House of Commons
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 008 • 2nd SESSION • 40th PARLIAMENT

EVIDENCE

Wednesday, March 11, 2009

Chair

Mr. David Sweet

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● (1530)

[*English*]

The Chair (Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC)): Good afternoon, ladies and gentlemen.

Bonjour à tous.

We're ready to begin the meeting now.

Today we have with us, Leigh Ann Skeens, executive assistant to the deputy secretary for benefits, Veterans Benefits Administration.

Welcome, Ms. Skeens.

Ms. Leigh Ann Skeens (Executive Assistant to the Deputy Under Secretary for Benefits, Veterans Benefits Administration, United States Department of Veterans Affairs): Thank you.

The Chair: Our tradition has been that we give guests the ability to make an initial presentation of about 10 minutes. But I'm looking at your deck right now thinking that your presentation is substantially longer.

Could you give me an estimate of about how long you think your initial presentation will be? We usually go to a round of questions after that. I understand that today we also have to split our call between yourself and Ann Patterson. Could you give me an estimate of your presentation?

Ms. Leigh Ann Skeens: Yes, sir. Generally, this presentation takes about 20 minutes. I'm not sure how you usually do things. I've done these briefings before where questions are thrown in as the briefing goes along. Either way, that's fine with me.

The Chair: What we'll do is allow you to go ahead and make the presentation, and make it as efficiently as you can.

Members of the committee, because of the situation we're in today, where we have the first guest for only one hour and her presentation will be approximately 20 minutes, and then we'll have to make another call to another department, to Ann Patterson, my suggestion would be that our rounds will have the same rotation but will be limited to one question per member. Is that acceptable to everybody today?

Some hon. members: Agreed.

The Chair: That's great.

Ms. Skeens, we'd love to have you begin.

Ms. Leigh Ann Skeens: Thank you very much for offering me the opportunity to present on veterans benefits to you today. I really appreciate that.

I would like to offer that if we don't have time to get to everyone's questions, I am happy to take any questions in writing and get those back to you or to schedule a follow-up video conference with you.

The Chair: Thank you very much.

Ms. Leigh Ann Skeens: If you look at slide 2, this gives you an overview of the five benefit programs that we do offer in the benefits administration here in the U.S. The compensation and pension program is by far our largest. About 70% of our employees work in compensation and pension.

VBA has approximately 51% of the Department of Veterans Affairs' total budget; however, 50% of that goes to mandatory benefits. Only 1% of the budget allocated to us is discretionary for VBA.

VBA has 16,000 employees. That's a very small percentage of VA's total of about 285,000 employees.

The next slide shows you geographically where our offices are located. We do have regional offices in each of the 50 states. We have 57 regional offices, so some states do have more than one office. We also have a regional office in Puerto Rico and Manila in the Philippines. Compensation and pension benefits are administered in all of those offices, as well as vocational rehabilitation and employment. Other benefits—education, loan guarantee, and insurance—are consolidated into central locations.

On the next slide, I'm going to go through each one of our benefits and give you a high level of overview of what they do.

In the compensation program for veterans we have disability compensation, and as you can see from the slide, that is for veterans who have suffered injuries or illnesses as a result of their service or if they had injuries that were aggravated during their service. The ratings that we give on these disabilities are based on an average loss of earning capacity. That's how the program was set up originally and that's how it's still run today.

A disability pension program is actually an income-based program, and as you can see here, that is awarded to veterans who have wartime service. They have 90 days' active duty, with one day in what is described as a wartime period. Wartime periods are prescribed by Congress—the beginning and end dates for each of those. Veterans who are eligible for pension have to meet an income requirement as well as service requirements.

On the next slide are survivors benefits. Under the compensation and pension program we have dependency indemnity compensation, which is the program for those survivors of veterans who died in service, who had service-related disabilities during life and died from one of those service-connected conditions, or if they were service-connected for a disability at 100%, for at least 10 years prior to death.

A death pension is the equivalent of a life pension for veterans. Surviving spouses have to meet an income requirement that is a little lower than that for veterans and they have to be a survivor of a veteran who served in that same wartime period.

We also offer a burial allowance. That's partial reimbursement for expenses that are incurred for a veteran's burial and funeral costs. The burial benefit is up to $2,000 for a service-connected burial.

The next slide gives you some numbers of what we did last fiscal year. In 2008 we had 2.9 million veterans on the rolls receiving compensation benefits—$31.6 billion in benefits paid. You can see the numbers here for pension benefits and survivor benefits as well. The only thing this slide does not include as far as moneys paid are ancillary benefits such as clothing allowance or specially adapted automobiles.

In the U.S., too, as of September 2007, which is the date of our last veteran population data, we had 23.5 million living veterans. You can see the percentage of that total who are actually on our rolls today.

The next two slides show some rough statistics of veterans serving in the global war on terror, how those veterans have impacted our workload and what benefits we're paying to them. Obviously, this is our newest population of veterans.

● (1535)

If you look at slide 8, so far we have had over 300,000 claims from those veterans. You'll also see that over 294,000 of those claims were awarded service-connected benefits. We still have quite a few of those pending, and we have them coming in all the time.

The global war on terror, or GWAT, claims make up about 18% of our current workload. As of February 1999, for rating-related issues we had a pending inventory of close to 400,000 claims. Again, 18% of them are from the GWAT veterans.

The VA's education programs were originally set up to provide readjustment to civilian life after service. They also serve as a recruitment and retention tool for our military. Our Department of Defense reports that education benefits from VA are one of the top five reasons reported for joining the military right now.

The next slide shows our current Montgomery GI Bill education benefits. The Montgomery GI Bill was signed in 1944. We've had some updates to that. You've probably heard about our Post-9/11 GI Bill benefits. It's our new education program that I will get to a few slides from now. What you see on slide 10 are the two open GI bill benefits right now for those service members who had active duty service after June 30, 1985.

To give you an idea of the current rate for the Montgomery GI Bill benefits, those who are in full-time training and active duty receive $1,321 per month for schooling. Those in the selected reserve receive a much smaller portion of that because they have a lesser time commitment to the military service.

The Montgomery GI Bill right now is our largest education program. If you go to slide 11, survivors' and dependents' education assistance is our second-largest educational program. It is available to survivors of service members. We offer them educational assistance as well.

Slide 12 shows what was our newest education program before the new GI bill was signed last year. The reserve educational assistance program was established in 2005 by the Department of Defense. It was designed to provide educational assistance to members of reserve components. We found that in the new war we had many more reserve and national guard members serving on active duty, and our education benefits for those service members were not equivalent to those for members serving on active duty. However, in the new war we had these veterans serving the same amount of time as our regular active duty members, so we were trying to make benefits commensurate for the two populations.

In 2008 we spent $3 billion in educational assistance for about 541,000 veterans, reservists, and their family members.

If you go to slide 14, this is the beginning of the information on the Post-9/11 GI Bill, which is a much enhanced version of our Montgomery GI Bill as we currently know it. This program will go into effect on August 1, 2009. We are currently in the process of implementing it. It will be completely new. We have had to set up an entirely new system and write new regulations, policies, and procedures for that program.

We estimate that we will get about 458,000 participants this year. On the difference between this GI bill and the other one, your active duty has to be after September 11, 2001, and your tuition and fees will probably be totally covered, depending on what school you go to. The other big difference for service members under the 9/11 GI bill is that you can have an aggregate of service. Rather than needing to have three years of continuous active duty, if you're called to duty for a year, go back home for six months, and go back, you can aggregate 36 months of active duty to receive this benefit.

