Cemetery. It's very impressive. It's a moving tribute.

I'm going to be going to your country, hopefully in a few hours, certainly by later today or tomorrow, travelling into Maine and New York State. Can you give me examples of places, ones that are relatively close, so that I can go and look at some of these? You mention marble, granite, bronze, etc. If I have a chance, I'd like to stop by one of those when I'm down there.

At some point, it might be an interesting thing for us to investigate in this country.

● (1630)

Mr. Steve Muro: Depending on where you'll be in New York, if you're going to be near the city, Calverton National Cemetery on Long Island is our third-busiest cemetery. They buried 6,000 last year. They have both upright marble and flat bronze markers there. Then we have Cypress Hills, which is in Brooklyn. That is one of our original 14 national cemeteries that date back to when President Lincoln started the national cemeteries. Then in Sarasota, New York, we have a national cemetery with upright marble. It's closer to the city.

The Chair: Are those all close to New York City proper?

Mr. Steve Muro: Yes.

The Chair: What about in upper state New York or Maine? Are there examples up in that neck of the woods?

Mr. Steve Muro: Yes. We have Elmira in the Buffalo area. Out on the cape we have Bourne, which is a Massachusetts national cemetery, and it has flat granite markers.

The Chair: Thank you. I appreciate that.

Mr. Steve Muro: You can find them online under www.cem.va.gov; there you can get the addresses to locate those cemeteries.

The Chair: My researcher will make sure he gets that address for me.

I think the idea of a memorial certificate is a good one. Can you give me some details on your Presidential Memorial Certificate?

Mr. Steve Muro: That dates back to President Kennedy. He developed the Presidential Memorial Certificate, and every president has carried it since then. We provide it to any veteran who has had an honourable discharge.

There are two ways they can get it. When they order a headstone we automatically generate it. The other way is through the benefits division. When they get the first notice of death, that automatically generates it electronically. So the family doesn't have to order it. Once they get one there is an order form, so they can order multiples of it and there's no cost to the family. We generate them here out of our central office. We'll get you an actual one and send it to you by FedEx.

The Chair: That would be very much appreciated, sir.

I still have a minute and 12 seconds left.

In your presentation you mentioned the educational components for veterans and their survivors or dependants. What were the dollar figures associated with that?

Mr. Keith Pedigo: The one for dependants pays $881 a month. For active duty it's $1,101. For the select reserve, the National Guard, it's $317 per month. For the National Guard and reserve who are called to active duty, it's a maximum of $880 per month.

The Chair: Thank you very much.

At this stage I'll end my time and pass it over to the Conservative Party of Canada, to Mr. Shipley for seven minutes.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Mr. Sweet is next.

The Chair: Mr. Sweet, excuse me.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): Thank you, Mr. Chairman.

Thank you very much for taking the time to share with us some of the strategies of the VA in the United States. I was very impressed with the electronic records, and particularly with the fact that the veterans are able to make additions and track their own records. It's fascinating, and really gets the patients involved in their own long-term health.

You mentioned interoperability, but it seemed that was strictly around electronic records and health. A concern of ours has been the interoperability between Defence and Veterans Affairs in places where there's obvious dovetailing. Are there other places of interoperability? Specifically, do you partner with DOD in preconditioning soldiers to help them deal with the trauma and stress of a theatre prior to deployment, to avoid PTSD?

● (1635)

Ms. Linda Fischetti: In terms of interoperability and who else we partner with for that, we currently have some national work taking place that's looking at creating the health information technology standardization through which we can then partner and move this information wherever the veteran seeks care, whether that's within the VA or outside. We're not yet at the point at which we have broad interoperability with the private sector. That work is being led by the Department of Health and Human Services. It's similar in some ways to the Infoway activity within Canada. We need that to be successful before we'll have broad interoperability.

We do, though, have some interoperability for public health reporting, so since we do have all our diagnoses and our symptomatology captured electronically, we're able to send that to our Department of Health and Human Services and the Centers for Disease Control and Prevention. They are then able to aggregate that information across the country from other entities that are sending in similar information. They are able to do some tracking across the country. That information, once it leaves, is sent to CDC and then is aggregated; of course, it's completely anonymized as to who it came from.

In terms of working ahead of time—and this sounds more like the clinical process of trying to pre-screen people—we really don't do that. I'll defer to my colleague, Gail Graham, who may add to this.

