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LEGISLATIVE HEARING ON H.R. 1448, H.R. 1853, H.R. 1925, H.R. 2005, H.R. 2172, H.R. 2173, H.R. 2192, H.R. 2219, H.R. 2378, and H.R. 2623

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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THURSDAY, JUNE 14, 2007

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

The Committee met, pursuant to notice, at 10:00 a.m., in Room 340, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Brown of Florida, Snyder, Hare, Miller, Brown of South Carolina.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. This hearing will now come to order. I'd like to thank everyone for coming today. I ask unanimous consent that all written statements be made part of the record. Without objection, so ordered.

I also ask unanimous consent that all members be allowed five legislative days to revise and extend their remarks. Without objection, so ordered.

Today's legislative hearing will provide members of Congress, Veterans, the U.S. Department of Veterans Affairs (VA and other interested parties the opportunity to discuss legislation within this subcommittee's jurisdiction in a clear and orderly process. While not necessarily in agreement or disagreement with the bills before us today, I do believe that this is an important process that will encourage frank discussion and new ideas.

We have ten bills before us that seek to improve healthcare for the Nation's veterans and I look forward to hearing the views of our witnesses. I also look forward to working with everyone here to continue to improve the quality of care available for our veterans.

There are two draft discussions that are not before us today. There is a discussion draft on homelessness, and a discussion draft on mental health services. Congressman Patrick Murphy of Pennsylvania has also introduced H.R. 2699. I'd ask that the members of the third panel, the veterans service organizations (VSOs), and the fourth panel, VA, provide comments and views on these three items for the record once they are made available. We'd like to have the written comments submitted to the Committee by June 21st of this year.

We may as well begin, starting off with Mr. Rodriguez.

[The prepared statement of Chairman Michaud appears on p. 53.]

STATEMENTS OF HON. CIRO D. RODRIGUEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS; HON. JAMES P. MORAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA; HON. DIANE E. WATSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; AND HON. STEPHANIE HERSETH SANDLIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE SOUTH DAKOTA

STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Mr. Chairman, thank you very much. And members of the Committee thank you for this opportunity to be here before you. I have my bill, H.R. 2173, a bill introduced by myself and my colleague Congresswomen Grace Napolitano, provides for increase in the capacity for mental health services through contracts with qualified community health centers.

This is an opportunity for veterans in rural communities, especially to be able to get access to services, not to mention in those areas where we don't have access to mental health services within our VA system. It's also a great opportunity to follow up on individuals that need the services.

Recent surveys show that one in eight returning Iraqi war veterans report symptoms of post traumatic stress disorder (PTSD). The same studies also report high incidents of major depression and anxiety disorders among returning members of the Army and Marine combat unit. As a member of this Committee, we have long identified mental health services as a major issue facing returning soldiers as well as the Department of Veterans Affairs.

Experts note that the manifestation of clinical symptoms of post traumatic stress disorder and other mental health disorders often occurs over several years. With the increase of active duty, guardsman and reservists returning from combat, the necessary capacity to provide mental health services is relatively unknown. It is difficult to know if our large number of returning veterans will need mental health services beyond what the VA is capable of providing.

My bill, H.R. 2173, authorizes the VA to contract with community mental health centers to increase the capability. In my opinion the need has out paced the capacity of the VA to provide mental health services in out patient clinics. Contracting out to the community mental health centers is already been done successfully in some States, and could serve as a model for the VA-wide implementation.

Mr. Chairman, in my previous career, I worked as a mental health field social worker. I am fully aware of the great services provided by the community health centers. And if there is any doubt of the quality of the care they can provide, I can tell you of the hundreds of families who's lives have been changed by the treatment received during my professional career in the field, but you don't have to take my word.

Each year community health centers have nearly six million children, adults, families and communities across this country the chance to recover and lead productive lives. Our returning soldiers deserve nothing less and we hope that we can provide them with that opportunity.

As I mentioned before, it is clear that our soldiers returning with an increased need for mental health services, but after this long war, it is unclear what the VA capacity to fulfill this need will be. It is my hope that H.R. 2173 can provide the VA with the tools to continue to provide top notch mental health services to our veterans in their own communities.

Mr. Chairman, once again I would like to thank you for allowing me this opportunity, and I urge your support, and just indicate that this piece of legislation, I think, will help enhance the quality of care for our veterans especially in rural communities and in those areas, urban areas, where there's a large number of our veterans.

Thank you.

[The prepared statement of Chairman Rodriguez appears on p. 54.]

Mr. MICHAUD. Thank you very much. As you know I am very concerned about access to healthcare benefits for veterans particularly in rural areas that need that access.

Mr. Moran?

STATEMENT OF HON. JAMES P. MORAN

Mr. MORAN. Thank you Mr. Chairman, and Mr. Miller, Mr. Salazar, Mr. Brown. I want to thank you for holding this important hearing today and commend the Subcommittee for the work that it has already undertaken on behalf of our Nation's veterans.

The problem of suicide among our veterans is one of the most serious issues that we have to address as we care for our older veterans and prepare for a new generation of returning soldiers.

The Centers for Disease Control recently released very troubling statistics. Each year approximately 115,000 veterans attempt suicide. This accounts for nearly 20 percent of all suicide attempts, and yet the veteran population only accounts for 11 percent of the entire population. So in other words, veterans are much more likely to attempt suicide as other groups of our society.

This disproportionate prevalence of suicide among veterans suggest that in addition to our overall national strategy on suicide prevention, particular attention should be paid to preventing suicide among this special population. Unfortunately, I expect this trend to continue as more of our brave men and women return from multiple deployments with the symptoms of post traumatic stress disorder.

As we have learned, the staggering 20 percent of soldiers returning from Iraq are experiencing depression, sleep depravation, anxiety, and other symptoms of PTSD. I am proud that this Congress has already acknowledged the growing problem of PTSD and dedicated substantial resources to it. Still, I believe as scientific evidence suggests, that as our returning soldiers are increasingly susceptible to PTSD, they are at an elevated risk for suicide attempts.

My bill, the "Veterans Suicide Prevention Hotline Act of 2007," would create a 24-hour National toll-free hotline to assist our Na-

tion's veterans in crisis. It would be staffed predominately by veterans trained to appropriately and responsibly answer calls from other veterans. The hotline would follow the models of the national suicide, sexual assault, and domestic violence hotlines who have volunteers trained in active listening and crisis de-escalation respond to a variety of crisis calls.

I believe that this cultural competency, the ability to connect to another veteran who understands what the caller may be experiencing can make a real difference in crisis counseling. It is difficult to connect on this level with anyone else, even trained doctors or other professionals.

So to build this capacity nationwide, my bill calls for a 3-year competitively awarded grant for two and a half million dollars in the next three fiscal years. The funding will be made available to a qualified non-profit crisis center to establish, publicize, and operate the hotline including developing curricula to train and certify volunteers.

We have reached out to the Department of Veterans Affairs and are encouraged that the Veterans Health Administration (VHA) is undertaking new efforts to establish a suicide hotline and address mental health needs. Their plan is to divert callers from the national suicide prevention hotline to a VA facility staffed by doctors, psychologists, and other certified counseling professionals. On the surface, the VHA's effort may appear duplicative of what I am proposing, but there are some very important differences that I feel need to be highlighted.

First, my legislation requires that the people answering the phones, those dealing directly with the veterans are veterans themselves. There are times when speaking with someone who has the cultural competence and the empathy to really understand the experiences of veterans in crisis can help make the difference between successful integration to mental health treatment and failure to reach a veteran in dire need of services.

Second, the VHA has many responsibilities for providing the highest quality of healthcare for our veterans. However, they have experienced stressed budgets and staffing shortages in recent years. Because the demands placed on any veterans hotline may be much greater as our Nation redeploys from Iraq in the future, I have concern that the VHA may not have the capability and commitment to the hotline that a non-profit organization dedicated to suicide prevention as its sole purpose might be able to provide.

Third, there are times when a person in crisis doesn't want to talk to a doctor. They want to talk to a volunteer. Mentally ill individuals all face societal stigmas associated with seeking care. Research from the Air Force's suicide prevention effort suggest that this is perceived to be even more profound in the military and veteran communities. Fear of the system, of an un-friendly mental health establishment or of potential job-related consequences keep many from seeking care. One of the motivations behind the National Suicide Hotline and this bill is to give people in crisis another option, an anonymous hotline that can respond to their immediate crisis.

To conclude, our vets deserve as much support when they return from combat as they receive while in battle. Too many of our vet-

erans are struggling to make the difficult adjustment back to society and need someone they can talk to, someone who has walked a mile in their shoes. This legislation will offer a caring voice at the end of the line when it feels that there is no where else to turn.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Moran appears on p. 55.]