● (1540)

The next slide gives you a little snippet of what the GI bill offers. It gives 36 months of benefits. It covers the highest amount of tuition and fees charged for full-time undergraduate training at a public institution by state. It's very complex to administer, which is part of the reason why we are working so hard to get this into place by August 1. We offer a monthly housing allowance as part of this program, as well as a books-and-supplies stipend. These are two additional benefits that we have not offered in the past.

The last issue is that it's transferable. The law includes a provision to allow service members to transfer any unused educational benefits to their spouses or dependants during their lifetime, or even after their death.

If you look at the next slide, we move to the loan guarantee program. It also resulted from the 1944 GI bill. It provides home financing assistance. We offer supplemental loan servicing to veterans who are in financial difficulty, special adapted housing grant benefits, and direct loans to native Americans.

On some of the benefits of a VA home loan, they are no down payment loans with a negotiable interest rate and no mortgage insurance premiums. VA guarantees the loans. They're made by private lenders. The guarantee means that the lender is protected against any loss if the owner fails to repay the loan.

The next slide gives you an idea of the loan volume over the past almost 20 years. In fiscal year 2008 we guaranteed over 179,000 loans, and 91% of VA home loans are made without a down payment. With the end of the subprime mortgage lenders in the United States, VA is now pretty much the only place where you can get a loan with no down payment.

Slide 19 gives you a little idea of our specially adapted housing workload. This has increased, and we have changed these benefits a little for the latest population of veterans because we have many more returning veterans with amputations and special needs. Our specially adapted housing program offers money to adapt a house for a wheelchair or other needs for those veterans with severe injuries.

The next slide discusses vocational rehabilitation and employment. Our two main programs there are to achieve and maintain suitable employment under the vocational rehabilitation program. If a veteran is not job-ready when he gets out of the service and has injuries or disabilities that make him ineligible to pursue employment at that time, we can put him into an independent living program so he is retrained on how to take care of his daily needs. Once he completes an independent living program, he is offered the opportunity to go into the employment program. Pursuit of an educational degree is another option under vocational rehabilitation, besides job training skills.

On the next slide, the pink areas show you how many veterans completed vocational rehabilitation programs. The blue show those who completed independent living programs.

The next page gives you an idea of how many of our veterans are receiving assistance through this program. While we've had 11,000 complete the programs, we have about 97,000 who are in some stage of vocational rehabilitation programs.

● (1545)

Last year we spent about $616 million in benefits for that program.

Lastly, we have the insurance program. It's located in one central office in Philadelphia, Pennsylvania. On the next two slides you can see a brief description of what each of the programs offers. The one I want to highlight for you, in the interest of time, is our TSGLI program; that's traumatic service group life insurance. It's the very last one on slide 23. It's our newest insurance program. All service members who receive service members group life insurance coverage are now automatically covered for this traumatic injury protection. It was designed to help traumatically injured service members and their families deal with the financial burdens of recovering from those severe injuries. It's a lump-sum payment of somewhere between $25,000 and $100,000 for those service members who have experienced a severe loss, while they recover from it—whether they return to service or whether they get out of service and go home to find employment later.

The last slide gives you our other insurance programs. For our service members group life insurance, once an active duty member leaves the military, they can convert that life insurance to the veterans group life insurance. On the last slide you'll see what we've paid in the fiscal year 2008 under our life insurance program. VA's life insurance program is the sixth largest life insurer in the United States. We are very proud of our insurance program. They do very good customer service. We have about 7.1 million people insured right now under all of these programs.

That's a high-level overview, hoping to meet your time requirements. I am happy to take your questions.

● (1550)

The Chair: On behalf of the committee, thank you very much, Ms. Skeens, for the time you've invested here in your presentation.

Now, as per agreement of the committee, we'll start with our regular rotation.

Madam Sgro will have one single question, and then you'll have a chance to respond as you feel fit to the question. We'll try to make sure that everybody gets an opportunity to ask at least one question in the 40 minutes we have.

Hon. Judy Sgro (York West, Lib.): How long can the question be?

The Chair: We'll try to keep them as brief as possible.

Hon. Judy Sgro: Thank you very much for appearing before us today and being helpful in our understanding of the differences between our systems.

Could you please elaborate a little on what you referred to as a "major loss" when it comes to a lump-sum payment?

On the issue of the loan guarantees that are offered, are there any other requirements than having served and being a vet when you're applying for a loan guarantee for the purchase of a home?

Ms. Leigh Ann Skeens: Were you referring, by mentioning a major loss, to the lump-sum payment under the life insurance program?

Hon. Judy Sgro: It's under the....

Ms. Leigh Ann Skeens: Okay. We have a list of traumatic injuries that make veterans eligible for it. To give you an idea, they include amputations, severe burns, loss of eyesight. It is that level of injuries that is included under it, if that gives you a better idea.

For the home loan guarantee program, you asked whether there was another criterion, other than being on active duty. Is that correct?

I'm having a little trouble hearing from your end.

Hon. Judy Sgro: Yes, it was to do with the loan guarantee for individuals purchasing homes.

Ms. Leigh Ann Skeens: Active duty service members and veterans are eligible to apply for the home loan guarantee, and it is open to any service member serving in the military and also any veteran. You can reuse the home loan guarantee as many times as you want, but you can only have one guarantee at a time, if that makes sense. If you sell your house, you can get another VA home loan guarantee, but you can only have one guarantee on one house at a time.

Hon. Judy Sgro: Thank you.

The Chair: Thank you, Madam Sgro.

Monsieur André, vous n'aurez qu' une seule question.

[*Translation*]

Mr. Guy André (Berthier—Maskinongé, BQ): Good day, Madam. I have a quick question for you.

When a service member dies on active duty, what kind of support are his survivors—his family and children—entitled to receive not only in terms of health care benefits but in terms of education benefits as well? University tuition fees in the United States are extremely high. This is also true here in Canada, and it's becoming increasingly true in Quebec. Are education benefits provided for an extended period of time, or only on a temporary basis? For how many years can the family count on receiving such benefits?

[*English*]

Ms. Leigh Ann Skeens: Particularly if a service member dies on active duty, they are offered our dependency and indemnity compensation. That was mentioned in the briefing under compensation and pension.

Once they're eligible for that, they get it for life. That payment right now is at somewhere around $1,091 per month. A surviving spouse of a veteran who died on active duty would receive that for the rest of her life. She also can be eligible for education benefits, with 36 months of entitlement, which gives you roughly the four years that it usually requires to get a bachelor's degree here.

As far as health benefits go, I am going to defer to my counterpart in health, who I think will be meeting with you after me.

Does that answer your question?

● (1555)

[*Translation*]

Mr. Guy André: What is the amount awarded for post-secondary studies over the four-year period? How much is the child eligible to receive? Does the amount cover all university tuition fees?

[*English*]

Ms. Leigh Ann Skeens: I have those figures for you, if you'll just give me a moment.

[*Translation*]

Mr. Guy André: Does this amount cover all of the student's university tuition fees, including housing costs?

[*English*]

Ms. Leigh Ann Skeens: For a spouse or a child who is going to school full time, for what we consider to be full time, they currently receive $915 per month. They can apply that to either their tuition and fees or their housing, whatever they feel they need.

Depending upon what school they go to, that may or may not cover all of their expenses. If it's a state institution or a community college, it definitely would cover their tuition and fees. It may not cover their total housing costs, but it is a substantial benefit.

