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OPTIMIZING FACILITIES AND IMPROVING THE DELIVERY OF HEALTH CARE AND SERVICES TO VETERANS IN THE STATE OF CONNECTICUT

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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OPTIMIZING FACILITIES AND IMPROVING THE DELIVERY OF HEALTH CARE AND SERVICES TO VETERANS IN THE STATE OF CONNECTICUT

MONDAY, JUNE 7, 2004

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

The subcommittee met, pursuant to call, at 9:30 a.m., in the Red, White, and Blue Room, VA Connecticut Healthcare System, Newington Campus, 555 Willard Avenue, Newington, CT, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representative Rodriguez.

Also Present: Representative Shays.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. Ladies and gentlemen, this hearing of the Veterans' Health Subcommittee of the Veterans' Affairs Committee will come to order. My name is Rob Simmons. I am the Chairman of the Subcommittee. I am joined here today by my colleague, the Subcommittee Ranking Member, Ciro Rodriguez, who represents the 28th Congressional District in the great State of Connecticut.

Ciro.

(Laughter.)

Mr. SIMMONS. Texas—excuse me—I keep getting confused with that because of course Connecticut is a great state as well. The great State of Texas. And I also am looking forward to having Chris Shays, of the 4th District of Connecticut, joining us at some point this morning. He has a busy schedule today, but I know that he did want to drop in and participate for a period of time.

Also to my far right is Eliott Ginsberg, standing in for our host, Representative John Larson of the 1st District, who today is in Europe celebrating the D-Day landing and involved in other issues. Eliott, it is good to have you here today, and John has been a great supporter of Connecticut's veterans, and we very much appreciate all that he has done.

On my left is our Staff Director, Subcommittee Staff Director, John Bradley, and we also have with us Susan, who is the Minority Staff Director, and counsel, and other members of the staff, and I am pleased to have them here today.

The genesis of today's hearing grows out of a meeting that Congressman Rodriguez and I had several months ago where we

agreed that it would be useful to go out into the field to see how the Veterans' Administration was working in the State-based environment. We have been to San Antonio, Texas a few months ago. There are very substantial military medical facilities there as well as Veterans' Administration facilities, and we examined the interrelationship of those facilities and found that it was very useful to the committee. In particular, we came back with a view of how we had to address the issue of nursing shortages, and that is an issue that may, in fact, apply to us here today.

In coming to Connecticut, we have a slightly different agenda. We will be looking at what I call the "Connecticut Model", and the Connecticut Model is somewhat different from what you have in Texas, which is a very large State. It is somewhat different from what you have in our very large States. It is a small State where the Veterans' Administration maintains a first-rate hospital in West Haven. We have a facility here in Newington that is actually consolidating with our Benefits Section that previously has been up in Hartford. We have, I believe, five CBOCs around the State that provide primary care, and we also have a very good and developing and constructive relationship with the Connecticut Department of Veterans' Affairs, and our commissioner is here today, Commissioner Schwartz. Would you stand up, please, so we can all recognize you? Linda, great to have you here. Thank you for coming.

(Applause.)

Mr. SIMMONS. A developing relationship with the Connecticut Department of Veterans' Affairs where we try to share facilities, share resources, for the benefit of our veterans.

Finally, we have also here in Connecticut, the Navy and the Coast Guard, all of which participate in providing services to our veterans. Connecticut has deployed a number of Guard and Reserve units to Iraq over the last year or so. Just to name a few, the 1109th AFCRAD from Groton, which is in my district down in Groton; the 1043rd Military Police Company of Hartford; the 104th Aviation Battalion of Windsor Lock; the 247th Engineer Detachment, also in my district in New London; the 248th Engineer Company of Norwich, which was in Iraq building and repairing roads; also in my district, the 118th Medical Battalion of Newington; the 107th Infantry Battalion, which has just deployed.

And one of the things that has come across my desk is the issue of how do these deployed Guard units intersect with the VA on their return? Many of them return to Fort Drum, which is in New York, in a distant and somewhat remote section of New York. It was originally established, I believe, to train the 10th Mountain Division, so there is lots of snow there. And, here, we have our folks coming back from Iraq or Afghanistan into Fort Drum for their demobilization and, for some of them, for their first introduction to the VA as veterans. So, that intersection is also extremely important to us.

We have a very substantial group of people on our panels this morning. We have a total of three panels. I look forward to hearing from them but, again, I wish to thank my colleague, Ciro Rodriguez, for being here today; thank Mr. Ginsberg, from Congressman Larson's staff; I thank John Bradley, Susan Edgerton,

and also Delores Dunn—where is Delores—who will be our timekeeper. Delores, we will be on a 3-minute or a 5-minute clock?

Ms. EDGERTON. Five-minute.

Mr. SIMMONS. We will be on a 5-minute clock, and when the light goes red, we will ask our panelist to summarize. And at this point, I would like to ask my colleague, Mr. Rodriguez, if he has any comments that he would like to make?

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. I want to first of all thank you for allowing us to be here with you, and I also want to personally thank you for coming down to San Antonio to visit our facilities in Texas. This is my second time to come to Connecticut, and I look forward to visiting the sites—you have a beautiful site here.

I am also very pleased that we have this opportunity to be able to come out. I have to tell you that I have been on the committee now 7 years, and we have not had too many hearings such as this. I do want to personally thank you for allowing us to be able to do this because we have not done this in the past as much as we should. So, I personally want to thank you for allowing us to do that.

Let me just briefly indicate that I know after the CARES recommendations have come out, we know that there is a lot of gaps that exist throughout the country in the types of services that are provided from one region of the country to the other, and we know the disparity that exists. We have to continue to work on that and make sure that no matter where veterans live throughout this country, that they get the quality access that they should, and that is one of the areas that we have to continue to work on.

And, Mr. Chairman, I also note we will be having hearings about various other topics including the infrastructure, physical infrastructure, in the subcommittee back in Washington next week. So, I want to thank you for that, and I am looking forward to working with you to ensure that our committee is prepared to authorize funds for the critical investments that are needed throughout this country. We haven't done that as much as we should, and that is one of the concentrations that needs to occur. We really need to invest in our infrastructure for our veterans, not to mention in terms of the quality of care.

The funds we have been willing to commit have not been adequate to cover the cost of improving health care or the research and our infrastructure. This underfunding affects all of the issues that the VA must contend with today, whether it is in their efforts to hire the right number of staff and the types of clinical staff, provide appropriate space and/or resources for fulfilling the VA mission. Those are the areas we need to work on.

Mr. Chairman, we will continue to work on these matters both here and in Washington, and I know that both of us have the same concerns in this area. So, thank you very much for allowing us to be here with you. Thank you.

Mr. SIMMONS. Thank you, Representative Rodriguez. I see we have been joined by my colleague and my friend, Chris Shays, of the 4th District. Welcome. Chris is the Chairman of the Govern-

ment Reform Oversight Subcommittee on National Security, Emerging Threats, and International Relations. He has a substantial background and interest in veterans issues, military and national security issues, but before I defer to him and ask him if he has some comments he would like to make, I would also like to acknowledge the presence today of Dr. Paul Arrera, a retired VA health policy expert, former VA National Director of Mental Health and Behavioral Sciences, a clinician, a researcher, and an academic. He has been a great leader at a national level in the mental health arena, and also, according to John Bradley, a mentor for many, many different people interested in veterans health. Dr. Arrera, where are you? Thank you for being here.

(Applause.)

Mr. SIMMONS. I think it is fair to say that much of the work that many of us have been doing in the area of veterans mental health is on the shoulders of Dr. Arrera and people like him, so we thank you for that.

We have been joined by my colleague, Mr. Shays. Chris, do you have a comment you would like to make?

OPENING STATEMENT OF HON. CHRISTOPHER SHAYS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mr. SHAYS. Thank you, Mr. Chairman, for conducting these hearings, and to my colleague from Texas, Mr. Rodriguez, wonderful to have you. Thank you for spending your time in Connecticut. I want to also thank our witnesses for their participation, and those in the audience who are here to listen and maybe catch us and tell us a thing or two as we leave.

I would just like to say that I know we need to spend more money on our veterans issues and our veterans benefits. I took tremendous price, though, in how Connecticut stepped up to the plate a number of years ago and did some consolidations and some efficiencies in Connecticut, but we fail to see that same kind of efficiency, for instance, in Boston where facilities were kept open that weren't quite needed, and then we saw some of the savings we made in Connecticut go up to the Massachusetts area. That was a little hard to take since we had kind of taken the responsibility.

I also want to say that we will be spending—at least in the budget, and maybe it will increase—$70.3 billion for veterans benefits and services—$70.3 billion. Even in Washington, that is a heck of a lot of money. And our budget increases funding for the VA by 55.8 percent over Fiscal Year 2001, up from $45.1 billion. We have added billions and billions and billions and billions and billions of dollars to veterans programs, and there are some veterans who recognize that we are on a pathway to including all veterans and benefits—we are not there yet—and are grateful, and there are some veterans who want it to happen tomorrow. And to those who want it to happen tomorrow, I apologize that it won't, but we are on our way.

And I take tremendous pride in a Congress that has increased veterans spending in just 4 years by 55.8 percent, and know we need to do more, and look forward to hearing from our witnesses the challenges they face and the suggestions they would like to

make to us. And, again, thank you, Mr. Chairman, for holding this hearing.

Mr. SIMMONS. Thank you, Chris.

Mr. Ginsberg, any comments you would like to make on behalf of Congressman Larson?

Mr. GINSBERG. Thank you. Congressman Simmons, Mr. Rodriguez, Congressman Shays, for the record, my name is Eliott Ginsberg, I'm Chief of Staff for Congressman John Larson. I want to express my appreciation for the opportunity to address you this morning.

On behalf of Congressman Larson, I would like to welcome you, first of all, to the 1st Congressional District. The Congressman, as Congressman Simmons has indicated, is currently in Normandy for the 60th anniversary of D-Day Invasion, with a delegation of other House Members, and he regrets not being able to be here this morning, but he has prepared and asked me to read a letter on his behalf for the record, since he could not be here personally.

Dear Chairman Simmons, Ranking Member Rodriguez: Having held a number of forums here in the 1st District on veterans health care issues, I am pleased the committee has taken notice of our efforts and I would welcome everyone who has come into our district to hear for themselves about the issues we have been raising and fighting for, which is to improve healthcare delivery for Connecticut veterans.

I would like to recognize the extraordinary work of the dedicated staff here in Newington. I toured the facility in April and met with the staff and patients, and am very much aware of how hard they are working to best serve our veterans with the resources they have available to them. They are doing an exemplary job and have made great improvements in recent years, but they must be given adequate resources to carry out their work.

Connecticut and New England face unique healthcare delivery challenges. Nationally, the Veterans' Administration is continuing to struggle for scarce budgetary resources, and locally the current funding model, the Veterans' Equitable Resource Allocation, VERA formula, does not distribute resources equitably throughout the country, since it is based primarily on population rather than need. Specifically, the Northeast generally does not have as large a veterans population as other places around the country, but the Northeast veterans population generally has more complex care needs.

This formula also does not take the overall regional cost of living into account, or the overall purchasing power of a dollar in different regions throughout the country. That is why despite Congress' efforts to increase the overall VA funding over the past 5 years, the Northeast as well as other areas of the country have never received their fair share of these increases. Instead, the VERA formula has resulted in a system which veterans in some regions of the Nation are forced to compete with veterans in other regions for healthcare funding.

The system should be providing the funding necessary to meet the healthcare needs of all veterans regardless of where they live, to ensure that all veterans have access to the level and quality of care they have earned and deserve.

To address this need, I have introduced legislation pending before the committee to codify VA's established performance goals, which are referred to as the 30-30-20, representing the VA's goal to schedule non-urgent primary specialty care visits within 30 days, and the maximum amount of time veterans must wait once they arrive to be seen by a doctor in 20 minutes. It would also require the VA to cover healthcare cost of any veteran forced to seek out-of-network medical coverage should the VA be unable to accommodate their need within this time frame.

Veterans are promised by the Federal Government that for their service to their country, they would be provided a lifetime of healthcare services as well as their own healthcare services network. This legislation, more specifically H.R. 2318, introduced by Veterans' Committee Ranking Member Evans to create a guaranteed funding stream for veterans healthcare would bring us more fully close to realizing this promise. That vision is in contrast to the budgetary course currently mapped out by the Administration.

While the budget resolution contains more funding than the President's budget for appropriated veterans programs, $31 billion appropriated for veterans programs, while obviously significant, is still less than the Veterans' Affairs Committee, on a bipartisan basis, stated is needed for the vital veterans healthcare programs.

An even more disturbing trend is seen in the memorandum from the President's Office of Management and Budget, dated May 19, confirming the Administration's 2006 budget would impose deep cuts in the Veterans' Administration by directing agencies to "assume accounts are funded at the 2006 level specified in the 2005 budget database", which shows the spending levels in the President's budget for agencies and programs for 2005 through 2009.

Through this directive, the President is already proposing budget cuts for next year to the Department of Veterans' Affairs below the 2005 requested level, which is already 1.3 less than the Secretary of the VA had originally requested. And there have been several efforts lately—some successful and some not—to reduce the number of veterans that are able to utilize veterans healthcare services or to charge new or increased fees to veterans to continue to be able to utilize services.

We, here in the 1st Congressional District, are very concerned about the potential impact of these types of policies in our region, where we continue to face consolidation of veterans services instead of expansion of available services, and struggle daily to see that our veterans facilities have the resources they need to provide appropriate services.

Again, Mr. Chairman, Mr. Ranking Member, thank you for holding this session in the 1st Congressional District. I look forward to the committee's efforts to learn first-hand about these issues and their commitment to work with me to make sure that the veterans in Connecticut and throughout the nation receive the level of service they have earned. Sincerely, John B. Larson, Member of Congress.

(Applause.)

Mr. SIMMONS. Thank you, Eliott, for that statement. I would say that one of the advantages of working with my colleague, Mr. Rodriguez, and with my colleagues, Mr. Shays, is that working in

a bipartisan fashion we have been able to dispose of some of those proposals in a fashion that is more advantageous to our veterans and to the VA, and that is part of the process and that is how the process works, that whatever the Administration may propose, then it is incumbent upon us to dispose of it. And one of the purposes of having these field hearings is to see how those dollars are working in the field for VA and for our veterans.

That being said, it is time for our first panel, and our first panel of witnesses include Jeannette Chirico-Post, M.D., who is the Network Director for the VA New England Healthcare System. Welcome, it is good to have you here. We also have Mr. Roger Johnson, who is the Director of the VA Connecticut Veterans Healthcare System; Mr. Ricardo Randle, Director of the VA Regional Office, now in Hartford, soon to be in Newington; Fred Wright, Medical Doctor, Associate Chief of Staff for Research at the VA Connecticut Veterans Healthcare System; Karin T. Thompson, APRN, BC, President of AFGE Professional Nurses Union, Local 2138—good to have you here, thank you very much. Thank you for the hat. I won't wear it indoors, even though my son does—he says that is the style, but I am a little more old-fashioned.

We will ask for each of you to make a statement, no more than 5 minutes, so feel free to summarize your remarks, which we have for the record. When the red light goes on, that means stop. And at the conclusion of all four statements, which will take approximately 20 minutes, the panel will have the opportunity to ask questions.

Dr. Post.

STATEMENT OF JEANNETTE CHIRICO-POST, M.D., NETWORK DIRECTOR, VA NEW ENGLAND HEALTHCARE SYSTEM; ACCOMPANIED BY MR. ROGER JOHNSON, DIRECTOR, VA CONNECTICUT VETERANS HEALTHCARE SYSTEM; MR. RICARDO RANDLE, DIRECTOR, VA REGIONAL OFFICE, HARTFORD, CT; FRED WRIGHT, M.D., ASSOCIATE CHEF OF STAFF FOR RESEARCH, VA CONNECTICUT VETERANS HEALTHCARE SYSTEM; AND KARIN T. THOMPSON, APRN, BC, PRESIDENT AFGE PROFESSIONAL NURSES UNION, LOCAL 2138

STATEMENT OF DR. JEANNETTE CHIRICO-POST

Dr. CHIRICO-POST. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to appear before you today to discuss improving health care services to the veterans in the State of Connecticut. I will focus my remarks on the Network perspective in systems improvement to provide high quality care to the veterans of New England.

Our health care system is an integrated and comprehensive delivery system providing care over the six New England States. We have over 30 community-based outpatient clinics which are strategically located to provide improved access for our veterans. Our goal is to provide the right care, at the right time in the right place, and at the right level required to safely and compassionately meet the unique needs of our veterans.

We are proud of the many accomplishments that demonstrate our commitment to our mission of providing the veterans of New

England excellence in health care, education and research. We have a longstanding affiliation with many of the most prominent medical schools in this country, including Yale and the University of Connecticut, here in Connecticut.

Research is another strong suit of the Network which Dr. Wright will address. Network 1 has transformed its delivery system from a hospital system to an ambulatory one based in primary care. We have achieved outstanding results by providing uniform high-quality services throughout the Network by reducing variations in care and standardizing availability, coordination and outcomes of services. Implementing the primary care model has improved continuity, improved outcomes, and improved satisfaction while there was a significant increase in the number of patients served. We have expanded access to the veterans of New England through community-based outpatient clinics, home-based primary care, and newer technology with telehealth and telemedicine. The Connecticut health care system was the first in the Network to expand home care using home telehealth technology and care coordination.

All eight VA medical centers utilize the electronic medical records. This enhances the safe delivery of care through computerized physician order entry. Access to the electronic medical record is made available to all nationally enrolled patients. The system fosters communication, coordination, and consultation among providers throughout New England.

VA now receives medical information on military retirees via the electronic record system that VA and the Department of Defense are developing. Network 1 has demonstrated progressive and consistent improvement in quality of care measures in the areas of disease prevention, the management of chronic disease, and use of nationally accepted clinical practice guidelines.

We have achieved success in significantly enhancing access to care by decreasing waits and delays for clinic appointments as a part of the Advanced Clinic Access initiative.

On May 7, 2004, the Secretary of Veterans' Affairs announced his decision about the National Capital Asset Realignment for Enhanced Services Plan. The Plan will provide even greater access to care for the veterans of New England. It provides an outline for modernizing and expanding health care, and bringing greater quality of care closer to where most New England veterans live. This is especially important to VA New England since our infrastructure has an average age of about 64 years.

Specifically, the plan includes the following recommendations: That the Network undertake a comprehensive study to assess the feasibility of consolidating the existing four Boston area medical centers; that the Network needs to increase inpatient demand by expansion of inpatient facilities at our West Haven campus and our Providence campus, and utilizing existing authority of community contracts where necessary for care.

The CARES Plan also asks the Network to increase its primary care access by expanding existing community-based outpatient clinics, and negotiating new contract care in the communities where needed. The plan also provides for the enhancement of inpatient and outpatient spinal cord injury services. The Hartford Regional

Office will collocate a benefits administration office to the Newington campus.

I am proud of the quality of care in New England, especially at the Connecticut Health Care System. The specifics about the Connecticut Health Care System Mr. Johnson will report to you.

Thank you for the opportunity to discuss the achievements and challenges of the Network. This concludes my opening remarks, and I will be happy to answer any questions for the members of the committee.

[The prepared statement of Dr. Chirico-Post appears on p. 48.]

Mr. SIMMONS. Thank you, Dr. Post. Mr. Johnson.

STATEMENT OF MR. ROGER JOHNSON

Mr. JOHNSON. Mr. Chairman and members of the subcommittee, it is an honor to meet with you today. You have my testimony, so I will not read it. I would like to highlight three items discussed in the testimony.

First, we are very pleased with the progress being made to revitalize the Newington campus of the VA Connecticut Health Care System. That process started in 2001, with the collocation of the National Guard on the grounds in 34,000 square feet of space. Last year, we worked with the Network and were able to establish a Network telephone call center here on the grounds, which brought ten additional positions to Newington.

This year is the year that we are really starting to hit our stride. We are part-way through bringing an 18-bed PTSD residential care program here. Five of those beds are already open, and the other 13 beds will be open in the near future.

By this fall, we will have reactivated the dermatology clinic which was closed a couple of years ago, and established a chiropractic clinic.

The final piece of the revitalization is the collocation of the Regional Office, which will be discussed by Mr. Randle in more detail in a few minutes.

Work is underway to create a new canteen to support the campus, and plans have been developed to expand parking. Finally, approval has been granted to pursue a 100-unit privately operated assisted living program on the grounds, as part of an enhanced use program.

The second issue we want to share is our efforts to outreach to the troops returning from Operation Iraqi Freedom and Operation Enduring Freedom. With the support of the DOD and the National Guard, we have joined with the Regional Office, the Connecticut Department of Veterans' Affairs, and the Department of Labor, to participate at the demobilization briefings of returning troops. Mrs. Will, who is on the next panel, has debriefed over 1500 returning troops. She has advised them of their eligibility for dental exam, if they do not get an exit dental exam with the military, and that we will treat them for any condition that could possibly be related to their service experience as if it were service-connected for a two-year period.

We have flagged the electronic medical records group of these veterans, to ensure that the veterans are screened for PTSD, de-

pression, alcohol use, infectious disease, and chronic symptoms endemic to Southwest Asia.

Over 230 returning servicemen and women have already enrolled with us for service. And consistent with the Secretary Principi's principal guidance, our focus is to care for them first and to worry about the paperwork afterwards.

Finally, I want to highlight our strength is not in what we do in isolation, but what we have developed over the years in partnership. Our affiliation with Yale and UConn have not only provided an excellent educational experience for medical students and residents, but has also allowed us to recruit an outstanding staff that provides high-quality care.

Of particular note, our partnership with Yale has allowed us to develop one of the premier research programs within the VA. Our six community-based clinics have allowed us to tie into communities around the State and put every Connecticut veteran within 30 miles of the VA primary care program.

Our partnership with the Coast Guard has allowed one of the CBOCs to be located at the Coast Guard Academy and to share services, while the staff at the Newington campus have come to consider the National Guard unit based here as family, which has been exhibited by a number of things that they have done in relationship to troops being deployed overseas.

Our partnership with the Regional Office has become very productive to ensure smooth coordination between the two programs.

In the third panel today, you will see that we have a dedicated veterans service officer group, who are excellent advocates for their fellow veterans. Their input and insight have proven invaluable to me, have assisted us on a number of occasions, but, most importantly, has been a tremendous value to the veterans they serve.

The partnership I would really want to highlight today is the partnership we have developed with the State Department of Veterans' Affairs. The new Commissioner of Veterans' Affairs, Linda Schwartz, has brought vision and a new sense of direction to the Rocky Hill Home and the whole State Department of Veterans' Affairs. We have come together as partners to integrate our services, to maximize benefits for the veterans and provide seamless services across our facilities.

In this effort, we have taken on providing primary and specialty care for patients from the State domiciliary program. We have provided the State access to our computerized medical record system to ensure that they have access to critical clinical information on the patients we share. We have collaborated to integrate a shuttle service that goes from Newington, to Rocky Hill, to West Haven, and then back, so that there is a smooth transportation system between us, as if we were all one group serving our veterans.

We are working to provide mental health services at Rocky Hill. At the same time, Rocky Hill has moved dramatically to significantly expand services and dramatically increase the number of Connecticut veterans served by their programs.

Mr. Chairman, we have many challenges ahead, but we believe we have seen very positive improvement in a number of areas, and we believe that the partnership that exists here in Connecticut will

ensure we can maximize the provision of high-quality care to the veterans who so richly deserve it.

Mr. Chairman, that concludes my statement, and I will be happy to answer any of your questions. Thank you.

[The prepared statement of Mr. Johnson appears on p. 53.]

Mr. SIMMONS. Thank you, Roger. Rick Randle.

STATEMENT OF RICARDO RANDLE

Mr. RANDLE. Mr. Chairman and members of the subcommittee, thank you very much for inviting me to participate in today's hearing. I am very pleased to be here today to talk about the Department's OneVA sharing opportunity between the Hartford VA Regional Office and the Newington Campus of the VA Connecticut Healthcare System, and to also communicate improvements in our service delivery to veterans in the State of Connecticut.