Mr. MICHAUD. Thank you very much. Ms. Watson?

STATEMENT OF HON. DIANE E. WATSON

Ms. WATSON. Thank you so much, Mr. Chairman, for holding today's hearing and letting me speak on the bill H.R. 1853, the "Jose Medina Veterans Affairs Police Training Act of 2007."

I believe this legislation is vital to protect our heroes and who have sacrificed their minds and bodies to protect our freedoms. And I feel the two previous bills presented will be complimented by this legislation.

Mr. Chairman, too many veterans are suffering from mental health problems after returning from combat, and they are not receiving the proper treatment they deserve. Congress has a responsibility to provide quality healthcare for our veterans. We must analyze every aspect of services associated with the treatment of post traumatic stress disorder or PTSD for our vets.

So I have introduced H.R. 1853, the "Jose Medina Veterans Affairs Police Training Act of 2007," a bill that will force the Department of Veterans Affairs to better prepare it's police force to interact with patients and visitors at the VA medical facilities who suffer from mental illnesses.

Jose Medina is a constituent of mine. He is a Vietnam vet who suffers from PTSD. In January of 2006, Mr. Medina was assaulted by two west Los Angeles VA police officers who kicked him and forced him to the ground after he isolated himself and fell asleep in a hallway at a VA medical center in Los Angeles.

After a physical altercation ensued, this 56-year-old veteran was forced to lay first face down on the hospital floor. The officers injured Mr. Medina, and after the altercation they did not allow him to use the hospital's emergency room. Instead, the officers handcuffed him and detained him for an hour before sending him home and gave him a loitering ticket.

This is not the way we should be treating veterans who have served and protected this country. What bothers me the most is that when we see someone sitting on a hospital floor, one would think law enforcement would have hospital staff come and question the individual to see if that individual was all right or in need of assistance. Instead, in this case, Mr. Medina was without medical treatment and was mistreated at the same time.

This is happening to too many of our brave veterans out of sheer ignorance. As we look to the future, thousands of veterans will be entering the VA healthcare system. We must ensure that the VA has the ability to administer quality healthcare services to veterans that suffer from mental illnesses. With over 20 percent of the one and a half million veterans that served in Iraq or Afghanistan showing signs of PTSD, we do not want any of them to endure what Mr. Medina went through. They simply deserve better.

So, Mr. Chairman, the Department of Veterans Affairs believes this legislation is unnecessary, but the story of Jose Medina and other veterans from around the country who have contacted my office with similar problems have confirmed that this training is indeed necessary.

As Congress debates funding strategies and time lines for our military missions, we must not overlook the fact that they not only—that we not only need for our vets to have the resources for results from the battlefield, but they must also be treated with dignity and respect once they resume their lives after combat. We must ensure that this occurs.

So, Mr. Chairman, I thank you for this opportunity to explain what this bill would do, and I urge the members to support H.R. 1853. Thank you.

[The prepared statement of Congresswoman Watson appears on p. 56.]

Mr. MICHAUD. Thank you very much. Appreciate your testimony. Ms. Herseth Sandlin?

STATEMENT OF HON. STEPHANIE HERSETH SANDLIN

Ms. HERSETH SANDLIN. Thank you, Chairman Michaud and Ranking Member Miller. I appreciate the opportunity to discuss here today the Services to Prevent Homelessness Act, a bill which I introduced May 17, 2007, to provide supportive services to very low income veterans.

The U.S. Census Bureau estimates that 1.5 million of our Nation's veterans live in poverty, including 702,000 veterans with disabilities and 404,000 veterans in households with children. Six hundred and thirty-four thousand of the 1.5 million poor veterans live in extreme poverty. These poor veterans face residential insecurity due to their low income levels or their past episodes of homelessness. They also face health and vocational challenges and access barriers to supportive services, which limit their ability to sustain housing and maintain independence for more costly public institutional care and support.

These poor veterans may benefit from flexible and individualized support services provided at home based settings. The services to prevent Veterans Homelessness Act would authorize the Secretary of Veterans Affairs to provide financial assistance to non-profit organizations and consumer cooperatives to provide and coordinate the provision of supportive services that addresses the needs of very low-income veterans occupying permanent housing.

The financial assistance shall consistent of per diem payments for each household provided supportive services. Supportive services that may be offered include physical and mental health, case management, daily living, personal financial planning, transportation, vocational counseling, employment and training, education, assistance in obtaining veterans benefits and public benefits, child care, and housing counseling.

Veterans sub-populations expected to benefit from the program include veterans transitioning from homelessness to permanent housing, poor disabled and older veterans requiring supportive services in home-based settings, and poor veterans in rural areas with distance barriers to centrally located services.

While Federal programs exist to help create veterans home ownership, there is no national housing assistance program targeted to low-income veterans. Permanent housing opportunities for veterans ready for independent living are limited.

In addition, the VA currently is not permitted to provide grants to create affordable permanent housing and the resources that are available for providers are inadequate and highly sought by competing housing projects.

Thank you again for the opportunity to be here today. I look forward to continuing to work with the Chairman and the Ranking Member to support efforts to meet the housing assistance needs of our Nation's low income veterans through the establishment of a permanent housing assistance program for this population.

I am happy to take any questions that you may have.

[The statement of Congresswoman Herseth Sandlin appears on p. 53.]

Mr. MICHAUD. Thank you very much. I have a couple of questions on some of the bills. The first one is to Ms. Watson.

You so eloquently explained the problem you had with one of your constituents at the VA facility. Is this typical? Is this the first case or is it really ongoing out there? Have you heard from the different VSOs?

And my second question, what type of training do you think additional training they need?

Ms. WATSON. Yes. To address your first concern, it is one of our top calls that comes in to my office and I had my staffers in here who could supply the actual numbers. But in Los Angeles, our homeless population on any given night is somewhere between 80,000 and 90,000. Those people who are homeless, 33 percent of them, are vets in need of mental health services.

So it is a pervasive problem that we must address. And I hope in Markup to put a provision in this bill that would say that the training must come from highly trained professionals. And the kind of training that it will supplement what is already called for in prior legislation is the handling and the respect for dealing with mentally ill patients.

And so we get in to the actual behavior of law enforcement and other personnel that deal with the mentally ill.

Mr. MICHAUD. Great. Thank you. My next question is for Mr. Moran. You had mentioned setting up this separate hotline. Do you know if there is currently a national hotline for suicide prevention? How many calls go in to that hotline that actually deal with veterans? Do you have any idea of that?

Mr. MORAN. I don't have the numbers, Mr. Chairman. The way I came up with this idea was that I was talking with some people that are involved with a group called Crisis Link that provides suicide prevention throughout the Washington Metropolitan area. And one gentleman I was asking what is going on and he said, "Well when veterans found out that we had a veteran volunteer that they could talk to, that veteran become overwhelmed with calls." He is spending overtime. It is taking up much of his life, because the word spreads. And there is a clear indication that most veterans would like to talk to another veteran that can empathize with them. That is what is distinct.

And I think that the numbers don't necessarily reflect that, but the fastest increasing number of calls with this group was because of the presence of that veteran on the other end of the line, but I don't have any specific numbers as you have asked.

Mr. MICHAUD. Great. Thank you. My last question actually goes back to Ms. Watson. Is the police force at VA facilities, is that a contracted service or are they regular VA employees?

Ms. WATSON. They are employees that have come in under a contract and I don't know whether they are paid from the contract or from the VA. Would you know that information? They are Federal officers.

Mr. MICHAUD. Okay. Great. And hopefully the VA officials here will be able to let us know of all facilities whether they are VA Federal officers or contracted positions.

Mr. Miller?

Mr. MILLER. Thank you, Mr. Chairman. Mr. Moran, I think we agree that the end result of what you are trying to have done is what we are trying accomplish, though I do have a question. We passed H.R. 327, the Joshua Omvig Veterans Suicide Prevention Act, earlier this year that required an in-house 24-hour hotline. Can you expand a little bit on why we would need this hotline. H.R. 327's hotline is veterans, these are members of the VA Office, and they are specially trained, why we would need to go outside and do this independently?

Mr. MORAN. That is a very good question. I think the difference, and I address this in my testimony, is that the VHA line is designed to get people into the VA system, it's doctors and psychologists who are not necessarily veterans that are on the other end of the line.

What this is, what I am suggesting is a volunteer organization. These organizations exist in many of our districts. People who are not necessarily professionals, but get specific training. And many people have found that they can relate better to the veteran. They are not trying to get them in to necessarily a mental health establishment immediately and there is some stigma to calling the VA. And while the VA does wonderful work, and the professionals associated with the VA do a great job, the veteran that may be attempting suicide is not necessarily wanting to get in to what they consider to be the establishment to talk to necessarily a professional who has an objective. We find that in other situations.