The Chair: Thank you, Madam Skeens.

Mr. Stoffer, one question only, please.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Mr. Chairman.

Do I detect a Kentucky accent there?

Ms. Leigh Ann Skeens: No, it's Virginia.

Mr. Peter Stoffer: Here's my question for you. In Canada we have a policy that says if a veteran's spouse passes away and he or she remarries after the age of 60, lives another 10 years, let's say, and then passes away, their pension is not transferable to the second spouse after 60. Do you have the same restrictions in the United States?

Basically we call it the "marriage after 60 act". If a veteran lives for 56 years with a particular spouse and then dies, under normal circumstances, 50% of that pension is transferred to the spouse. But if he or she dies in their fifties, and then the veteran remarries after the age of 60 and lives for another 10 years, that pension dies with them. It's not transferrable to the second spouse. Do you have the same restrictions in the United States?

Ms. Leigh Ann Skeens: If I'm understanding your program correctly, our program works a little bit differently. We can only pay one spouse of a veteran at a time.

Mr. Peter Stoffer: But if the first spouse dies and the veteran remarries after the age of 60 and lives for 10 years, and then dies, would the second spouse be entitled to the individual's pension?

Ms. Leigh Ann Skeens: Now I understand better.

Actually, yes. In our program, they can get that benefit. It doesn't matter how old a veteran is or how many times he has married. If he is eligible to receive additional benefits for a spouse and he divorces that spouse or that spouse dies and he remarries sometime later, we will then establish that spouse as a dependant on his benefits program. At the time of his death, the spouse he is currently married to would be the one who would be eligible for any death benefits that might be available.

Mr. Peter Stoffer: Thank you.

The Chair: Thank you, Madam Skeens.

And because I'm getting some concern about this, and I have great respect for the concern, that's not gender-specific, is it? If it were a woman who was the service person, it would be the male who would receive the pension, or vice versa. Is that correct?

Ms. Leigh Ann Skeens: Yes. I apologize. I should have said he or she.

The Chair: That's quite all right. I just wanted to give you the opportunity to clarify that.

Now, Mr. Kerr, one question, please—although Mr. Stoffer did ask two questions.

Mr. Greg Kerr (West Nova, CPC): I was going to point out that Mr. Stoffer struck out on the first question.

Mr. Peter Stoffer: It's a great accent she's got.

Mr. Greg Kerr: I'm going to try to meld one and a half together, if I could.

On page 2, you talked about the discretionary part of your budget being about 1%. That's available to you.

● (1600)

Ms. Leigh Ann Skeens: Yes.

Mr. Greg Kerr: I'd like you to explain how that's utilized or what you do with the discretionary funds.

The other part of that same first question is, what are the biggest pressures that you can't cover, either in your regular budget or on your discretionary side?

Ms. Leigh Ann Skeens: Our discretionary funds are primarily used for administration of new initiatives and programs: information technology programs, any enhancements to how we process claims, employee training, and those sorts of issues. So the 1% is generally adequate to cover what our needs are.

The remaining part of our budget, the other 99% of DVA's budget, is mandatory to pay all the benefits that we administer. Our benefits are mandated by Congress, so they are always covered. We never have a shortfall on those.

Mr. Greg Kerr: Thank you.

The Chair: Thank you.

Thank you to the committee members. You're being quite disciplined.

Madam Foote, one question please.

Ms. Judy Foote (Random—Burin—St. George's, Lib.): Thank you, Mr. Chair.

Welcome, Leigh Ann.

Ms. Leigh Ann Skeens: Thank you.

Ms. Judy Foote: I have just one question.

On your comprehensive home care program, I'm wondering if it covers the spouse and dependent children and things like medications for the entire family, that is, the spouse and the dependent children?

Ms. Leigh Ann Skeens: When you mention comprehensive home care, which program are you referring to?

Ms. Judy Foote: Well, I'm just looking at some analysis that's been done for us here. It shows that in the United States there are 108 comprehensive home care programs, so I can't be specific in terms of which one. But maybe you can elaborate on the type of home care programs that you do offer veterans and whether or not they apply to the family.

Ms. Leigh Ann Skeens: Our home care programs would fall under the Veterans Health Administration. Hopefully, Ms. Patterson will include that in her presentation. If not, please feel free to ask her that.

From the benefits side, we do just strictly pay out moneys for veterans who are eligible to receive benefits based on service-related injuries, or who have had wartime service and meet our income requirements.

So we don't...if that makes sense?

Ms. Judy Foote: Sure. I guess—

Ms. Leigh Ann Skeens: The benefits administration, actually, does not administer home care programs. That would fall under our Veterans Health Administration.

Ms. Judy Foote: Okay, well, I'll ask the question, then.

Thank you.

The Chair: Thank you very much.

[*Translation*]

You may ask a question, Mr. Gaudet.

Mr. Roger Gaudet (Montcalm, BQ): Thank you, Mr. Chair.

I have a short, simple question. When you provide loan guarantees, do you often see foreclosures?

[*English*]

Ms. Leigh Ann Skeens: Part of our loan guarantee program is the loan servicing program, and part of that is foreclosure avoidance. We have a very good foreclosure avoidance rate. So very few of our veterans foreclose—I'm sorry, I don't have the exact percentage for you—or fewer veterans have loan foreclosures than the general population in the United States.

We do a very good job of working with lenders, working with our veterans who have home loans, in developing ways and getting lower interest rates and working out payment plans, so they can stay in their home and can continue to make their payments and are not foreclosed on.

In addition, if the lender is getting ready to foreclose, VA has the ability to take over that mortgage and administer it themselves, which is another avoidance mechanism for the veterans, so they can stay in their home.

[*Translation*]

Mr. Roger Gaudet: Thank you very much.

[*English*]

The Chair: Thanks once again.

Mr. Lobb.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you. I'm going to ask this question. I don't know whether it falls directly under your jurisdiction, but I noticed on your website that there's an allusion to about 150,000 veterans who are homeless. Do you have any programs or benefits to get those veterans off the street?

● (1605)

Ms. Leigh Ann Skeens: We have a lot of specific outreach that we do to veterans, and the health administration has some specific programs geared toward homeless veterans and to getting them off the streets. Ms. Patterson can speak more specifically to those.

As far as benefits are concerned, we try to do significant outreach to let these veterans know that they may be eligible for benefits. Once they receive benefits, they are more likely to be able to get back into a home or get some financial stability. So we do consider those hardship cases, and they are worked as one of our priorities on the benefits side.

The Chair: Thank you very much.

Madam O'Neill-Gordon.

Mrs. Tilly O'Neill-Gordon (Miramichi, CPC): Thank you.

Is there an appeal process in place for the veterans if they don't agree with a decision made by your department?

Ms. Leigh Ann Skeens: Yes, Ma'am, there is an appeal process. Once a decision is made, a veteran or a beneficiary has up to a year from the date of the decision notification to come in and file an appeal for an increase in benefits.

Mrs. Tilly O'Neill-Gordon: Thank you.

The Chair: Thank you. You've been very expeditious in answering these questions. It's fantastic.

Since we mentioned that we're trying to give everybody a chance to have at least one question first, I'm going to modify the order a bit to make sure that happens.

Mr. Andrews, do you have a question?

Mr. Scott Andrews (Avalon, Lib.): Yes, I have one quick question.

It's in regard to the disability pension that you award to your veterans. In your slide you talk about it being needs-based. Could you explain a little more how your disability pension works and to whom it's awarded?