OneVA sharing opportunities are priorities for the Department. In many cases, VA is spending significant resources on rental space for its Regional Offices. With rental costs rising each year, the Veterans Benefits Administration must take advantage of opportunities to collocate on VA property where such action enhances services and is economically favorable. VA has placed great emphasis on maximizing the use of our assets to meet the service delivery goals of the each of its administration. Collocation allows VA to maximize its resources and redirect significant savings from rental costs into claims processing and other benefits delivery missions. Further, collocation will improve access to services, improve employee morale, and productivity by relocating to facilities in new, modern, and efficient office space.

Here in the State of Connecticut, we have adopted the OneVA sharing opportunity concept, and have embraced what we call "The Connecticut Model". "The Connecticut Model", by your own definition, Mr. Chairman, is a progressive and dynamic example of government entities working together to improve the efficiency of operations.

The collocation of the Hartford VA Regional Office to the Newington Campus of the VA Connecticut Health Care System is an excellent example of "The Connecticut Model".

Currently, the Hartford Regional Office is located in the Federal Building in downtown Hartford. We have been at that existing location for over 40 years. We occupy approximately 30,0-00 square feet of space. We provide space for service organizations who have full-time representatives—the American Legion, the Veterans of Foreign Wars, Disabled American Veterans, AMVETS, and the Connecticut Department of Veterans' Affairs.

The scope of the Hartford VA Regional Office collocation project encompasses the renovation of three floors and approximately 43,000 square feet of space on the third, fourth, and fifth floors of this building.

The collocation project will provide the Regional Office with a state-of-the-art facility, with the latest in information technology.

This project offers unique opportunities for VBA and VHA and will benefit VA as a whole. The Hartford-Newington collocation will improve service to veterans by providing "one stop service" for benefits and medical needs. It will provide free parking. If you have

ever had to come down to Hartford, downtown, parking is a bear, and it will provide fully accessible benefits.

Operational efficiency will occur with increased collaborative communication. Employee working conditions will be improved. Access to existing training and support facilities will further contribute to employees' productivity.

Close proximity of VBA and VHA personnel will further enhance accuracy and timeliness of the examination process. We expect to see improvements in the quality and timeliness of completed examinations. The average days to complete a hospital exam within the VA Connecticut Healthcare System is 17 days. Although this is better than the national average of 28 days, we believe that we can continue to improve.

Net costs will be reduced by eliminating the payment of annual GSA rent. In addition, VBA and VHA will investigate opportunities to integrate various operational functions, which have the potential to reduce costs even further. The new facility—and this has been a long time coming—is scheduled to be occupied September of this year.

In the area of service delivery, we have made significant progress in meeting the priority set by Secretary Principi in improving the timeliness and accuracy of claims processing. Between 2001 and 2003, the average number of claims we completed per month grew by 85 percent, from 227 to 421. Two years ago, the inventory of rating-related compensation and pension claims peaked at over 2500. As of today, we have reduced that backlog of pending claims to just over 1700, a drop of over 32 percent.

In 2002, it took an average of 214 days to process a claim. Today, it takes us about 157 days. We continue to make improvements in this area, and we are on track to reach the Secretary's goal of processing claims within 100 days by the end of September of this year. One of the main reasons we will be able to meet and then sustain this improved timeliness level is that we have reduced the proportion of claims pending over 6 months from 48 percent to just 16 percent during the last three years. At the same time that we are improving timeliness, we will increase the accuracy of our claims processing. We are on track to meet the 2004 performance goal for the national accuracy rate for compensation claims of 90 percent.

Our close relationship with National Service Organizations plays an integral part in our ability to improve benefit services to veterans. We have provided instruction in the Training, Responsibility, Involvement and Preparation Program to accredited veterans service organization representatives who work in the Regional Office building. This TRIP program involves leveraging the expertise of service officers to assist our customers in providing us with more complete evidence for their claims.

To ensure effective coordination of services, the Hartford VA Regional Office and the VA Connecticut Healthcare System have developed case management procedures to provide seriously disabled servicemembers returning from Operation Enduring Freedom and Operation Iraqi Freedom with a seamless transition to veteran status.

We provide personalized service to seriously disabled servicemembers by calling them when they return to Connecticut

for convalescent care or if recently separated from the military to thank them for their service and to remind them of their eligibility for VA health care and other VA benefits.

We conduct demobilization briefings to provide specific information to all servicemembers about VA healthcare and benefit services. To date, we have conducted a dozen demobilization briefings with over 1,000 servicemembers in attendance. We received approximately 125 claims and we have processed 40 of those claims.

Mr. Chairman, during the past three years, the Hartford VA Regional Office has seen significant improved service delivery to Connecticut veterans. The collocation of the Hartford VA Regional Office to the Newington Campus of the VA Medical Center will further enhance and improve our delivery of world class service to deserving Connecticut veterans and their families. Our commitment to work in partnership with the VA Connecticut Healthcare System, the Connecticut State Department of Veterans' Affairs, and the other National Service Organizations will serve as a model approach to effective and efficient improvements in healthcare and benefit services to our veterans.

Mr. Chairman, that concludes my formal remarks, and I would be pleased to answer any of your questions.

[The prepared statement of Mr. Randle appears on p. 57.]

Mr. SIMMONS. Thank you very much, Mr. Randle.

The next witness is Fred Wright, the Associate Chief of Staff for Research, VA Connecticut Veterans Healthcare System.

Dr. Wright.

STATEMENT OF DR. FRED S. WRIGHT

Dr. WRIGHT. Mr. Chairman and members of the subcommittee, I am grateful for the opportunity to testify. I will focus on the importance of research to the VA Connecticut Healthcare System.

Our research program has hundreds of projects led by more than 100 principal investigators, the majority of whom are clinicians who also provide patient care. The research activities of the VA Connecticut Medical Staff range from basic science to clinical research. We are exploring new ideas in animal studies and are testing new treatments in clinical trials. Last year, the competitively awarded funding for all projects exceeded $30 million. Most of this research activity is concentrated at the West Haven campus.

Research is vitally important to our hospital and to our ability to deliver high quality primary and specialty care to veterans. Nearly all members of the VA Connecticut medical staff have dual appointments as both VA physicians and medical school faculty members. In addition to their VA patient care activities, VA Connecticut physicians have responsibilities in teaching and research.

The Research at VA Connecticut is relevant to diseases that affect the veteran population and is aimed at improving the health and health care of veterans. In addition, it is important to recognize that the research program brings outstanding individuals to the medical staff. These are individuals who are committed to academic medicine and who are attracted to work at VA Connecticut by the combination of providing care for veterans, teaching students, and conducting research in an environment that is enhanced by the resources of the nearby medical school. Without a robust re-

search program, we would not be able to recruit the nationally recognized clinician investigators who serve as attending physicians, clinical leaders, and specialist consultants to whom our primary care physicians refer patients.

Of course successful research requires energetic and imaginative researchers. Successful research also requires both funding for project costs and facilities in which to carry out difficult and exacting work. Research funding comes from several sources. Approximately one-third of the direct cost funding for VA Connecticut research comes from the VA research appropriation. Nearly one-half of our funding is provided by grants from the National Institutes of Health, NIH.

We have been able to fund a wide range of VA research projects by competing successfully for funds provided both by VA and, in addition, by initiatives sponsored by NIH and other non-VA agencies. Research facilities are, however, a more difficult problem. In this case, VA Connecticut is in danger of being left behind.

In the non-VA research world of public and private universities and medical schools, facilities for research—whether laboratories, offices, or patient care settings—are maintained, are replaced, or are expanded by a combination of funds from State governments, private philanthropy, and Federal agencies such as the NIH. These sources of funds are not generally available to VA medical centers. Unfortunately, maintenance and improvement of VA research facilities is a currently unmet need. I can cite my own experience at VA Connecticut.

The laboratory facilities of our large research program are mostly located in buildings that were constructed in 1918. More than ten years ago, we recognized the need to replace these laboratories with space that would be structurally sound, adequately ventilated, and supplied with sufficient electricity. We worked with an architect available at that time through the generosity of Yale, and in 1993 completed a preliminary design for a research building to replace our outmoded laboratory. We have, however, not been able to secure the capital funds required to begin this kind of project.

Recently, the Yale Medical School opened a large new research building on its campus. During the ten years it took for Yale to plan and construct this building, our facilities have become ten years older and are even less attractive to the clinician investigators that we must recruit. We believe that replacement of our current well-used research facilities with modern laboratories that are safe, efficient, and conducive to high quality research will make a vital contribution to maintaining the quality of health care that we can provide to veterans in Connecticut and New England. Thank you very much.

[The prepared statement of Dr. Wright appears on p. 63.]

Mr. SIMMONS. Thank you.

Now we will hear from Karin Thompson, Registered Nurse, President of Local 2138 of the American Federation of Government Employees. Welcome.

STATEMENT OF KARIN THOMPSON

Ms. THOMPSON. Good morning, Mr. Chairman, committee members and distinguished guests. Thank you for the invitation to

speak at this oversight hearing before the House Veterans' Affairs Subcommittee on Health. My name is Karin Torson Thompson. I am an Advanced Practice Nurse and Clinical Specialist in clinical psychiatry. I am also President of AFGE Local 2138, the Professional Nurses Union at VA Connecticut. Our union represents all RNs and APRNs who work at the Newington and West Haven VAMC, in addition to all CBOC's, (clinical based outpatient clinics), across the State of Connecticut. I have a Master's Degree in nursing from Yale University, and the focus of my advanced education and nursing practice has been in treating veterans who suffer from Post-Traumatic Stress Disorder with substance dependence.

On behalf of the nurses, I want to thank you for inviting our union to speak at this hearing. As nurses at VA Connecticut, we have a unique vantage point for observing health care as many of us are direct care providers for veterans. Potential improvements to health care services and benefits for veterans are of great interest to our profession.

In the past ten years, many changes have occurred within VA, an adaptation to the multitude of forces which impact on the health care delivery system. The optimization of existing facilities in Connecticut continues to evolve in a manner which facilitates mutually beneficial partnerships in VA, while providing better access for patients. The increased patient access to health care has at the same time impacted facility employees, who strive to maintain the same standards of care given diminishing resources. Nurses who work for VA are proud to be a part of a system which provides care for the unique health care needs of our Nation's heroes. Nurses are first and foremost strong advocates for quality patient care.

VA nurses recognize that we must advocate for systemic change to improve patient safety. Being part of a labor union gives us a voice in our practice and environment. Our concerns stem from the current patient care environment that has become more demanding and evokes additional stress. It is imperative that we provide safe health care for our patients, yet we are often left to work without the resources needed to accomplish our mission as direct care providers.

We talk about the nursing shortage, when there may be just be a shortage of nurses who want to work in traditional nursing roles. The longer the problem continues, the higher the probability we will have a true shortage. In a very short time, many nurses who work for VA will reach retirement age. It is a known fact that VA nurses tend to be older than the national average and VA Connecticut is no exception. A heavier workload will serve only to drive out employees who cannot keep pace with an impossible task. Having worked in the private and state sector, it has been apparent that the VA nurse-to-patient ratio is less than optimal. In addition, VA characteristically has inadequate ancillary staff supports. This places the burden of non-clinical tasks on clinical personnel. Clinicians need to be able to spend time in direct patient care. This practice cannot be continued if we are to provide safe and effective care. It is also not cost-effective.

Research has demonstrated that patient outcomes decline if RN numbers are too low. The risk of patient mortality has been shown

to increase in a linear fashion when this occurs. Mandated minimum staffing levels do not exist in the VA, nor have staffing levels increased. This continues despite a patient population that has become more acutely ill over time. This phenomena occurs due to a number of factors. Patients leave the hospital setting more quickly and return to outpatient. At the same time, the overall number of inpatient beds requiring skilled nursing care has been drastically reduced. The years ago, six inpatient psychiatric units existed at the West Haven campus. Today there is just one. Patients with many different types of acuity levels of psychiatric illness are forced to co-exist on one locked unit. An anxious, hypervigilant patient with PTSD who needs an inpatient bed for safety, will be placed in an environment with psychotic and demented patients of all ages. Some of these patients can become violent. From a therapeutic aspect of treating trauma, this is not good care. Our combat veterans needing this treatment deserve better.

While waiting for an inpatient psych bed, patients are kept in the Psychiatric Emergency Room. The unit was designed for six patients, yet it now has ten beds and only one bathroom. To complicate the situation, the census frequently goes to 17, and patients have to attempt to sleep in chairs due to a lack of beds. In a short period of time, the length of an evaluation stay in the Psych ER has increased from 18 to 32 hours. It is unconscionable that we cannot provide a veteran in crisis a bed, much less state-of-the-art care. Staff levels in that area cannot always flex in response to changes in census and acuity. One unplanned absence may result in serious short staffing, for whom the only relief is a fatigued nurse on overtime. Research has also demonstrated the negative influence of fatigue on a nurse's ability to provide good patient care after 12 hours on duty. Overtime is not a viable long-term solution to a predictable ongoing problem. Short-term solutions should not be employed in the absence of a coherent, comprehensive long-term plan to address staffing problems.

The logjam in the Psych ER is a result of too few inpatient psychiatric beds, including skilled nursing beds for detoxification from substances. The locked inpatient psychiatric unit at West Haven must also service all veterans from Newington and the CBOCs. To cope with the backup of patients in the Psych ER, the patients may be boarded overnight in the Medical Emergency Room. This area is not equipped to handle psychiatric patients who may be a danger to themselves or others. There are hazards in the environment and the nurses on duty may not have the specialty training that is required for appropriate care. Restraints may be used in the absence of staff available to provide 1-to-1 monitoring. In addition, patients from inpatient medical units may be boarded in the same medical ER, due to a lack of beds on the wards.

On general medical/surgical units at the West Haven campus, the RN-to-patient ratio is also not sufficient to provide a high level of care.

Mr. SIMMONS. Ms. Thompson, due to the time limit—we have the full statement which will be part of the record. If you could summarize, then I would like to begin asking questions about your testimony.

Ms. THOMPSON. Okay. I would like to focus heavily on the nurse-to-patient ratio. The research basically shows that you require one RN for every four general med/surg patients, and at West Haven, on the inpatient med/surg unit, the ratios are 1-to-10 on day and evening shifts, and 1-to-15 on a night shift, which is widely disparate from what would be considered minimum standards.

I would also like to just briefly address the outpatient setting where the patient caseload has risen dramatically in the past 4 or 5 years, with nurse practitioners and clinical specialists caseloads going up in primary care from 560 to 850. AT the same time, these clinicians are also forced to take on a variety of clerical tasks and data entry to the point where clinical people are complaining that they have to spend approximately two-thirds of their day in non-direct patient care activity.

Those are the most important things.

Mr. SIMMONS. What I will do is I will ask unanimous consent that the full statement be inserted into the record as if read.

[The prepared of Ms. Thompson appears on p. 66.]

Mr. SIMMONS. What I would like to do is begin some questions.

Ms. THOMPSON. Okay. Can I say just one more thing?

Mr. SIMMONS. Of course.

Ms. THOMPSON. I would like people to know that there are statutes that exist that preclude labor from having any real involvement or participation in patient care, discussion of patient care. There is a statute that affects Title 38 employee nurses. And because this statute, 7422, precludes our involvement, people are often in a position—and the proverbial charge is the employee cannot do so, we are blocked from doing so, and we would like your support.

Mr. SIMMONS. Thank you very much for that testimony. It is customary now to go to questions. I have several. I will then defer to my colleague, Mr. Rodriguez, to Mr. Shays, and to Mr. Ginsberg, if he has questions.

Why don't we start with the issue of Title 38. It is my understanding from the testimony that we just heard, the Title 38 law blocks our ability to raise the issues nurses care about most, that apparently they are restricted in having a collaborative role in dealing with management on some of the issues that concern them most specifically, ratios and staffing. And I would ask Dr. Post or Mr. Johnson if they have any thoughts or comments on that subject.

Mr. JOHNSON. I am going off of what I believe is the center of this question, which I think is that the statute does prohibit negotiation over staffing levels, but that does not mean that we do not work with the unions to talk about those issues. We have a partnership council. We meet on an ongoing basis with the unions. We discuss a variety of issues. It is just one of those issues that is not an issue that you can invoke formal binding arbitration in those kinds of processes.

In terms of the overall issue, I personally share the concern. I think we have seen about a 40 percent increase in the number of patients treated since 2001, and I think all the staff have been stressed to a significant degree, including the nursing staff. So, we

understand that issue, but we also have a responsibility to take care of our veterans, so we have to continue to try to do that.

Mr. SIMMONS. Dr. Post, any comments?

Dr. CHIRICO-POST. I don't know how much I could add to what Mr. Johnson has already said. Not only is this issue discussed at the Network level in our Labor Department Council and through our Executive Leadership Board, but as Roger has just said, our role is to primarily provide the care to the veterans and, as best we can, we meet that.

Mr. SIMMONS. Thank you. I will just make a brief comment. It has been said that the doctors treat the disease or the injury, the nurses treat the patient, and I believe that. I think that a good functioning relationship between a capable nurse and a patient is tremendously important. And when there are shortages, when nurses get tired, when their shifts get longer and longer, that does have an impact, a negative impact, on overall patient care. This is a serious issue that the subcommittee has taken up at the national level. We are trying to find ways to facilitate VA attracting more nurses into the system. We are addressing the issue of whether they should have a Bachelor's Degree as opposed to an Associate's Degree, and I personally believe that the VA needs to be more flexible in how it attracts and rewards the nursing staff.

But that being said, I would like to ask a second question. Mr. Randle has focused quite a bit on the merger or the consolidation by bringing the Benefits Section from Hartford down here to Newington, on two floors of this facility—new floors, new construction, new equipment, new spaces for our benefits folks, and tremendous advantages to the veterans who come here. They can park for free. It is easy to find. We are centrally located in the State, nor in the North Central portion. No problems for Mr. Larson because it is still in his district, we tried to accommodate him on that.

(Laughter.)

Mr. SIMMONS. We actually took Newington out of Nancy Johnson's district so there wouldn't be any problem there. But Mr. Shays raised an important point. As we here in Connecticut are working hard on what we call "The Connecticut Model" to maximize services to the veterans and to create efficiencies and to save money, then the question is, are these savings going to come back to us, or are they going to go to Massachusetts or Rhode Island or Maine or some other place—and the red light just went on, so I will shut up. Maybe Dr. Post would like to answer that larger question.

Dr. CHIRICO-POST. Let me say that from a research point of view, when we became Network in 1995 until around 2000, the purchasing power of the VA New England had decreased by over 25 percent. The VERA methodology that Congressman Shays alluded to did not initially provide adequate resources for the Network. And when I became Network Director in 2000, 2001 and 2002, VA provided a supplement to this Network to provide the basic care for the increasing numbers of veterans who were coming to us.

Every change that has happened in the VERA allocation methodology has been a positive impact on VA New England, such that geographic change, labor adjustment, high costs, the change from VERA 3 to VERA 10, resulted so much so in the last year that Network 1 received the third largest increase of all the Networks

across the country. And we, in the last 2 years, have been able to meet our budget, and it has not only been because of the increasing resources that we received from VERA, but by the efficiencies that we have identified as an organization to do what is right.

The allocation that happened through VERA into the Networks and has been distributed primarily from a workload point of view to the facilities. It is not the Network's intention to take any of the efficiencies garnered out of the Connecticut Health Care System and funnel those resources up to Boston. That has never been our position.

I would like to add that with Mr. Johnson's leadership, we have been able to garner even more out of VERA because he chairs the subcommittee for us in the Network.

Mr. SIMMONS. Thank you for that response. My time is up. I would like to defer now to my colleague, Mr. Rodriguez. And coming from Texas, he took a deep breath when he heard that Connecticut veterans have a facility within 30 miles of where they live.

(Laughter.)

Mr. SIMMONS. He is lucky if they have a facility within 300 miles of where they live. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman. Let me just add a couple of comments. I know Dr. Wright had talked about research, and I know that there are some recommendations. The Administration's budget cuts about $50 million, at least in recommendations. I was just wondering what type of an impact that would do. And you mentioned that the VA is about one-third of the research there, and I am sure that is used also to leverage the rest, or some of the other, and how important that is.

Dr. WRIGHT. Very much so. The National VA Research Program, in relation to national research, is very small. It is about $400 million this year. And our share of that is, in active research projects, as I said, is about $10 million here in Connecticut.

This $400 million covers all of the costs that VA can provide for its research program, which includes projects, some administrative costs, and some facilities and infrastructure, but all are quite small.

The NIH program is billions of dollars, and so I think the VA Research Program should not really be expected or thought of as in direct competition with NIH or the source of all of the answers for the problems of health and health care. It does contribute answers, and it has contributed new ideas and new treatment, but I think equally important is that another purpose of the VA Research Program with this small core funding is to support the medical staff of clinician investigators who are recruited to serve in and be based at VA medical centers, most of whom also have dual appointments at medical schools and academic responsibility.

Having this core of VA funding—in our case, about a third of our research costs—is really vitally important to recruiting those people for the medical staff. And in that way, I think, does more for patient care than the discoveries that will come inevitably from research in usually a somewhat unexpected way.

Mr. RODRIGUEZ. Let me also just inquire—I know you mentioned Post-Traumatic Stress Disorders that you work with. I just wanted to get some feedback as to how—and that includes Ms. Thompson

and anyone else who wants to make any comments in that area—how do we initiate that a little sooner, because I know that one of the symptoms is denial initially, and not coming to the system or not recognizing the problem as quickly as we can, or we should, and I was wondering how we might be able to expedite that, or what you are doing now to make that happen.

Mr. JOHNSON. I can tell you in terms of the initial group of returning troops, that about 8 percent of those were seeking PTSD care, and that is one of the issues that we are pushing when Michelle goes out and talks to the returning troops, that we are there for them. We have actually worked with the Department of Mental Health at Yale and have actually worked with some of the units to help work with the families, even while the troops are still over there. We had to find some cover for some of that, so we had to work through the Department, but through that we are actually working with some of the children and the spouses who are themselves going through a very difficult time that they are making adjustments to the initial deployment, and then the subsequent postponements—you know, "You said Daddy was going to come back", and all of a sudden Daddy is not back—and it has been difficult. So, we have been trying to reach out with them.

Dr. CHIRICO-POST. If I could answer that, a comment about the Network initiative and the understanding that it doesn't necessarily happen on Day One, and that there is a unified attack, if you would, in how we would manage folks like that with their specific questions.

If I could go back to the question that you asked Dr. Wright about research for a minute, I'm very proud in New England that the total VA allocation from a research point of view, Network 1 receives the largest share of VA dollars in research. That enables us, I think, to have a synergy throughout the Network where there are research endeavors that go on here in Connecticut that there is sharing of opportunity in other parts of the Network as well.

Mr. SIMMONS. Thank you very much. My colleague, Mr. Shays.

Mr. SHAYS. Thank you very much, Mr. Chairman. I first want to express gratitude to all of you who serve our country in the capacity that you serve, and then I want to ask some questions that may seem a little less friendly.

I am deeply distressed by the fact that in Connecticut we have basically two facilities, one here that was asked to really tighten and one major facility in New haven. I was glad you were away so you didn't hear my——

(Laughter.)

Mr. RANDLE. You have 4 minutes left.

Mr. SHAYS. The Boston area was given an additional study that the Secretary's decision seems to emphasize Boston's priorities over West Haven's needs. You have one inpatient VA hospital, Boston has four. Our hospital dates to 1950, Boston's Jamaica Plain to the 1980s, yet the Secretary seems more focused on Boston than West Haven, and I want to just ask—I would love to ask you, Madam Director, how should I feel comfortable by the fact that in Connecticut we are doing our job, in Boston they keep delaying tough decisions. In Connecticut we have one major hospital for a population of 3 million, in Boston they have four with a population of

5 million. It just doesn't add up, and it is making me feel very concerned that we are not addressing the problem.

Dr. CHIRICO-POST. I will counter that. I think that—and I can't speak for the Secretary's decisionmaking in the way he approached what we did in our recommendations to the Network. I can only tell you that based on the demographic information that we had, we knew that we needed to expand inpatient facilities here in Connecticut. That is a definite for us. That was not hidden in any way in what was the recommendation to meet inpatient medicine.

The difficult decision about Boston predated me as the Network Director by just a couple of years, but a decision was made to take two tertiary care facilities located five miles apart and combine them into one. That has taken several years. It continues in a very positive direction. We share medical staff. We share residents. We have a dual affiliation with a university and it has been very positive.