And what we are going to try to do if this is established, if it is not then groups will try to do it on their own, is to find a great many veterans who are willing to volunteer to get the training to be there for other veterans on a volunteer basis. So it is a different kind of thing.

One is professional. It is an official arm of the Department of Veterans Affairs. It is designed to get people in to the VA system. Another is volunteer hotline for people that can perhaps empathize to a greater extent with who will be there for them if they are having difficulty coping.

And so it is different personnel. It is a differently run organization. The ultimate purpose, of course, is the same; to save people's lives and to be there for people in crisis.

Mr. MILLER. Thank you, I had some other questions, but all of you did such a good job. Ms. Watson?

Ms. WATSON. Yes. If I can extend the response. I mention that we have 33 percent homeless vets on the streets, and so this service nationally will allow them an opportunity. They are not necessarily in-house, but wherever they are and I was just thinking as Representative Moran was speaking, that we might want to locate these services in homeless shelters, on skid rows, and places that will be assessable.

What we find in Los Angeles is that many of our people who are homeless are committing suicide through overdoses of drugs. And they really need someone to talk to. They don't know how to access that. So I think the idea of having them locate it where homeless people or homeless vets would go on the streets is something that we need to fill in our chain of services.

Mr. MILLER. I think, if I am correct, Mr. Moran's proposed legislation is a single provider, a single hotline. That is why I was asking the questions in regards to the single hotline that is already provided or will be provided under the Omvig bill that we passed earlier this year.

There may be a desire to expand it, but then you are talking about other mental health providers. Now we are really beginning to go far beyond what I think the original intent and scope, which is to provide a single call that that veteran can make to somebody when he or she is at their very darkest, lowest moment.

That was what my question was. Again, I think we are all trying to get to the same place, and I salute everybody here. My other questions you have already answered in your opening statements. Thank you.

Mr. MICHAUD. Mr. Salazar?

Mr. SALAZAR. Thank you, Mr. Chairman. I just have a question for, let's see, Ms. Watson, Mr. Moran, and Mr. Rodriguez. Most of your issues deal with mental health issues of veterans. Is there a way to be able to coordinate your three bills into one bill, which might be a little more effective way of addressing the issue of veterans and mental health issues?

Mr. RODRIGUEZ. Let me just indicate that the need for us to provide especially in mental health settings to provide training for those officers to treat people and to recognize them is essential. And that has got to happen. That has to occur. Those people that are law enforcement, first responders, need to be aware of that whether they are public sector or private sector.

Secondly, the area of mental health we just have one too many veterans that are committing suicide. So we need to provide that access. And you yourselves and your offices I have had veterans come in to my offices that threaten our office and they are mentally ill. And they need services. And that is why we really need to push forward, and because we are just having one too many of them committing suicide.

The contracting out to the community mental health centers throughout this country, those are the ones that provide the most access to mental health than anyone else in this country. Those were created in the sixties. It is a great opportunity to provide that

access. Major metropolitan areas have crisis intervention centers that have 1–800 numbers.

But one of the ways to look at it is maybe in some of the rural communities, there is one thing to provide the access, but the other thing is the referral that are needed and the follow up that is required in order to respond to those needs. And some how we have to fill those gaps.

And I think a comprehensive program that allows that to occur, and especially in rural America where you don't have as much and some of those mental health services are available where you don't have VA services. So I think a comprehensive program is needed and the sooner we can do that the better.

Mr. SALAZAR. Mr. Moran?

Mr. MORAN. Mr. Salazar, everything that we have recommended is complimentary and deliberately complimentary of everything that the Department of Veterans Affairs is doing. Mine is pretty limited in scope. It is simply to have one single national hotline number that is available any time that veterans can memorize and call and find another veteran at the other end of the phone to expand it to include these, which is fine. The dollar amount that is being recommended over a 3 year period would have to be substantially greater to do it right. That is why the amount of resources that I suggested is pretty limited.

So they are all fine things, it is just that as you expand them you would have to contribute provide more money to make them work properly.

Ms. WATSON. And in response, we gave a name to our bill because we want to send a message out there. So we are naming the Jose Medina. And if it would fit in to other pieces of legislation that is to be considered as well. But we wanted to tag this with his name to send the word out there like the Miranda Act, and so, it comes out of an event. And we want to let the veterans know that these incidents are very important. We are sensitive to them so we put his name on it.

And so I guess we could integrate this in to another piece of legislation and we can talk about that.

Mr. SALAZAR. Thank you. Ms. Herseth Sandlin, your bill talks about housing and the transition from homelessness toward someone who can actually live in a home. Does your bill address the issue of those who are almost at the transition point of becoming homeless? They have a home, but because of their income they are almost there or are in danger of becoming homeless?

Ms. HERSETH SANDLIN. I think the bill is more focused on the transition of the veterans subpopulation that has had episodes of homelessness, has transitioned to temporary housing programs of which we may be familiar with in our districts, but then addresses really that next hurdle of moving to more permanent housing.

So your question is a good one. I think that we could certainly as the Secretary would have the authority in establishing the criteria for the non-profit organizations or cooperatives, consumer cooperatives, that would be utilized to extend the service that certainly it could address those that might be at danger of homelessness, although I think we are catching them already to a degree,

at least a significant percentage of them in the subpopulation that has previously had episodes of homelessness.

So I appreciate the question and it is something that we could pursue I think more if we were to get this enacted with the Secretaries. We work with them to establish a formula and the criteria as it relates to contracting with the non-profits.

Mr. SALAZAR. Thank you. I yield back, Mr. Chairman.

Mr. MICHAUD. Mr. Brown?

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman and I thank the witnesses for coming and bringing testimony to solve a problem that we have been trying in this Committee for a long time to connect to the homeless veteran. We recognize that there are many homeless veterans that do have a mental condition.

We have tried to provide resources, and I believe they are adequate resources out there if we could just match the homeless veteran to the resource. I appreciate the effort that you are trying to do that.

Ms. WATSON. If I might respond, Mr. Chairman? One unique feature of our bill is that we address police brutality. We have received complaints from not only the West Los Angeles Medical Center, which is just right next to my district it is coterminous, but from Michigan, San Antonio, Texas and so on and it is all referring to the police brutality. So we address that issue uniquely in our bill.

Mr. BROWN OF SOUTH CAROLINA. I know, Mr. Moran, in your bill and I appreciate that for the trying to reach out to those veterans that need particularly care. And I know in our region we have like the 2–1–1 number where they can call and talk to some counselor that is online all the time.

Is part of your bill to require that there be some voice at the end of that line all the time?

Mr. MORAN. Thank you, Mr. Brown, for asking that question. The answer is yes. Many of these suicide prevention hotlines are very good and they have very fine people, but I notice that the volunteers tend to be young, single people who have the time to provide. They don't necessarily tend to be veterans. And what this would do is to put a special emphasis upon getting trained veterans on the other end of the line.

Now, they are not veterans who have the career choice or interest, ability, whatever, to become doctors or psychologists or specific mental health counselors. They are trained simply to be there to listen and to try to get help, get somebody to get through a crisis. So we would be going out to veterans organizations just trying to get recruits to volunteer to help them to be there and have one single line nationally that would be toll free that people could call.

That is why it is fairly limited in scope, but it is particularly designed to get a veteran on the other end of the phone.

Mr. BROWN OF SOUTH CAROLINA. Thank you. Thank you, Mr. Chairman.

Mr. MICHAUD. Mr. Hare?

Mr. HARE. Thank you, Mr. Chairman. Thank you for holding this hearing this morning, it is very important. Let me thank my four colleagues for being here today and for proposing various legislation. You know we have seen a lot and heard a lot about all

wounds that people have aren't necessarily wounds that people can see. So I am really delighted that you have come together on this and I want to commend you all for that.

I have a question, if I could, for Mr. Rodriguez as soon as I find it. Sir, like you, I have a lot of rural area in my district. I know your district is extremely large, probably one of the largest in the country. And I wonder if you could tell me a little more about how the bill that you have would address the problems that your constituents face accessing mental healthcare particularly in a geographic area that is so incredibly large?

Mr. RODRIGUEZ. First of all, the one of the few organizations that is responsible for that and that provides some degree of access to healthcare to in mental health throughout this country is the community mental health centers.

And so to provide services, and this is one of the few areas that where we can provide that access and the follow up. The purposes of the community mental health centers were basically were to try to get the mentally ill out of the institutions in the sixties. So they were created to reach out to the community throughout America and meet those needs.