Ms. Leigh Ann Skeens: To be eligible for our disability pension program a veteran has to have 90 days of active duty. One of those days has to be in a war-time period as prescribed by law, and once they meet that threshold they also have to meet an income threshold. Under our current pension income limits, the income of a veteran with no dependants has to be less than $11,830. He can use recurring medical expenses to reduce his amount of countable income to become eligible for a VA pension. We consider those elements as part of the determination.

Such things as social security count against VA pension, so if a veteran is receiving social security or receiving a retirement pension from a job, such as railroad retirement or any other job where they receive regular pension, if they receive more than this $11,830 limit for the year, they won't be eligible for our program.

Mr. Scott Andrews: Thank you.

The Chair: Thank you very much.

I believe Mr. Clarke does not have a question, so it's over to Mr. McColeman. Then we'll go back to the original rotation to see whether we can each get a second question.

Mr. McColeman.

Mr. Phil McColeman (Brant, CPC): Thank you for joining us today and giving us this information.

I'm interested from a demographics point of view, if I may follow that train of thought. I know we're facing in our country the gradual passing away of the Second World War veterans. Then in our situation, of course, we have our veterans from Afghanistan now. In any of your planning, does your department do any projections based on any kind of actuarial or similar tables?

Ms. Leigh Ann Skeens: We do. That function falls under our policy and planning, over at the department. They maintain veteran population statistics and all sorts of demographic statistics. Within the different administrations—benefits, health, and cemetery—we do our own predictions for our workload. As you mentioned, the World War II veterans are quickly passing away, so that population is decreasing. What we're seeing is that the Vietnam veterans applying for benefits and those on our rolls are coming in at a higher rate to receive increased benefits or coming in for the first time to receive benefits, now that they are getting older.

We also have done some preliminary projections on what our population is going to look like, depending on how the global war on terror goes in Afghanistan and Iraq.

● (1610)

Mr. Phil McColeman: Thank you for that; it's interesting. If I get a subsequent question, I'd like to go down that road further.

The Chair: Thank you very much.

Now we'll go back to Madam Sgro.

Hon. Judy Sgro: Is there a cap on the dollar amount you spend on someone in a medical centre or hospital? Is there a cap dictating that you will spend only so much money per veteran?

Ms. Leigh Ann Skeens: The medical centres are administered under the health administration, so that again would fall under Ms. Patterson.

As far as benefits are concerned, if a veteran is in the hospital or anything, the benefits still continue. We don't have any sort of limit on that. If they're in a nursing home, sometimes we can grant additional benefits to cover aid and attendants. There are some additional benefits that we offer as part of this, but we don't have a limit on the amount they can receive.

Hon. Judy Sgro: Thank you.

The Chair: Thank you.

Monsieur André, do you have another question?

[*Translation*]

Mr. Guy André: Yes, I have two questions for the witness.

When a service member dies on active duty, how much money does the family receive in the form of death benefits? If a service member is disabled or injured while on active duty, what procedure is followed to determine the disability benefits to which that service member is entitled? Does it depend on the number of limbs affected? If a service member loses a limb—an arm, for example—is he entitled to receive a certain amount of money or are overall benefits determined on the basis of the disability?

[*English*]

Ms. Leigh Ann Skeens: On your first question, concerning death benefits, the veteran's service will determine the amount of the death benefits a family receives. If the veteran had a service-related disability for which he was receiving benefits and he died from that particular disability, then his spouse specifically, and his child also, can be entitled to dependency indemnity compensation. The current rates for a spouse who is receiving dependency indemnity compensation are $1,154 a month; if it's a child, it's $488 a month. If the veteran did not die of a service-related condition, the spouse may be eligible for death pension, but again it is an income-based benefit, so they also have to meet the income threshold to be eligible.

We also offer a plot allowance of $300 that can be paid to the family to help cover costs of burial. If the veteran died from a service-related disability, that burial benefit can be up to $2,000; that is a one-time payment to cover expenses.

The Chair: Okay.

If you have more to add to your answer, go right ahead. I'm sorry.

Ms. Leigh Ann Skeens: The second part of the question, I believe, was about how we rate disabilities for service connection. We have what we call a rating schedule of disabilities, and it is broken down by parts of the body. It's also broken down by body systems.

I'm trying to think quickly of something to relate it to.

A veteran who has a knee condition or limitation of motion in their knee.... We have specific ratings that are related to each individual disability. It includes mental health disabilities as well as physical disabilities, impairments to vision—all those things are covered in that rating schedule. And it's based on the "whole body" theory; that was established many years ago. The percentage that is granted for the particular disability—for instance, a disability of the knee where you have limitation of motion—can be anywhere from 10% service connected up to 60% service connected, depending on the level of disability and the incapacitation.

● (1615)

The Chair: Thank you very much, Madam Skeens.

Now back to Mr. Stoffer.

Mr. Peter Stoffer: Thank you.

Madam, on page 4 of your deck here it says, "Disability pension —awarded to wartime veterans with permanent and total disabilities which are not the result of military service or to veterans at least 65 years of age".

Correct me if I read that incorrectly. Say I served in Iraq as an American citizen, and I did two tours, came back, and was fine, then I went and did my normal job and on my way to that job I was in a severe car accident and lost both my legs. Would VBA then assist me in any assistance that I required, even though it wasn't service related?

Ms. Leigh Ann Skeens: Yes, sir. If you are rated permanent and totally disabled from your disabilities, you can be eligible for pension. You still have to meet the income threshold, however, which is relatively low for veterans who are working full time or even part time.

The instance that you presented I would say would fall more under assistance under our vocational rehabilitation program, so that a veteran could get some help for employment, as long as you're still able to perform some type of regular job duties.

Mr. Peter Stoffer: The second part of that is if I'm a 67-year-old veteran and all of a sudden my hearing is going, which is not service related, and I meet the income eligibility, would you assist me, for example, with my hearing aids?

Ms. Leigh Ann Skeens: With your hearing aids, the health administration has a program specifically for hearing and hearing aids and Ms. Patterson can cover that.

From a pension perspective, if you're over 65 and you're determined to have a disability that makes you permanently and totally disabled so that you can't work at all—it could be a heart condition, it could be a back condition, it could be anything—it does not have to be service related. As long as you're 65 years old and you have one day of wartime service and 90 days of active duty service total, then yes, you can be eligible for pension if you meet the income requirements.

Mr. Peter Stoffer: Thank you.

The Chair: Thank you very much.

Mr. Kerr, do you have another question?

Mr. Greg Kerr: Yes. I'll ask on Mr. Clarke's behalf.

On deck 12, I was interested in the reserve educational assistance program.

Ms. Leigh Ann Skeens: Yes, sir.

Mr. Greg Kerr: If I understood you correctly, after 2005 the change meant that all reservists who were active would get the same consideration, the same eligibility, as active soldiers who were not reservists. And you said, I think, it's strictly because of the call-up requirements in the recent wars.

If that changes, if all of a sudden the world circumstances change and the reservists weren't called up, would that automatically stop that program? And is there any other way for a reservist to enter this educational program?

Ms. Leigh Ann Skeens: Before this new GI bill that's going to be in effect August 1, 2009, it wouldn't necessarily go away. This program is going to continue, so a veteran who is in the reserves but who is called up as part of a national emergency or wartime period would still be eligible for this benefit.