Very much we are trying to increase our transparency into the DOD process for them as well as us at the time of hand-off, which is very much toward the end of service, so once someone has returned from the theatre and is being treated—for example, at Walter Reed Army Medical Center—they will actually meet a VA employee who will help with that transition point.

I'll defer to Ms. Graham to see if she has anything to add.

Ms. Gail Graham: We have several collaborative groups between the Department of Defense and VA on different disease processes. They develop clinical guidelines, so we're both using the same sets of clinical guidelines as we deliver treatment to patients. The proactive measures would come at that point.

The other thing we do is participate with the Department of Defense in what's called the PDHRA, the evaluation and assessments that they do within 30 days, 60 days, 90 days, and a year from deployment. In this engagement it has been very different for both the Department of Defense and VA because so many of these people are National Guard and reservists, and they're going back and forth and back and forth, so we've all had to interject some different practices because of that.

Dr. Katz, who is our mental health officer, could go into a lot more detail about collaborative clinical groups that are taking place.

Mr. David Sweet: You mentioned specifically about benefits and that someone who feels they have post-traumatic stress disorder would have to fill out an application. Although it was somewhat difficult, we had the good fortune to have two sessions with people who had served and were suffering from post-traumatic stress disorder, sessions that were more casual than this very structured meeting right now. For reasons of privacy I won't go into any kind of identification, but it was a commissioned officer who said that when they suffered post-traumatic stress disorder, even the capability of being able to bring oneself to fill in an application brought on a great deal of distress.

We have also had a session here with our own Veterans Affairs staff about having professionals who can ask good questions to see if that level of support is required. Have you found that, and do you provide professional assistance when you have someone who is quite drastically affected by PTSD?

● (1640)

Mr. Keith Pedigo: With respect to the disability compensation, we do a lot of outreach to service members who are transitioning out of the military. We try to provide extensive briefings to each of them to let them know what avenues are open to them in terms of applying for disability compensation and to include PTSD, but we rely to a great extent on the veteran service organizations to try to identify the veterans in their local areas who may be in need of disability compensation for any number of disabilities, including PTSD.

We also get referrals from the U.S. veterans health administration. When they see veterans who are suffering from PTSD, they refer them over to the veterans benefits administration so that they can apply for their disability compensation. We're always willing to sit down with them and help them complete the application form, because we do recognize that for some of these veterans it is a monumental task when they're in a depressed state.

Mr. David Sweet: We're really asking you to educate us today. One of the things I'd have to say most impacted me was the fact that one of the major symptoms of post-traumatic stress disorder is isolation. Sometimes the only initiative they'll take is the one call, and if that means an application, then that could mean they actually don't get the treatment they have coming to them because in fact they're incapable of actually filling out the application.

Thank you very much for all of your insight and for taking the time.

Thank you, Mr. Chair.

Mr. Steve Muro: There's one thing that might help, if I could add to that. The veterans organizations and the VA medical centre partner with Stand Downs to help bring in the vets, and we also participate. It helps those veterans with PTSD to be able to go to someone for help to fill out the application.

The Chair: Thank you.

Now we go over to the Liberal Party of Canada, to Mr. Russell for five minutes.

Mr. Todd Russell (Labrador, Lib.): Good afternoon. It's a pleasure to have you with us.

Like my colleague Mr. Valley, I come from a rural, remote area of Canada. I come from Labrador. We have some veterans, of course. This is not a unique circumstance given the size of Canada and its geography. I'm just wondering, in terms of the profile of your veterans, how many people would live in sort of rural or remote areas within the United States, as opposed to the number of people who live in primarily urban areas? How does that affect service delivery? We find in the rural, remote areas there are obviously fewer services, and the accessibility issues are compounded.

As well, there's a heavy emphasis here—and I appreciate your efforts, and I'm sure our country will be moving in this direction—on the technology aspect of the delivery of services, particularly with the Health*e*Vet program. I'm just wondering, because it's based on technology, and I'm looking at it from the rural and remote aspect again, if there is widespread Internet access out there in rural and remote parts of the United States. Do people have access to this type of technology and the hardware required so they can even take advantage of this? We tried to use technology as a bridge to overcome some of the geographic boundaries, but sometimes, for instance in some parts of Canada, there is no Internet access whatsoever, or what is there is very primitive by certain standards today.