And so these centers are trained to do that. And I really believe that we have some figures that we have seen of three million veterans committing suicide every year directly are tied in to the VA and there is a larger number that are not tied to them. And so we really need to you know, provide those services as quickly as possible. And I really believe I would of preferred it under the VA System, but I really believe that they don't have the capability at the present time to meet the massive need that is needed out there.

And so I really believe that this is one of the few ways of meeting that need and that is reaching out through the community mental health centers that exist throughout the country, even in rural communities. And they can reach out and get some kind of professional treatment that is required. There are some areas where we don't. I got one psychiatrist in one community and I think it was a contract that was out there in the private sector, but the community health center there is actually a little better equipped to handle that.

Now the urban areas have the crisis centers and have the for the homeless and others, but in those other areas you know we have got to do more to those individuals that are out there, especially the ones who have hit the bottom of the totem pole which is the homeless veterans that find themselves without anything and find themselves without access. And you have got to have those outreach workers that do that.

And I think that that is one of the better ways. Now we still have a problem in that in rural America in terms of how do we, you know, in those areas where you have to provide that. I have that problem in terms of trying to provide offices. I have five offices right now and I don't have the manpower to provide the staffing throughout my office. And so there is still a need to provide some mobile units to go out in to rural America.

Mr. HARE. Thank you. And I just have a question for my colleague Ms. Herseth Sandlin. And I apologize for coming in just a bit late, I was on the floor. But you know we see the stand downs

that we have throughout the country every year to help homeless veterans. The problem is that is a weekend, excuse me, that is a weekend opportunity. And I was amazed in my district that when Congressman Evans was hosting these and working on them, that the number of veterans that would use, you know, the stand down and be able to come in.

I am wondering could you just expand a little bit on what your bill would do to establish assistance program so that we can move homeless veterans into, to give them some decent housing that they clearly, "A," need; and "B," deserve?

Ms. HERSETH SANDLIN. Well thank you for the question. And you are right. With the weekend stand downs one of the wonderful things about that is that you have generally this a centralized location that offers a whole host of other services that are either important to veterans who are interested in what they can access to avoid homelessness, if they are very low income veterans, but certainly those that have had episodes of homelessness that have perhaps been in transitional housing but the eligibility is 24 months of transitional housing and then what more may be needed in terms of financial counseling, access to other benefits to which they are eligible to have a more holistic approach, comprehensive approach to what the needs of the veterans are on a more consistent basis than the weekend stand downs where they look forward to that opportunity and word gets around the veteran population of a particular community or particular region of a district or a State.

And so what the bill does is I think it addresses a gap that currently exists in what the VA can provide in setting up a grant program, establishing a formula and the criteria for non-profit organizations and consumer cooperatives to access the grant and provide these services, particularly targeted toward veterans and their families who are very low income who are in that transition period.

But as Mr. Salazar asked earlier, I think that the availability of support services for very low income veterans and their families that may already be in housing but at great risk for homelessness can also be provided within the terms of this bill.

So I think it addresses a significant gap that exists and I think especially at this time in our country's history when we have many veterans returning who have very young children, who are very young themselves, this is an important grant program that needs to be established.

Mr. HARE. Thank you very much. And once again, Mr. Moran and Ms. Watson, thank you very much for your legislation. I think they are wonderful pieces of legislation. I yield back.

Mr. MICHAUD. Dr. Snyder, you have any questions?

Once again, I would like to thank our first group of panelists for your testimony today and look forward to working with you as we look at this legislation later on. Thank you.

Mr. MORAN. Thank you.

Mr. RODRIGUEZ. Thank you.

Mr. MICHAUD. I would now like to welcome our second panel.

The first individual I will ask to give his statement is Mr. Hodes. I want to thank you, Mr. Hodes, for your interest in veterans issues. I know you have been a strong advocate for veterans issues,

we have dealt with your legislation earlier in the year as well. So thank you very much for coming here today. Mr. Hodes?

STATEMENTS OF HON. PAUL W. HODES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW HAMPSHIRE; HON. JOHN T. SALAZAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO; HON. NITA M. LOWEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK; AND HON. JEFF MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

STATEMENT OF HON. PAUL W. HODES

Mr. HODES. Thank you, Chairman Michaud, and Ranking Member Miller for holding this important hearing today. I appreciate the opportunity to come before this Subcommittee to testify about H.R. 2192, the bipartisan bill I introduced establishing an Office of the Ombudsman in the Department of Veterans Affairs. I also want to thank Chairman Filner, who is not here, for his support of the bill.

This bill grew out of the visits I made to Walter Reed Army Medical Center and the hearings held by the Oversight and Government Reform Committee on which I sit. I talked with numerous soldiers about the problems they experienced transitioning out of active duty and into the VA. I also talked with numbers of veterans organizations within my own State, New Hampshire, and numbers of veterans.

Veterans in my district have repeatedly told me their compelling stories of the great difficulties and challenges they have faced in understanding and receiving all the benefits and services to which they are entitled. The ombudsman's office, which as proposed in this bill, should serve as the outreach master office. A coordinating and coordinated center for benefits and health information services available both within and outside of the VA.

I am not interested in creating another meaningless layer of bureaucracy. Instead, I would like the Ombudsman Office to become a one stop shop for veterans. A CENTCOM for veterans benefits information. I applaud the VA for their hard work in providing information that veterans need. The VA has numerous hotlines and support services available to veterans. I have counted ten different 1–800 numbers on the VA's website to help with different types of benefits. One for disability pension, another for healthcare benefits, another for life insurance, etc.

And while the VA provides veterans benefits and services information, the veterans may not know where they put their informational pamphlets 6 months or one year down the road when they have a question or a problem. Our veterans are falling through the cracks and do not know where to turn.

It was very interesting to me, recently a number of both active duty wounded soldiers and veterans came to the floor of the House to talk with a number of Members of Congress. There were seven or eight members of Congress there and we heard compelling stories there on the floor from veterans who described what they—described as their ordeal working through the bureaucratic maze and the red tape in the Veterans Administration. And this office is de-

signed to provide that one stop shop that would help them cut through the red tape.

It would provide a focal point of information within the VA. The office should head up the advocacy and information campaigns that the VA already has in place and consolidate the information services with an 800 number to address all the veterans needs and complaints. For a veteran who has just returned from active duty an Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF) with traumatic brain injury, it would be a whole lot simpler and easier to have only one office to call to receive the information he or she needs.

The VA has a patient advocacy program for healthcare but a lot of brave men and women need help with loans for their homes and schooling too. They shouldn't have to run around asking the same ten questions to ten different offices. The Ombudsman's Office can help the veteran figure out all the services in the benefit system not just the healthcare and not just about disability.

I have reviewed the testimony of the esteemed panelists, the VA and VSOs who have presented written testimony before this Subcommittee. And just in the six testimonies that specifically discuss the Ombudsman's Office, the panelists referred to 14 different programs both within and outside of the VA that veterans could turn to for help with benefits coordination. That is good news and the bad news.

The good news is the services are available. The bad news is there are so many of them which can be confusing. These 14 programs are extremely important to our veterans in providing specialized services. But as a healthy member of Congress and not a PTSD patient or an ailing elderly veteran, I am even confused to some degree about which programs to use and under which circumstances.

So, Mr. Chairman, I am not trying to make redundant services. The VA provides advocacy and resources and many VSOs provide advocacy and resources. I look forward to working with the Honorable Members of the Committee to mold the Office of the Ombudsman in to a viable helpful resource for veterans. I believe that this consolidation of various information sources in to a coordinated center of information will help make sure the veterans receive the care they need and cut through the seemingly endless amounts of bureaucratic red tape.

I would like to point out to the Subcommittee that especially with respect to the duties section as it is currently set forth in the draft bill, I believe that through markup and working with the expertise of the Committee, that section probably didn't come back as complete to me from legislative counsel as it ought to be and should be expanded so that the duties include coordination of services and benefits both within the VA and also that may be available through VSOs and or the communities in which the veterans are so that it is a comprehensive coordination effort.

Thank you again for giving me the opportunity to testify before this Subcommittee and I look forward to working with the Committee to help veterans understand and access the benefits they deserve.

[The prepared statement of Congressman Hodes appears on p. 60.]

Mr. MICHAUD. Thank you very much, Mr. Hodes. Mr. Salazar?

STATEMENT OF HON. JOHN T. SALAZAR

Mr. SALAZAR. Thank you Chairman Michaud and Ranking Member Miller and Members of the Subcommittee. I want to first of all thank you for your interest in rural veterans healthcare and I know that you have both been major leaders in this fight.