In addressing the issue of the Boston Health Care System and its relationship with the rest of the Network, because in VA New England, we have two tertiary care sites, one in West Haven and one in the Boston Health Care System. What would we need to do to take the four sites, which include Bedford, Jamaica Plain, West Roxbury, and Brockton, into a single location. It really does require an in-depth analysis in terms of where we could put it, its relationship to the school, where you could put it in relationship to transportation——

Mr. SHAYS. Let me just interrupt you because I think we can consume all of my time here. I just want to say to you publicly in this hearing that I think it is inexcusable—and I realize that is your assignment there—but with all due respect, people from Fairfield County go to West Haven. People from New London may go to West Haven, and people from Hartford may go to West Haven, and yet we have four hospitals in a very concentrated area. And so I just feel what we should probably do is move some of our people who have made tough decisions up there, and then we will all benefit because we will end up with more resources down here. We are having to see too many of our resources go and be used inefficiently. And one of the things that concerns me is West Haven is No. 40 on the VA CARES list, not likely to be funded for years. And we have the best research folks in the country at Yale. And I am astounded that this would be the case. What do we do to get that 40 moved up?

Dr. CHIRICO-POST (continuing). Can do locally to change that——

Mr. SHAYS. I chair the National Security Subcommittee. I oversee the Department of Veterans' Affairs, not for appropriations, not for loss, but for hearings, for programs, to see whether they are run efficiently. If you would give me some advice on what kind of hearing I could have to encourage the VA to reprioritize this list, I look forward to talking to you in private about that. And let me apologize for not yet coming up to visit with you and interact with you on a more personal way.

I want to again thank all of you and just say to our nurse—to eke out another 3 minutes—that nurses have nurses have a way of learning how to deal with sometimes an unfriendly environment

and get the job done, and you got the job done, and that is one reason why we didn't feel we had to ask you as many questions.

(Applause.)

Mr. SIMMONS. Thank you, Chairman Shays, for your pointed questions. Just as a point of interest, on the ranking of 40th, the cutoff was 28 or 29, and a substantial amount of work was done to move the West Haven project up. There was a curious relationship between the ranking and those States with large numbers of electoral votes, but I won't pursue that at all. I will just simply say that I noticed that, and that my expectation is that sometime after November perhaps we can be revisiting these issues. But that being said, I will now defer to——

Mr. SHAYS. Instead of speaking to Madam Director, I should speak to——

(Laughter.)

Mr. SIMMONS. We are all in this together for the right outcome, I believe. But, anyway, Mr. Ginsberg.

Mr. GINSBERG. Thank you, Mr. Chairman. Just one quick question to Mr. Johnson. In the past, the transportation access has been an issue here for veterans in terms of going to West Haven as well as Newington. You expressed some statement about there was a shuttle. If you could just tell me the frequency and your evaluation of its success to date.

Mr. JOHNSON. I'm saying this off of memory, but I think the shuttle is about six times each way, each day. We have a problem that we had 15-passenger vans and we could not use those as 15-passenger vans. We have actually purchased, but not yet received, 17-passenger minibuses to expand the capacity because we have run out of room on those shuttles. and I am pleased to say that we have started—are starting in about a week, a shuttle to the New London Clinic that is going to go back and forth initially twice a day, so that a patient can be picked up in the New London area and brought over. And we have plans to hopefully try to expand that out to our CBOCs, if it proves successful in New London.

Mr. GINSBERG. Is there a sense of evaluation being taken—in other words, a set time when you were going to evaluate the success of the program for changes, or input into additional routes or different times?

Mr. JOHNSON. I think we need to get about 6 months under our belt in terms of the New London shuttle, to look at the volume, to look at its usage. I am hoping that it will prove successful. That is our largest CBOC, with 4,000 veterans. If that volume demonstrates it, then we can look at our other CBOCs, which have about 1200.

Mr. GINSBERG. Thank you.

Mr. SIMMONS. I want to thank our first panel for their testimony. I have not fulfilled my obligation, Mr. Chairman, we have run over about half an hour, but I think it has been very productive to have the testimony and have the questions that have been asked.

Thank you all very much.

Mr. SIMMONS. We will begin to move to Panel 2. On Panel 2, we will have Colonel William Sobota, Director of Manpower and Personnel for the Connecticut Army National Guard. He will be joined by Captain J.A. Bashford, Deputy, Naval Health Care New Eng-

land, at the Naval Ambulatory Care Center in the Groton-New London Submarine Base. Gentlemen, come forward.

We also have Mr. Rick Sapp, Legal Instruments Examiner, Department of Veterans' Affairs, For Drum, New York. I met him during a recent visit to Fort Drum when the 1109 AFCRAD from Groton-New London came back from a year of service in Kuwait and Iraq, and he has done a great job working with returning members of the Guard.

Also, Mrs. Michelle Will, Enrollment Coordinator for the VA Connecticut Healthcare System, and I have taken the liberty, as the Chairman, to add Commissioner Linda Schwartz to the panel, to make some brief and perhaps unprepared comments for the record, but knowing Linda Schwartz, she does not need a lot of time to get ready to talk about how her organization is intersecting.

I will remind the members again of the 5-minute rule. We have your full testimony in the record, except for Dr. Schwartz, and so in the interest of timeliness, if you could summarize your main points for the panel, that would be very helpful. And why don't we begin now with Colonel Sobota. Welcome.

STATEMENT OF COLONEL WILLIAM SOBOTA, DIRECTOR OF MANPOWER AND PERSONNEL, CONNECTICUT ARMY NATIONAL GUARD; ACCOMPANIED BY CAPTAIN J.A. BASHFORD, DEPUTY COMMANDER, NAVAL HEALTH CARE NEW ENGLAND, NAVAL AMBULATORY CARE CENTER, GROTON, CT; MR. RICK SAPP, LEGAL INSTRUMENTS EXAMINER, DEPARTMENT OF VETERANS AFFAIRS, FORT DRUM, NEW YORK; MRS. MICHELLE WILL, ENROLLMENT COORDINATOR, VA CONNECTICUT HEALTHCARE SYSTEM; AND LINDA SCHWARTZ, CONNECTICUT DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF COLONEL WILLIAM SOBOTA

Colonel SOBOTA. Mr. Chairman, members of the subcommittee, and distinguished guests, I want to thank you for the opportunity to speak before you this morning on veterans health issues. I am Colonel William Sobota, Director of Manpower and Personnel of the Connecticut National Guard.

Just in the way of a little bit of background, the Manpower and Personnel Directorate provides a full range of personnel services to Connecticut National Guard members. It is comprised of many areas which interface with veterans issues in educational services, personnel transactions and records management, personnel policy, military funeral honors in casualty operations, family programs and health services. The Directorate also has staff oversight of recruiting and retention, and the Chaplain services.

Shortly after 9/11, our primary mission has been personnel support for the mobilization and demobilization of approximately 2,000 soldiers and airmen and their families. Operations Noble Eagle, Enduring Freedom, and Iraqi Freedom, along with support to SFOR in Bosnia and other contingency operations, has the potential to produce more Connecticut National Guard veterans than any era since World War II.

I would like to use this opportunity to highlight the key points of the written testimony that I have provided. First, the Con-

necticut National Guard enjoys an excellent working relationship with the Veterans' Administration representatives in Connecticut. They have been invaluable in providing services to our Guard members. Mr. Johnson, Mr. Lankford, Mr. Farrington, Mrs. Will, a special note for all their effort.

Second, the VA and TRICARE are linked in providing health care to our veterans, and I would like to underscore the importance of the VA Hospitals being TRICARE Network providers. This allows our ill or injured soldiers returning to Connecticut to enter the VA system prior to release from active duty. This results in the elimination of an intermediate health care provider, better continuity of care, stabilization of treatment, and less stress on the soldier and his family.

Along those lines, I would also like to point out the lack of TRICARE providers in Tolland and Litchfield Counties, and I have provided some ratios here in relation to the population of Guard members. Better distribution of providers relieves the stress on the VA and the military treatment facilities at the Navy Submarine Base at Groton, and also at West Point. Also, readily available health care benefits our soldiers.

I would also ask for your support to make extended TRICARE benefits permanent, specifically the availability of medical and dental care prior to mobilization and upon alert, for soldiers and families.

Typically, 20 to 25 percent of alerted soldiers do not meet deployment dental standards and must be brought to standard in a very short time in some cases, prior to reporting to the mobilization station. Although medical problems are fewer, there still are a significant distraction in the mobilization process.

The extension of the TAMP benefits to 180 days is very important to us, and allows additional time for the soldier and his family to become re-established in the post mobilization health care system.

TRICARE Select, which provides health care to the unemployed or uninsured, will benefit family health care and mobilization readiness for those soldiers who do not have access to health insurance.

A healthy soldier results in a potentially healthier veteran. Soldier health care not only increases personal readiness for mobilization, but also addresses the needs of soldiers' families which has also been our priority. The long-term collateral effect is the retainability of a ready and experienced force.

We extend our appreciation to the VA system for services they provide to our soldiers. It is also important to mention that the Navy Submarine Base at Groton has been also invaluable in providing medical and dental services to support our mobilization and demobilization process.

Since I have a couple minutes left, I would just like to underscore something that Mr. Johnson said in response to the PTSD question. We also reach very far forward and try to engage health problems as soon as we can during the mobilization process, even to the extent where we monitor a soldier's health while he is in-theater on active duty, so that we can better prepare ourselves to bring him back into the National Guard system. We have the capability to track an injured or an ill soldier through to Walter Reed,

and then upon demobilization, along with the VA, we reach out to the demob station. We have teams—not only medical, but also administrative and logistics teams that go forward to start to begin the demobilization process.

I think it is also, along with lines important to mention that we not only focus on the soldier, but we take a little more holistic approach in that we also look at the effect that the Guardsman has when he re-enters the community because the majority of our force is a part-time force. So, we look at how health care affects the soldier, how it affects his family, how it affects his job, his relationship to his employer, and since a good percentage of our Guardsmen are students, we try to give him the best care and the most readily available care so it doesn't impact on his education.

Again, thank you for the opportunity to speak to you this morning. This concludes my comments, and I will be happy to answer any of your questions.

[The prepared statement of Colonel Sobota appears on p. 71.]

Mr. SIMMONS. Thank you, Colonel, very much. Captain Jeffrey Bashford, Deputy Commander, Naval Ambulatory Care Center Groton. Welcome.

STATEMENT OF CAPTAIN J.A. BASHFORD

Captain BASHFORD. Mr. Chairman, other committee members, thank you for this opportunity to appear before the committee to provide an overview of Navy Medicine's collaborative efforts with the Veterans' Affairs Health System to provide health care for Connecticut veterans.

I am the Deputy for the Naval Ambulatory Care Center, Groton, CT, one of five ambulatory care centers that make up the Naval Health Care New England command. Our other facilities are located in Newport, Rhode Island, Portsmouth, New Hampshire, Brunswick, Maine, and Ballston Spa, New York. We provide a comprehensive array of medical, surgical, pediatric and mental health ambulatory care services, including pharmacy, laboratory and radiology to Department of Defense Military Health System eligible beneficiaries.

Additionally, we provide limited inpatient care services through External Resource Sharing agreements with two local civilian hospitals in the Groton area, Lawrence & Memorial and William W. Backus Hospitals. These services are available to Department of Defense Military Health System eligible beneficiaries from across the State of Connecticut. Patients that require additional services not available in our direct care system are referred to a network of local civilian providers under a managed care support contract administered by the TRICARE Management Activity. DOD MHS eligible beneficiaries may receive inpatient care at the West Haven Veterans' Affairs Medical Center under the TRICARE contract. However, due to the distance and drive time from the Groton area most of these beneficiaries do not elect to use this arrangement.

Service members separating or retiring from active duty in the Groton area complete a separation physical examination at the Naval Ambulatory Care Center, Groton, and are screened for disability and potential veterans' health care system benefits in collaboration with the Veterans' Affairs Office on Submarine Base

New London. The servicemember is provided a copy of his military health record, and is referred for further evaluation as necessary to the Community Based Outpatient Clinic at the Coast Guard Academy in New London.

Finally, Naval Health Care New England recently signed an agreement to expand to all our facilities, a pre-existing agreement with the Naval Ambulatory Care Clinic, Newport, to utilize Veteran Integrated Service Network One laboratories as reference laboratories for clinical laboratory services not available within our direct care system. This cost-effective and mutually beneficial measure will allow needed consolidation and centralization of laboratory services throughout Naval Health Care New England in times of reduced staffing. Additionally, VISN One staff have been instrumental in assisting us with meeting accreditation standards throughout all our laboratories through "mock" inspections. As a consequence, we have had unparalleled success in meeting College of American Pathologists Laboratory certification, with all Naval Health Care New England laboratories fully accredited "with distinction".

This concludes my prepared statement. I would be happy to answer any questions from the committee, and I hope to keep you on time a little bit more with this brief statement.

[The prepared statement of Captain Bashford appears on p. 80.]

Mr. SIMMONS. That has been very helpful and we appreciate that very much, and you get an additional ribbon for timeliness.

(Laughter.)

Mr. SIMMONS. Next is Richard Sapp, who is the Military Services Coordinator, Fort Drum, New York, and people might ask "why New York", and that is because returning Guard units go to Fort Drum. I had the opportunity to meet Rick a few months ago when the 1109th came back. He was short of some supplies from the VA. I got on my cell phone, called a certain Secretary Principi, and I believe you got those supplies, is that correct?

Mr. SAPP. Yes, sir, and then some.

Mr. SIMMONS. And then some. In other words, you were bombed with——

Mr. SAPP. We had to find a new storage facility.

Mr. SIMMONS. You got it. Welcome, good to have you here.

STATEMENT OF MR. RICHARD A. SAPP, JR.

Mr. SAPP. Thank you, sir. Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss how the Department of Veterans' Affairs at Fort Drum assists the Connecticut National Guard and other troops during the demobilization process.

The Buffalo Regional Office currently have three Veterans Benefits Administration employees assigned to the Benefits Delivery at Discharge Program at Fort Drum. The goal of the Benefits Delivery at Discharge Program is to provide benefits information and services to all separating servicemembers.

During the next several months, separations at Fort Drum are expected to increase with a total of 2,245 demobilizations expected this month, 649 demobilizations expected in July, and 453 demobilizations expected in September 2004. The Fort Drum team's re-

sponsibility is to provide information regarding VA benefits and services to all separating servicemembers and assist these servicemembers in obtaining benefits for which they are eligible prior to returning home.

In addition, we provide all separating servicemembers with information about medical care, disability claims processing, education benefits, the home loan guaranty program, the importance of obtaining a physical before discharge from active duty, and the importance of obtaining associated documentation. We also provide general information regarding benefits available at the State and county level and the points of contact for these types of benefits. We make ourselves available to answer questions on an individual basis before the unit departs Fort Drum and returns to their home stations.

Mr. Chairman, we at Fort Drum take great pride in the services we provide for demobilizing soldiers. Showing that the VA is available to support them is essential for the servicemember to make the transition into civilian life and increases the likelihood of a successful adjustment. The service that we provide is an essential part of the transition process for that servicemember and the military unit.

That concludes my formal remarks. I would be pleased to answer any questions.

[The prepared statement of Mr. Sapp appears on p. 83.]

Mr. SIMMONS. Thank you very much. We are on a roll. Ms. Michelle Will, Enrollment Coordinator, VA Connecticut Healthcare System. Welcome.

STATEMENT OF MICHELLE WILL

Mrs. WILL. Thank you very much. I am here today as an accompanying witness for the VA and available here for questions and answers. I won't be giving testimony at this time. Thank you.

Mr. SIMMONS. Thank you very much. And now Dr. Linda Schwartz, Commissioner at the Connecticut Department of Veterans' Affairs. Welcome, Linda. How do you fit into the VA puzzle?

STATEMENT OF LINDA SCHWARTZ

Dr. SCHWARTZ. Well, thank you very much for inviting me to the table this morning, and thank you very much for your leadership and the leadership of Congressman Rodriguez. I think that the way that Rocky Hill fits into—is connected to Department of Veterans' Affairs is that, first of all, at Rocky Hill I have 584 veterans today. They range in age from 101 to 24. I have a chronic disease component to our healthcare facility. We recently dropped the name "hospital" because we were the only State in the Union that had a hospital and we really didn't do hospital work.

I think, by consensus, Mr. Roger Johnson and I came to the table with the idea in mind of what we wanted to create here is a seamless continuum of care for Connecticut veterans, that we would not duplicate, but that we would share resources and have a continuous dialogue to assure that the veterans receive what they need. To that end, dropping the name "hospital" from Rocky Hill's title, we were able to qualify for almost $28 million in Federal funds to

assist us in our renovation and new construction, to be matched by $14 million from the State of Connecticut.

Rocky Hill was built in the late 1930s and has its original wiring and, therefore, it does not have air conditioning, does not have—we have the original Otis Elevators, and we really don't have the ADA compliant facility. Additionally, we have about 320 homeless veterans, some of them Rocky Hill is going to be their home forever, but for others, the younger ones, they have an opportunity to re-enter the community and to have a life.

Also, one of the things that we do at Rocky Hill, we have a substance abuse treatment program which is 6 months long, and one of the nice things about having something that is that long in length—and we also give the opportunity for veterans, when they have completed the program, to stay with us until they are able to get a job, that they are able to save some money so that when they go out in the community, they will succeed. Our success rate—and this has been in existence since 1994—is 80 percent. We have an 80 percent rate of no-return, which is what you want.

This year—and I have just finished my first year as the Commissioner of Veterans' Affairs, and I feel blessed because of some of the people in this room, about how the VA works, and we have been able to work to dovetail much of what we can offer veterans at Rocky Hill. For example, we have a contract with the prior hospital to care for our veterans. Because we have been looked at, did a needs test—Michelle helped us with this—we went to all the veterans that we had at Rocky Hill to see who was eligible and who actually did have a VA health care card. It was amazing that most of them, or the majority of them were not only eligible, they already had been using the VA.

So we have a clinic on-site. We have physicians on-site for our chronic disease and mostly bed-bound veterans. So, Mr. Johnson and I decided to look at just doing a pilot project with the ambulatory veterans who could come in and access care through the VA here at Newington, and with the help of Mr. Ed Kovolinski, we have been able to do that.

We also are using readjustment counseling. We have four sessions a week that is provided by the center on grounds at Rocky Hill. I don't know if Dr. Wright knows this, but I have already been contacted by some of his researchers because I am a doctorally prepared epidemiologist. We are looking to do some joint research with VA at Jamaica. Also, Mr. Rick Randle read about our women veterans in the paper and called me up to say he wanted to cut down on his staff to assist our women veterans who had had problems with sexual trauma while they were in the military.

So, as you can see, what we are trying to do here is, by talking to each other, by listening and watching the press, looking for the No. 1 reason that we exist and why we are in this room, and that is veterans. I can't tell you really if it—it does have its problems. Transportation is a problem. We have been working with Roger Johnson, and we will be interfacing with his shuttle, Rocky Hill will be using some of those circuits so that we will have better transportation for our veterans.

We have a contract to bring two Advanced Practice Nurses to Rocky Hill. We are contracting with VA Connecticut.

Mr. SIMMONS. Thank you for that excellent testimony. We will now go to questions, and I would like to yield my time to my colleague, Mr. Shays, who has to leave——

Mr. SHAYS. I can wait because I have enough time.

Mr. SIMMONS. Are you sure?

Mr. SHAYS. Yes.

Mr. SIMMONS. Well, in that case, I will ask my questions. First and foremost, I would like to state briefly that as a Vietnam veteran, the process of returning home was probably one of the more traumatic events in my life. It was not just——

Mr. SHAYS. For your wife.

(Laughter.)

Mr. SIMMONS. For my family as well, probably—but I think we all know that times were different then. But as a consequence of that experience that I had, I have always felt that it is critically important that we, first of all, welcome our soldiers home from their service but, secondly, that we be aggressive in making sure that they are demobilized in a positive and comprehensive way. In my experience, as soon as I got to Oaklin Army Base, it was like, you know, I just want to get the heck out of here. They threw some civilian clothes on us and off we went. And it was years later that I actually discovered that I had some benefits under VA, et cetera, et cetera.

And I would simply like to ask the panelists, in particular Colonel Sobota, but also Rick, we have a new model, and the new model is that we reach out and we are aggressive. It is like Rick Randle said, he actually calls people on the phone and says, "You may be eligible for benefits, why don't you come on in". How is this proactive model working? Do you feel that it is being successful and, if there are problems with it, what are those problems and how can we help?

Colonel SOBOTA. Congressman, yes, I think it is successful. The ability for the various providers to be able to engage far forward, No. 1, gets the word out to the soldiers, gets them into the correct systems, and also sends a message that we are paying attention to them, and we do display this caring attitude.

Also, there is a redundancy in the way that we go forward. Fort Drum has a very comprehensive program providing benefit information, but as you mentioned, soldiers still want to get the heck out of there. So, within 72 hours after they return to the State of Connecticut, we then have our State demobilization process, which really is a Federal but localizes the process a little bit more so that the soldier has a name and a phone number in Connecticut of a provider that he can call.

We also have a very active family support program in Connecticut, that is very closely tied. Yes, we have the first mobilization screening process at the—as part of the mobilization, but also we are in touch with the families, and we get all our information on health issues through that venue also. So, yes, I think it is working very well. I think all the agencies working together, the proactive approach is very effective. The link between TRICARE and VA is very effective, as I mentioned previously. Other than that, I cannot think of any difficulty that I am aware of. Thank you.

Mr. SAPP. Mr. Chairman, I, too, think the process at Fort Drum especially is successful, with the possible exception of talking with the returning soldiers after they have been home for a while, after they have something else on their mind other than getting home, getting out, and doing those things. I mean, that is most important to them at that point.

I feel strongly that we beef them up with the information they need before they leave, but I also worry that that information falls on deaf ears because of all the other things they have on their mind.

Mr. SIMMONS. Commissioner Schwartz.

Dr. SCHWARTZ. I have been to Fort Drum, and I have attended as many of the homecomings here in the State of Connecticut as I possibly can, and I still remember at 7:00 o'clock in the morning when nobody wants to hear anything, and I say, "If you don't really hear anything else about what I have done here today, don't throw this away". But there is concern. Let me just say, since we have a committee meeting here, there is a concern that many of the people are wanting to just get out, leave the demobilization center. I will give you an example from our own backyard in Groton when I met with a returning aviation battalion at Groton. And I remember one there who had been injured not enough— he had a smashed jaw, needed dental work. They gave him an opportunity—"You can stay at Fort Drum for 3 months or you can go home, what are you going to choose?" He's going home. Second of all, they gave him a piece of paper that said VA consult, didn't tell him where to go. He said they told him to return this and get my teeth fixed. He said, "I don't think so". So you know what he did? He was still on active duty. They fixed his teeth.

Mr. SIMMONS. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman. Let me also follow up on the same question. Let me ask you, what is your staffing there? Are you going to handle 2,000 per month in the next 2 months? What is the staffing that you have?

Mr. SAPP. Well, we have actually three veterans benefit counselors at Fort Drum. One now is deployed to Germany.

Mr. RODRIGUEZ. This is the buckshot type of thing that occurs. How long do you have them?

Mr. SAPP. We meet with the troops that are demobilizing for about an hour, which is not nearly the time that we would like to have, but in conjunction with everything else that goes on, it is adequate.

Mr. RODRIGUEZ. We had gotten some testimony back home about the need to maybe have—and I can understand that anytime somebody is coming—you want to go home, you don't want to be listening to that kind of stuff—but maybe some way later on or to follow up back home in some way, because I know they had recommended a need to follow up after 40 days—I think the G.I. Forum had made some recommendations in those areas. A three-member staff is not sufficient to pull that off.

I was also going to ask in reference to additional legislation on Project 112, or SHAD (phonetic), on those individuals in the 1960s and 1970s that we have identified some 5,000 to 6,000 mainly Navy individuals that went through those tests. I was just won-

dering for the State of Connecticut, if we have identified any, or if anybody has any data on that?

Mrs. WILL. We do have a SHAD compensation in our VA Health Care System, and we are aware of that, approximately 5,000 letters did go out to the participants in the SHAD project. I think we have had one inquiry based on those letters in the VA Connecticut Health Care System, that I am aware of.