I'd just like to understand a little better what the situation is in the United States in that regard, and how you're addressing that.

Ms. Linda Fischetti: Certainly.

Within the United States, we as well are increasing the technical capability to have that type of access throughout the rural areas. Other departments are working on that as well. The Department of Agriculture and a couple of others have just put out some major grants to be able to extend broadband to areas that don't currently have it. It's also true that being able to reach the rural communities is very much a cooperative event. The VA can't do it alone. We need to rely on our partnerships that already exist in those communities.

When we do schedule the future meeting for mental health, you may also be interested in inviting to attend a new office that has just been started, called the Office of Rural Health. This office was created just in this last year to address many of the issues that you were talking about. They can talk broadly to not just the technology but also some of the other clinical issues.

As an example, it is true that when we work with rural areas, we need to have a different way of reaching out. Ms. Graham and her team, as well as the team that works on the personal health record and My Health*e*Vet, realize that.... I talked about in-person authentication as the precursor to being able to import the information from your electronic health record. They are looking at ways in which we could possibly write policy to be able to have visiting nurses or someone else who's present in the community do that in-person authentication when the veteran is in the rural community, versus our precursor at this point in time, which is bringing them into the local VA medical centre.

It is true that when you reach out to the rural community, you need to be able to adjust and be a bit more creative than you do in urban centres. My recommendation would be to have the Office of Rural Health participate in a future presentation.

● (1645)

Ms. Gail Graham: I just want to make a few comments about what we do today.

For many years we had just these tertiary facilities, some 153, depending on the kind of medical centres that veterans actually had to travel to over the last 15 years or so. That's why you see our sites of care expanded to in excess of 2,400. Many of them are located in rural cities and small municipalities around the country, where they provide mental health and primary care services locally. Some have consulting services there as well.

It's also the reason that we have expanded the whole telemedicine approach for care in homes and the use of remote monitoring devices that monitor weight, blood pressure, and other physiologicals that feed into medical centres. So as Ms. Fischetti indicated, it's a real issue for us. I think you may beat us in the degree of rurality and the access to Internet, but it's certainly an issue for us as well.

Another benefit we give under veterans health benefits is to reimburse veterans for the travel to and from medical facilities when they require travel. Also, if there is excessive travel, which is really common, for example, in Alaska, we're more likely to pay for care to be received locally if we don't have a clinic so that we don't burden the veteran with long-distance travel.

The Chair: Thank you very much.

[*Translation*]

Mr. Perron, from the Bloc Québécois, you have five minutes.

Mr. Gilles-A. Perron: Good afternoon once more. I have another problem to explore with you, but in a completely different area. I will set post-traumatic stress disorder aside so that I can talk to you a little about our aboriginal people. I am sure that you have the same problems and the same concerns as we do.

Without taking him out of his environment, how do you take care of an elderly aboriginal veteran who lives on his reserve with his nature, his customs, his language, his culture and so on? He would surely die if you put him into a hospital in a large centre. How do you take care of him? This is a problem for us.

[*English*]

Ms. Linda Fischetti: We do have a close collaboration with the Department of Health and Human Services' Indian health service. So there is a designated portion of the federal government that is outside the Department of Veterans Affairs that works very closely with both the citizens and the governance of the tribes to be able to provide service to the Native Americans.

We do in fact work closely with them in terms of shared clinical service in the local areas, as well as trying to share as much as we can in terms of clinical practice guidelines, committee reports, sharing technology, sharing information as much as we can with our clinical colleagues who are in the Department of Health and Human Services' Indian health service.

● (1650)

[*Translation*]

Mr. Gilles-A. Perron: We have had veterans here who have had some unkind things to say about how complicated our application forms are, our care requests, our compensation applications, and so on.

Are your forms as incomprehensible as ours? If not, if this is not a problem for you, could you send us some samples so that we can look at them?

[*English*]

Ms. Gail Graham: It's definitely a problem for us; we're not immune from any bureaucratic problems. We've tried over the years to decrease these, and we are working on a one-VA portal, which is not there yet, where the veteran's application would actually satisfy multiple needs and then be thoughtful enough to branch out to specific requirements that may be relative to cemetery benefits or health.

We'd be happy to share with you the multitude of application forms that we have currently and a bit about what we're trying to do to bring those to a more user-friendly format.