Mr. Chairman, today I am happy to bring H.R. 2005 to the Subcommittee. I am looking forward to discussion of this important legislation. This bill called the Rural Veterans healthcare Improvement Act seeks to improve healthcare services to veterans in rural areas.

As many of you have heard over the last several years in this Committee that a study of more than 767,000 veterans by researchers working for the Department of Veterans Affairs shows vets in rural areas are in poorer health than vets living in the cities.

The VA found that the health of rural veterans still persist even after researchers adjusted for social economic factors such as race, education, and employment status. It was identified in this study that access is a care—to care is a key factor. The study suggested that in addition to establishing more clinics in rural areas VA should consider coordinating services of Medicare and other healthcare services based in rural areas similar to what Mr. Rodriguez was talking about earlier in the earlier panel.

As a way to begin addressing some of these issues, the Veterans Benefits Health Care and Information Technology Act of 2006, which passed at the end of the 109th Congress created the office of Rural Health within the VA. Dr. Kussman's testimony will tell you that the VA is opposed to this legislation because the Office of Rural Health is charged with these tasks.

I would like to make the point that even though Congress directed VA to establish this office it has not yet been implemented. This new office, when the VA decides to set it up, needs support, direction, and resources in order to fulfill its mission of coordinating care in this vital constituency. The Rural Veterans Health Care Improvement Act of 2007 would task the director and the Office of Rural Health with developing demonstration projects, centers of excellence, and a transportation grant program. And the bill would also more fairly reimburse veterans in rural areas for traveling expenses they incur when driving long distances to VA medical clinics.

Mr. Chairman, with both an ailing veteran population to care for and a new generation of veterans returning from service in Iraq and Afghanistan, we immediately need to address access to care issues in rural areas. It is estimated that nearly 45 percent of all new recruits are coming from rural America and with a large percentage of this war burdened on our national Guard, the number is only going to increase.

Many vets must travel hundreds of miles to access medical care that we promised and they do so almost entirely at their very own expense. Currently we reimburse veterans at the rate of 11 cents a mile. The rate has not been increased since 1978. In 1978 the average price of a gallon of gasoline was 63 cents a gallon. Today in

rural America, in rural Colorado, the average is right around $3.39 a gallon.

This legislation would increase the reimbursement rate to 48 cents a mile the same rate paid by—to Federal employees. This legislation also establishes a transportation grant program called Vet's Ride. Vet's Ride encourages veteran service organizations to develop innovative transportation options to vets in rural areas. With a grant up to $50,000, the VSO can purchase a van or find other ways to assist veterans to travel to VA medical centers.

This bill also establishes centers for excellence to research waste, to improve care for rural veterans. These centers would be based at VA medical centers with strong academic connections. The outcome of these centers would be the development of specific models to be used by VA in providing health services to vets in rural areas.

The Rural Veterans Health Care Improvement Act of 2007 also tasks the office of Rural Health with following their studies own advice. It develops demonstration projects that would examine the feasibility of expanding care to rural areas through partnerships. Partnerships between the VA centers for Medicare and Medicaid services, the Department of Health and Human Services through critical access hospitals and community based centers.

Demonstration projects would also be carried out in partnership with Indian Health Services to improve healthcare for Native American veterans. In 2003, the VA entered into a memorandum of understanding with the departments to encourage partnerships like these. However, 4 years have passed without accomplishments and our vets have suffered.

Mr. Chairman, we must explore every option to ensure that healthcare services we promised to our veterans were delivered. The Rural Veterans Health Care Improvement Act of 2007 aims to improve one of the greatest problems that plagues the VA system. I am proud of this bipartisan work. We have—we currently have over we are close to 40 co-sponsors. Very bipartisan legislation.

And I want to thank the Chairman and the Ranking Member and members of this Subcommittee for allowing us to testify in front of this Committee.

[The prepared statement of Congressman Salazar appears on p. 57.]

Mr. MICHAUD. Thank you very much, Mr. Salazar. Ms. Lowey?

STATEMENT OF HON. NITA M. LOWEY

Ms. LOWEY. Thank you very much, Mr. Chairman. Mr. Ranking Member, members of the Subcommittee. I really do appreciate, number one, your holding this hearing and for considering the VA Hospital Quality Report Card Act of 2007.

I introduced this legislation in an effort to provide increased disclosure and accountability in the VA hospital system, and ultimately increase the quality of care for the men and women who have served in the armed forces.

The treatment provided to our veterans is not a partisan, a political issue, and I am pleased that this legislation is cosponsored by some of my republican colleagues as well. I do believe that we can all agree that quality care initiatives and public disclosure should not end when an individual leaves active military service. In fact

the quality of care for those who have bravely served our Nation should be of the highest standard possible.

To achieve that goal, we must have a clear picture of the quality of care provided by the Department of Veterans Affairs, and this information must be continually assessed and updated. As we learned, unfortunately, with Walter Reed Army Medical Center, a facility that once defined excellence may not do so the next time without constant internal assessments. My legislation would require the Department of Veterans Affairs to establish a formal Hospital Report Card Initiative and publish reports on individual hospitals level, and quality of care.

The resulting report cards would provide clear outcomes data to be used for peer review and quality improvement, galvanize hospitals to make changes by creating public accountability, and provide our veterans with the information they need to make sound healthcare decisions. Several States, including Pennsylvania, New York, California, Florida, and Illinois have already implemented Hospital Report Card Initiatives.

March 2007 Veterans Administrative report exposed major deficiency in the physical condition in many veteran's facilities. In this report, the VA Hudson Valley Health Care System, which serves over 25,000 veterans throughout my district and the surrounding areas, was cited for ceiling molds, suicide hazards in the psychiatric ward, and cosmetic deficiencies.

I am going to repeat one part of that because I think it underscores the level of neglect seen throughout the VA healthcare system. Suicide hazards in a psychiatric ward in area in hospitals that most certainly should limit the ability of an individual to harm him or herself.

Dr. Michael Kussman, Under Secretary for Health at the VA previously stated, "VA hospitals are inspected more frequently than any other healthcare facilities in the Nation." If this is true, then the Department should have no problem complying with the requirements of this legislation.

If we are serious about ensuring a seamless transition between the U.S. Department of Defense (DoD) provided healthcare and VA provided healthcare, we must have an accurate assessment of the VA system and the VA Hospital Quality Report Card Act of 2007 would provide just that.

So, I thank you very much. Thank you for your work. And I would be delighted, as I know my colleagues are, to respond to any questions.

[The prepared statement of Congresswoman Lowey appears on p. 61.]

Mr. MICHAUD. Okay. The last member of the panel is also the Ranking Member of this Subcommittee, Mr. Miller?

STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you very much, Mr. Chairman. I have two bills for the hearing today. The first one I would like to discuss is H.R. 2623. This bill is designed to prohibit the collection of copayments for all hospice care furnished by the Department of Veterans Affairs.

Currently VA offers a compliment of hospice and palliative care options as part of the comprehensive healthcare benefit provided to

all enrolled veterans. Hospice and palliative care are a continuum of comfort oriented supportive services provided across settings including a hospital, extended care facilities, outpatient clinics, and private residences.

Under current law a veteran receiving hospice care in a nursing home is exempt from any applicable copayments. However, if hospice care is provided in any other setting such as an acute care hospital or even in the veteran's home, the veteran may be subject to an inpatient or outpatient primary care copayment. Essentially, VA's current policy penalizes a veteran who chooses to remain at home for their hospice care or out of medical necessity receives that hospice care in an acute care setting.

Mr. Chairman, this legislation would correct this inequity by exempting all hospice care provided through VA from copayment requirements. This bill is important to ensuring that every veteran preference for end of life care is provided for in an equitable and compassionate manner.

I thank you for the opportunity to present this bill and I would be available to answer questions.

If I could move to H.R. 1925, a bill to direct the Secretary of Veterans Affairs to establish a separate Veterans Integrated Service Network (VISN) for the Gulf Coast region of the United States. I have a couple of charts. We will go—we will flip back and forth. This will give you an idea of the work loads at the different VISNs. I apologize for the people in the audience not having an available one for you to see as well.

[Chart.]

Mr. MILLER. Twelve years ago most of you know that the VA instituted the VISN. The plan was put in motion as a way for the large VA network that healthcare that VA provides would be more attuned to the needs of its patients.

You can see where it basically is today and graphically it's there are 22 VISN's although there is a number 23 on there some time ago, there were two VISN's that were combined into a single VISN, but that gives you the idea. The gray is the enrollees, the red is the actual patient load.