Dr. SCHWARTZ. I am aware that Congressman Shays had some hearings last week on the entire, and I would like to just echo something for all of you. From my vantage point, having been very intimately involved with—and Agent Orange is the focus of my research. The most important thing the VA has to do is keep track of what people are reporting and tracking where and when, because you will have exposures that you will never know what it was. But the commonality of diseases that are reported in an area will tell you a lot more than trying to figure out what was it that caused it. And so I was listening and I know that was suggested.

VA has a lot of history, but they don't use it the same way we do because they didn't advise people of that history. When we had a tumor, we documented everything—where did they go, what kind of tumor was this. And when we had, for example, Agent Orange, they would take down the name of the person and did they serve in Vietnam. These are very basic elementary things and it could really help on some of the long-term for our troops returning from Iraq and Afghanistan where they were exposed to things they don't even know.

Mr. RODRIGUEZ. And I agree with you totally because I know we are concerned after looking at some of those projects and some of those tests that we did on ships. I would presume that even after those soldiers were gone, those ships were still to some degree contaminated, and we continued to allow troops to go in there. Thank you very much.

Mr. SIMMONS. Thank you. Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman. I would just say to Mr. Sapp that I have not had a second hearing in New York. The first hearing I had there were about 300 people, and it involved the closing of a facility. And I thought it was going pretty well until—there were about 300 people—and a police officer came up to me and said, "Mr. Shays, if you have to go out the back door, we can show you where it is". There was a near riot in New York. This is a much calmer hearing, Mr. Chairman, I want to thank you for that.

(Laughter.)

Mr. SHAYS. We have had 17 hearings on Gulf War illnesses, and we had the wonderful assistance of a lot of people, including Ross Perot, who helped fund what was viewed as not standard research, which turned out to be really the essence of what we need to be doing now, and I think that hearing that you referred to, I felt we were kind of finally over the hill of opposition. But I just looked at—because you got me thinking about it—2004. The war was 1991—13 years.

And so, Mr. Chairman, I am grateful that you are asking these questions now about particularly our National Guard, who are being asked to handle the same workload that the active forces are. They are being given hand-me-down equipment, and then they are

over in the battle. They come back with not the same records that the active services have.

And I would like the VA to tell me, is it your sense that the folks who are interacting with our new veterans, that they aren't jumping to a conclusion right away that it is Post-Traumatic Stress Disorder, and that they are more willing to recognize that it could be something else, as we found with our Gulf War veterans?

Mrs. WILL. I am not a clinical person, I am the administrative person that goes out to the demobilization bases in the State of Connecticut, and I give a very general discussion on stresses and the adjustment problems that in the VA Health Care System we are very, very aware of. We do encourage all the veterans that we speak with, all the soldiers at that point to come in and go through our triage department, to come in and talk to our vet centers, talk to someone if they think they are having any problems. Our clinicians do have alerts in the computer to screen for stress, and it is uniform in the VA Connecticut Health Care System that they ask certain questions, and we do leave it up to our clinicians to make a determination whether these are environmental problems or psychiatric problems or readjustment problems.

Mr. SHAYS. I like the first part where you talk about the outreach efforts. The emphasis again, though, on stress concerns me a little bit. What we did in our hearing, Mr. Chairman—we had all these sick veterans who would come to the hearings, and the first panel would always be the government, and the government say "We have no sick veterans". And then they would leave, and then we would have the hearing with sick veterans who were visibly sick and who had records to document it, and doctors' statements to accompany it.

And so what we did was we had the veterans go first, and we had the government officials had to listen to their testimony. And what I am thinking is at least to date I have not heard the same kind of complaints that we did before but, admittedly, we are not talking about 700 people potentially flooding the system.

But I just would say to all of you, I would hope that your antenna would be up. The one thing I think we learned from Gulf War illnesses is that we need to trust the veterans more and believe them more when they said they weren't well, and not make an assumption that it was just a mental challenge that they were dealing with. And I get the sense that we are a little more alert to that. I didn't have any other question other than to voice that, Mr. Chairman. Thank you.

Mr. SIMMONS. Thank you, Mr. Shays. And let me just say that your concerns are right on, and perhaps it is self-serving, but I would say that in Connecticut, because it is a small State, because the various government providers know each other, because the Network with the Guard and the Reserve is relatively good due to the proximity, I think we have been reasonably successful in trying to reach out proactively. I worked a few years ago on the Agent Orange issue, and I worked for Senator John Chaffe, and we were familiar with the VA not accommodating our concerns. Post-Traumatic Stress Disorder, the same sort of thing. Of course, that doesn't always manifest itself right away. And what the VA has to do is be open to the fact that those manifestations may come at a

later date. Right here on this campus, we have an excellent counseling program that is just being built up here and that we expect to get larger, but many of the veterans who were in that program did not manifest right off the bat on their return. So, the return scan is just part of the process, and we have to be mindful that some veterans may manifest later, of those stress factors.

Mr. SHAYS. Could I ask the gentleman to yield for one second?

Mr. SIMMONS. Yes.

Mr. SHAYS. Just to say that the recordkeeping is actually essential, and I appreciate you mentioning it. And I was thinking, Mr. Chairman, it is nice that you get to deputize more witnesses at your will. It was nice to have you make that contribution.

Mr. SIMMONS. The Chairman, with the permission of course of the Ranking Member, Mr. Ginsberg, do you have any questions?

Mr. GINSBERG. No, thank you.

Mr. SIMMONS. Let me again thank the witnesses all very much for their participation, and encourage them to stay in touch with each other and with our VA folks up in Washington, so that we can continue to provide the very best care we can to our returning veterans. Thank you all very much.

Mr. SIMMONS. We will welcome Panel 3. For those up here or in the audience who wish to make a restroom break, call it what you will, now is a good time as we are swapping over to our third panel.

The third panel will be made up of five witnesses. First, Mr. Edmund J. Burke, who is the Secretary/Treasurer of the Connecticut Veterans Coalition Forum, who will be accompanied by Mr. Paul J. Pobuda, Department Service Officer of the American Legion Department of Connecticut; also, Mr. Donald Johnson, National Service Officer, AMVETS Department of Connecticut; Mr. Allen Gumpenberger, National Service Officer, Disabled American Veterans Department of Connecticut; and, Mr. Glen Tewksbury, Department Service Officer, Veterans of Foreign Wars Department of Connecticut. If these five gentlemen will come forward and assume their seats, we will proceed as soon as possible.

[Recess]

Mr. SIMMONS. Let me take this moment, if I could, to thank my colleague, Representative Shays, for being here this morning. He does have another engagement and he will be leaving the panel. I also want to recognize for the record my hearing coordinator in my office in Norwich, Mr. K. Robert Lewis—if you would stand and face the crowd and wave and be recognized. He is a Vietnam Era veteran, and does a tremendous job up in Norwich working with the whole delegation to ensure that our veterans get the very best treatment that we can provide. Also, from our Washington office, Amy Pellogrino—please stand up, Amy, wave to the crowd. Thank you very much. She does Veterans' Affairs issues on my personal staff in Washington, DC, working with the rest of our group. I appreciate all of you very much the participation and hard work of our staff. Without their input, the members would simply not know what to do and we would not know what to say. So, we appreciate very much their hard work.

I believe our panel has gathered. Why don't we start with Mr. Edmund Burke, the Secretary/Treasurer of the Connecticut Veterans Coalition Forum.

STATEMENT OF EDMUND J. BURKE, SECRETARY/TREASURER, CONNECTICUT VETERANS COALITION FORUM; ACCOMPANIED BY PAUL J. POBUDA, DEPARTMENT SERVICE OFFICER, THE AMERICAN LEGION DEPARTMENT OF CONNECTICUT; DONALD JOHNSON, NATIONAL SERVICE OFFICER, AMVETS DEPARTMENT OF CONNECTICUT; ALLEN GUMPENBERGER, NATIONAL SERVICE OFFICER, DISABLED AMERICAN VETERANS DEPARTMENT OF CONNECTICUT; AND GLEN TEWKSBURY, DEPARTMENT SERVICE OFFICER, VETERANS OF FOREIGN WARS DEPARTMENT OF CONNECTICUT

STATEMENT OF EDMUND J. BURKE

Mr. BURKE. Thank you. I have to commend you on your perseverance. Thank you for chairing this. I want to go through this as quickly as I can.

Mr. Chairman and other distinguished members of the committee, I am grateful for this opportunity to present my views on the current state of VA healthcare delivery in Connecticut. I currently serve as the Coordinator of Veterans' Services for the Department of Mental Health and Addiction Services. I would like to clearly state, however, that I come before you today as a veteran, as Secretary of the Connecticut Veterans Coalition Forum, as Co-Chair of the VA Connecticut Healthcare System's Community Mental Health Advisory Board, and as one of two Connecticut members of the VISN I Mental Health Community Advisory Board. I would appreciate your entering my prepared statement into the record.

Mr. SIMMONS. Without objection, so ordered.

Mr. BURKE. Thank you. Over the past 8 years, healthcare in Connecticut has gone through VERA, and it was dramatically cut and money sent to the Southern States. It reached a point where programs were closed, staffing reduced to where it was almost unable to function in the programs that were kept alive and well. We then got to this new, improved CARES model that was going to be of some benefit for services and, again, we were faced with the possibility of Newington closing, some of the CBOCs that were put in place were going to be very short-lived and were on the chopping block as well because of the staffing and other issues.

Thank you for the legislative involvement in getting both Newington kept alive and also the CBOC in Willimantic, which you were directly involved in keeping that alive as well. I really think that you did a terrific job. Also, we also had a change in administrative staff in VA Connecticut Health Care System. We seem to have replaced the Health Care Director's position about every 6 months for a temporary basis, and it was always they were going to cut something and it seemed they were sending someone here who was very efficient and cutting something. We now have a Director, Mr. Johnson, and his staff, who are more than willing and able to help and listen to the veteran community at-large. Things have improved in the last few years, I must say that, and I think

it is the dedication of both the veteran community, the administration in the VA, and also the legislatives in Connecticut who fought to keep health care in Connecticut are improving. However, there are a couple of areas that concern me.

I work with veterans who are homeless often. They are displaced by family and community, on the street, I find them in public hospitals, and they are in pretty dire straits by the time they get to me.

I have tried on any number of occasions to get veterans into psych beds in the VA for long-term care. There are no psych beds in Connecticut for long-term care. In 6 years, I have seen one veteran admitted directly into an inpatient program. My testimony also looks at the need for nursing home level of care on a long-term basis for Connecticut veterans. There aren't any. There is just no way that you can get a veteran into a nursing home care bed. I have 100-percent service-connected veteran who has—was in Vietnam, he has exposure to contaminating blood products, he had hepatitis C. He has a service-connected mental illness. He was seen by a doctor in Hartford Hospital, needed a liver transplant, went to the VA, was told, "Yes, we will do the liver transplant". They would do the surgery, they would do the clinical care, but he needed to be in a nursing home because he needed constant monitoring and treatment on a daily basis. He was not paid for that nursing home level of care. He had to use his VA disability payments, pay that down until he reached a Title 19, which is basically poverty level, and then Title 18 would pay for his care in a nursing home, but he had to spend his disability payment for a psychiatric illness and hepatitis C to get to a poverty level, and that is not what the promise to veterans was. And I think we really have to do something about the need for long-term care beds, the need for inpatient psychiatric beds, and the treatment of both of those conditions.

Also in Connecticut, if you go to the VA and you are homeless and you are going to be in for treatment for, say, substance abuse, mental health, and I am including also physical issues, you may end up in a homeless shelter as your residency. I think we have to honor the dignity of the veterans of the State of Connecticut. They do not belong in a homeless shelter while they are receiving treatment through a VA facility. I think that is deplorable. We need to house them and care for their residency as well.

Again, I thank you for this. I find it somewhat interesting that I testified before Congressman Shays committee a couple of years ago in Washington, and to do this testimony for you today, I really didn't have to write it, I just had to rewrite the one that I did 2 years ago. So, I think that the issues need to be addressed, and thank you for your concern and time.

[The prepared statement of Mr. Burke appears on p. 86.]

Mr. SIMMONS. Thank you very much for that. The next witness will be Paul Pobuda, Department Service Officer of The American Legion, and I will note that he is accompanied by Fred Stockman. Welcome, gentlemen.

STATEMENT OF PAUL J. POBUDA; ACCOMPANIED BY FREDERICK C. STOCKMAN

Mr. POBUDA. Thank you, Mr. Chairman, members of the subcommittee. You have my written statement, I am not going to elaborate from that. I am going to give some brief testimony with regard to Regional Office activities as I have experienced them in my 21 years as a veterans' advocate as the Department Service Officer for The American Legion.

Over the years, many changes have taken place in the Regional Office. Most have been in the affirmative and good for veterans. When I started working there 21 years ago, there were 142 employees, full-time employees, working in the Regional Office. Today there is less than 70, if I am not mistaken, doing about the same work that 140 employees did 20 years ago. I realize the number of claims has diminished over the years, but the claims have become more complicated. It takes a lot longer to adjudicate the claim in the proper manner.

Appeals, too many of them in this small Regional Office. I don't know whether the veterans themselves are totally dissatisfied with what is coming forth, or they don't understand the simplicity of the claim. As a veterans advocate, we have talked different veterans out of the appeal process simply by explaining to them what is the law entitling them to. It is difficult at times, but at the same time it is very rewarding to see that the veteran gets everything he is entitled to.

Without further ado, I will turn this over to Mr. Stockman, who will give you some brief notes with regard to the medical aspects.

Mr. SIMMONS. Without objection, your full statement will be entered into the record.

Mr. SIMMONS. Mr. Stockman.

STATEMENT OF FRED STOCKMAN

Mr. STOCKMAN. Mr. Chairman, I thank you very much for this opportunity, and I will be speaking on health care funding, long-term care, and something about appeals.

Veterans continue to suffer as a result of a system that has been repeatedly underfunded and, is now ill-equipped to handle the large influx of veterans wanting to use the services. The simple fact is the VA does not have the funding needed to treat all veterans seeking care from VA, and they continue to deny health care to eligible veterans and it does not solve the problems resulting from inadequate budgeting, and that would be Category 8 under Denials.

Funding requirements of health care service for disabled veterans are not guaranteed under discretionary spending. VA's ability to treat veterans with service-connected injuries is dependent on funding approval from Congress every year. However, if we went to mandatory funding, VA health care would be funded by law for all enrollees who meet eligibility requirements, guaranteeing annual appropriations for earned benefits for veterans.

Mandatory funding would not prohibit the use of other revenue sources to meet physical obligations such as co-payments, third-party reimbursements from all health care insurers including Medicare. The MCCF, Medical Care Collections Fund, requires those amounts to be collected and recovered and deposited in the

fund, offsetting the estimated appropriations for the fiscal year. These funds should be used to supplement rather than offset, and help the VA take care of their obligations.

Regarding long-term care, there are no VA nursing home beds available in Connecticut long-term. VA would be required to maintain its nursing home capacity as intended by Congress. VA must create centers and receive appropriate funding to maintain nursing home beds rather than abandon them to alternate services. These beds are a vital component of the VA long-term care and are essential in addressing the needs of our aging veterans population.

Even though Connecticut Department of Veterans' Affairs has changed Rocky Hill's status to a Veterans Home, the VA should not rely on Rocky Hill to fulfill its needs, the veterans nursing home should only be used to supplement, and CARES did not address VA's nursing home capacity or mental health facility capacity.

Just one short statement on the Board of Veterans Appeals. In the year 2002 and the first 2 months of 2003, the Board affirmed only 38 percent of the appeals. The cases rejected, 59 percent, because high numbers of remands are not being corrected in Regional Office, and the 59 percent VA has implemented at the AMC, the Appeals Management Care Center in Washington, to develop, adjudicate and remand and appeal claims. The AMC, in my opinion, is the VA plainly admitting the failure of some of their regional offices. I thank you, and I will answer any questions that you have.

[The prepared of Mr. Poduba and Fred Stockman appears on p. 89.]

Mr. SIMMONS. Thank you very much, Fred.

We next have Mr. Donald Johnson, National Service Officer, AMVETS Department of Connecticut. Mr. Johnson.

STATEMENT OF DONALD JOHNSON

Mr. JOHNSON. Thank you, Mr. Chairman, members of the subcommittee. We are just here to bear witness today. I will pass this over to Mr. Tewksbury.

Mr. SIMMONS. Mr. Glen Tewksbury, Department Service Officer, Veterans of Foreign Wars Department of Connecticut.

STATEMENT OF GLENN N. TEWKSBURY

Mr. TEWKSBURY. Thank you very much, Mr. Chairman and Mr. Rodriguez, for conducting this hearing on improving health care for veterans. I also have been a Veterans Service Officer for over 15 years, and have seen many changes within the VA system. And there are a few things that I would like to bring to the attention of the panel some of the concerns of the Veterans Millennium Health Care and Benefits Act, H.R. 2116. This bill significantly changes the VA authority to provide emergency care in non-VA facilities to non-service connected veterans who were not previously eligible for this type of care.

I have personally witnessed several veterans who were faced with medical bills and who were faced with mo medical insurance and then landed in a private hospital with medical bills of $60,000 or $80,000. Each and every time in which I contacted the Fee Basic Department at VA Connecticut Medical Center, they went to work on the emergency medical bills and negotiated with the private

hospitals and paid the emergency medical bills for these veterans. I want to thank the VA Connecticut Medical Center for being receptive to this particular bill and accommodating the veterans in Connecticut.

Another good development from the Millennium Health Care Bill is addressing the long-term care which we have heard this morning from this panel. In Connecticut, the VA Medical Center does not have any long-term nursing home beds at VA West Haven Medical Center. If the veteran meets the requirements of the Veterans Millennium Health Care bill of being service-connected of 70 percent or more, then his long-term care is contracted out to private nursing homes in Connecticut, and paid for by the VA. So, this bill is a good bill, however, VA Connecticut still needs long-term care beds at their medical center at VA in West Haven.

The Veterans of Foreign Wars would like to see a 90-bed long-term care facility built at the VA. And Mr. Roger Johnson's testimony this morning, he stated that there is a proposal of a 100-unit private operated assisted living unit that is proposed, but the Veterans of Foreign Wars does not believe that this will be the answer or the solution because of many different reasons, and we will go ahead and advocate further on when the developments come in.

Also, during the past 5 years, the establishment of seven outpatient centers has significantly improved the accessibility to VA Health Care in Connecticut, and I was very pleased to see the opening of the New London Outpatient Clinic, Stamford, CT, Waterbury, CT, Rowayton, CT, Winsted, and Danbury. This has made much improvement for our veterans in the State of Connecticut. These new outpatient clinics have reduced the travel time to and from the medical centers. Many veterans in other larger States have to travel 200 and 300 miles to a VA Medical Center. These are seven outpatient clinics definitely reduces a lot of travel time for our veterans in Connecticut, and I would like to thank VA Connecticut for being onboard and doing a good job for our veterans in Connecticut. Thank you for having this panel.

[The prepared statement of Mr. Tewksbury appears on p. 94.]

Mr. SIMMONS. Thank you very much for that testimony.

Next, we have Allen W. Gumpenberger, National Service Officer of the DAV. Welcome.

STATEMENT OF ALLEN W. GUMPENBERGER

Mr. GUMPENBERGER. Thank you, sir. First of all, I would like to have my written testimony entered in the record.

Mr. SIMMONS. Without objection, so ordered.

Mr. GUMPENBERGER. Thank you. I would like to say first to Mr. Rodriguez, I was treated in the San Antonio VA Medical Center, and went through a bone marrow transplant there. The staff was great. The doctors were great. And here I am still alive 7 years later, so they must have done something right.

I am a disabled vet myself, and I am here to speak on behalf of Disabled American Veterans, and we appreciate this opportunity to speak on some very pointed issues. Given that my testimony has now been incorporated into the record, I am going to just speak from my heart as to why I feel that these issues are such—that you should take drastic measures on and get them approved.

First of all, I would like to talk about being a Priority 1 veteran, when I get seen by my doctor and he says, "You need to go see a specialty clinic", and I wait 6 months or more to see a specialty clinic doctor, that really makes me wonder what is the problem here.

So, I go to the VA and the VA tells me—and Roger Johnson has been very receptive, listening, he has been very helpful, he agrees with us, and we very much appreciate the efforts he does—but just helping me out is not enough. I want to make sure you help out all disabled vets, and they should get quality time, quality care, to a place that is reasonably close to them so they can get to the appointment, that is really the issue here.

And what happens is, we hear from the VA, "Well, we don't have enough money, the budget is tight, blah, blah, blah", so they have great arguments for all that. Okay. Great. We go over to you guys and we ask you guys for help, and it is like—it is almost like you get the feeling you are saying, "Well, the problems are the inefficiencies of the VA system. If they would become more efficient, then the problem would be fixed".

Bottom line is, from a disabled veteran standpoint, let us just fund whatever they need and take care of those veterans. For the VA to get all the kinks out of their system, make their system more efficient, give them the money they need, they can make all the changes they need, but to do it on a tight budget is tough. So I really feel that mandatory funding is a huge priority.

Reading from one of my—guaranteed funding—let me put it this way. Guaranteed funding—when you are a disabled vet, you are basically told, "When you get out of the service, you are going to be treated for the rest of your life for those disabilities you incurred". And then you come here and you wait 6 months for an appointment, that makes you really wonder is that really a promise. And then we have to come and lobby each year to try to get that passed. So you guys argue back and forth about it, and each year we find ourselves lobbying for the funds necessary to keep the VA on its toes so we get quality health care. Guaranteed funding would be the promise of caring for us followed through, and that is how we see it. I mean, you guys work it out within your own organization is great, but I think that is a very important issue.

Transportation, travel time. I understand in Texas 300 miles, I know that things can be a long way away. Maybe the VA needs set up more CBOCs out there in Texas so they don't have so far to go. But I will say, in Connecticut, that is no excuse for us—well, it is okay to travel 45 minutes. We have got nearly 20,000 vets that live up in—that live more than 40 minutes away given rush hour traffic, from the West Haven campus, and you want them—there are as many living that far away as there are living close to it, to travel all the way down to West Haven. And the solution always seems to be, "Well, they can catch a shuttle in Newington". They have to take a whole day off of work to do that. That is a lot of pressure on the younger veterans like my age.

Concurrent receipt. Thank you for the legislation so far. Got to be frank, though, it is not enough. We have got guys that did more than 20 years active duty service, and they are entitled to their retirement because they did over 20 years of service. They are also

entitled to their VA compensation because they incurred disabilities from the service. The two bases or fundamental basis to get these benefits do not overlap each other, so why are we penalizing these guys? If they worked in some other government agency, they would get a pension from the government and they would get their—well, that is my time, but as you can see, I am very passionate about these issues, and I would hope that you take them under advisement. Thank you.

[The prepared statement of Mr. Gumpenberger appears on p. 95.]

Mr. SIMMONS. Thank you very much for that testimony, and congratulations on the work of the VA doctors in San Antonio, you are looking pretty good, let us keep it that way.

A couple of questions that I have, and I appreciate the comments of the panel, there was a discussion of efficiency—for me, efficiency creates resources that we then recycle to our veterans. And efficiencies make it easier for our veterans to access the services that they deserve.

One of the issues that has come up is the consolidation of the Benefits Section here in Newington, so we have basically multiple activities taking place on this one site. It is my understanding that that process will take place in September. That move will be complete. I have toured the facility upstairs. It is underway. It is taking place. Veterans service organizations have talked about it for 15 years. Now it is coming to pass. Gosh, it seems to take a long time to get things done, but it is coming to pass. It will, I think, provide benefits to our veterans. My assumption is that the veterans service organizations will have a space in this new facility. Do you have any comments on that—pros, cons— we would be interested to hear that.

Mr. GUMPENBERGER. Absolutely. Collocation is a great idea. I think it is very beneficial to the veterans that we represent. I would like to add that the staff at the VA Regional Office has been very helpful in many ways. We are talking about entering into a training initiative and having the facility here is going to give us a better training room to facilitate that training. Having that right down the hall from where my new office—our new offices are going to be——

(Laughter.)