Mr. Keith Pedigo: On the benefits side of the VA, we've been working very hard to put all the applications for the various benefits online so that veterans can go there, fill out the form, and then electronically send it into our regional offices to begin the processing of their claim. We think we've made considerable progress in that area.

Additionally, we've been working assiduously to try to simplify the process.

[*Translation*]

Mr. Gilles-A. Perron: Excuse me, sir, but up here, that is a problem. About 98%, perhaps 100%, of our veterans 85 and older do not even have the Internet. Do not ask them to start surfing the Internet. You must have a problem with people who have difficulty with the Internet. I am 67 years old, and I have a hard time surfing the Internet.

[*English*]

Mr. Keith Pedigo: Yes, and we recognize that many veterans are not computer-savvy.

We are very fortunate to have this strong network of veterans service organizations out there located in almost every community in this country, even in many of our rural communities. Their primary purpose is to try to help the veterans who are members of their organizations submit their claims, and they're able to assist the veterans in better understanding some of the more complex forms that we have.

[*Translation*]

Mr. Gilles-A. Perron: Thank you very much, ladies and gentlemen. I appreciated your comments and your replies.

[*English*]

The Chair: Thank you very much, Monsieur Perron.

Now we'll go over to the Conservative Party of Canada, to Mr. Shipley for five minutes, with Mr. Valley on deck.

Mr. Bev Shipley: Thank you, Mr. Chairman.

Thank you, witnesses, for taking part today.

I want to express to you my appreciation for the depth and the quality of your presentation to our committee today, and I want to thank you for your willingness to present.

I would like to start off with a question on the cemeteries. Is the service, and services, provided in your national cemeteries the same as for someone who wanted to be buried in a private cemetery?

Mr. Steve Muro: No. In a national cemetery, we provide the burial space, the outer container, and we also assist with honours, and chaplains and ministers.

At the private cemetery, we basically provide a headstone for the eligible veteran. We don't put the spouse's name on it, but we do leave space for the veteran's family to go ahead and add the spouse's name at the time of the spouse's death.

In a national one, we put them on.

Mr. Bev Shipley: Okay.

I think this one will likely go to Ms. Graham, and Ms. Fischetti may have a comment too.

Regarding your electronic health records, your digitized health records, you indicated that you've been using those for some 20 years. Later on, I believe, Ms. Fischetti, you indicated that some of the records you have are mainly paper-driven and that some could be a foot thick.

I'm wondering if you could just help me a little bit on these two comments, please.

● (1655)

Ms. Gail Graham: I think the difference was between the claims file in the veterans benefit administration and the medical records in veterans health administration.

Some 20 years ago we adopted lab, radiology, and pharmacy, for example, so that information has been electronic for a long time. About 10 years ago we adopted clinician order entry and became almost 100% reliant on the electronic record.

The claim file may contain some veterans health administration records. It may contain private sector records. It may contain military records that the veteran assembles and currently puts in a paper format to gather them together for the claims processing part.

I do want to point out that the claim adjudicator has access to the VA health record for treatment that we've delivered. That information is available to them in real time. The example that was used was that if a clinician who identifies a patient that they are concerned about who's suffering from post-traumatic stress disorder or another medical disorder makes contact with VBA, they can actually look immediately to see what the clinician has documented.

So it really has more to do with...and I'll defer to you about your processing.

Mr. Bev Shipley: Okay. Thank you very much.

If I understood you correctly, pretty much all of your health services and benefits come from Veterans Affairs—mainly the services—but you talked about an example, I think in Alaska, where it's difficult to reach rural or very remote areas. You also mentioned the number of female military who now are becoming veterans.

You likely won't have time to get into detail on this, but I would like to understand at some point in time—you can maybe forward this to us—the different type of service that is required between male and female. Obviously we're two different individuals, but we're being asked to do a similar task when we get into the military. So as we come back out, how is that dealt with, the difference between a male and a female?

Ms. Gail Graham: I'll just quickly comment that many of the services that the female veterans need in terms of general primary care, orthopedics, and those types of things are frequently delivered within our medical centres. However, we're seeing, for example, a younger veteran population now who are in need of obstetric services. We really don't provide obstetric services, so we would normally pay for that female veteran to receive those in the private sector, as an example of things.

We have added more and more services relative specifically to the needs of the female veteran, but we have an office of women veterans, and we can certainly give you that breakdown of what additional services there are.