The VISN's were implemented as a way to maintain the high quality of care while allowing more regional management so that the central office in DC was not unnecessarily micro managing the day-to-day aspects of the delivery of the healthcare. The network has enjoyed its successes in providing better access and more patient centered care. However, as always, there is room for improvement and I think that the Gulf Coast region of this Nation is an area where such improvement is needed.

Having already seen, as I said earlier, the consolidation of two VISN's since it's creation, it is clear that flexibility within the healthcare system is necessary. This bill creates a VISN specifically targeted to improving the delivery of healthcare to a large and ever increasing number of veterans living in the Gulf Coast. In other words, a Gulf Coast VISN.

It would create a better healthcare network that can better respond to veterans and the unique needs and problems facing veterans in the area. The area involved would, if you would flip it over, give you an idea. Everything the gray shaded areas are not

part of VISN 16, but the teal and the purple and the peach color that is VISN. There is also a little green down at the very bottom, that is VISN 16. So basically it goes from the center of the Florida panhandle all the way to the Oklahoma panhandle geographically. It is the largest geographic VISN, but that is not necessarily the point. The point is the workload that is in there now.

Obviously, my district, district one is on the southeast corner of the panhandle, so that gives you an idea of how large the VISN is. If you would, there are some and I don't know if staff going to handout, smaller charts for you to look at. VISN 16 is actually the second largest in patient enrollment and patients as well.

This creates again, as I said, the ability for VA to deliver to the unique needs and problems facing veterans in the area. It does stretch all the way from the Florida panhandle over to the State of Louisiana and up into Alabama. The Capital Asset Realignment for Enhanced Services (CARES) Program did identify this area as under served, and its unique geographical location is no doubt part of the reason that it was so designated. Most of the region would be in VISN 8. It would be where VISN 16 meets VISN 8. By the way, VISN 8 as Ms. Brown knows is also the number one VISN in the country. It happens to be the peninsula part of the State of Florida.

You can see that the veteran population continues to grow in those regions. Looking back and looking at the map you can see how diverse and how largely rural. As we have talked about with other testimony today, regions can be over looked because of major metropolitan areas that are being served. We don't think, and I am sure that most people would agree that the 300,000 veterans that are currently being served in that region there are many, many more veterans, but these are enrolled veterans. They certainly don't want their healthcare overlooked either.

Several reasons why I see this bill as important and successful. Again, a new Gulf Coast VISN director could take great advantage of the sharing opportunities that are there between DoD and VA. The Gulf Coast is home to multiple defense installations and while a few DoD/VA facilities exist now, there is tremendous opportunity for expanding this relationship to deliver a wider range of healthcare service.

I would say that all of our veterans across the Nation deserve more timely access to VA healthcare. The intent of my bill, albeit there could be other geographic areas that are as under served as ours, is to get a first step toward creating that access. Again going all the way back to it's original creation, obviously the demographics have shifted and time for a re-look is upon us.

Mr. Chairman, thank you for letting me testify on this bill, and I can and am ready to answer questions on this or the other bill as well.

[The prepared statement of Congressman Miller, and the charts attached to Congressman Miller's statement, which he referred to, appears on p. 58.]

Mr. MICHAUD. Thank you very much, Mr. Miller. A few questions: The first one for Mr. Hodes. If I understand correctly, what you want to do is look at all of these programs and work toward

having one access point for veterans to be able to access these programs.

Have you given any thought about also trying to streamline the process? And for those who can use a computer, to ask just a few basic questions on a computer-based system that will tell them where to go?

The reason why I mention that is when we had a couple of mills shut down and healthcare was a big issue, drug companies offered programs for individuals. There are 329 different programs that drug companies offered with applications for each one of those programs. And if you are laid off trying to find a job and healthcare, you are not going to do it.

However, what they did was take all of these programs, narrowed it down to four basic questions, established an 800 number and that will show an individual applying for one of these programs where to go.

Is that something that you would envision under your legislation as well?

Mr. HODES. That would certainly be part of a good way for the Ombudsman Office to accomplish it's work, because I guess if I had to use a word I see the Ombudsman Office as providing the hub to which people go. And it—the Ombudsman Office would then help route people through the system. They could then return to the Ombudsman Office as they are working their way through the system for other questions.

So your suggestion would certainly be a good part of implementing the Office of the Ombudsman. Thank you, Mr. Chairman.

Mr. MICHAUD. Ms. Lowey, I have read the testimony from the Department and they talk about the Joint Commission previously known as the Joint Commission Accreditation of Health Care Organizations (JCAHO). They have a website that provides a lot of the data that you were talking about. Have you looked at that website and is it inclusive of what you are including in your legislation?

Ms. LOWEY. Well, I thank you for bringing up that question, because the Joint Commission does reviews. We have been told it is about every two, 3 years and it is not as—it is not as comprehensive as the kind of review we propose.

And again the basic idea here is to do it frequently at least twice a year, provide up-to-date information, transparency so that VA's veteran's can access this information and actually make some decisions based upon the information provided.

Mr. MICHAUD. Great. And my last question actually deals with one of Mr. Miller's bills, the hospice bill. If I read and heard your testimony correctly, veterans will not have to pay the copayment if they go through VA for services. Now does that include contract services? I am just thinking of someone in a rural area that needs hospice care, how do you envision that?

Mr. MILLER. It would cover them. Absolutely.

Mr. MICHAUD. It would cover them. Okay. Good. Thank you. Mr. Miller do you have any questions?

Mr. MILLER. Ms. Lowey, I am interested in and we all can appreciate the desire to set some type of standard. Do you envision measuring VA hospitals against private facilities in some way where or is this just within the VA healthcare system where you

are saying this one is an "A," "B," "C." Are we going to measure them against other facilities?

Ms. LOWEY. That is an important question. And it has been suggested to me and I certainly would be flexible about it, that we might call it VA Medical Center because it would encompass a more extensive group of hospitals that would be included in this review.

I was thinking about the VA system, but I would certainly be open if the Committee would suggest it to making it more expansive.

Mr. MILLER. The reason I ask the question is the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards that you know all hospitals go through accreditation, how would this be more in depth? How would it compare to those standards, and if you are not sure right now you can report back.

Ms. LOWEY. I am not sure about the JCAHO standards.

Mr. MILLER. No, I would like to know in regards to standards that are out there that VA currently has to abide by how far we are looking at going forward.

Ms. LOWEY. You know I am very interested in the idea of providing facilities that specialize, for example, in traumatic brain injury (TBI) to veterans making them inclusive and expanding opportunities for veterans getting these services.

So, although I was talking about the VA system, I am hoping that we can bring in hospitals such as the Helen Hays Hospital in part of my district in Rockland County which has expertise in traumatic brain injuries.

So it is another issue that I know some people are thinking about, because the numbers of people that are coming out of the hospital. Just recently I was talking to a group called the "Wounded Warrior Project." And they are providing the role of the intermediary. I was interested in what my colleague was talking about in the ombudsman position, because many of these veterans come out so lost and need additional guidance and additional help.

So with this bill, I was talking about an assessment of the VA hospital system to provide the transparency and to provide the information to the veterans. But I certainly would be happy to work with you, Mr. Miller, to see if you believe that it should be more expansive and more inclusive.

Mr. MILLER. Thank you very much. The other question, Mr. Salazar is in regards to the mileage reimbursement, would you envision it paying for service and non-service connected visits or just service connected visits?

Mr. SALAZAR. Basically just service-connected visits and it would just be similar to what we get. I mean, as members of Congress we get 40 or we are allowed to get 48 cents a mile. The current reimbursement rate of course is only 11 cents.

And I get the story, I represent a district that is larger than half of the State of Colorado. And many of my veterans have to drive 5 hours to one center or another and some even have to go to Albuquerque. And many of them will tell me that their wives cannot go with them because gas is so expensive they can't afford the hotel to stay in over night. So for that reason I think it is only fair that we look at this. You know gas was only 63 cents a gallon in 1978

and that is when the last raise was or the last, I guess, increase was made. So thank you.

Mr. MICHAUD. Mr. Hare?

Mr. HARE. I don't have any questions, Mr. Chairman.

Mr. MICHAUD. Dr. Snyder?

Mr. SNYDER. Thank you. I wanted to ask our Ranking Member, Mr. Miller, just a couple questions. I notice that the bill regarding the hospice co-pay is not on the list that Dr. Kussman discusses. Was that a late add on or do you know what the VA position is on that bill?

Mr. MILLER. VA supports it.

Mr. SNYDER. Supports it. Okay. And then the second with regard to the VISN lines. Were all the VISN boundaries have they been set by statute in the past or were those set administratively?

Mr. MILLER. I believe they have been set administratively.

Mr. SNYDER. Administratively. Thank you.

Mr. MICHAUD. Ms. Brown.