Mr. GUMPENBERGER. I just want to say that as far as I can tell, even though there are a lot of problems with efficiencies and governmental red tape and stuff like that, the VA, across the board, both the health care system and also the VBA, are determined to help the veterans. And being here collocated is going to give them a really good accessibility to do that for the veterans of the State for us. And I have got to say that one of the problems that I see—and I hear this from employees all the time in the VA—they are stretched to the nth degree. They are understaffed. They are asked to do a lot more than they can in the 8 hours that are given each day. And it is becoming the norm for the guys at the Regional Office to work overtime each week, and it is just really tough. And I think those are some issues that really need to be taken up.

Mr. SIMMONS. Anybody else?

Mr. STOCKMAN. As a disabled vet myself, and employee of the American Legion, I think this is long overdue. Personally, it is a

raise for me because I won't have to pay for my parking any longer, and I won't have to take so much time off to see a clinic here at Newington Hospital. So I will be able to just pop out of the office, see the doc, get right back to work, so it will be beneficial, I think, all the way around for all of us. And, really, I think this facility is going to make it better for all veterans. However, transportation from the outermost borders of the State, like North Grosvernorsdale and Salem still are difficult. It still makes it difficult to get to these facilities, so we need to address that from some other angle.

Mr. POBUDA. Well, believe it or not, one of the first things I learned when I went to work in the Regional Office in 1983 is we were going to move to Newington. And it is finally going to happen. Thank goodness for that.

Mr. SIMMONS. Thank you all very much. And let me ask a second question, and let me also say this. The VSOs should participate in the victory dance because it was your recommendation, it was your initiative. We assisted in pushing it, but you guys made it work. Well, darn, I won't ask my second question then. Mr. Rodriguez. I will ask my second question.

On the issue of long-term care, we talked earlier about the Connecticut Model. We have heard from our Connecticut Commissioner on Veterans' Affairs. We have heard from a plan proposal for a private provider to provide some kind of long-term care domiciliary through a public/private partnership. I personally am intrigued by the idea of the VA working in a partnership with the Connecticut DVA to capture the value of Rocky Hill for long-term care purposes. It is a veterans facility, albeit a State facility. It is the oldest State veterans home in America, which reflects Connecticut's interest in supporting its veterans. It provides a veterans environment and is a home environment, may well be an excellent location for this kind of care to be provided, better in fact than down at West Haven, which is more of an urban environment, maybe less congenial for the veterans. It is centrally located. Would you, as a panel, be willing to explore this idea with us, or do you have any thoughts on VA partnering with Connecticut DVA to explore these options?

Mr. TEWKSBURY. Thank you very much for opening up that particular question because each one of us has spoken to that particular issue. And here, again, I love the proposal of a 100-bed private unit that Mr. Johnson is advocating, but I don't think that is the answer. And now you bring up the proposal of the Rocky Hill beds.

I have a question for you, Congressman, and that would be, how much would the veteran have to pay per day at Rocky Hill to live there in that particular bed, because at the present time they are mostly on Title 19, and that is on the Medicaid rate of like $290 a day. And they bill the patients every month. They have invoices and they keep track of the money that they owe the State of Connecticut, and if they live there for 10 or 20 years, some have invoices of $990,000.

Now, if their aunt or something leaves them some money, you know what is going to happen to that. If they win the lotto, you know what is going to happen to that.

I believe the VA health care for the veterans who serve in the service should be given the care at the VA hospital. And I don't believe it should be privatized, and I don't believe the State of Connecticut should be subsidizing our veterans with the high cost of care, and that is what is being done at the present time. So, therefore, I don't think that is going to be the solution either. Thank you for allowing me to talk about that.

Mr. POBUDA. There is only one small problem with Rocky Hill. The only veteran that can get in there is a wartime veteran, and the wartime dates of the State of Connecticut do not coincide with the wartime dates of the Federal Government. And if you look at it, a veteran is a veteran is a veteran, whether he served during peacetime or whether he served during wartime. And that puts a restriction on Rocky Hill as far as who they can take and who they can't take.

Mr. SIMMONS. I concur that a veteran is a veteran is a veteran. I see the Commissioner furiously shaking her head. Don't let it fall off. But my guess is that on that particular point, it may well be that Rocky Hill does not have a separate set of admission criteria. But, again, I think that this is an important issue that I would look forward to working with you folks on, but let us wait until you get moved into your nice new offices right here at Newington, and then we will schedule it for some time in October.

I have taken too much of my colleague's time. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much, and let me thank all of you for the testimony and what you do for all our veterans. I was very pleased to hear the push in terms of the mandatory funding which I also agree is critical for us to do, and I am hoping that we will take it in that direction. I just want to get some additional feedback from you all because I know we were able to get hold of that letter that was sent out regarding the Administration's proposal to basically cut—on the President's proposal for this year, which is $1.3 billion less than we were given already for the following, for 2006. And we know the inflation rate is almost an additional $1.3. So you are looking at almost a—actually, it is going to be a cut of over $2 billion for 2006 if that stays in effect. So, I just want to get some feedback from you.

Mr. STOCKMAN. Mr. Rodriguez, other folks on the panel, basically when we are looking at that kind of funding situation, Social Security is mandatory. Medicare is mandatory. Veterans benefits are mandatory. Why not veterans health care? If we have enough money to take care of those Category 8, even if they are in the system, with their co-pays, can still assist to raise the money needed to keep very quality health care. So, mandatory funding of VA health care is, I think, ingenuous if the United States Government continues to make it a wicket that we toss around every year for money, is very ingenuous to the veterans who deserve care. If they put their life on the line for the country, the country ought to put their health care on the line for the veteran.

Mr. GUMPENBERGER. I just think someone should talk to the President.

(Laughter.)

Mr. SIMMONS. Other questions from Mr. Rodriguez?

Mr. RODRIGUEZ. No.

Mr. SIMMONS. Mr. Ginsberg.

Mr. GINSBERG. First, let me also echo both Congressman Simmons' comments to you about the work that you do. Clearly, our offices interface with all of you and appreciate the efforts and time you put into resolving and assisting those who are in need.

I guess—specifically, this is to Mr. Burke—we have heard this morning about the outreach to returning Guardsmen who may some kind of psychiatric disorder, possibly some stress, or something related in terms of their mental illness. And I guess, with your experience, I know in the past with the system, is there capacity in the system to handle those who you presently have, and also those who are looking forward to coming back and possibly unfortunately having disorders that may need immediate attention?

Mr. BURKE. The answer to the first question is, no, we don't have enough capacity for those we serve right now. The answer to your second question is, no, we can't provide services for what we have. And here, again, I am talking about introducing new patients. It is my opinion that anytime you send someone into a conflict, their psyche is impacted by that experience, and that just seems to be plain out fact. The people who are coming back from this war have similar situations as we had in Vietnam, there is never a safe place. There is no place to rest your head. They also face possibilities of—we had great short-timers' calendars—their short-timers' calendars just got extended. So the stress level on these returning veterans is going to be incredible. And a lot of these, like National Guard people, who were not on a daily basis confronted with training and practices and exercises, these people went from being car mechanics and lawyers and salesmen into a uniform, into a conflict, in a very short time. And even though they may have been weekend trained, war is not a weekend experience.

And I think the level of psychiatric concerns is going to be very, very high in this population, and CARES never addressed either the need for mental health care as it exists, long-term care that maybe required for that or any disability, and never took into account or factored in new veterans coming into the system. If this war is a long one, there are going to be lots of veterans with psychiatric conditions that need treating, and that goes on for the rest of their lives. Thank you.

Mr. SIMMONS. Let me just make a brief comment of support for that statement that was just made. We do have hearings in Washington, DC on these subjects, and do hear testimony. I am a Vietnam veteran. World War II veterans had battle fatigue, I guess is what they called it then, or shellshock, Post-Traumatic Stress Syndrome, call it what you will, and those are conditions, those are wounds, what I call injuries or wounds that occurred as a consequence of stress under combat over a long period of time.

The interesting thing about fighting a group that does not wear uniforms, in a location where there is no front line, where the weapon of choice is often an IED, an improvised explosive device, where a person who smiles at you one minute and tries to kill you the next, where terror and terrorizing and mind games are part of the weapons of war—the interesting thing is that perhaps as never before our men and women are exposed to these types of stresses.

And so for our panelists and for others to point this out is tremendously important, and I guess I am glad that that has been raised because that is an important point. And I guess the comfort that I have at this point, as somebody who was a returning veteran so many years ago, is that people sitting on this panel, as people sitting in the audience, who are charged with dealing with these issues are actually talking about it aggressively and proactively as opposed to saying, "No, no, no, there is nothing to it". So I am really appreciative of that. And I think, again, if there is anything that comes out in the Connecticut Model, it is that people at each level—Federal, State, local, volunteers, veterans service organizations, full-time and part-time—are all trying to work out these issues.

That being said, I would like to ask my colleague, Mr. Rodriguez, if he has any closing statements, at which point I will make a closing statement.

Mr. RODRIGUEZ. Let me just thank everyone who has testified, and thank you very much for coming this morning to testify and to help educate us on the issue. I look forward to going this afternoon and visiting the site. Thank you.

Mr. SIMMONS. Thank you very much. I want to thank Eliott Ginsberg for being here today representing in a very professional way my friend and colleague, Representative Larson, who is, again, attending D-Day ceremonies in Europe. And I would like to thank everybody for their participation today. I note that my friend, Mr. Shays, who is now gone, said that in years past when he would have hearings, we would have the VA up front, and then the veterans would come in at the end, at which point the Veterans' Administration people had all left.

Well, let me note for the record that the Veterans' Administration officials have not left, they have been here—Dr. Post, Mr. Johnson, Rick Randle—they have all been here throughout the whole of this hearing, and to the best of my ability to observe with my glasses, they have been very attentive, and I appreciate that very much. I appreciate the teamwork that has been displayed by these officials over the last several years, as we have wrestled to maintain a very proactive program here in Connecticut, here in New England generally, fighting for our dollars that we see sometimes heading south, fighting to keep our CBOCs open because even though we have very different geographic challenges than you might have in Texas, nonetheless, the traffic issues, the stress of trying to drive highways that are overburdened, that are bumper-to-bumper often that you are creeping along at 20 miles an hour, that can often be as difficult a challenge for a disabled veteran as a 100-mile drive on an open highway. So I think it is the teamwork that I really appreciate.

We are going to have some exciting times here in the next few months, with the move of the Benefits Section down. I think we are going to have some exciting times addressing some of the issues that have been raised, such as money issues, which Representative Rodriguez and I have worked together on in a bipartisan fashion. In some cases, my performance has not brought me great accolades from my side of the aisle, but I feel it is important to stick our neck out for our veterans; after all, they stuck their necks out for us,

and put their lives on the line for us, and we owe them something in return.

Thank you all very much for your participation, and thank you, audience, for being here. I thank my friend and colleague, Mr. Ginsberg. This hearing is now adjourned.

[Whereupon, at 12:11 p.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF CIRO D. RODRIGUEZ
RANKING DEMOCRATIC MEMBER, SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS

HEARING ON OPTIMIZING FACILITIES AND IMPROVING HEALTH CARE AND BENEFIT SERVICES TO VETERANS IN THE STATE OF CONNECTICUT
JUNE 7, 2004

Mr. Chairman, I want to thank you for inviting me here to your beautiful home state of Connecticut. I also appreciate your visit earlier this spring to my hometown, San Antonio, Texas.

I would like to tell all the veterans and advocates present today that they have a good friend in you. This Subcommittee truly works in a bipartisan fashion and it is because of the leadership of Mr. Simmons.

Looking at some of the statements that were shared with us prior to the hearing, Mr. Chairman, I could almost imagine I was back home. Unfortunately, some of the problems and issues that are relevant here are just as pressing in my hometown, and I would imagine, elsewhere throughout the veterans' health care system. Like so many areas throughout the country, the Capital Asset Realignment for Enhanced Services (CARES) recommendations will affect Connecticut.

In my view, Congress must commit to spending billions in the next few years to update, expand and improve VA's physical infrastructure to ensure better access to timely, high-quality health care for our country's veterans. Some of this may be accomplished by sharing with our military partners, but much of it simply requires funding.

Mr. Chairman, I know we will be having a hearing about this topic in our Subcommittee back in Washington next week.
I'll look forward to working with you to ensure that our Committee is prepared to authorize funds for these critical investments—for the veterans in Connecticut, Texas and elsewhere.

We must continue to work to ensure that an adequate appropriation is made for veterans' health care. In the last two years, Congress has appropriated funding for VA health care well into the 2nd quarter of the fiscal year. The funds we've been willing to commit have not been adequate to cover the costs of improving health care or research. This underfunding affects all of the issues VA must contend with today, whether it is in their efforts to hire the right number and types of clinical staff or provide appropriate space and resources for fulfilling VA's missions.

Mr. Chairman, we'll continue to work on these matters back in Washington and I know you and I will be on the right side of this fight. Again, I'm glad to be here with you and look forward to hearing the testimony of our witnesses.

Statement of
Jeannette Chirico-Post, MD
Network Director
VA New England Healthcare System
Department of Veterans Affairs
Before the
Subcommittee on Health,
Committee on Veterans' Affairs
U.S. House of Representatives
June 7, 2004
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Mr. Chairman and members of the Committee,

I appreciate the opportunity to appear before you today to discuss improving health care services to veterans in the State of Connecticut. With me today are Mr. Roger Johnson, Medical Center Director, VA Connecticut Healthcare System, Newington and West Haven, Connecticut and Dr. Fred S. Wright, VA Associate Chief of Staff for Research, West Haven, Connecticut.

Network Perspective

The VA New England Healthcare System (Network 1) is an integrated and comprehensive health care delivery system that provides care in six New England States: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut. Over thirty community based outpatient clinics are strategically located throughout New England to provide increased access to health care services for veterans. Our goal is to provide the right care, at the right time and at the right level required to safely and compassionately meet the unique needs of each veteran.

In Network 1 we are proud of the many accomplishments that demonstrate our commitment to our mission of providing the veterans of New England excellence in health care, education and research. Network 1 has significant, longstanding affiliations with some of the most prominent medical

schools in this Country, including Boston University, Brown, Dartmouth, Harvard, Tufts, Yale, Universities of Connecticut, Massachusetts and Vermont Medical Schools. Research is another strong suit of Network 1. VA research funding was over $34 million last year, one of the highest among Networks.

Network 1 has transformed its health care delivery system through a primary care- based service line delivery system that has resulted in outstanding health care achievements. Service lines enhance the provision of uniform, high quality services throughout the Network by reducing variations in care and by standardizing availability, coordination and outcomes of services. This allows for improved management of patients along a seamless continuum of care. Our system is organized around five core clinical service lines: Primary Care; Mental Health and Behavioral Sciences; Specialty and Acute Care; Spinal Cord Injury and Disorders; and Geriatrics and Long-Term Care. Implementing the primary care-based health care delivery system has resulted in improved continuity, improved outcomes, and improved satisfaction while there was an increase in the number of patients served. The transition from a hospital-based system to one that is outpatient-based has facilitated veteran's access to care, such that 97% of our veterans are now within 30 miles of VA care.

The new emphasis on community-based programs has resulted in an expansion of programs such as community-based outpatient clinics and home-based primary care. New technologies such as telemedicine and telehealth are also expanding access to care for patients. VA Connecticut was the first in the Network to expand home care using home telehealth technology and care coordination.

All eight VA medical centers are using the computerized patient medical record. This enhances the safe delivery of care through computerized physician order entry. This state-of-the-art information technology allows clinicians anywhere in the VA New England Healthcare System to access the electronic

medical record for any nationally enrolled patient. These systems foster communication, coordination, and consultation among physicians throughout New England. Network 1's Internet/Intranet sites also facilitate access to information.

In addition, VA now receives medical information on military retirees via the electronic medical record system that VA and the Department of Defense (DoD) are developing. VA and DoD will be able to share all medical information between departments on all retirees and veterans by 2005.

The VA New England Healthcare System integrates and emphasizes customer feedback to assure that value is added for patients and other stakeholders. Feedback from patients is one of the most significant measures of quality. On quality of care measures, Network 1 has demonstrated progressive and consistent improvement in the areas of disease prevention, the management of chronic disease, and use of nationally accepted clinical practice guidelines.

We have achieved success in significantly enhancing access to care by decreasing waits and delays for clinic appointments as a part of the Advanced Clinic Access initiative. Over the last year, we have decreased our wait list by 83 percent. We are proud of Network 1's accomplishments and are aggressively spreading lessons learned to include clinics Network-wide.

On May 7, 2004, Secretary of Veterans Affairs Anthony J. Principi announced his decision about the National Capital Asset Realignment for Enhanced Services (CARES) Plan. I am pleased that the Secretary's decision on the CARES Plan will provide even greater access to care for the veterans of New England. The Plan provides the outline for modernizing and expanding health care, and bringing greater quality of care closer to where most New England veterans live. This is particularly important since the average age of our

infrastructure in New England is 64 years old. The National CARES Plan includes the following recommendations for New England:

- VISN 1 will undertake a comprehensive study of the feasibility of consolidating its existing four Boston area medical centers into one state-of-the-art tertiary care facility that will act as a referral center for VA health care for the greater Boston area. The study will consider the best location for existing functions at the West Roxbury, Jamaica Plains, and Brockton campuses of the Boston VA Healthcare System and the Bedford VA medical center.
- Increasing inpatient medicine demand in the VISN will be met by expansion of inpatient facilities and utilization of existing authority for community contracts where necessary for care. The CARES Plan provides for an expansion of inpatient services at VA Connecticut Healthcare System's West Haven campus and an expansion of inpatient services in Rhode Island at the Providence VAMC. A major construction project at Connecticut will include the renovation of medicine, surgery, and nursing units.
- Additionally, the CARES Plan will increase primary care access across the Network by expanding existing community based outpatient clinics, using existing authority to negotiate new contract care in the communities where needed, expanding telemedicine, and establishing a new CBOC in Cumberland County, Maine.
- The CARES Plan provides for the enhancement of inpatient and outpatient spinal cord injury services.
- Hartford VA Regional Office will collocate a benefits administration office at the Newington VAMC.

Medical Center Perspective

I am proud of the quality of care demonstrated by the VA Connecticut Health care System. This is exemplified by their performance outcomes, customer satisfaction, and the many Centers of Excellence, including Ambulatory Care, the Eastern Blind Rehabilitation Center, Rehabilitation Research Center, Renal Dialysis, and Seriously Mentally Ill.

Also, VHA and Network 1 have successfully begun operation of new Community Based Outpatient Clinics in Danbury, New London, Stamford, Waterbury, Windham and Winsted. Mr. Johnson will provide you with more information on a few of the many successful local initiatives.

Conclusion

Thank you for the opportunity to discuss the achievements and challenges of VHA at the National, Network and local level. This concludes my opening statement and I, along with my colleagues, will be pleased to answer any questions you or the members of the committee may have.

Statement of
Roger Johnson
Director
Connecticut VA Healthcare System
Before the
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives
June 7, 2004
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Mr. Chairman and Members of the Subcommittee:

It is an honor to share with you our efforts to revitalize the Newington Campus of the Connecticut VA Healthcare System. I am pleased to have an opportunity to share VA's Quality of Care Initiatives, the efforts to reach out to the Rocky Hill State Veterans Home and to troops returning from the Operation Iraqi Freedom/Operation Enduring Freedom, and discuss activities to address the infrastructure needed to support these initiatives.

The Newington Campus has provided care for our Nation's veterans for 74 years. The shift from inpatient to outpatient care had a major impact on the facility over the last 10 years. Inpatient units were reduced, and consolidated in 1995 to the West Haven Campus. A number of outpatient specialty services were also consolidated at West Haven. The staffing level at the Newington campus was eventually reduced to about 250.

The first successful efforts to revitalize the Newington Campus occurred in 2001 with the leasing of 34,730 square feet of space to the Connecticut National Guard. In 2003 the Newington campus became the site of the New England VA Healthcare System's Customer Service Call Center that brought another 10 positions to the facility.

In 2004, there are a number of major initiatives underway to revitalize the Newington Campus. The first change has been the relocation of the Post-Traumatic Stress Disorder Residential Rehabilitation Program (PRRP) to the Newington Campus from the West Haven Campus. The PRRP is an 18-bed, 90-day program that offers a combination of classes, and individual and group therapy. The focus is on Veterans developing sustainable daily life skills and pursuing activities that are personally

meaningful. Veterans are helped to develop a personal health and fitness regimen and are matched with supported, part-time volunteer activity that meets treatment goals and offers opportunities for personal fulfillment. PRPP veterans work cooperatively, and with staff support, perform house chores, shopping and cooking. In its new location the program offers a home-like atmosphere well suited for a rehabilitation program.

The next change expected during 2004 is the re-activation of the Dermatology Specialty Clinic and a Chiropractic Clinic. Both clinics are expected to be in place no later than this fall.

The most significant change in 2004 will be the co-location of the Hartford Regional Office to the Newington campus, in a location covering approximately 42,300 square feet. You will hear more about the co-location later in the hearing.

For 2005, we are exploring the re-activation of the Gastroenterology Clinic, and the establishment of an additional support function for the VA New England Healthcare System at Newington.

One of the most exciting initiatives for Newington is that the facility has been approved to pursue, via the enhanced use lease program, a 100-unit privately operated assisted living program on the grounds. It is expected that the Request For Proposals (RFP) will be available this fall. We hope that the project will actively move forward through 2005.

We have continued our focus on providing quality care to the veterans we serve. VA has established an aggressive performance measurement system that looks at 74 different quality indicators. These indicators look at clinical quality issues for cardiac, diabetic, and mental health patients and a host of preventative health indicators. We are proud to report that Connecticut exceeds the VA national average in meeting these indicators. It should be noted that 18 of these indicators can be benchmarked against the private sector, and that the VA exceeds the private sector in all 18.

One of the reasons the VA Connecticut Healthcare System is able to provide such good care is that Newington is a clinical training site for University of Connecticut residents and fellows. Residents and fellows take care of Veterans in Primary Care and Specialty Clinics such as Cardiology, Endocrine, Geriatrics, Renal, Pulmonary, Psychiatry and Rheumatology. In addition, Newington Campus provides clinical training

opportunities for pharmacists, optometrists, podiatrists, advanced practice registered nurses and phlebotomists.

We have worked to reduce waiting times over the last 18 months. The Primary Care Service Line implemented an open access program that facilitates the provision of same day or next day appointments. This program has improved both patient and staff satisfaction, while demonstrating improved patient care. Additional efforts have been made and are continuing to be made to reduce the waiting times for specialty clinics.

The VA has an ongoing program to track patient satisfaction. The most recent quarterly report reflects that Newington exceeds the national average in 8 out of 13 areas.

Finally, we understand and have fully embraced our responsibility to reach out to our returning troops from Operation Iraqi Freedom and Operation Enduring Freedom. Staff from VA Connecticut Healthcare System have attended the demobilization briefings of the Connecticut National Guard and Connecticut Reserve Units for approximately 1500 returning Connecticut troops, and have enrolled 230 of them for VA care. In collaboration with VBA, veterans who have filed claims but not applied for VA healthcare benefits are contacted and offered additional assistance with their benefits. Software has been installed to identify combat veterans, and VA Connecticut intake staff has been provided training to efficiently process returning combat veterans. Our staff reviews each case to preclude billing for care associated with their combat service. In addition, in our electronic medical record, a clinical reminder alerts the health care provider at the time of treatment to screen for PTSD, depression, alcohol use, infectious diseases and chronic symptoms endemic to Southwest Asia. We can now verify a claim of combat service, preventing any delay in access to VA health care. Consistent with Secretary Principi's guidance, our focus is to care for the patient before the paperwork.

To support these efforts, we have initiated a number of construction projects. At Newington, a project is underway for a new Canteen Service and plans have been developed to expand parking. At the West Haven Campus, we are currently renovating space that will be used for our Medical Intensive Care Unit (MICU)/Step Down and Clinical Epidemiology. A proposal has been submitted, as supported by the CARES

process, for a major project that will replace and expand inpatient capability as well as provide additional research space to meet the shortfall identified within the CARES process.

Mr. Chairman and Members of the Subcommittee, I have tried to share with you our efforts to revitalize the Newington Campus of the Connecticut VA Healthcare System. We believe these changes are going to have a very positive impact on the facility and will cement Newington as a Center for Veterans Services for many years.

Mr. Chairman, this concludes my statement, and I will now be happy to answer any of your questions. Thank you.