Mr. Bev Shipley: Thank you. I haven't gotten the pull yet indicating my time's up, so I guess I have a second here.

One of the issues we have—I suspect it is not much different for you folks in the States—is educating and communicating with our veterans. I think it's more of those we would call our traditional veterans than it is our new veterans who maybe don't want to acknowledge that they have an issue, particularly outside of a physical one. So if it's an operational stress injury, we seem to have trouble getting the communications to them.

How are you dealing with that, educating them that the services are available and that in fact it's good and proper to come forward?

Ms. Gail Graham: The examples were given of what are called Stand Downs. We may also have health clinics we'll run in the veterans service organizations buildings and places around the country where we have VA clinicians there to talk to these individuals, but I think we have some of the same challenges. I think we're more educated in screening for some of these things—in primary care, for example, not waiting for a referral to mental health. These community-based outpatient clients we have were initially focused on primary care but have added mental health services to all of those community-based clinics.

So I think it's an ongoing effort for us. I think there's some stigma still on their part. It can be a challenge to get over.

● (1700)

Mr. Bev Shipley: Thank you so much for your time. I appreciate it.

The Chair: Thank you.

We now go over to the Liberal Party of Canada, to Mr. Valley for five minutes, with Monsieur Petit on deck.

Mr. Roger Valley: Thank you.

I got what I wanted when I asked the question about gaps, because one of the comments I picked up on is about the low percentage of veterans who are served or who come forward, which my colleague also commented on.

The number is very similar, I believe, here in Canada. We have huge difficulty reaching out to the veterans. We think it's as simple as maybe they could talk to their members of Parliament or their Congressman. We don't know who they are. And with the privacy laws that are in place, this is where we're failing them. We're failing to let them know that those services are out there. We're failing to let them know that parliamentarians like me are there to service them.

I don't know how to get around that, but if we look at all the things we do, if we could reach more people or get them to come forward.... I don't know the situation where you serve, and if politicians are allowed to have names of people coming back. There's something we're not doing right, up here, and based on the percentage of veterans who are being served, it may not be the best situation down there.

As the senior people who are looking after many of these people, we have to find a different way of doing this, so we look to you to help us, because we can't figure it out up here. And it's the same question that was asked before, but it's not about one specific issue, PTSD. How are we going to get the veterans to come to us?

I struggle with that, because we need them to come. We are people persons; that's how we get elected. We can recognize a lot of things, and we'll know where these people are. It's as simple as a letter we could send them once a month, but we're not allowed to know where the veterans are located.

We're charged with many things in government. We know many things the general public doesn't, and yet we cannot know where the people we're trying to serve are.

Do you have any suggestions? Obviously you suffer from the same problem yourselves.

Mr. Keith Pedigo: One of the things we have found very useful is information that comes off of service members' discharge papers. When one of our members gets out of the military they're given a discharge. We call it a Department of Defense form 214.

VA gets a copy of each service member's discharge papers. More recently we've been getting electronic copies. The VA uses this information to immediately send what we call a “welcome home” package to the veteran. It's a booklet written in very understandable language that goes over the health care, memorial services, and all the benefits available to the veteran. We've found that to be extremely useful.

In addition to that, once again I'll mention our veterans' service organizations, the extensive network we have in this country in virtually every community. They're almost always there to try to recruit new members when our veterans get out of the military.

Finally, for about the last 12 or 13 years we have been partnering with the Department of Defense. In the last six months of a service member's term of service, we go to military bases around the country, in partnership with our Department of Labour, and put on a three-day seminar for veterans. They are fully informed at that point on the VA benefits that are available, as well as the Department of Labour and other benefits that might be available to them as a result of their military service.

Last year 400,000 veterans went through these briefings. We've found that to be a very useful tool in making sure that the level of information gets elevated.

Mr. Roger Valley: Would one of the pieces of information you give out be that politicians are there to act on their behalf? In Canada it doesn't work that way. I've been to 11 bases in the last year, and one of the questions I keep bringing up is, “Has anyone ever thought to go to their politician first, last, or in the middle of the process?”

Are your politicians allowed knowledge of where your veterans are located?

● (1705)

Ms. Gail Graham: There are provisions under which Congressmen or Senators can request addresses of veterans. It goes through a clearing process to protect privacy rights, but there are conditions.