Ms. BROWN OF FLORIDA. I don't have any questions at this time.

Mr. MICHAUD. Thank you. Once again, I would like to thank the panelists for your testimony this morning. I look forward to working with you as we move forward with these pieces of legislation. Thank you very much.

Mr. HODES. Thank you very much.

Ms. LOWEY. Thank you.

Mr. MICHAUD. I would like to ask the third panel to come up. We have Shannon Middleton, American Legion; Kimo Hollingsworth, AMVETS; Adrian Atizado, Disabled American Veterans; Carl Blake, Paralyzed Veterans of America; Dennis Cullinan, Veterans of Foreign War; and Barry Hagge, Vietnam Veterans of American.

I would like to welcome all the panelists here today and I look forward to hearing your testimony.

We will start with Ms. Middleton and just work down the table.

STATEMENTS OF SHANNON MIDDLETON, DEPUTY DIRECTOR FOR HEALTH, AMERICAN LEGION; KIMO S. HOLLINGSWORTH, NATIONAL LEGISLATIVE DIRECTOR, AMERICAN VETERANS (AMVETS); ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND BARRY HAGGE, NATIONAL SECRETARY, VIETNAM VETERANS OF AMERICA

STATEMENT OF SHANNON MIDDLETON

Ms. MIDDLETON. Mr. Chairman and members of the Subcommittee, thank you for this opportunity to present the American Legion's views on the several pieces of legislation being considered by the Subcommittee today.

The American Legion commends the Subcommittee for holding the hearing to discuss these very important issues. And I will limit my comments to just a few of the bills being considered.

Mr. MICHAUD. Could you pull the microphone up a little bit closer please?

Ms. MIDDLETON. This better?

Mr. MICHAUD. Much better.

Ms. MIDDLETON. Much better. H.R. 2005, the "Rural Veterans Health Care Improvement Act of 2007," addresses many issues affecting veterans who reside in rural areas. It seeks to increase the beneficiary travel rate to make it equivalent to the rate provided to Federal employees; establish centers for rural healthcare—rural health research, education, and clinical activities; offer transportation grants for service organizations to assist rural veterans; and explore alternatives to improve transportation to medical facilities for rural veterans. The American Legion fully supports this the provisions in this bill.

Beneficiary travel pay has not been increased from its current rate since 1978. The price of gasoline has steadily increased since the 11 cent per mile rate was established, creating a financial hardship for veterans who have to travel long distances for care, or those who have limited financial resources.

Since service-connected veterans and other veterans authorized beneficiary travel only receive 11 cent per mile and are subjected to a six dollar per trip deductible, this amount does very little to defer the cost of travel.

There are no provisions in law that VA must increase the per mile travel authorization on a regular basis. The beneficiary travel program is discretionary and the Secretary of Veterans Affairs has determined that it is necessary to maintain the current reimbursement rate in order to allow the VA healthcare system to accommodate the increasing patient workload.

The lack of a consistent and reliable mechanism to periodically adjust the rate authorized for beneficiary travel creates an injustice and an unfair economic burden for many veterans. The American Legion believes that mandatory funding for VA healthcare would allow the Secretary to provide adequate healthcare without inversely affecting programs designed to mitigate the cost of accessing that care.

Establishing centers for rural health research, education, and clinical activities would afford VA the opportunity to build strategies to improve it's system of care for rural veterans, as well as educate and train healthcare professionals on health issues prevalent in specific rural veteran populations.

And offering transportation grants for organizations that can assist rural veterans and exploring alternatives to improve transportation to medical facilities for rural veterans would make accessing care easier for those who are not financially able to travel to facilities, especially those who, due to their financial—sorry—their physical condition are not able to make extremely long trips in 1 day. If more transportation options became available it may also improve coordination of care for those who have to travel distances for special services, especially in the unavailability of a family care giver.

H.R. 2173 seeks to amend title 38, U.S. Code, to authorize additional funding for the Department of Veterans Affairs to increase

capacity for provision of mental health services through contracts with community mental health centers, and for other purposes.

The American Legion believes that VA should contract with community providers only when it is unable to provide needed services to the veteran, if travel for the veteran would be a danger to his or her health, or the veteran resides in a rural area. As long as VA healthcare remains discretionary, VA will always struggle to maintain sufficient funding to provide access to quality care for eligible veterans seeking care in VA facilities. Mandated funding would provide a method to provide dependable stability, stable and sustained funding for veterans healthcare.

H.R. 2378, Services to Prevent Veterans Homelessness Act. This bill aims to establish a financial assistance program to facilitate supportive services for very low income veteran families to assist them in ending their chronic homelessness state and to prevent chronic homelessness.

Enactment of this legislation will enable funding to provide much needed supportive services to veterans and their dependants. It takes into account that the VA Grant and Per Diem Program can only provide services to veterans and fill a much needed gap of caring for their dependents.

Veterans require a coordinated effort that provides secure housing and nutritious meals; essential physical healthcare, substance abuse aftercare, mental health counseling; as well as personal development and empowerment. They also need job assessment training and placement assistance.

The American Legion fully supports this bill in it's efforts to assist homeless veterans. And we applaud that the bill recognizes that families also suffer alongside the veterans struggling with homelessness.

Again, thank you Mr. Chairman for giving the American Legion this opportunity to present it's views on such important issues and we look forward to working with the Subcommittee to address these and other issues affecting veterans.

[The prepared statement of Ms. Middleton appears on p. 62.]

STATEMENT OF KIMO S. HOLLINGSWORTH

Mr. HOLLINGSWORTH. Mr. Chairman, members of the Subcommittee, I am pleased to offer testimony on behalf of AMVETS regarding the health legislation for this Subcommittee.

Regarding the Hospital Quality Report Card Initiative, AMVETS would like to note that the Government Performance and Results Act requires that agencies develop measurable performance goals and report these results against these goals.

In addition, the Department has tracked and monitored the quality of care at VA facilities since the early seventies through comprehensive quality management programs. In addition, there are some Federal laws that require VA Office of Inspector General to oversee VA Quality Management (QM) Programs at every level. And a large part of the VA Inspector General's Office performs the Combined Assessment Program (CAP). These reports review focus on quality safety and timeliness of VA healthcare.

Overall AMVETS supports efforts to improve VA healthcare and supports the intent of H.R. 1448. However, we believe the bill

would mandate a duplicative effort as many of the items to be reported in the report card are already reviewed and reported through either the VA QM and CAP programs.

Regarding the training of police officers to interact with visitors and patients at medical facilities who are suffering from mental illnesses, AMVETS supports this bill.

Regarding the creation of a new VISN, AMVETS has testified previously that CARES was supposed to be system-wide process to prepare the VA for meeting the current and future healthcare needs of veterans. Overall, AMVETS supported the CARES process, and we believe that Congress should consider the CARES recommendations in deliberations about VA infrastructure to include deliberations about the current VISN model.

I would like to note that there has been some considerable time has elapsed since implementation of the VISN model, and there clearly have been some demographic changes within the general population that would most likely include changes to the veteran population as a whole.

Regarding the Rural Health Care bill, AMVETS continues to support an increase to the mileage reimbursement rate. Regarding the overall Centers of Excellence, AMVETS would like to note that Congress did set up the Office of Rural Health Care and we urge Congress to fully fund and require the VA to conduct that assessment.

With regards to the establishment of the Ombudsman within the Department of Veterans Affairs, AMVETS supports this bill. H.R. 2219 would direct the Secretary to award a grant to a private nonprofit entity to establish and publicize a toll free suicide prevention.

Overall, Mr. Chairman, AMVETS would oppose efforts by Congress to mandate the Secretary enter in to contracts with a private entity for these services. And we believe that the Secretary must continue to have the flexibility in how he implements these services.

Lastly, H.R. 2378 regarding a financial assistance program to facilitate the provision of supported services for very low income veteran families in permanent housings. We support the intent. A large part of this bills, many of these services are already available to veterans. However, we do have concerns with the provision that specifically targets payments to veterans. And we would urge Congress instead to consider priority assistance at one of the other agencies that deals with housing.

This concludes my testimony. I would be happy to answer any questions.

[The prepared statement of Mr. Hollingsworth appears on p. 65.]

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Mr. Chairman, Ranking Member Miller, members of the Subcommittee, thank you for inviting the DAV to testify at this important legislative hearing. For the sake of brevity, I will cover a number of bills or provisions relevant to the DAV and would request the Subcommittee refer to my written testimony for more details regarding all the measures under consideration with

exception to the two draft bills that we were unable to provide comments due to time constraints.

While we support sections two and four of H.R. 2005, the "Rural Veterans Health Care Improvement Act of 2007," we consider these provisions a good first step to ensure sick and disabled veterans are able to access the medical care they need.