Statement of
Ricardo Randle

Director
Department of Veterans Affairs (VA) Regional Office
Hartford, CT

Before the
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

June 7, 2004

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to participate in today's hearing. I am pleased to be here today to discuss the Department's ***OneVA*** sharing opportunity between the Hartford VA Regional Office and the Newington Campus of the VA Connecticut Healthcare System and to communicate improvements in service delivery to veterans in the State of Connecticut.

Recent world events have shown how essential the sacrifices made by servicemembers and their families are in preserving peace and liberty. President Abraham Lincoln's solemn promise – "to care for him who shall have borne the battle and for his widow and his orphan" – defines the heart of the mission of the Department of Veterans Affairs. This vital mission of serving nearly 300 thousand Connecticut veterans and their family members is highly motivational to the 71 employees of the Hartford VA Regional Office. Our employees are known for their dedication, professionalism, integrity, and accountability.

OneVA sharing opportunities are a priority for the Department. In many cases, VA is spending significant resources on rental space for its VA Regional Offices. With rental costs rising each year, the Veterans Benefits Administration (VBA) must take advantage of opportunities to collocate on VA property where such action enhances services and is economically favorable. VA has placed great emphasis on maximizing the use of our assets to meet the service delivery

goals of the Veterans Benefits Administration (VBA), Veterans Health Administration (VHA) and the National Cemetery Administration (NCA). Savings from effective consolidations can be better spent on the human and technology resources used to process compensation, pension, and education claims and provide loan guaranty and vocational rehabilitation and employment services. By operating in this manner, VA will ensure it maximizes its resources to provide services to veterans and redirect significant savings from rental costs into claims processing and other benefits delivery missions. Further, collocating also improves access to services, employee morale, and productivity by relocating facilities in new, modern, and efficient office space.

Here in the State of Connecticut, we have adopted the ***OneVA*** sharing opportunity concept, and have developed what we call "The Connecticut Model". "The Connecticut Model" is a progressive and dynamic example of government entities working together to improve the efficiency of operations.

The collocation of the Hartford VA Regional Office to the Newington VA Medical Center campus is an excellent example of " The Connecticut Model".

The Hartford VA Regional Office is currently housed in GSA leased space in the federal building in downtown Hartford. The office has been at the existing location since 1963. We occupy approximately 30,000 square feet of space. The following veterans service organizations have full-time representatives located in the Regional Office: the American Legion, the Veterans of Foreign Wars, Disabled American Veterans, AMVETS, and the Connecticut Department of Veterans Affairs. We also provide space to representatives from the Buffalo VA Regional Processing Office and the State of Connecticut Department of Labor.

The scope of the Hartford VA Regional Office collocation project encompasses the renovation of three floors and approximately 43,000 square feet of space on the third, fourth, and fifth floors of Building 2E at the Newington campus.

The collocation project will provide the Hartford VA Regional Office with a state-of-the-art facility and infrastructure that will enable the Hartford VA Regional

Office to provide optimal customer service in the form of improved business processes.

This project offers unique opportunities for VBA and VHA and will benefit VA as a whole. The Hartford/Newington collocation will improve service to veterans by providing "one stop service" for benefits and medical needs, including free parking and fully accessible facilities.

Operational efficiency will occur with increased collaborative communication between claims examiners and physicians, and redesigned division work areas that increase and enhance workflow, accuracy and timeliness.

Employee working conditions will be improved by providing a new, well designed work environment with the latest information technology. Access to existing training and support facilities will further contribute to employees' productivity.

Close proximity of VBA and VHA personnel will further enhance accuracy and timeliness of the examination process. We expect to see improvements in the quality and timeliness of completed hospital exams. The average days to complete a hospital exam within the VA Connecticut Healthcare System is 17 days. Although this is better than the VHA standard/goal for performance in this area (35 days), we believe that we can continue to improve.

Net costs will be reduced by eliminating the payment of annual GSA rent. In addition, VBA and VHA will investigate opportunities to integrate various operational functions, which will potentially reduce costs still further.

The new facility will incorporate improvements to the overall work environment for visitors and employees with improved lighting, noise abatement, temperature control, health and safety features, and accessible accommodations for handicapped veterans. The new facility is scheduled to be occupied in September 2004.

Within the Hartford VA Regional Office, we have made excellent progress in meeting the priorities set by Secretary Principi in improving the timeliness and accuracy of claims processing. Between 2001 and 2003, the average number of claims we completed per month grew by 85%, from 227 to 421. Two years ago

the inventory of rating-related compensation and pension claims peaked at 2,515. By the end of 2003, we had reduced this backlog of pending claims to just over 1,883, a drop of over 25 percent. We expect to meet our fiscal year 2004 claims inventory goal of 1,405 rating claims pending.

In 2002, it took an average of 214 days to process a claim. Today, it takes about 157 days. We also continue to make improvements in our average days pending and are on track to reach an average days pending of 100 days by the end of 2004. One of the main reasons we will be able to meet and then sustain this improved timeliness level is that we have reduced the proportion of claims pending over 6 months from 48 percent to just 16 percent during the last 3 years. At the same time that we are improving timeliness, we will increase the accuracy of our claims processing. We are on track to meet the 2004 performance goal for the national accuracy rate for compensation claims of 90 percent.

Our close relationship with National Service Organizations plays an integral part in our ability to improve benefit services to veterans in the State of Connecticut. We have provided instruction in the Training, Responsibility, Involvement, and Preparation (TRIP) Program to accredited veterans service organization representatives who work in the Regional Office building. This TRIP program involves leveraging the expertise of veterans service officers to assist our customers in providing us with more complete evidence for their claims.

Connecticut is fortunate to be one of the few sites nationally to have a Homeless Veterans Outreach Coordinator (HVOC) assigned to the local Healthcare for Homeless Veterans (HCHV) Program. This program provides improved access to benefits and services for homeless veterans.

To ensure effective coordination of services, the Hartford VA Regional Office and the VA Connecticut Healthcare System have developed case management procedures to provide seriously disabled servicemembers returning from Operation Enduring Freedom and Operation Iraqi Freedom with a seamless transition to veteran status.

We provide personalized service to seriously disabled servicemembers by calling them when they return to Connecticut for convalescent care or if recently

separated from the military to thank them for their service and to remind them of their eligibility for VA health care and other benefits.

We conduct demobilization briefings to provide specific information to all servicemembers about VA healthcare and benefit services. To date, we have conducted 11 demobilization briefings with over 850 servicemembers in attendance and processed over 40 compensation claims.

Closing

Mr. Chairman, during the past 3 years the Hartford VA Regional Office has significantly improved service delivery to Connecticut veterans. The collocation of the Hartford VA Regional Office to the Newington VA Medical Center campus will further enhance and improve our ability to deliver world class service to deserving Connecticut veterans and their families. Our commitment to work in partnership with the VA Connecticut Healthcare System, Connecticut Department of Veterans Affairs, and the other National Service Organizations will serve as a model approach to effective and efficient improvements in healthcare and benefit services to veterans in the State of Connecticut. That concludes my formal remarks. I would be pleased to answer any questions.

Statement of
Fred S. Wright, MD
Associate Chief of Staff for Research
VA Connecticut Healthcare System
Before the
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives
June 7, 2004

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Mr. Chairman and Members of the Subcommittee:

I am grateful for the opportunity to discuss health care facilities and opportunities for improving health care for veterans in the State of Connecticut. I will focus on the role of research. The VA Connecticut Healthcare System (VACHS) Research program has more than 380 active projects led by more than 130 principal investigators. The majority of our investigators are clinicians who also provide patient care in Internal Medicine, Surgery, Mental Health, or Neurology. The research programs of the VACHS medical staff range from basic science (including molecular biology, cell biology, and genetics) to clinical research (involving clinical trials, health services, epidemiology, and rehabilitation). Approximately two thirds of the projects are clinical research studies involving human subjects. The remainder involve animal subjects and other laboratory research. Last year the competitively awarded funding for these projects exceeded $30 million. Most of this research activity is concentrated at the West Haven campus

Research is vitally important to our hospital and to our ability to deliver high quality primary and specialty care to veterans. This is true because of our affiliations with Connecticut's two medical schools: the Newington campus with the University of Connecticut Health Center and the West Haven campus with the Yale University School of Medicine. Nearly all members of the VACHS

medical staff have dual appointments as both VA physicians and medical school faculty members. In addition to their VA patient care activities, VACHS physicians have responsibilities in teaching and research. The medical school affiliations provide benefits to both partners. Consider, for example the affiliation with Yale University. The VACHS is important to Yale: the West Haven campus is an important site for clinical rotations by medical students, residents, and fellows in specialty training programs where they contribute to the care of VA patients and are taught by Yale faculty who are based at the VA medical center. Yale is important to the VACHS: our ability to recruit physicians to the VACHS medical staff is greatly enhanced by the associated appointment to the Yale faculty, the opportunity to serve as a teacher for medical students and residents, and the chance to carry out independent research in an environment enriched by the proximity of the medical school.

Research at the VACHS is relevant to diseases that affect the veteran population, and is aimed at improving the health and health care of veterans. In addition it is important to recognize that the research program brings outstanding individuals to the VA medical staff. These are individuals, who are committed to academic medicine, and who are attracted to work in VA by the combination of providing care for veterans, teaching students, and conducting research in an environment enhanced by the resources of the nearby medical school. Without a robust research program we would not be able to recruit the nationally recognized clinician investigators who serve as attending physicians, clinical leaders, and specialist consultants to whom our primary care physicians refer patients.

Of course successful research requires energetic and imaginative researchers. Successful research also requires both funding for project costs and facilities in which to carry out difficult and exacting work. Research funding comes from several sources. Approximately one third of the direct cost funding for VACHS research comes from the VA Research appropriation. Nearly one-half of our funding is provided by grants from the National Institutes of Health.

The VA research program is different in both size and purpose from research supported by NIH. VA research provides necessary support for clinician-investigators who are based at the VA in order to serve as VA clinicians providing care to veterans. The opportunity to carry out research and to teach in medical school-affiliated VA medical centers is critical to recruiting VA medical staff, particularly at hospitals offering advanced specialty services. We have been able to fund a wide range of additional VA research projects by competing successfully for NIH and other non-VA funds.

Mr. Chairman, this concludes my statement, and I will now be happy to answer any of your questions. Thank you.

STATEMENT OF

KARIN T. THOMPSON, RN, MSN, APRN, BC

PRESIDENT LOCAL 2138

OF
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

ON

IMPROVING HEALTH CARE TO VETERANS
IN THE STATE OF CONNECTICUT

JUNE 7, 2004

AT

THE VAMC IN NEWINGTON CONNECTICUT

Good Morning Mr. Chairman, committee members and distinguished guests. Thank you for the invitation to speak at this oversight hearing, before the Committee on Veterans' Affairs, Subcommittee on Health. My name is Karin Torson Thompson. I am an Advanced Practice Nurse (APRN) and President of AFGE Local 2138, the Professional Nurse's Union at VA Connecticut. Our union represents all RNs and APRNs who work at the Newington and West Haven VAMC's, in addition to our 6 Community Based Outpatient Clinics (CBOC's) across Connecticut. I have a master's degree in nursing from Yale University and the focus of my advanced education and nursing practice has been in treating veterans who suffer from Post-Traumatic Stress Disorder with Substance Dependence.

On behalf of the nurses, I want to thank you for inviting our union to speak at this hearing. As nurses at the VA CT, we have a unique vantage point for observing health care as many of us are direct care providers for veterans. Potential improvements to health care services and benefits for veterans are of great interest to our profession.

In the past 10 years many changes have occurred within VA, an adaptation to the multitude of forces which impact on the health care delivery system. The optimization of existing facilities in CT continues to evolve in a manner which facilitates mutually beneficial partnerships in VA, while providing better access for patients. The increased patient access to health care has at the same time impacted facility employees, who strive to maintain the same standards of care given diminishing resources. Nurses who work for VA are proud to be a part of a system which provides care for the unique health care needs of our nation's heroes. Nurses are first and foremost strong advocates for quality patient care.

VA nurses recognize that we must advocate for systemic change to improve patient safety. Being part of a labor union gives us a voice in our practice and environment. Our concerns stem from the current patient care environment that has become more demanding and evokes additional stress. It is imperative that we provide safe health care for our patients, yet we are often left to work without the resources needed to accomplish our mission as direct care providers.

We talk about the nursing shortage, when there may just be a shortage of nurses who want to work in traditional nursing roles. The longer the problem continues, the higher the probability we will have a true shortage. In a very short time, many nurses who work for VA , will reach retirement age. It is a known fact that VA nurses tend to be older than the national average and VA CT is no exception. A heavier work load will serve only to drive out employees who

cannot keep pace with an impossible task. Having worked in the private and state sector, it has been apparent the VA nurse to patient ratio is less than optimal. In addition, VA characteristically has inadequate ancillary staff supports. This places the burden of non-clinical tasks on clinical personnel. Clinicians need to be able to spend time in direct patient care. This practice cannot be continued if we are to provide safe and effective care. It is also not cost effective.

Research has demonstrated that patient outcomes decline if R.N. numbers are too low. The risk of patient mortality has been shown to increase in a linear fashion, when this occurs. Mandated minimum staffing levels do not exist in the VA, nor have staffing levels increased. This continues despite a patient population that has become more acutely ill over time. This phenomena occurs due to a number of factors. Patients leave the hospital setting more quickly, at a lower level of wellness. At the same time the overall number of inpatient beds requiring skilled nursing care has been drastically reduced. Ten years ago 6 inpatient psychiatric units existed at the West Haven campus. Today there is just one. Patients with many different types and acuity levels of psychiatric illness are forced to co-exist on one locked unit. An anxious, hypervigilant patient with Post-traumatic Stress Disorder who needs an inpatient bed for safety, will be placed in an environment with psychotic and demented patients of all ages. Some of these patients can become violent. From a therapeutic aspect of treating trauma, this is not good care. Our combat veterans needing this treatment deserve better.

While waiting for an inpatient psychiatric bed, patients are held for lengthy periods of time in the confines of the Psychiatric Emergency Room (PER). This unit was designed for 6 patients, yet it now has 10 beds and one only bathroom. To complicate this situation, the census frequently goes higher and female veterans may be admitted. At times the census reaches 17 and patients have to attempt to sleep in chairs due to the lack of beds. In a short period of time the length of an evaluation stay in the PER has increased from 18 to 32 hours. It is unconscionable that we cannot provide a veteran in crisis a bed, much less state of the art care. Staff levels in that area cannot always flex in response to changes in census and acuity. One unplanned absence may result in serious short staffing, for whom the only relief is a fatigued nurse on overtime. Research has also demonstrated the negative influence of fatigue on a nurse's ability to provide good patient care after 12 hours on duty. Overtime is not a viable long term solution to a predictable ongoing problem. Short term solutions should not be employed in the absence of a coherent, comprehensive long term plan to address staffing problems.

The logjam in the PER is a result of too few inpatient psychiatric beds, including skilled nursing beds for detoxification from substances. The locked inpatient psychiatric unit at West Haven, must service all veterans from Newington and all of the CBOC's. To cope with the backup of patients in the PER, the patients may be boarded in the Medical Emergency Room (MER). This

area is not equipped to handle patients who may be a danger to themselves or others. There are hazards in the environment and the nurses on duty may not have the specialty training that is required for appropriate care. Restraints may be used in the absence of staff available to provide 1:1 monitoring. In addition, patients from inpatient medical units may be boarded in the same MER, due to a lack of beds on the wards.

On general medical/surgical units at the West Haven campus the RN-to-patient ratio is also not sufficient to provide a high level of care. Research shows that when an RN cares for more than four medical/surgical patients, there are increased risks for those patients. At West Haven, the nurse to patient ratio on medical/surgical wards is 1 to 10 on the day and evening tour. On the night shift it worsens to 1 to 15. AFGE Local 2138 is very concerned that patient safety may be in jeopardy if improvements are not made to these RN-to-patient ratios. Chairman Simmons, we urge you to support H.R.4316 which would improve patient safety by establishing nationwide minimum RN-to-patient ratios for all hospitals, including VA.

Staffing patterns do not fare better in outpatient settings, where we now treat sicker patients who have been discharged earlier from the outpatient setting. Nurse Practitioners in Primary Care verbalize frustration over caseloads that have risen from 560 to 850 in 4 years. They have been forced to see patients in 30 minute blocks, despite the complexity of the presentation. Many of these patients are elderly WWII veterans who have numerous medical problems. In this short visit they must provide physical and emotional assessments, check tests and labwork, provide patient teaching, and prescribe medication. In addition they must document this work in the computer, make phone calls to family members or other providers, fill out insurance forms, and send faxes as needed. Many of these tasks may be accomplished by clerical staff, but at VA, the Primary Care Provider is responsible to get the job done. In an attempt to fulfill the tasks, the time spent with the patient is drastically shortened., much to the dissatisfaction of clinical staff. Having your highest skilled staff spend a large part of the day engaged in clerical work is not cost effective, nor good for patient care or satisfaction.

The same scenario is played out in Outpatient Psychiatry, where Advanced Practice Nurses (Clinical Specialists) have burgeoning caseloads. We are directed to spend less time with patients, even though these patients are more ill outpatients than in the past when greater numbers of inpatient beds were available. Nurses who treat patients with serious mental illness such as Major Depression, Schizophrenia, and PTSD, often compounded by Substance Abuse, are encouraged to see patients for 15 minutes and adopt a model more similar to medical Primary Care. Psychiatry is a specialty. Fifteen minutes is not enough time to assess the veteran's current mental state, prescribe medications, and to conduct a therapy session sufficient to insure a safe disposition for a return to independent living. During that abbreviated visit, the nurse must type in

all computer orders and documentation of the visit in front of the patient. There is no way this can constitute a respectful, nor therapeutic visit.

It seems our push to increase the quantity of patient contacts has at times lost sight of the quality of the care of the patient. In 1999 I treated 35 PTSD (with Substance Abuse) patients, a caseload which would rise to 110 by 2002. Some of my patients were homeless with few social supports and medically ill. Approximately 85% were Service Connected for PTSD and many were in a destabilized condition, leading marginal lives in the community. Given the complexity of their psychiatric illnesses, they present as a higher risk population. This is not a group that can be seen infrequently for a brief periods, nor can they be prescribed a large amount of psychotropic medication at a time. This means frequent contact for safety and support.

As a nurse and union official I have raised concerns about how the lack of staff and beds are adversely affecting veteran's access to services. In today's hospital environment nurses want to identify and raise problems about the delivery of direct patient care and to work with management to address these problems. Our goal is to advocate for the best nursing care for veterans and to safeguard the public interest. Unfortunately, the current Title 38 law blocks our ability to raise the issues nurses care about most. Workplace policies and procedures are the underpinning of the nurses' ability to practice safely and provide quality patient care. Chairman Simmons, I urge you to help expand the opportunities for APRNs and RNs to work with management to improve the delivery of healthcare for our veterans. I urge you to support giving RNs and APRNs a collaborative role with management in developing and implementing workplace policies that impact on the practice of nursing.

Again, thank you for the opportunity to share with you, some of the thoughts and concerns of RNs and APRNs in the VA CT Healthcare System.

Statement of
Colonel William S. Sobota
Director of Manpower & Personnel (J1)
Connecticut Army National Guard

The United States House of Representatives
Committee on Veterans' Affairs
Subcommittee on Health

"Improving Health Care and Benefit Services to Connecticut Veterans"

June 7, 2004

Salutation

Mr. Chairman, members of the subcommittee, and distinguished guests, as the Director of Manpower and Personnel (J-1) of the Connecticut Army National Guard, I want to thank you for the opportunity to discuss improving health care and benefit services to veterans in Connecticut. As my duties relate primarily to the Connecticut National Guard, I will confine my statements to our organization's experiences concerning the mobilization of our force and the transitioning of personnel to the Department of Veterans Affairs (VA) health care system.

Background

The Connecticut National Guard, comprised of the Connecticut Army and Air National Guards, is a unique dual-status agency, having both federal and state missions. The National Guard's federal mission is to maintain properly trained and equipped units available for prompt federalization for war, domestic emergencies or other exigencies. Collectively, the Connecticut Army and Air National Guards (when not in a federal status) and the Connecticut Organized Militia comprise the Connecticut Military Department, which administers the armed forces of the state. The Military Department's mission is to protect life and property; preserve peace, order and public safety; conduct community service programs; and coordinate all resources to assist the state in recovering from any disaster, man-made or natural.

The Adjutant General, who is appointed by the Governor to a four-year term, is in charge of the Military Department. The Adjutant General, Major General William A. Cugno, is the commander of the state's armed forces, directly responsible to the Governor (Captain General), the commander in chief of the state's armed forces. The Military Department is functionally divided into three components: Army National Guard, Air National Guard and Organized Militia. The Military Department, under the auspices of the National Guard Bureau, manages more than 5,000 federal employees (soldiers and airmen), of whom nearly 1,000 are full-time employees. The Military Department employs 120 full-time state personnel. The Connecticut National Guard authorized federal strength is 4,200 soldiers, 1,200 airmen. The four companies of state militia are authorized a combined strength of 700.

Introduction

Over the past thirty years, as the United States Armed Forces have transformed into a voluntary force[1] and the reserve components have become more closely integrated with the active duty force[2], force demographics have significantly changed.[3] For example, the

[1] Conscription (1073) abandoned in favor of an all-volunteer military, see http://www.hhsdebate.org/Files/Briefs/selectiveservice.htm.

[2] See: http://www.arng.army.mil/history/Constitution/default.asp?ID=17, "Following the experience of fighting an unpopular war in Vietnam, the 1973 Total Force Policy was designed to involve a large portion of the American public by mobilizing the National Guard from its thousands of locations throughout the United States when needed. The Total Force Policy required that all active and reserve military organizations of the United States be treated as a single integrated force. A related benefit of this approach is to permit elected officials to have a better sense of public support or opposition to any major military operation. This policy echoes the original intentions of the founding fathers for a small standing army complemented by citizen-soldiers." For a historical perspective, see also http://www.defenselink.mil/execsec/adr98/chap9.html.

modern active duty force is now significantly older, better educated, more ethnically diverse, and more likely to dependents than the pre-1973 force. Females now comprise more than fifteen percent of the force, as opposed to 4 percent in 1973. Over fifty percent of the active force is married. In the year 2000, more than 600,000 active duty members had children (1.23 military children) -- 85,000 of these members were single parents.

The Connecticut National Guard Force is demographically similar to the active force. The average age of a Connecticut Army National Guard soldier is 27 years old. Ninety-five percent of the force has a high school degree. Fifteen percent of the force is female. Twenty-five percent is of a minority group. Only thirty-five percent of the Connecticut National Guard is married. Forty percent have dependents. Twenty-five percent of the Connecticut National Guard is enrolled in college courses.[4] Nearly every traditional member of the Connecticut National Guard is either a full-time student or fully employed (civilian employment).

Since the terrorist attacks of September 11, 2001, the demand for and length of National Guard mobilizations has exponentially increased.[5] As of May 1, 2004, the National Guard has 150,000 soldiers and 6,000 airmen on active duty in support of the Global War on Terrorism (GWOT). During the peak of the mobilization in the spring of 2003, the Connecticut National Guard had nearly 2,000 of its soldiers and airmen mobilized or alerted for mobilization. Since September 11, 2001, over half of the Connecticut National Guard have performed active duty missions. Currently, we have nearly 300 soldiers mobilized and have two units alerted for mobilization. The economic and demographic characteristics of the force cause Guardsmen, their families and employers additional mobilization concerns and hardships.

Army National Guard Mobilization

The National Guard currently mobilizes forces under the guidance of the Forces Command Mobilization and Deployment Planning System (FORMDEPS). The objective of FORMDEPS is to provide consolidated mobilization, deployment and demobilization procedural planning guidance, responsibilities, instructions and execution.[6] FORMDEPS

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[3] See U.S. General Accounting Office, *Military Personnel: Active Duty Benefits Reflect Changing Demographics, but Continued Focus Is Needed,* GAO-02-557T (Washington, D.C.: Apr. 11, 2002); U.S. General Accounting Office, *Military Personnel: Active Duty Benefits Reflect Changing Demographics, but Opportunities Exist to Improve,* GAO-02-935 (Washington, D.C.: Sep. 18, 2002).