Our privacy laws also allow representatives to represent veterans if they approach politicians. So if I write to you to say, “I'm having difficulty getting my claim for any of these services”, as a politician you are then empowered to act on my behalf. Politicians frequently contact us on behalf of veterans, and we work through their representatives.

Mr. Roger Valley: Thank you.

The Chair: Thank you.

[*Translation*]

Mr. Petit, from the Conservative Party of Canada, now has the floor for five minutes.

Mr. Daniel Petit (Charlesbourg—Haute-Saint-Charles, CPC): Thank you very much, Mr. Chair.

Good afternoon, ladies and gentlemen. I hope that you can understand me. I have two or three brief questions for you because I would like to have a few more details.

Earlier, someone mentioned education programs, specifically something that you called the "Montgomery GI Bill". Could you give me a few more details about that? I understand that it is an education program intended for veterans, as well as for their dependents and those who survive them.

Here in Canada, we do not have quite the same kind of program. In some cases, we have employment protection, at least, we are going to. Soldiers going overseas have employment protection for two years. That is not in effect yet, but it is coming. There are also support programs for returning soldiers. This, of course, is the medical support that we have been talking about all through the session.

I would like to hear about your experience. What do you mean by education programs? Are the programs specific—because a lot of soldiers have professions or trades? I would like to know what you mean when you say education programs.

[*English*]

Mr. Keith Pedigo: The typical VA education program permits the service member or veteran, once they've served a certain amount of time in the service, to seek either a college education or technical training. While they are in college they receive a monthly stipend from VA. So we pay a single veteran who served in active duty $1,101 a month while they are enrolled full-time in a course of education. For various other programs, we pay lesser amounts for those who are pursuing degrees.

This program has been in force now since 1944, and 21 million veterans have received these benefits. And 70% of veterans who have left the military since the beginning of the current conflict have utilized this program.

[*Translation*]

Mr. Daniel Petit: Thank you. Now I am looking for an explanation.

Someone mentioned earlier that you operate about 150 hospitals and more than 600 clinics. That is what I understood when you were making your comments just now.

I am from Quebec. One of our largest military bases, CFB Valcartier, is located in my constituency. We have a state system, meaning that the hospital belongs to the government, and doctors and nurses are paid by the government. Everyone is paid by the government in my constituency and throughout the province of Quebec.

When you say that you operate 155 hospitals and 600 clinics, is your system the same? Does that mean that you pay everyone, the doctors and nurses and so on? Is that what you mean when you say that you operate hospitals and clinics?

[*English*]

Ms. Gail Graham: The hospitals and clinics that are under the veterans health administration are ones that we own, operate, and staff with both VA employees and, possibly, for scarce resources, contract physicians. They are separate from private hospitals in the United States. As I indicated, in some instances, we may pay for services to be obtained from private hospitals, but these clinics, nursing homes, and hospitals are VA-owned and -run entities.

● (1710)

[*Translation*]

Mr. Daniel Petit: Thank you very much.

[*English*]

The Chair: Thank you.

We have somebody who is indisposed and won't be able to ask any questions, so we're now moving from the third party over to the Conservative Party of Canada and, once again, Mr. Sweet for five minutes.

Mr. David Sweet: Thanks.

I just have two questions I'd like to ask. One is very simple: are the disability benefits all tax-free?

Mr. Keith Pedigo: Yes, they are.

Mr. David Sweet: Okay, thank you.

Could somebody there tell me about Virtual Iraq? I understand it's being piloted right now for treatment of PTSD. I just want to know how that's going and if it's a tool that's going to be substantially more effective in the treatment of PTSD, etc. Are you familiar with it and are you using it?

Ms. Gail Graham: It's operated by the Department of Defense, is it not?

We can get more information for you, but it is operated by the Department of Defense.

Mr. David Sweet: Okay, thank you very much.

The Chair: Is that all, Mr. Sweet?

Is there anybody else who wishes to pick up on the four minutes that Mr. Sweet has left?

Mr. Bev Shipley: May I just add one point, Mr. Chairman?

Ms. Graham, you talked a little earlier about how you're trying to provide long-term care, in other words, outside of the institutions. Could you expand on that for us just a little bit? That's part of what we call our VIP, veterans independence program, but we're trying to improve on it to see where the strengths and weaknesses are in it.

Ms. Gail Graham: Thank you.