However, we expect that many of these programs will become obsolete because the new Post-9/11 GI Bill is a much better benefit from the perspective that it pays so much more totally your tuition costs, your housing cost, books, and supplies. We expect that most all of our service members are going to choose to go under the Post-9/11 GI Bill. And because of the relaxed eligibility requirements for that, so that you can have an aggregate of active duty rather than having to serve your continuous three years, the reservists and national guardsmen will be able to be eligible for that benefit as well.

They'll have to probably be in for a little longer to get the aggregated service that's required, but they will still be eligible for that benefit. In that case, under the new GI bill starting this year, all the veterans who are eligible for that will get the same amount of money if they're going to school full time and they have the required aggregate number of months of active duty.

So it brings the active duty service members and the reserve service members who serve the same amount of time over a longer period to an equal level.

Mr. Greg Kerr: Thank you.

● (1620)

The Chair: Thank you very much, once again.

Now, Madam Foote.

Ms. Judy Foote: Thank you.

When we talk about independent living, you break it down into training activities of daily living, technological assistance, and personal adjustment counselling.

I'm wondering if you can give us any idea of the percentage of veterans who actually avail of those services.

Ms. Leigh Ann Skeens: With respect to the percentage of veterans...I'm trying to see if I have that number with me. I don't have an exact percentage of those in independent living programs, but I can certainly get that information to you.

Ms. Judy Foote: One of the issues we keep hearing is that veterans are reluctant to go for personal adjustment counselling, as an example.

I'm wondering if you are aware of that. Is that the situation in the U.S. as well?

Ms. Leigh Ann Skeens: Yes, that is the situation here as well. That's something we have worked hard on with our vocational rehab program, as well as with the Veterans Health Administration, to encourage those veterans who are coming back with severe disabilities to get some readjustment counselling.

We've developed some additional programs to help and encourage them to go for that sort of counselling and also to make a smoother transition from hospital care into benefits care so they are more aware of the services from the vocational rehabilitation and employment program. As part of that program, we do offer that readjustment counselling, independent living services, and some of those additional benefits.

Ms. Judy Foote: Do you follow up with every veteran when they come back from war to make sure they are aware of the programs?

Ms. Leigh Ann Skeens: Yes, we do.

In conjunction with the Department of Defense, the Department of Veterans Affairs offers transition assistance program briefings. All service members who are getting ready to retire or to be discharged from service are afforded an opportunity to go to those briefings. It's one to three days of information on what benefits are going to be available to them. The VA is offered a large chunk of that time to talk about the benefits I've talked to you about so far and what you're going to be hearing from the health and national cemetery administrations as well. So they are covered.

In addition, we do follow-up mailings. For our different programs, for example, the education people do routine mailings to service members who have been out of service for six months, a year—I think 18 months is the last one we send—to remind them they could be eligible for education benefits and to encourage them to take advantage of that. Some of our other programs do a similar mailing and outreach as well.

Ms. Judy Foote: Thank you.

The Chair: Thank you very much.

I think time is winding down for this presentation. I'll try to see if I can get one more afterwards, but Mr. Lobb right now, for one question, please.

Mr. Ben Lobb: In the briefing notes we're looking at, for example, 10% disability. If there were three cases for one individual, where they were maybe disabled at 10% in both arms and 10% in a leg, I know you currently don't add those together. Is there any chance down the line you may consider that so that it would be 30% in total?

Ms. Leigh Ann Skeens: I'm not sure if you're familiar with how we do this. We have a formula to compute those. If a veteran is 20% for a condition, 10% for a condition, and 30% for another condition, there's a formula we have that allows us to.... They don't add together strictly as 20, 10, and 30, but we do add them together for a combined evaluation.

A veteran who has two 10% disabilities will sometimes come out to be 20; a veteran who has three 10% disabilities may also be 20%. It's a little confusing, but it's the whole body theory and the percentage of earning capacity that's lost.

Does that answer your question? We do have combined evaluations for our veterans. You can have multiple issues and be service connected for multiple issues and get higher benefits for those. Does that make sense?

● (1625)

The Chair: Thank you very much again, Madam Skeens, for taking the time for the presentation and for answering the questions. That will finish up our time here. We have about four minutes, and I'm going to try to get some business done between now and the next call.

Again, on behalf of the committee, thank you very much.

Ms. Leigh Ann Skeens: Thank you very much.

The Chair: Madam Sgro, you had something you wanted to discuss. We'll try to deal with as much as we can here between calls.

Hon. Judy Sgro: I'm getting a lot of letters, and I suspect so are the other members of the committee, regarding the issue of the change in the pension when an individual becomes 65. There's a drop in one pension when they start getting the CPP. It's an issue that Peter Stoffer has raised a lot.

This is where I find the challenge. If I figure I'm getting letters from veterans complaining about this issue, others must. In order to be able to give them an appropriate answer, the answer I have is tied into agreements made many years ago, and we may not be in a position to go back in the future to make changes that would affect—

The Chair: Sorry, there's no way right now that the translation can work because the phone call is going right through the line. So we'll have to suspend that call for a minute while we're dealing with this.

Go ahead, Madam Sgro.

Hon. Judy Sgro: The question is, could we take one of our meetings and focus on that issue a bit? Most of us I think are new here. We really understand that issue well as we move forward. Maybe in the future we want to come up with an idea that we can move forward and change for future veterans who are contributing, if this is where I think it's going. It's just that I'm getting an awful lot of letters, and rather than give them the non-descript “Thank you for your letter” answer, I think it would be worthwhile for all of us to really understand what's going on.

I don't know where Mr. Stoffer's bill is, but it's going to come up as well, and I think it would help us all to understand the issue better. It is just a suggestion, if we could maybe have one of our meetings after the break just to get us to fully understand what that issue is all about.

The Chair: Mr. Kerr, then Mr. André.

Mr. Greg Kerr: Mr. Chair, I think it's a valid question. I also think it's very indepth. It involves DND as well as ourselves. We talked about raising something, perhaps even progressing into a study or a review, because there is a lot of misunderstanding as well as a lot of interest in the issue. I would suggest it might be appropriate to have officials from both departments come before a meeting. I think we'd allow time in that meeting to hear the whole thing, because I'm still trying to understand, with all the briefings I'm getting.

I agree with you totally. It should be brought up here, but I think we may start with an overview briefing and then decide whether we want to have some sort of study or review done beyond that. I think we should start with those who have a background on it first, if you don't mind.

Hon. Judy Sgro: Great idea.

The Chair: Thank you, Mr. Kerr.

Monsieur André.

[*Translation*]

Mr. Guy André: I would tend to agree with the comments made. Perhaps we could have a meeting or a briefing to bring us up to speed on this project. We come here and we meet people. I'm having a problem following and understanding where the government wants to go with this.

I understand that Mr. Rossignol has done a comparative study of the services provided by both countries, but for what purpose? Should the subcommittee also meet to set an agenda? I haven't seen an agenda. I don't know if you are merely continuing with the agenda that was set before the elections, but I think we need to pause at some point and review all of this. I agree with the suggestions made to that effect.

● (1630)

[*English*]

The Chair: Monsieur André, I'm certainly open to the will of the committee as far as the subcommittee goes. I have to say to you that the tradition on this committee so far has been to deal with our business in the aggregate committee. If the committee votes and wants to change that, as I said, I've always been at the service of the committee.

[*Translation*]

Mr. Guy André: I didn't know that. I didn't know how you operated. These are some basic things that we are not aware of. Do you understand? This is part of...