[4] Cite Statutory foundation for tuition waiver.

[5] U.S. General Accounting Office, *Reserve Forces: Observations on Recent National Guard Use in Overseas and Homeland Missions and Future Challenges,* GAO-04-670T (Washington, D.C.: Apr. 29, 2004. "With the high pace of operations since September 11, more than 51 percent of Army Guard members and 31 percent of Air Guard members have been activated to meet new homeland and overseas demands."

[6] Department of the Army, Forces Command Regulation 500-3, "Emergency Employment of Army and Other Resources: Forces Command Mobilization Deployment Planning System," 15 June 1998. FORMDEPS is published in 5 volumes. Volume I, "FORSCOM Mobilization Plan (FMP)," FORSCOM Regulation 500-3-1. This plan assigns responsibilities and provides guidance, instructions, and procedures for mobilization planning and execution. Volume II, "Deployment Guide," FORSCOM Regulation 500-3-2. This document provides guidance and assigns responsibilities for deployment of units. It prescribes types of deployment to include standard, modified, direct deployment, and Home Station Deployment. Volume III, Reserve Component Unit Commanders

is directive in nature and supports Army policy and guidance for mobilization planning.[7] The statutory and regulatory foundation for the mobilization is complex, involving the participation of all levels of command across the entire spectrum of the Department of Defense. As executed by the National Guard, mobilization of units from a state armory to the battlefield is more than the movement of a military force from one location to another.[8] It is the transition of citizen soldiers -- as well as their families and their employers -- from a "hometown" military training (part-time) status to a deployed operational combat mission status.

The mobilization process, conceptually, works efficiently. Forces Command,[9] in working with combatant commanders[10], identifies the units necessary to execute required combat missions. Once identified, Forces Command notifies the Department of the Army. If the unit is a National Guard unit, the Department of the Army notifies the National Guard Bureau[11]. The National Guard Bureau notifies the state command in which the unit is located. The state command notifies the unit.

The notification officially comes by way of an alert order. Both the National Guard Bureau and the Department of the Army through official command channels issue the alert order. The order identifies the effected unit, alerting the unit as to its pending mobilization. The alert may also identify other requirements, such as the number of soldiers required for the mobilization. The alert gives the unit's command time to ensure that the assigned personnel are properly qualified and equipped. The alert also functions as a stop-loss order, which prohibits personnel from leaving the unit, as detailed in recent headlines and news articles.

Handbook, FORSCOM Regulation 500-3-3. This document is designed to be a single-source document for RC unit commanders. It provides planning information and requirements necessary to alert, mobilize, and move a RC unit to its mobilization station. Volume IV, Installation Commanders Handbook, FORSCOM Regulation 500-3-4. This document has two sections. Section I is the directive for preparing installation mobilization plans. Section II contains mobilization and deployment planning and execution requirements with a brief discussion of appropriate references. This section serves as a guide for the mobilization station commander to ensure all aspects of mobilization and deployment are considered in planning. Volume V, Demobilization, FORSCOM Regulation 500-3-5. This document assigns responsibilities and provides guidance, instructions, and procedures for redeployment and demobilization of Reserve Component (RC) units and individuals. It also includes guidance for demobilizing Individual Mobilization Augmentees, Retirees and members of the Individual Ready Reserve.

[7] For Army policy and guidance on mobilization planning, see Army Regulation 10-5, Organization and Functions, Headquarters, Department of the Army;" Army Regulation 10-87, "Major Army Commands in the Continental United States, Chapter 5, "Forces Command;" Army Regulation, "Army Mobilization;" Joint Pub 4-05, "Joint Doctrine for Mobilization Planning."

[8] See "It Is Different When a National Guard Unit Deploys," Jim Garamore, American Forces Press Service, Fayetteville, N.C., February 14, 2004.

[9] The mission of Forces Command is to train, mobilize, deploy, sustain, and reconstitute combat ready forces to meet Combatant Commanders' requirements across the spectrum of current and future operations. Conduct homeland defense operations and support civil authorities. See http://www.forscom.army.mil/default.htm.

[10] See http://deploymentlink.osd.mil/deploy/info/commands.shtml. Operational Control of the U.S. combat forces is assigned to the nation's Unified Combat Commands. A Unified Combatant Command is composed of forces from two or more services, has a broad and continuing mission and is normally organized on a geographical basis. The number of unified combatant commands is not fixed by law or regulation and may vary from time to time.

[11] National Guard Bureau is the federal agency that administers the Army National Guard and the Air National Guard and acts as an official liaison and communications mechanism between the Army and the Air Force and the several National Guard State commands. For the charter, organization and functions of the National Guard Bureau, see Army Regulation 130-5, AFMD 10, Army National Guard: Organizations and Functions of National Guard Bureau, 30 December 2001; See also 10 USC 10503.

Shortly after the alert order is issued, a mobilization order is issued. The mobilization order identifies the unit to be mobilized, sets the required strength of the unit and provides the date the unit is to report to the unit's armory in an active status. The mobilization order further specifies the date the unit is to report to its mobilization station.[12] At the mobilization station, the unit personnel and collectively the unit conducts battle-focused training, and undergoes a validation and certification of individual and collective training to ensure that the soldiers and the unit are capable of performing their assigned combat missions. Once the unit is validated and certified, it deploys as ordered.

Home Station (State) Mobilization

Once alerted, the state National Guard focuses mobilization resources to successfully execute the mobilization of the members of the unit. This requires not just the involvement of the command, but of the community. All Joint Forces Headquarters sections are engaged in the process of ensuring the soldiers, their families and their employers are ready to deploy. It is important to recognize, the mobilization of our Reservists, whether National Guard or U.S. Reserve, is more than the mobilization and deployment of individuals. Mobilization of Reservists effectively requires mobilization of their families and their employers, who experience tremendous disruption and sacrifices over the course of the deployment.

The Directorate of Manpower & Personnel is responsible for the overall personnel management of our membership. The directorate is divided into sections: Personnel Plans & Actions, which generates orders for personnel movements; Education Services, which oversees tuition (e.g., GI Bill) and other educational benefits; Personnel Services, which maintains personnel records; Chaplain Services, which provides for the spiritual needs of our members; Family Services, which provides information and assistance to our members' families; Recruiting and Retention, which maintains our force; Health Services, which medically provides for our members and serve as a TRICARE facilitator; and the Staff Surgeon, which ensures the medical fitness of our membership. Each directorate section -- along with the sections from other organizational directorates and supporting organization, including a VA representative, is deeply involved in the mobilization process.

In general, our personnel section processes soldiers to ensure that their personnel records are properly ordered. The personnel files contain information necessary to ensure dependents are properly identified and provided for. The processing includes enrollment of dependents in the Defense Enrollment Eligibility Reporting System,[13] which is

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[12] See http://www.dtic.mil/doctrine/jel/doddict/data/m/03458.html. The designated military installation to which a Reserve Component unit or individual is moved for further processing, organizing, equipping, training, and employment and from which the unit or individual may move to an aerial port of embarkation or seaport of embarkation.

[13] DEERS is a computerized database of military sponsors, families and others worldwide who are entitled under the law to TRICARE benefits. DEERS registration is required for TRICARE eligibility. For additional information on enrollment, see http://www.tricare.osd.mil/factsheets/viewfactsheet.cfm?id=126

required for access to the military health system (TRICARE).[14] The personnel section also validates Family Care Plans,[15] and ensures all necessary identification cards for soldiers and their dependents are issued. The personnel section also directly interacts with military families through the Family Program.

The medical section ensures that all soldiers meet the standards of medical fitness. The process requires the validation or giving of physical examinations and required vaccinations and inoculations. Dental examinations are also conducted. Blood testing for HIV antibodies is also performed. Personnel who do not meet the standards of physical fitness are not permitted to deploy. Depending upon the physical deficiency, the soldier may be processed for a medical discharge. If during mobilization or the demobilization process, a soldier is determined to have a disqualifying medical deficiency, and if the medical deficiency is "line-of-duty" (service connected), or if the soldier is eligible for VA health care based his or her service, the process of transitioning the soldier to the VA is commenced.

Continuity and Standardization of Health Care for Service Members/Veterans

The relationship between the Connecticut National Guard and the VA of CT is one of cooperation and mutual respect. We share the common goal of ensuring quality health care services for our returning service members from Operations Noble Eagle, Iraqi Freedom, and Enduring Freedom. Of our 1,600 (1,100 soldiers and 500 airmen) members released from active duty (REFRAD) since the beginning of the Global War on Terrorism, to date we have transitioned 64 to the VA. Further, the VA accepts our members' Department of Defense Form 214 (generated from the TRANSPROC System) without any problems, eliminating unnecessary delay in processing claims.

Our relationship has, by the increased use in recent years, strengthened. Our personnel have developed strong ties and understand the organizational requirements to provide quality services to our service members and veterans. The increased mobilizations of the National Guard during GWOT was positively resulted in three very important health care goals: (1) the continuity of care for our service members and (2) the standardization of care for our service members, (3) an experienced VA/National Guard health care community.

Since the Newington and West Haven VA facilities are TRICARE Network Providers, service members in their geographic regions can receive all medical and dental care prior to deployment -- as well as post deployment care -- from a single provider. The health care provider, therefore, has a complete picture of the service member's health history

[14] For TRICARE information, see http://www.tricare.osd.mil.

[15] Army Regulation 600-20, "Personnel-General: Army Command Policy, paragraph 5-5, requires essentially all unmarried soldiers who have minor dependents to have a valid plan to ensure the care of their families during periods of deployment. The plan, DA Form 5305, as a minimum includes proof that a guardian has agreed to care for dependent children under the age of 18. Powers of Attorney for medical care, guardianship and the authorization to start or stop financial support should be in the packet. The regulation also requires a letter of instruction to the guardian/escort that should contain specific instructions for the guardian to ensure the care of the dependents.

and is able to provide appropriate treatment on an individual basis. Further, in instances of VA claim submission, the transition is seamless, due to the fact that medical records are already at the VA, eliminating the need for records transfer from the Connecticut National Guard. The efficiency of this continuity of care itself creates a strong incentive for making the recently enacted (November 2003) TAMP Benefit permanent.[16] Additional examples of benefits arising from the continuity of care are stated below.

As more and more soldiers are mobilized[17] to and return from current military operations, the strain on Military Treatment Facilities (MTF) has also increased. Limited resources are stretched to cover more service members both before and after deployment. Therefore, timely access to care has decreased. Service members who live outside the 50-mile catchment area of the MTF can use either VA Facility during their terminal leave at no cost so long as the service member elects the VA as their TRICARE Primary Care Manager. Once the service member completes the terminal leave period, they may continue to use the VA facility at no cost under their veteran's status.[18] This reduces the strain on each facility as well as reducing the service member's travel time to and from appointments and out of pocket costs.

Many VA Health Care Providers are prior service members who understand the Military Health Care System. With this understanding, these providers assist the MTF in processing Medical Boarding Actions, Fitness for Duty Determinations, and Physical Profiling Actions. Many of our MTFs throughout the region are understaffed and overburdened due to their providers being deployed to support Operations Noble Eagle, Iraqi, and Enduring Freedom. Many MTFs are overflowing with wounded and injured service members who have been evacuated back to the U.S. Tapping into VA Resources facilitates the expeditious disposition of patient cases and allow for more timely care.

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[16] "The Fiscal Year 2004 National Defense Authorization Act required DOD to temporarily extend the period of TRICARE coverage for reservists and their families and provided the option for some reservists to buy into the TRICARE program. Specifically, the NDAA 2004 provisions required DOD to
1) extend the Transitional Assistance Medical Program (TAMP) to allow recently demobilized reservists and their families to retain TRICARE benefits up to 180 days [previously from 30 days to 60 or 120 days depending on the members' accrued total active federal military service];
2) make reservists and their families eligible for TRICARE benefits as soon as they receive a delayed-effective-date order for activation or 90 days before activation—whichever is later; and
3) allow certain reserve members, who are not mobilized, and their families who do not have any other health care benefits to enroll in TRICARE by paying 28 percent of program costs. [This enrollment would allow them to receive TRICARE benefits for any period that the member is an eligible unemployment compensation recipient or is not eligible for health care benefits under an employer-sponsored health benefit plan.]" See "Status of Defense Health Requirements for Fiscal Year 2004," GAO-04-563R, March 17, 2004

[17] "Since September 2001, about 360,000 reservists have been called to active duty to support the war on terrorism, conflicts in Afghanistan and Iraq, and other operations." *Ibid.*

[18] Veterans who serve on active duty in a theater of combat operations during a period of war after November 11, 1998 or in combat against a hostile force during a period of hostilities are eligible for hospital care, medical services, and nursing home care for a period of two years from their date of discharge. See VA Website at http://www1.va.gov/elig/page.cfm?pg=34

The resources of the Newington and West Haven VA are great resources for providing health care for the hundreds of service members that are now becoming eligible for both VA and TRICARE Benefits. Operations Enduring and Iraqi Freedom are scheduled to continue for the foreseeable future. This interconnection between the VA and TRICARE leans itself to the provision of timely, efficient and professional health care services for our redeploying service members and veterans.

Access to permanent pre-mobilization health care authorization for our service members and their families is also improving under TAMP. However, this access is scheduled to expire on 31 December 2004. In order to ensure our service members are ready to mobilize at a moment's notice, medical care coverage must continue to be available. Reserve families who utilize TRICARE will not experience health care coverage disruptions during mobilizations, as will other families whose deploying service member may have to "trade" their commercial employer sponsored health plan for TRICARE.

Eventually all Reservists mobilized for GWOT will become eligible for care in the post-mobilization period. To establish continuity of care pre- and post-mobilization, it is in the best interest of the service member and medical readiness to ensure that medical care is available during the pre-mobilization period. If care is provided before mobilization, this ensures service members are deployable assets upon activation. Service members that are healthier prior to deployment will not require last minute specialty care and are ready to immediately begin training for their wartime mission. The extension (and expansion) of the Unemployed and Uninsured Medical Benefit (TRICARE Reserve Select) is prudent, as envisioned by the Senate version (S. 2400) of Fiscal year 2005 National Defense Authorization Act. Preventative medicine is the key to both medical readiness and health care cost reduction.

Understanding that DoD and VA facilities are becoming more and more overwhelmed by the new OEF/OIF patient and family population, additional providers/facilities need to be acquired into the TRICARE Network. Currently, there are not enough facilities or Primary Care Managers/Providers in Litchfield and Tolland Counties. The Patient/Soldier ratio to providers for CT Army National Guard members in Litchfield County is 59:1 and in Tolland County is 214:1. In all other counties in Connecticut, the ratio is 10:1 or less with the exception of Middlesex County, which has a ratio of 17:1. Additional providers in Litchfield and Tolland Counties will enhance both the pre-mobilization and demobilization phases by expanding access to care for soldiers who live outside the 50-mile catchment area of our one and only MTF, the Sub Base in Groton, CT.

As stated above, soldiers with access to care are healthier, making them a medically deployable asset and reducing the medical bottlenecks created during times of large-scale mobilizations. Medical processing during mobilizations is time consuming. Medical disqualifications discovered during unit mobilizations potentially undermine the overall readiness of a unit to mobilize and deploy. Moreover, if deploying service members know that their families can get their health care locally, without disruptions, they have one less problem to resolve while preparing for deployment. Ultimately, such peace of

mind and reduction in unnecessary travel to a distant network provider, facility or MTF allows deploying service members to concentrate on their duties without worrying about their family's wellness. A healthier soldier is potentially a healthier veteran.

Conclusion

The experiences of the Connecticut National Guard as they relate to veteran health care provided by the VA has improved because of the strong relationships developed through our interaction and the TAMP Benefits, which underscore continuity and standardization of care of service members and veterans alike. However, to capitalize upon these recent improvements, the temporary provisions of the TAMP benefits of National Defense Authorization Act of 2004 need to be extended to continue ensuring a better quality of life for our service members and their families, thereby enhancing overall medical readiness of the Connecticut National Guard to efficiently and effectively mobilize and deploy to execute its wartime mission. A healthy Reservist is potentially a healthier veteran.

The Connecticut National Guard's successful experience in transitioning our members to the VA originates from our strong relationship with the VA. VA personnel, especially Mr. John Lankford, Mr. Hal Farrington, and Ms. Michele Wils provide direct and full support. They dedicate themselves to servicing the health care needs of veterans and service members. Ms. Michelle Wils and Mr. John Lankford from the VA provide invaluable assistance to our service members upon demobilization, volunteering their time, resources and expertise to provide our service members with a comprehensive review of VA services and benefits. They provide our returning service members useful information on how to make a claim to the VA for medical care benefits as well as where to file the claim and where to receive medical care once the claim has been approved. During the claim process, Ms. Wils and Mr. Lankford counsel them every step of the way and assist in gathering necessary documentation to establish the service members' eligibility for the claim. Both of these outstanding individuals have committed themselves to following each case to its conclusion and providing any necessary assistance along the way.

The Connecticut National Guard extends our thanks to the VA for the assistance it provides for our service members. We appreciate the VA's cooperation throughout the entire mobilization and demobilization process and their providing quality service member support services. We look forward to continuing this productive relationship. Our appreciation is also extended to the Groton Navy Sub Base for its performance in providing MTF support beyond our expectations.

NOT FOR PUBLICATION
UNTIL RELEASED BY
THE HOUSE VETERANS'
AFFAIRS COMMITTEE

CAPTAIN JEFFREY BASHFORD, NURSE CORPS

DEPUTY COMMANDER

NAVAL AMBULATORY CARE CENTER GROTON

BEFORE THE

IOUSE ARMED VETERANS' AFFIARS COMMITTEE'S

SUBCOMMITTEE ON HEALTH

ON

IMPROVING VETERANS CARE

7 June 2004

NOT FOR PUBLICATION
UNTIL RELEASED BY
THE HOUSE VETERANS'
AFFAIRS COMMITTEE

Thank you for this opportunity to appear before the committee to provide an overview of Navy Medicine's collaborative efforts with the Veterans' Affairs Health System to provide health care for Connecticut veterans. I am the Deputy for the Naval Ambulatory Care Center, Groton, Connecticut, one of five ambulatory care centers that make up the Naval Health Care New England command. Our other facilities are located in Newport, Rhode Island, Portsmouth, New Hampshire, Brunswick, Maine and Ballston Spa, New York. We provide a comprehensive array of medical, surgical, pediatric and mental health ambulatory care services, including pharmacy, laboratory and radiology to Department of Defense (DoD) Military Healthy System (MHS) eligible beneficiaries. Additionally, we provide limited inpatient care services through External Resource Sharing agreements with two local civilian hospitals in the Groton area, Lawrence & Memorial and William W. Backus. These services are available to DoD MHS eligible beneficiaries from across the state. Patients that require additional services not available in our direct care system are referred to a network of local civilian providers under a managed care support contract administered by the TRICARE Management Activity. DoD MHS eligible beneficiaries may receive inpatient care at the West Haven Veterans Affairs Medical Center under the TRICARE contract. However, due to distance and drive time from the Groton area most of these beneficiaries do not elect to uses this arrangement. .

Service members separating or retiring from active duty in the Groton area complete a separation physical examination at the Naval Ambulatory Care Center, and are screened for disability and potential veterans' health care system benefits in collaboration with the Veterans Affairs Office on Submarine Base New London. The

service member is provided a copy of his military health record, and is referred for further evaluation as necessary to the Community Based Outpatient Clinic at the Coast Guard Academy in New London.

Finally, Naval Health Care New England recently signed an agreement to expand to all our facilities, a pre-existing agreement with the Naval Ambulatory Care Clinic, Newport, to utilize Veteran Integrated Service Network (VISN) One laboratories as reference laboratories for clinical laboratory services not available within our direct care system. This cost-effective and mutually beneficial measure will allow needed consolidation and centralization of laboratory services throughout Naval Health Care New England in times of reduced staffing. Additionally, VISN One staff have been instrumental in assisting us with meeting accreditation standards throughout all our laboratories through "mock" inspections. As a consequence, we have had unparalleled success in meeting College of American Pathologists laboratory certifications, with all Naval Health Care New England laboratories fully accredited "with distinction".

This concludes my prepared statement. I would be happy to answer any questions from the committee.

Statement of
Richard A. Sapp, Jr.

Military Services Coordinator
Fort Drum, NY

Before the
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

June 7, 2004

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss how the Department of Veterans Affairs (VA) team at Fort Drum assists the Connecticut National Guard and other troops during the demobilization process.

The Buffalo Regional Office currently has three Veterans Benefits Administration (VBA) employees assigned to the Benefits Delivery at Discharge Program at Fort Drum. The goal of the Benefits Delivery at Discharge Program is to provide benefits and services to all separating servicemembers, assist in the application process, and complete the disability rating (for all benefit applications received) prior to or within close proximity to the actual separation date.

Servicemembers with more than 45 days remaining until separation are identified through the Transition Assistance Program (TAP) and given assistance in completing the VA Form 21-526 (Veteran's Application for Compensation and/or Pension Benefits). The Fort Drum staff provide TAP briefings to over 200

servicemembers per month. In addition, we most recently are processing over 80 claims per month with an average processing time of 45 days.

One of Ft. Drum's employees was recently moved to Landstuhl, Germany to assist servicemembers being discharged from there. This is a reflection of the expertise that the Buffalo Regional Office has developed in assisting servicemembers with the disability claims process.

During the next several months, separations within Fort Drum are expected to increase with a total of 1,233 demobilizations expected in May 2004, 2,245 demobilizations expected in June 2004, 649 demobilizations expected in July 2004 and 543 demobilizations expected in September 2004. The Fort Drum team's responsibility is to provide information regarding VA benefits and services to all separating servicemembers and assist these servicemembers in obtaining benefits for which they are eligible prior to returning home.

In addition, we provide all separating servicemembers with information about medical care, disability claims processing, education benefits, the home loan guaranty program, the importance of obtaining a physical before discharge from active duty, and the importance of obtaining copies of associated documentation. We also provide general information regarding benefits available at the state and county level and the points of contact for these types of benefits. We make ourselves available to answer questions on an individual basis before the unit

departs Fort Drum and returns to their home stations. To that end, an additional VBA staff member has been added at Fort Drum to ensure we are available to assist all returning servicemembers.

Closing

Mr. Chairman, we at Fort Drum take great pride in the services we provide for demobilizing soldiers. Showing that the VA is available to support them is essential for the serviceperson to make the transition into his/her civilian life and increases the likelihood of a successful adjustment. The service that we provide is an essential part of the transition process for that serviceperson and/or military unit. That concludes my formal remarks. I would be pleased to answer any questions.

Testimony

Of

Edmund J. Burke

Before the

HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

June 7, 2004

Concerning

Optimizing Facilities and Improving Health Care
And Benefit Services
To Veterans in the State of Connecticut

Mr. Chairman and other distinguished members of the committee, I am grateful for this opportunity to present my views on the current state of VA healthcare delivery in Connecticut I currently serve as the Coordinator of Veterans' Services for the Department of Mental Health and Addiction Services. I'd like to clearly state, however, that I come before you today as a veteran, as Secretary of the Connecticut Veterans Coalition Forum, as Co-Chair of the VA Connecticut Healthcare System's Community Mental Health Advisory Board and as one of two Connecticut members of the VISN I Mental Health Community Advisory Board. I would appreciate your entering my prepared statement into the record.

Over the past eight years veterans in Connecticut have seen their healthcare delivery system dramatically cut under VERAs' knife. We were told that the veteran population was shifting to the southern states and therefore VA healthcare funding would follow them. Programs within the Connecticut system were cut, inpatient beds were lost and staffing in the hospital was allowed to drop to such a level that some clinics had to close totally. VA Connecticut's' response to this funding dilemma was to do massive outreach to the veteran community in an attempt to register more veterans into the VA healthcare system. It was believed that if more veterans were being served, more funding would follow. This effort served only to clog the hospitals and clinics with veterans who could not get timely appointments and needed treatment.

During this same time period, administration with in VA Connecticut Healthcare was in constant flux. We seemed to change "temporary" directors on a six month basis. It appeared that VA healthcare was in crisis and in need of critical care.