We have an Office of Care Coordination Services, and it's really a combination of things, both home health and home telehealth, where we monitor the patients remotely so that if there's some vital sign that goes awry, the nurses monitoring those feeds will know right away.

Those are some of the programs. And we have a couple of pilots in residential programs, all trying to get away from the institutional, traditional nursing home care.

So there is a variety of things we're trying to do to keep the veterans in their homes.

We also have programs where we can support the family members to help in the care and treatment of the veteran, where we subsidize them for providing those services in addition to professional home health services that we would either provide directly or pay for.

Mr. Bev Shipley: I just have one final quick question. Are there opportunities where the veterans affairs departments of different countries actually get together and correspond and look at different programs and how they can integrate and do what we're doing?

Mr. Keith Pedigo: Yes, there is a program. In fact, there was a meeting of this group about three weeks ago. We call it the "ministerial forum". The ministers from Australia, New Zealand, Great Britain, Canada, and the VA Secretary, as well as staff from veterans affairs departments of those different countries, met for a two-day period here in Washington and we discussed how we run our veterans benefits and health care programs. We shared best practices with one another.

There will be another meeting of a subcommittee of that group in London in about two weeks, and we will be sending people, as will your country and the other three.

We have found this to be extremely beneficial, a good venue for sharing information and comparing perspectives on how we provide benefits and health care to our veterans.

Mr. Bev Shipley: No, I apologize, I guess I knew that you did; I was just trying to get what you answered at the last, and that's how you actually feel about it and how successful it is in terms of information-sharing.

Again, thank you very much.

● (1715)

The Chair: Thank you.

Now we'll go to the Liberal Party of Canada, to Mr. Valley for five minutes.

Mr. Roger Valley: Thank you.

I have just one question. I'm not sure how much of a comment I'm going to get.

Someone mentioned the difference in veterans nowadays, that our veterans are much more sophisticated, much more savvy in how they deal with issues. In fact, both our countries' veterans are having to deal with issues that former vets, especially when you go back to the World War I and II, never had to deal with. I guess from that we can draw that different wars, different conflicts, different theatres of operation are all going to have different approaches to veterans.

Is there much planning in the future? Here we seem to be trying to play catch-up all the time. I don't know how you can look forward to serving somebody when you don't know what the issues are going to be, but is there much looking to the future? Or do we deal with what we have to face and try to serve the needs that we have already?

I'm suggesting that here we play catch-up. Is it the same thing in the United States?

Ms. Gail Graham: We have a process that we call “veteran population”, where we look at where the projected growth is—for instance, among different age groups, or among men or women—so that we can plan services accordingly. For those, we look at areas that are expanding in growth.

For example, Florida has greatly expanded in the number of veterans who are living there part time and full time, so we've had to expand services there. It was one of the first places we used more home health and telemedicine, simply because of the expansions.

We're currently building three new hospitals. They are certainly different models from the hospitals that we have today, recognizing that the average age of our basic medical centre facilities is about 50. So we're certainly planning for rooms to be wired with Internet access, for both the patient and the providers, and for families to be present. We see in this generation that the wife may be there, but also the mother and the father and the siblings may be with that person the entire time too.

We have developed four acute polytrauma centres throughout the country, but we are also divided into 21 networks. They each have a secondary polytrauma centre to be able to deal with these things locally as well.

I think we have the same challenges and could learn from each other. In some things we're trying to play catch-up, such as in technology. Technology is really advancing at a rate that is very difficult to keep up with. So I think we have some similar challenges.

Mr. Roger Valley: Thank you.

The Chair: Thank you very much.

At this stage, ladies and gentlemen, we're getting close to the end of the allocated time.

I would like to thank our witnesses tremendously. I've learned a great deal today. You've given me some ideas for the committee to pursue in the future on maybe some interesting streams that I hadn't thought of before, other than, for example, electronic records and so on.

Thank you very much for the work you do. You've been great representatives of your country and your country's efforts on behalf of veterans. I'm humbled listening to some of the things you've talked about that you do for veterans in the United States. I hope to work with you in the future, as I'm sure other committee members do, to do these things.

Some hon. members: Hear, hear!

The Chair: Thank you very much for your time.

Committee members, I think we have come to an exhaustion of business for today, unless anybody has something else to add.

Mr. David Sweet: I move that we adjourn.

The Chair: All right, the meeting is adjourned.

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