[*English*]

The Chair: We did have quite an extensive business meeting five or six meetings ago. We set the agenda for what we had. We're going to need to have another business meeting shortly to fill our future schedule. And of course one of these items may very well be the topic that we're dealing with right now.

I have to say I'm going to use the privilege of the chair to take this under advisement, because it does span another department and I want to make sure, as your new committee chair, that we fit into the framework of the mandate of this committee. Mr. Stoffer's bill will not come before this committee because in fact it's a DND issue.

Mr. Stoffer, go ahead.

Mr. Peter Stoffer: For Judy and for anyone else, I'd be more than happy to provide you with my briefing notes on it.

Just to give you a very quick synopsis, there is nothing illegal that the government did in the past. There is nothing wrong. There's an interpretation of how that was done. Quite briefly, what happens is that at age 65 every federal and provincial public servant in this country...when they receive CPP, that amount gets deducted from their superannuation. That affects everyone except senators, judges, and members of Parliament. It's funny how we left ourselves out on that.

The other one of concern, of course, is the RCMP officer with 32 years' experience who has a stroke at work and can no longer work. He or she applies for Canada Pension Plan disability, they receive it, and the amount they receive for the Canada Pension Plan disability is automatically clawed back from their superannuation. It happened to an RCMP friend of mine who is 56 years old. He said, "Why did I apply for Canada Pension Plan disability?" So there is that concern.

But it is a DND, Treasury Board, and Finance concern. I'd also have to have a royal recommendation, which I'm fully aware of.

So I will be more than happy to provide my notes to you and provide a briefing from the group that has come to me over the years on this issue. I'd be happy to share what I have with you.

The Chair: Is it okay if we move in camera for a second, folks?

Some hon. members: Agreed.

[*Proceedings continue in camera*]

● _____ (Pause) _____ ●

[*Public proceedings resume*]

● (1640)

The Chair: Hello, Ann Patterson.

Ms. Ann Patterson (Acting Chief of Staff to the Under Secretary for Health, Veterans Health Administration, United States Department of Veterans Affairs): Good afternoon. How are you?

The Chair: Very good. We have good video and it sounds like we have good audio now as well.

Ms. Ann Patterson: Excellent.

The Chair: Thank you very much on behalf of the committee for taking the time today. I apologize that we were late engaging the call.

Ladies and gentlemen of the committee, Ann Patterson is the Acting Chief of Staff to the Undersecretary for Health, Veterans Health Administration.

Do you have an initial opening presentation for us, Ms. Patterson?

● (1645)

Ms. Ann Patterson: What I wanted to do was introduce myself to all of you and find out a little bit about how much of an overview you need. Some folks around here this morning, as we were talking about it in the undersecretary's morning meeting, indicated.... Dr. Cross mentioned that he may have met some of you previously, so I don't want to go into a real basic overview if many of you already have a sense of our organization and what we look like.

The Chair: Most of the members of this committee are brand-new members.

How long would it take for you to do an overview?

Ms. Ann Patterson: Let me just do this. I think we have about 45 minutes. I have a PowerPoint presentation that does go a little bit into how we're organized, what we look like, the budget, and some of our most important and key initiatives right now. I think that should do it. Then if there are some topics as we go through this—and I move along fairly quickly—that you want us to focus on, maybe we can arrange for another time where we could go through some of the key topics in a little bit more detail.

The Chair: Ms. Patterson, is there any chance that you may be able to keep it to 20 minutes, and then every member could at least have one question for you?

Ms. Ann Patterson: Well, I will tell you that we planned an hour. If you want me to do just an overview, yes, we can skip some slides and just move right along.

Let's do this. You stop me at any time. If there's something you want me to focus on, I can. Otherwise, I'll just go through the slides very quickly.

The Chair: That would be fine. If after the questions there is desire from the committee to have more detail, then we'll ask you at the end to arrange another meeting. Go ahead with your presentation, and then we'll have questions after.

Ms. Ann Patterson: That's not a problem.

● (1650)

The Chair: Ann Patterson, do we have good audio now?

Ms. Ann Patterson: I can hear you. Let's get the PowerPoint up very quickly.

The Chair: Unfortunately, it's the video connection.

While we're waiting, ladies and gentlemen, while the phone isn't ringing, I might be able to get this announcement through, with translation.

March 26 is a Thursday. It's the only time we're able to get the British Service Personnel and Veterans Agency. That's March 26, from 10 a.m. to 12 a.m., because of the time change.

I just wanted to advise you of that. Of course, it's not a mandatory meeting in our schedule or anything, but it would be good if most of the members could make that. It was the only time we could get. Try to put that in your schedules and see if you can make it. That is March 26.

We'll have a meeting on March 25...no, excuse me, I'm wrong. On March 23 we'll be Washington. March 26 will be the British VA.

Hon. Judy Sgro: Mr. Chair, while we're waiting, can I thank Michel for the graph you put together here? This is very helpful, being able to compare the two. Thank you very much for the fast work you did pulling them together.

The Chair: It is from 10 a.m. until noon.

Mr. Peter Stoffer: You're probably aware that, prior to Christmas, Britain announced some changes to their Compensation Act. If we can get that, that would be very helpful.

Mr. Michel Rossignol (Committee Researcher): Yes, there's some information.

Mr. Peter Stoffer: They give $1 million now in the event of it. They don't give a lump-sum payment on the death.

Mr. Greg Kerr: They've never given one yet.

Mr. Peter Stoffer: Not yet.

In the States they don't give a lump-sum payment. They give a certain amount every month.

Mr. Greg Kerr: Yes.

[*Translation*]

Mr. Guy André: The 26th might work, Mr. Chair, but do we not have a meeting scheduled for March 25 as well?

[*English*]

The Chair: No.

[*Translation*]

Mr. Guy André: So then, on Monday and on Thursday.

[*English*]

The Chair: It is March 23 and then March 26. So yes, that's correct.

[*Translation*]

Mr. Guy André: Fine then.

[*English*]

Mr. Greg Kerr: So it is basically March 25.

The Chair: That's correct, yes.

Mr. Greg Kerr: Which would have been right here.

We won't have any time for questions. We only have half an hour left.

The Chair: No.

Mr. Greg Kerr: If she does come on, though, and we don't get questions, should we submit the questions to them, and they can send them back?

The Chair: I think she indicated that.

● (1655)

Ms. Ann Patterson: Hi, this is Ann.

The Chair: Okay, we have audio, but we don't have video yet, Ann.

Ms. Ann Patterson: I will run through this as quickly as I possibly can. I apologize that you can't see the PowerPoint. That would have been much easier, but let me go ahead.

I'm Ann Patterson. I'm the acting chief of staff here. I've been acting since the presidential inauguration, so not for very long. There very well may be some questions that you have in the end that I won't be able to answer, but I'm certainly willing to get back to you if we can establish a point of contact.

The Department of Veterans Affairs has been in operation for about 20 years. We're getting ready next weekend to have our 20th anniversary celebration.

We're divided into three administrations: Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration. I work for Veterans Health Administration so that's what I'll focus on for the time we have.

To honour America's veterans by providing exceptional health care that improves their health and well-being is our motto. Our Under Secretary for Health is Dr. Michael Kussman, and his priorities are putting patient care first, leadership, promoting improved business practices, and producing and maintaining meaningful performance measures. Those were rolled out to our entire staff about a year ago. I think most everybody is very familiar with those priorities, and certainly he has established initiatives to make sure that we promote those.