We in the veteran community were then informed about a new attempt to better serve our needs for care. VA would initiate CARES and as part of this new initiative. We in Connecticut could possibly be negatively impacted by this as the Newington Hospital and community clinics were mentioned as candidates for the chopping block. During this same time period, Connecticut VA Healthcare finally got a new permanent Director who was willing to listen to and work with the veterans VA serves. We also were fortunate to have several very supportive legislators who actively listen to and supported veterans in their fight to save their healthcare.

With the active support of legislators, VA administrators and the veteran community we were able to save the Newington VA Hospital, the Willimantic Community Clinic and bring more money to shore up the badly sagging VA healthcare system. I sincerely thank all of you for your efforts.

However, there are several areas of concern that I must address at this time. On an almost daily basis I am confronted by veterans who suffer from difficulties as a result of their persistent mental illness and/or resulting substance abuse. Many of these veterans are homeless and abandoned by family and community. I find them in public hospitals and homeless shelters. They often are in need of inpatient hospitalization and even though they are eligible for VA care (in many cases they are service connected for their

conditions) there are no beds available for long term care of these veterans in Connecticut. I have been told by VA that long term care for these veterans is available at the VA facility in North Hampton Massachusetts. But, in the past seven years I have only known of one case in which a veteran from Connecticut needing long term inpatient mental health care was admitted directly into an inpatient bed in North Hampton. We need long term care for these veterans made available and accessible.

I also find it disheartening that veterans who come to the VA for extended outpatient treatment my find themselves housed in homeless shelters while receiving treatment. VA Connecticut should find a way to house these veterans in a setting which reflects the degree of dignity these veterans service should have guarantee them.

Along with mental health treatment, long term care for an ever increasing population of veterans who are growing older was never addressed by CARES. This issue seems to be the elephant in the middle of the room the no one sees. Long term care at a nursing home level needs to be addressed now. Let me relate to you the case of a Vietnam veteran who was one hundred percent service connected for a mental health condition as well as hepatitis C as a result of exposure to Agent Orange. VA agreed with a treating physician at Hartford Hospital that this individual was in need of a liver transplant. VA agreed to do the surgery but he would have to wait until a liver was available. During this waiting period he would need daily monitoring and treatment in a nursing home. VA would not fund this treatment and the veteran was forced to spend his VA service connected disability compensation to pay for his nursing home treatment until he reach a level and could access title nineteen eligibility. Basically, he was forced to go into poverty to pay for his treatment for a condition created by his service in Vietnam. Is this part of the promise this nation made to its veterans? I ask those of you who represent us not to make our healthcare a political football that is kicked about by party politics. Find funding and methods to provide long term care for veterans who need it.

In closing I would like to thank the Connecticut VA Healthcare Director, his administrative staff and the employees of Connecticut VA Healthcare system.
I have had the pleasure of working with them at all levels and I find them to be truly dedicated and caring in their treatment of Connecticut's veterans. I also would like to thank the Representatives of this Committee for their willingness to listen to the concerns of this states veterans and I ask you to do all that you can to insure that this nation does not breach the moral contract it has made to its veterans.

STATEMENT OF
PAUL J. POBUDA & FREDERICK C. STOCKMAN, DEPARTMENT SERVICE OFFICE
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
VETERANS'S AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
OPTIMIZING FACILITIES AND IMPROVING HEALTH CARE AND BENEFIT SERVICES TO VETERAN IN THE STATE OF CONNECTICUT

JUNE 7, 2004

Mr. Chairman and members of the Subcommittee;

As Veterans Advocates, we appreciate this opportunity to present the view of the members of The American Legion, Department of Connecticut regarding Department of Veterans Affairs Health Care and Veterans Benefits. This hearing could not have been scheduled at a better time in light of the recent release of the Secretary of Veterans Affairs Capital Asset Realignment for Enhanced Services (CARES) Decision. This two-year project to reassess the structure and facilities of the Department of Veterans Affairs (VA) was intended to identify and create efficiencies to better utilize the assets of the department and to enhance heavily demanded services for veterans. While the initial decision makes great recommendation in overall facility usage, expansion of healthcare services remain unresolved. We must remain cognizant of the fact that VA continues to bar Category 8 veterans from enrolling in the VA health care system, effectively turning away hundreds of thousands of enrollees due to budgetary constraints.

In addition, The American Legion remains deeply concerned that VBA's efforts to reduce the backlog of pending claims and, thereby, improving service to veterans is having just the opposite effect. The veterans of Connecticut ad across the nation continue to experience delays, premature denials, and unnecessary appeals.

CARES

VA is the nation's largest direct provider of health care, serving veterans at hundreds of locations nationwide. In 1995, to keep pace with industry changes such as the rapid growth of medical technology; the market restructuring of American healthcare; and an aging veterans population, VA began to shift from a hospital focused system that emphasized impatient care to one of ambulatory care that focused on outpatient treatment. To help reduce the reliance on large hospitals, VA

developed regional networks known as Veterans Integrated Services Networks (VISNs) that would provide a continuum of care focusing on an outpatient setting.

In addition, Congress passed the Veterans Health Care Eligibility Reform Act of 1996, providing key changes to ensure a successful transformation including:

- new eligibility rules that allowed VA to treat veterans in the most appropriate setting:
- introduction of managed care principles , such as a uniform benefits package;
- an expanded ability to purchase services from private providers and to generate revenue by selling excess services to non-veterans.

The transformation occurring in the delivery of health care outpaced VA's ability to make significant infrastructure changes. VA facilities were built at a time when bed based care was the standard mode of providing health care. The change form inpatient to outpatient service became the impetus for VA to find a new delivery system to meet veterans' health care needs.

The Veterans Health Administration (VHA) has over 4700 buildings in its inventory and more than 18,000 acres of land. A majority of the buildings are over 25 years old and maintaining the safety and usefulness of them is expensive. In 199, the General Accounting Office (GAO) issued a report claiming VHA "wastes" up to 1 million a day in maintaining unused and underused assets.

When VHA initiated the CARES Program it was designated to guide VHA's future capital investment decisions to realign and allocate capital resources. The implication and impact the CARES decision would inevitably have on veterans throughout the nation was startling. The American Legion was propelled into action and as an organization got involved and has remained so during the past four years.

With the release of the CARES Decision in May 2004 the process has now entered the implementation phase or step 8 of the 9 step CARES process. The American Legion fully expects VA to re-evaluate previous decisions as environments change and shifting of health care priorities takes place. The capacity of VA to provide care to returning veterans from current military operations has yet to be tested. VA needs to remain diligent in is planning and to prepare for a new generation of veterans.

CARES not only impacts the delivery of health care, but also the delivery of disability benefits and burial services. The CARES process included a comprehensive look as collaborations with the Department of Defense, Veterans Benefits Administration about the National Cemetery Administration. These collaborations are designated to maximize facility space and save money while providing more efficient services to the veteran.

Connecticut

VA's presence in the State of Connecticut includes an array of services and facilities:

Hartford Regional Office
VA Connecticut Healthcare System Newington Campus and West Haven Campus
Six Community Based Outpatient Clinics

Three Vet Centers

CARES projections indicate an increase in demand for inpatient, primary and outpatient specialty care. To meet this demand the decision has been made to expand, within the existing facilities to the extent possible and then contract out into the community for the remaining demand.

During the proposed expansion of space, veterans should not experience undue delays or cancellations because of construction. The American Legion believes that transformation should be seamless and VA should take every step to mitigate potential problems.

The contracting of care in the community should be kept to an absolute minimum and only contemplated after all other avenues have been exhausted. The veterans' quality of care is an issue when forced to go outside the VA system. It is important that safeguards be put in place to ensure that standards for care remain high and veterans are not lost in the contacted care system.

Long-term care, mental health and domiciliary care were not evaluated during the CARES process. VA is in the midst of correcting this problem. The American Legion intends to follow the progress of the various committees that have been put in place to correct this problem. However, until a solid plan has been put in place through out the system, there should be no significant changes in these services unless it is to the advantage of the veteran.

The American Legion believes there are many effective approaches to maximizing the efficiency of facilities:

- P.L. 106-117, the "Veterans Millennium Health Care and Benefits Act", mandates VHA to provide long-term care to service-connected veterans rated 70 percent and higher and those veterans with service-connected conditions that require long-term care. VHA has yet to fulfill the requirements of this law. As previously mentioned, long-term and domiciliary care are not included in CARES.
- Do and VA could use these facilities in an effort to integrate their health care services through additional sharing agreements and joint venture opportunities. There are Reserve and National Guard medical units across the country that could use these facilities to meet their training requirements and storage of medical equipment and supplies.
- VA's medical education programs provide excellent training opportunities for health care professionals, many are full-time students living on fixed incomes and in need of affordable housing. Serious consideration should be given to renovations of unused or underutilized facilities to provide on-campus lodging for health care professional students or academic training facilities, such as, labs, classrooms, or research centers.
- Homeland Security requirements will begin at the grassroots level and many VHA capital assets may serve local, state and national needs in its role as a contingency back-up to DoD medical services and the National Disaster Medical System (NDMS) during national emergencies.

The American Legion believes that any evaluation of underutilized or empty buildings should be considered in the context of a fully utilized VA health care delivery system that takes into

consideration VA/DoD sharing, the "Veterans Millennium Health Care and Benefit Act", VA's medical education program, and Homeland Security.

Claims processing

Mr. Chairman, The American Legion is also very concerned by problems affecting the processing of veterans' benefit claims at the VA regional office here in Connecticut and the 57 other regional offices s across the country. The mission of these offices is to render decision on these claims in a fair and proper manner, in accordance with VA statutes and regulations, in a timely manner. We believe very strongly that, over the pas three years, VBA's all out effort to fulfill Secretary Principi's often-stated goal of reducing the backlog of pending claims to 250, 000and bring down processing time to an average of 100 days has skewed the regional offices' priorities, to the detriment of those they are mandated to serve. Veterans are ill served by policies that sacrifice quality decision making for the sake of meeting some arbitrary production standards. When it comes to deciding VA claims, which very often involve multiple disabilities and complex legal and medical issues, faster is not always better.

It is true that there was a dramatic reduction in the backlog of pending claims. The backlog went form almost 550,000 at the end of 2001 down to 253,000 by the end of September 2003, as promised. However, there was a series of precedent decisions from the U.S. Court of Appeals for Veterans claims and the U.S. Court of Appeals for the Federal Circuit holding that the VA had violated the law and its own regulations. These decisions affected about, 100,000which now have to be reworked and reviewed. In addition, the region offices have been required to do a number of re-evaluations of diabetes claims, as a result of the court decision in *Nehmer v. Brown.* The reworking of tens of thousands of cases previously completed or in process takes time and scarce resources away from the completion of other types of claims. It hurts veterans and their families and, ultimately, is an unnecessary waste of taxpayers'money.

Mr. Chairman, the regional offices, had been focused almost exclusively on reducing the backlog of pending claims. As it declined, a corresponding growth in the backlog o new appeals and remands grew. This continues to be of particular concern to The American Legion, since appeals by their very nature are among the oldest type of claim in the VA system and they deserved to be finally decided as expeditiously as possible. Many veterans will die before their claim is finally decided. We believe the increase the appellate workload stems directly from the regional office overriding concern for the quantity assurance or personal accountability tends promotes the churning of cases through the regional office and up to the Board of Veterans Appeals where the majority of regional office decisions continue to be overturned in whole or part. This fundamental problem is also reflected in the decisions of the U.S. Court of Appeals for Veterans Claims, which remand sand average of fifty percent of the cases back to the Board of Veterans Appeals for further needed action.

The bottom line is that for too many veterans must endure months of frustration and financial hardship while waiting for VA to "do the right thing". While a claim is in process, unfortunately, the is a good chance the veteran will not be fully or correctly informed of the evidence needed to support their claim, or the claim will not fully developed, as required by the Veterans Claims Assistance Act of 2000. The rise in the number of appeals and their outcome reflects the fact that thousands of

veterans each year who feel that their claim have been prematurely or arbitrarily denied or that they did not receive the full measure of benefits to which they are legally entitled.

The American Legion believes that VBA must change its policies and make quality the regional offices' top priority. Unless and until this is done, veterans and their families will have to endure needless hardship and delay, which is not what Congress intended when it established the Department of Veterans Affairs.

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VETERANS OF FOREIGN WARS OF THE UNITED STATES

DEPARTMENT OF CONNECTICUT

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June 7, 2004

The House Committee on Veterans' Affairs
Subcommittee on Health

Dear Mr. Chairman and members of this Committee:

My name is Glenn N. Tewksbury. I am the service officer for the Department of Connecticut, Veterans of Foreign Wars of the United States. I am speaking for 26,000 plus veterans who are V.F.W. members in Connecticut and 6,000 Ladies auxiliary members. I have been a Veterans' Service Officer for over 15 years and have seen many changes within the VA Health Care System.

There are a few things which should be noted concerning The Veterans Millennium Health Care and Benefits Act, H.R. 2116. This bill Significantly changes VA authority to provide emergency care IN non-VA facilities to Non-service connected veterans who were not previously eligible for this type of care.

I have personally witnessed several veterans who were faced with no Medical Insurance and then landed in a private Hospital with Medical Bills of $60,000 or $80,000. Each and every time in which I contacted the Fee Basic Department at VA CT Medical Center, they went to work on the Emergency Medical Bills and negotiable with the private Hospitals and paid the emergency medical bills for these veterans. I want to Thank the VA CT Medical Center to being receptive to this bill and accommodating these Veterans.

Another good development from the Millennium Health Care Bill is addressing the LTC Issue. In Connecticut the VA Medical Center does not have any long-term nursing home beds at VA West Haven Medical Center. If the Veteran meets the requirements of the Veterans Millennium Health Care bill of being service-connected of 70 per cent or more, then his Long Term Care is contracted out to private nursing homes in Connecticut. So this is a good bill, however, VA CT needs Long Term Care beds at their Medical Center. VA CT used to have a 90 Bed Long Term Care facility and they closed it. We still have a need for a 90 bed LTC facility in Ct. The Veterans of Foreign Wars would like to see a new 90 bed LTC facility build in CT.

During the past five years the establishment of seven out- patient centers has significantly improved the accessibility to Health Care in Ct.
These out-patient clinics has reduced travel time to and from VA Medical Centers. Many Veterans in other Larger states have to travel over 200 or 300 miles to a VA Medical Center. These new seven out-patient medical centers definitely reduces a lot of travel time for our Veterans in Ct.

STATEMENT OF
ALLEN W. GUMPENBERGER
NATIONAL SERVICE OFFICER
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
JUNE 7, 2004

Mr. Chairman and Members of the Subcommittee:

On behalf of the local members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on the Department of Veterans Affairs (VA) benefits and medical services for sick and disabled veterans. VA Connecticut Healthcare System has shown positive improvements over the past two years, but improvements are still necessary especially with respect to appropriate funding and accessibility.

The improvements to the VA Connecticut Healthcare system are due in part to the quality leadership we have in Roger Johnson, Director of the VA Connecticut Healthcare System, his staff, and his employees at each of the VA health care facilities in Connecticut. From our experience, most of the VA employees are working hard to carry out their mission, but often find themselves undermanned and overbooked.

Mr. Johnson has been responsive to issues and complaints we have raised. For example, one of our veterans, who was rated 100 percent service connected, was being denied nursing home care at VA's expense and was basically informed that he would have to resort to Title 19. We contacted Mr. Johnson with the veteran's concerns, and he contacted the VA Community Nursing Staff and resolved the problem quickly and professionally. Mr. Johnson periodically holds meetings with Veteran Service Officer (VSO) to keep us informed on recent developments in the VA Connecticut Healthcare system to include expansion of services at the Newington Campus and the CARES recommendations and implementations. During these meetings he has expressed his goals of expanding specialty care services at Newington by adding a dermatology clinic and a gastroenterology clinic.

Although this is the right direction, in our opinion, progress is still necessary in the VA Connecticut Healthcare system. In addition to local Community-Based Outpatient Clinics (CBOCs), which do not provide sufficient hours of operation and are understaffed, we feel more specialty clinics need to be erected at the Newington Campus to include an orthopedic clinic and a pain management clinic. Nearly 20,000 veterans rely on the VA Connecticut Healthcare system and live more than 45 minutes away during rush hour traffic from the West Haven Campus, including approximately 13,000 in the Hartford area, 3,000 in the Litchfield area, and 3,000 in the Tolland and Windham areas. Orthopedic and pain related disabilities plague a large number of these veterans. This patient population should have access to specialty care without being forced to travel the distance to West Haven for specialty care.

Transportation to and from VA medical treating facilities still remains a largely debated issue here in Connecticut. We are concerned about the aging veteran population. With more elderly veterans becoming unable to drive, they are relying more heavily on others to assist them in getting to and from the VA medical facility. We have had our disagreements locally when the VA Connecticut Healthcare system took a very narrow interpretation of the legal guidelines to authorize VA transportation; however, this interpretation has since relaxed and we are progressing toward a better system. At one point, they determined that a veteran had to be in a wheelchair to get VA transportation. After in-depth discussions with Mr. Johnson, he agreed that some patients are medically unable to drive to the VA treating facilities and are not wheelchair bound. He agreed that patients who are epileptic, blind, or on some debilitating medications are not medically advised to drive. A committee made up of physicians selected by Mr. Johnson has been created, and now determines whether veterans are entitled to VA transportation. We appreciate these efforts, but more needs to be done. We hope that you agree that leaving a veteran at home to suffer daily without medical aid until he or she progresses to a point where they need emergency care is an **outrage,** especially when that veteran is eligible for VA health care and simply needs a ride.

Through the DAV transportation network, we make every effort to provide transportation for our fellow veterans in need of medical care. Though our system is manned by volunteers, mostly disabled veterans themselves, we will continue to make every effort to support and care for our comrades. However, if it is truly this Subcommittee's intent to provide high quality health care in a timely manner, then transportation is vital for veterans in need of medical care. We appreciate Mr. Johnson's liberal interpretation of the law, but the VA transportation system is still restricted by the legal guidelines. **As our elected representatives, we look forward to working with you to liberalize the VA transportation guidelines so that no sick and disabled veteran suffers without relief because of his inability to get from his home to the VA hospital.**

Another problem is the waiting time for specialty care. In most specialty clinics, disabled veterans are waiting 6 months to a year. For example, a colonoscopy requires an average of 6 months waiting, and sleep studies are taking up to year. Access means that the quality care must be timely and within a reasonable traveling distance. Access to priority health care has seriously eroded **due to drastically inadequate health care funding.**

In order to combat these major problems infesting our health care system, mandatory health care funding is necessary. On January 7, 2003, Senator Tim Johnson (D-SD) introduced S. 50. A leadership bill (S. 19) introduced by Senator Tom Daschle (D-SD) also recognized the need for guaranteed funding. In the House, Representative Lane Evans (D-IL) introduced H.R. 2318, the Assured Funding for Veterans Health Care Act of 2003, on June 4, 2003. If passed, adequate level of funding for the VA health care system would be mandated.

Many of our elected officials believe that the status quo is working and that the current process of bickering over funding for VA health care should commence year after year, while the health care system continues to erode. The rising cost of medical care continues to result in an increase in demand for VA health care. As this demand increases, so does the demand for funding to provide care to these newly enrolled patients. Right now, the VA health care system

has to depend on the imperfect guesswork of Congress and the White House to come up with a level of funding adequate for health care. **Each year, this funding proves to be inadequate.** Each year, we come back to you with the same problems and each year, you bicker about it among yourselves and brag to us about how much you care about veterans and all the good you do for us. Each year, we are forced to wait on a list to get quality care.

The solution is simple, straightforward and proper. The VA should not be forced to ration health care to eligible veterans. We believe that it is an outrage for our government to promise health care and then expect us to lobby each year to get funding to pay for this promise. **Guaranteed funding would be this promise followed through**. It would ensure that the VA receives its funding level by October 1 each year, the first day of the fiscal year, instead of waiting for Congress to pass an appropriations bill. Guaranteed funding would provide the VA with the funds necessary to tackle the problems imposed by the rise in demand for VA health care and the rise in cost of providing this health care without relying on the governmental guesswork now in place.

After being frank with you with respect to the VA Connecticut Healthcare system, we would be remiss not too mention the efforts and leadership of Mr. Ricardo Randle, Director of the Veterans Service Center in Hartford, his staff, and employees of the Hartford Veterans Service Center (VSC). We share their optimism about being co-located at the Newington campus. Mr. Randle has a great attitude. On his first day as the Director, he stated that we need to "grant if we can and deny only in those situations where there is no other alternative." He has carried this attitude with him in our daily dealings with him. He and his staff hold VSO meetings to keep us informed on the progress, goals, and accomplishments of the VSC. It is apparent that the morale of VSC employees has improved and they are moving toward a brighter atmosphere of compassion for the disabled veteran.

One area of concern is the adequacy of training of the VSC employees and VSO service officers. Mr. Randle approached us about this concern, and together we began to construct a Corroborative Training Initiative (CTI) to discuss our weaknesses and differences in the interpretations of the law. We hope that by training together we can understand each other better, communicate our positions on issues more directly, and offer a more liberal and fair service to all veterans. We remain optimistic about this initiative.

Two areas of major concern remain, however. One is the Veterans Claims Assistance Act (VCAA) requirement to provide a letter to each claimant on what is needed to support each claim submitted and the other is the appeals backlog. The current VCAA letters are vague and the language misleading, often confusing the claimant. The most difficult problem with the VCAA letter is devising a form letter that fits every mold and claim. In order to truly have an effective VCAA letter, each letter must be individually prepared with the unique circumstances of the case presented; the accumulated material evidence discussed; and the evidence required to support the grant of each claim considering every possible avenue of entitlement. As you can imagine, this requirement is difficult, if not impossible to attain to perfection. But nevertheless, the VSC employees are working diligently to meet this requirement.

The appeals backlog still plagues the VSC, but we hope that we can work together to try to bring this down. Neither issue really directly impacts the VA Connecticut Healthcare system. However, indirectly, the claims process relies on the health care system to provide adequate compensation and pension examinations to assist the VSC in making a good decision the first time. Many cases are remanded by the Board of Veterans Appeals requesting a thorough comprehensive examination to adequately portray the disability or disabilities or to resolve the question of etiology of a disability or disabilities. The Compensation and Pension (C&P) unit has been timely in Connecticut, often having the examination completed within 30 days of the VSC's request.

We have noticed, however, that the C&P unit often returns the request as cancelled, if the veteran is unable to attend within that 30 day period. The VSC now must make another request for the exam. The C&P unit does this in order to meet their goal of scheduling the veteran within 30 days of the VSC's request regardless of the reasons or circumstances.

Medical opinions and conclusions are very important elements to a veteran's claim. When a veteran requests the C&P examining physician's opinion with respect to etiology or severity, they are often told that the examiner will only address questions raised by the VSC. The examining physician should be encouraged to address any and all medical questions raised by the veteran and the VSC. We have heard the complaints of rating specialist arguing that when an examiner provides a medical opinion, they have to deal with it and it frustrates them. They argue that these opinions often are speculative and result in slowing down the process. Even though they may indeed have good reasons for their opinions, the idea is to gather all the facts, answer all the questions, and develop every theory of entitlement plausibly raised to provide a correct decision the first time.

Encouraging health care providers to provide medical opinions should be constant throughout the system, and not just during C&P exams. When a veteran has a question of etiology or severity with respect to one of his disabilities and poses this question to his treating primary care physician or appropriate specialty care physician, he is often referred to the VSC to raise his question in the form of a request for a C&P examination. The problem with this is that VSC is not required to request C&P examinations merely because the veteran request it. According to VHA Directive 2000-029, VHA health care providers shall provide a statement or opinion describing a patient's medical condition upon his or her request for a statement. This policy encourages health care providers to provide opinions whenever asked and would resolve this "catch-22" many veterans find themselves in when asking innocent questions regarding their disabilities, which may or may not prove useful in the claim process. In any event, a VA health care provider should never advise the veteran to ask the VSC to request a C&P examination to resolve a medical opinion.

Since we are discussing compensation, there is one issue of utmost concern that we must bring to your attention, which is concurrent receipt legislation. For nearly two decades, we have aggressively lobbied to end the ban on concurrent receipt of career military retirement pay and VA disability compensation. Last year, measures were passed to begin a 10 year phase-in of concurrent receipt. This move was a step in the right direction, but far from sufficient. It only applied to veterans with VA compensation combined ratings of 50 percent or more. Those

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