These are some of the key facts that may be interesting to you. In 2008 we cared for 5.6 million veterans. We are among the largest providers of health professional training in the world. We train 100,000 students each year and are affiliated with 107 medical schools. We're among the largest and most productive research organizations in the United States. We're a principal federal asset for providing medical assistance in major disasters, and we're the largest direct care provider for homeless persons in the United States.

Quality is something we have really focused on over the last decade. Now I'm proud to say that we're recognized as a world leader in providing high-quality health care. We have an elaborate performance measurement system that was established back in 1996, and we believe this really has moved us and advanced us to the point where we are today.

We meet or exceed the performance of commercial health plans, Medicare or Medicaid, in each of the 18 quality measures that are pertinent to VA patient populations. We are and have been the benchmark in patient satisfaction through the American customer satisfaction index, for the past seven consecutive years.

A few years ago the RAND Corporation demonstrated that VA leads the nation for preventative health services and chronic disease management. The study found that VA patients received higher-quality care than comparable patients receiving care from other providers.

One of the latest products is a book called *Best Care Anywhere*, which was written by an investigative reporter named Phil Longman, who went searching for the hospital in the United States where Americans received the best health care available after his wife died of cancer. After several years of study he indicated that VA was the place where Americans got the best health care, and his recent book called *Best Care Anywhere* explains that.

You are all very aware of the electronic health record that we have, and I think Gail Graham, who is a colleague of mine, is going to spend some time with you in about two weeks going over the electronic health record. For now, in the interest of time, I'm not going to go into that very much.

The one thing I do want to say is that My HealtheVet, which is a fairly new functionality, allows veterans to actually dial in and get information, order prescriptions, and talk to their physicians. That is one of our most impressive functionalities now. I think Gail will go into that, as well as Vista Imaging, bar code medication administration, clinical reminders, and online prescription refills. Again, I think we filled nearly 8.8 million refills through 11/30/08.

● (1700)

We also have seven consolidated mail-out pharmacies. I think we were the first to establish a consolidated mail-out pharmacy. We provide 200 million 30-day equivalents per year.

As I said, we treat 5.6 million patients, or we did in fiscal year 2008. The median age of our veterans is 63. In the next 10 years there will be a 42% increase in veterans 85 years and older.

By 2018, the number of enrolled women veterans is expected to increase by 58%. I have a number of statistics about female veterans. We are really focusing on female veterans now. We have recently required every VA facility—we have 153 of them—to have its own women veterans coordinator.

One of the other things that we have focused on in the last 10 years or so is community-based and ambulatory care. Back in 1996, I think we had about 100 or maybe 200 community clinics. Now we have 919 community-based clinics. They are established, actually, through our local facilities, which determine, based on geography and a number of other things such as market penetration, where we need to have community-based outpatient clinics.

We have actually brought that process into central office recently to make sure that we are consistently applying our access standards. So now there is not only the expectation that medical centres will determine where they need CBOCs, but they have to come into headquarters for an approval through central office.

We're also focusing on rural care. We have established a new Office of Rural Health. Many initiatives are being rolled out. One is mobile clinics. Ten of them are being implemented. I don't think more than two have actually started operation, but ten of them are expected to be operational in the next year.

We have 135 community living centres. Last year we changed the name of our nursing home care units to community living centres, and there are initiatives to try to make those environments more homelike.

We have 230 vet centres. Vet centres are non-institutional. They are usually away from our main facilities. Mostly, they are a kind of peer-to-peer counselling centre. We also have 50 mobile vet centre vans that are being deployed this year.

We have 48 domiciliaries.

I've mentioned central office a number of times. We're organized regionally. We have 21 veterans integrated service networks. All of our facilities fall under one of the directors of VISN, the veterans integrated service network. The VISNs range between about three facilities in some of our small geographic areas like Washington, D. C., and New York City, where we may have a few facilities, and up to ten facilities in some of our western areas.

I mentioned our community-based outpatient clinics, CBOCs, a little while ago. Some of those are VA-staffed and some are contract care. We make sure that our contracts include all of the quality issues, the credentialling and privileging and all of those things, so that there will be no difference, really, in the type of treatment that a veteran gets should he or she choose to go to a contract clinic.

● (1705)

In 2009 our budget is $44.5 billion. We have three appropriations to which our money is allocated. There are medical services, medical support and compliance, and medical facilities appropriation. I have a lot of information about what goes into each appropriation, which I could certainly share with you.

Our method for allocating dollars is called VERA, which is veterans equitable resource allocation system, which was developed in 1997. It uses a modified capitation allocation methodology to distribute the money each year to the 21 networks.

We have 245,000 employees, 31% of whom are veterans. We have 18,000 physicians, about 6,000 pharmacists, 49,000 nurses, and about 900 dentists. I'm sure you all understand that we have tons of workforce challenges. Approximately 40% of VHA employees are eligible to retire by FY 2014, and more than 80% of our senior executives are eligible to retire by 2014. Clearly we are experiencing, as everyone is, the shortage of health care workers, for example, registered nurses. We have all kinds of recruitment enticements for nurses.

We are very proud of some of our research milestones. There are a lot of accomplishments that have occurred through the research of the DVA: the invention of the cardiac pacemaker, our first successful liver transplant, the first rehabilitation program for blind persons, and development of the nicotine patch.

With respect to our newest returning veterans, we continue to work on our seamless transition from the military. There are a lot of ways in which we try to reach out and touch the new veterans who are coming back. We send letters to every veteran welcoming them home. We have a very elaborate care management system that we have put into place. Every facility has an OEF/OIF point of contact and an OEF/OIF program manager.

This year our previous secretary initiated a combat veteran call centre. We went back and looked at every single person who had been separated from the military and who had not used the VA system and we called every one of them. We left messages. We had scripts that were developed to talk to them to explain to them what their benefits were, and we're now tracking to see how many of them will come to the VA to use our services.

When combat veterans come home, they are offered five years of free VA health care. We have screening programs that we've established for these new veterans. One is for PTSD and one is for TBI.

As I said, we've put points of contact in every facility. We have outreach coordinators in almost every facility. We have transition patient advocates who help transition our returning service members from Walter Reed, from the military facilities to the VA facilities.

With respect to polytrauma, I mentioned TBI and PTSD. There are a number of folks who come back and who fall into a category called polytrauma. We have established polytrauma centres in four of our big medical centres. We're getting ready to establish a fifth one in San Antonio. Every vision and every facility has at least a polytrauma support clinic.

Mental health is another huge initiative for us. We have hired 4,000 new mental health clinicians in the last couple of years. Every CBOC has to have a professional in mental health who can treat patients who go to a CBOC.

● (1710)

Regarding suicide prevention, back in July 2007 we established a suicide prevention hotline through health and human services. We have coordinators in every facility. The hotline is 24/7, and we believe we have saved about 2,800 lives since the hotline started.

We are tracking the common injuries and issues of our OEF/OIF population, and we actually have made sure that anyone with a severe injury has a case manager assigned to them.

I have run through most of my slides. Why don't I stop now and see if there are questions you all have?

The Chair: Okay. Thank you very much Ms. Patterson.

I think there's probably a question everybody has, because there was an acronym you used with PTSD that I don't think any of us is familiar with. Was it TBI?

Ms. Ann Patterson: TBI, traumatic brain injury. I am sorry.

The Chair: Traumatic brain injury, okay, thank you. And CBOC?

Ms. Ann Patterson: I am sorry. Community-based out patient clinic.

The Chair: Community-based out patient clinic.

There is one more: polytrauma. Could you just expand on what polytrauma is in the clinics?

Ms. Ann Patterson: Sure. We have a lot of veterans coming back who have more than one or two injuries. So polytrauma is typically two or more of the following: an amputation, a burn, blindness, traumatic brain injury. Really a polytrauma patient needs a lot of complex care.

So we decided we would take our four big centres that used to have traumatic brain injury as kind of a focus and make them polytrauma centres and actually bring in specialists who could treat all kinds of war injuries.

The Chair: Okay. Thank you very much.

We probably have time for about four questions, and we just happen to have four political parties here. How do you like that?

Madam Sgro.

Hon. Judy Sgro: Thank you very much for your information. It was very helpful.

Recently there was a handful of mothers of severely wounded soldiers who challenged the care their sons were receiving in the veterans affairs hospital, and they won the right to have them treated in private facilities.

Has the policy changed for all soldiers, or do they still have to receive their care strictly in a veterans hospital?

Ms. Ann Patterson: It is a very interesting question. We believe that our polytrauma centres—let me tell you that we have one in Tampa, Florida, one in Minneapolis, Minnesota, one in Richmond, Virginia, and one on the west coast, in Palo Alto—are able to provide the best care that is offered anywhere.

However, we do know there have been some families—and to be honest, I think most of these were early on in 2006 and 2007—who did not feel their sons or daughters or wives or husbands did receive the best care possible. Typically, when they came to us and said, "We're very dissatisfied with the care and would like to go to one of the other rehab hospitals in the United States", we have paid for them to go.

There have not been many. In my memory I can't think of any in the last year or so. But yes, that has happened, and yes, we have paid for them to go.

● (1715)

Hon. Judy Sgro: Thank you very much.

The Chair: Thank you.

Who will it be, Monsieur André or Monsieur Gaudet, for the question?

[*Translation*]

Mr. Guy André: I'll ask the question.

What various methods, programs or procedures are employed to prevent and, in some cases, make a diagnosis of post-traumatic stress syndrome in a soldier? With respect to treatment, what methods are used to treat sufferers of post-traumatic stress syndrome and how is the family of the victim involved in the treatment process? Have you developed some expertise in this area? I'd like hear what you have to say on the subject.

[*English*]

Ms. Ann Patterson: Preventing it is really very hard. What I think we try to do is recognize it and screen everyone who comes home from combat for PTSD. We have had the best experts we know of develop some screening tools that we have made available and we've mandated the use in every one of our facilities. So everyone gets screened, and if you screen positive then you get a mental health visit right away.

So I think we have become very good at recognizing PTSD and in making sure that when we find somebody with a positive screen we refer them on immediately. We also have what we call our mental health initiative, which began about two years ago, whereby we have required that anyone who comes to us or who calls us with a mental health issue be seen—if it is an urgent situation—immediately. But in all cases, a mental health appointment needs to be made in seven days.

The Chair: Thank you very much.

Mr. Stoffer.

Mr. Peter Stoffer: Thank you, Ms. Patterson, for your presentation. In Canada we were experiencing some challenges when a military person was released, either honourably discharged or medically released, and then became a veteran. The indications of the paperwork, the medical files and all of that, moving over to that other department have been quite a concern. Mind you, the government now has realized that was an issue and they are improving upon it.

Can you give us your scenario of what it's like when a military person is leaving your military and then becoming a veteran? In terms of any medical concerns they might have or any other documents they need, how smooth is that transition for them?

Ms. Ann Patterson: We believe it is getting better every day. I mentioned the four polytrauma centres. For the most part, when combat veterans come home and they have severe medical issues, and they're coming from one of our army or navy facilities, they will be transferred initially to one of our four polytrauma centres. We have made arrangements for records to go back and forth. As I said, we have our electronic health record, and now we are working with DOD to make sure that pieces of it are interchangeable. We spend an awful lot of time talking about a single record or how we can establish common services so that the DOD records and the VA records can talk to one another.

We have video conferences now between the staff at each of our polytrauma centres and the DOD centres that typically transfer patients. We have our own social workers who have offices now in DOD facilities and vice versa, so there is an awful lot of talking and communicating and sharing. I mentioned our patient transition advocates. They actually will go and meet with the family, and get to know the family, and serve as a case manager while the family is still at a military facility, and they move with them, actually transfer with them to a VA, so that there is continuity in the transfer.

So we have put an awful lot of effort and initiative into working with DOD to make sure that the transition goes as smoothly as possible. It's not perfect. I worked on the Seamless Transition Task Force about five years ago, and I think we have just come so far with how we're able to make sure that nothing falls through the cracks.

● (1720)

The Chair: Thank you very much.

Mr. Clarke.

Mr. Rob Clarke (Desnethé—Missinippi—Churchill River, CPC): Thank you, Mr. Chair.

Thank you, Ms. Patterson, for being with us here today. I'm sorry for the communication problems.

Ms. Ann Patterson: Yes, I apologize for that as well.

Mr. Rob Clarke: From what I understand, you have five years of free health care for all veterans upon return, correct?

Ms. Ann Patterson: For combat veterans.

Mr. Rob Clarke: Combat veterans, okay.

When young female veterans return from combat missions, some of them would like to start families. Would these health care benefits also apply to the female veterans?

Ms. Ann Patterson: Yes, they do.

Mr. Rob Clarke: Let's say a female veteran reaches about four and a half years, would her benefits roll over in certain circumstances?

Ms. Ann Patterson: What happens in the five years is that we encourage everyone to get a compensation and pension exam. Many times veterans, once they have their compensation and pension exam, are eligible anyway. The five years is really without that.

I don't know if you're familiar with our priority system, but actually, in the VA we have veterans in categories 1 through 8. Clearly, all veterans in priority groups 1 through 7...and I can send you those. Priority 1 is 100% service connected, and it goes on down to 0%, non service connected. The priority 8 veterans are non service connected who typically have a higher income level.

We have, over the past couple of years, not enrolled priority 8s. With some of the new initiatives with our new administration we are going to start opening the doors back up, slowly, to priority 8 veterans. So there will be a time I think in the next couple of years when all veterans, service connected or non service connected—which means you don't have to worry about the free care any more—will be able to come in and receive care here.

Mr. Rob Clarke: Thanks very much.

The Chair: Thank you very much, Ms. Patterson.

I want to ask you one question before we end our meeting.

Do you have some statistics in front of you on the increase in post-traumatic stress disorder from, let's say, Operations Desert Storm and Desert Shield, and now, with Afghanistan and Iraq?

Ms. Ann Patterson: Not in front of me, but I could send you that because I do know where it is.

The Chair: Thank you very much. We'll rely on you for that.

I just want to confirm whether you will be forwarding your PowerPoint presentation to us.

Ms. Ann Patterson: Yes. I thought you had it. Let me talk with the folks in Public and Intergovernmental Affairs to see if they can get that to you.

The Chair: On behalf of the committee, I want to thank you very much for the investment of your time, and also for your willingness to forward extra material to us for answers to our questions. You even went the extra mile and said you'd be prepared to come to another meeting, and we appreciate that.

Again, on behalf of the committee, thank you.

Ms. Ann Patterson: You're very welcome. Thank you.

The Chair: Unless there is any further business....

● (1725)

Ms. Ann Patterson: I will sign off. Thank you.

The Chair: Thank you. And we will sign off too.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

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