As funding for both provisions will most likely come from VA's medical services account, we urge first and foremost that Congress and VA correct inequity in the VA beneficiary travel program. This program unlike the Transportation Grant Proposal affects access for all veterans residing in rural, urban, and medically under served areas.

Second, for good stewardship of taxpayer dollars and for the most effective use of such precious medical care funds, we urge that this Transportation Grant Program not be duplicative of current services, particularly those provided by the DAV Transportation Network or other transportation networks in existence.

Further, the implementation of this proposed program should be coordinated through the Office of Rural Health to assure that unmet needs of rural veterans are addressed. As you may be aware, the DAV knows first hand the benefits of a Transportation Program. The DAV, in coordination with VA's Voluntary Service Program, began buying and donating vans to the VA facilities. To date, we have donated nearly 2,000 vans at a cost exceeding $39 million.

Since inception, these vans, the dedicated VA volunteer drivers and volunteer transportation coordinators have transported more than 10 million veterans over 397 million miles to and from VA medical appointments.

Having said that, we must not forget one of the reasons our transportation program began in 1987. Regulations amended by the VA, effective April 13, 1987, severely curtailed and restricted the eligibility and method by which beneficiary travel was paid. Many veterans in need of VA medical care found themselves effectively precluded from receiving such care.

In addition to our transportation program, DAV has a longstanding resolution to repeal the beneficiary travel pay deductible to create a line item budget for this program and to increase travel reimbursement rate, which remains unchanged since 1977 at 11 cents a mile.

We urge this Subcommittee to approve and enact legislation this year to reform the VA beneficiary travel program.

H.R. 2173 would allow the VA to provide mental health services through contracts with community mental health centers. The DAV believes that VA-purchased care is an essential tool in providing timely access to quality medical care.

However, as VA's contract workloads have grown significantly at a cost of about $3 billion this year, we are concerned that this bill does not provide any consideration for the judicious use of purchased care. Nor does it address our concerns regarding the lack of a systematic process to improve VA contract care services.

H.R. 2219, the "Veterans Suicide Prevention Hotline Act of 2007," would require the VA to award a grant to a private, non-

profit entity to establish and operate a national toll-free suicide prevention hotline.

The DAV notes that there is already in existence a Federally funded 24-hour, toll-free suicide prevention service comprised of over 120 individual crisis centers across the country. From the toll-free number, a caller is seamlessly routed to a certified provider of mental health and suicide prevention services nearest to the call of origination.

If applied to service veterans, a veteran could be transferred similarly, but to a VA mental health provider if the individual wants the services and support of the VHA.

We would like to thank Ranking Member Miller for introducing H.R. 2623 and Chairman Michaud for including it in today's hearing. This bill seeks to prohibit the collection of copayments for all hospice care furnished by the VA.

The DAV has previously testified before this Subcommittee on this important issue, and we support the intent of this measure. We would just like to ensure that its scope is broad enough to include exemption of veterans from copayments for hospice care provided in any treatment setting.

This concludes my testimony. I'd be happy to answer any questions you may have.

[The prepared statement of Mr. Atizado appears on p. 68.]

STATEMENT OF CARL BLAKE

Mr. BLAKE. Mr. Chairman, Ranking Member Miller, and members of the Subcommittee, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today.

Given the broad spectrum of bills on the agenda, I will limit my comments to only a few items.

Although PVA has no objection to the requirements for a Hospital Quality Report Card Initiative, as outlined in H.R. 1448, we remain concerned that this wealth of information will go unused.

Collecting this information and assessing it without acting on any findings from that information, would serve no real purpose. We would hope that the congressional Committees will use this information published in these reports each year to affect positive change within the VA.

PVA generally supports H.R. 2005, the "Rural Veterans Health Veterans Health Care Improvement Act." However, we have concerns about the demonstration projects that will establish partnerships between the VA and the Centers for Medicare and Medicaid Services to seek care in critical access hospitals or community health centers.

Principally we believe that this legislation is "jumping the gun" by getting ahead of the Office of Rural Health, which is responsible for determining if solutions, such as this proposed demonstration project, are feasible.

We think that this new office in the VA should be given time to do its job before Congress begins legislating solutions to the problems that rural veterans face. However, this certainly does not say that Congress should not pressure the VA into implementing this office expeditiously as we believe they have not done so.

PVA has serious concerns about the provisions of H.R. 2172. PVA strongly opposes the provisions of H.R. 2172. PVA strongly opposes the provision of section 2 of the bill that would allow the VA to contract for service and repair of prosthetic devices.

We interpret this legislation to mean that the VA can contract with a single entity to provide these services and repairs. This is absolutely a bad idea. By using a single entity, the pool of devices and services available will be severely limited.

A one-size-fits-all approach to prosthetics cannot be applied. As an example, prosthetics departments that serve PVA members needing wheelchairs often, if not always, contract with multiple different vendors to provide those wheelchairs.

Because every PVA member, and every disabled veteran for that matter, is different, the equipment they need varies. Although an Invacare power chair may be suitable for one spinal cord injured veteran, another spinal cord injured veteran might be better served by a Jazzy wheelchair.

Two uniquely different veterans cannot be expected to use the same equipment simply because it might streamline processes for the VA.

PVA has no objection to the provision of the legislation that would require certification of VA orthotic-prosthetic laboratories with the ABC in Orthotics and Prosthetics or the Board of Orthotics and Prosthetic Certification.

However, we believe that the VA already meets these requirements, but if this provision will reinforce that action, then we have no problem with it.

The incidence of suicide among veterans, particularly OEF and OIF veterans, is a serious concern that needs to be addressed. PVA principally supports H.R. 2219. Any measure that will reduce the incidence of suicide among veterans is certainly a good thing.

However, we must emphasize a couple of important points. First and foremost, there need to be absolute standards established that ensure that the individuals staffing this hotline are adequately trained to handle the complex issues associated with individuals contemplating suicide.

We certainly support the idea that this service should be staffed by veterans, but they must have the proper training to deal with these cases. Simply having the shared experience of military service is not enough.

Secondly, clear steps for referral into VA mental health clinics and other VA facilities with related services must be outlined. The private entities responsible for the operation of the suicide prevention hotline must understand how to refer veterans dealing with these problems into programs that will provide the services that they actually need.

These services are essential to helping the veteran overcome the suicidal feelings he or she may be dealing with.

Mr. Chairman, Mr. Miller, and members of the Subcommittee, we look forward to working with this Subcommittee to develop workable solutions that will allow all veterans to get the best quality care available.

I would like to thank you again for allowing us to testify, and I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake appears on p. 72.]

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Mr. Chairman, distinguished members of the Subcommittee, On behalf of the men and women of the Veterans of Foreign Wars, I want to thank you for inviting us to participate in today's most important legislative hearing.

The VFW is pleased to support H.R. 1488, the "VA Hospital Quality Report Card Act." Resulting data would allow veterans to compare quality of services the VA provides, letting them make more important judgments about their healthcare.

It would allow VA to identify areas of improvement, and it would provide essential data for Congress to better use its essential oversight.

We only urge that this action not conflict with the reporting requirements that VA is already undergoing and attempting to implement.

The VFW supports H.R. 1853, the "Jose Medina Veterans Affairs Police Training Act." Given the large numbers of returning veterans who are suffering from mental illnesses of various degrees, extra training for VA employees on how to deal with these patients is entirely appropriate. This is especially true for those patients who are vulnerable and suffering the most. The extra training will ensure that wounded warriors are treated with dignity and respect.

The VFW has no objection to H.R. 1925, legislation that would establish a new VISN in the Gulf Coast Region.

The VFW is pleased to support H.R. 2005, the "Rural Veterans Health Care Improvement Act." The legislation is aimed to solve one of the greatest problems facing the large number of veterans who live in remote areas: access to care. It aims to improve services including transportation for disabled vets, research and partnerships with small communities.

We are strongly supportive of section 2, which would increase the mileage reimbursement rate veterans receive for their travel expenses related to VA healthcare to the rate provided to all Federal employees.

The VFW is supportive of H.R. 2172. However, the VFW is not sure if changing the rules of VA's prosthetic programs is needed, and we have concerns that the certification requirements that would affect all service and repair programs for prosthetics and orthotics is necessary.

We are also concerned that some efforts to create a certification process could lead toward excessive standardization that aims for one-size-fits-all solution.

The VFW supports H.R. 2173 that would allow the Secretary to enter into contracts with service for community mental healthcare.

With the number of returning servicemembers who are suffering from mental health conditions, it is clear that VA can and must do more.

However, an over reliance on contract care, especially the mental health area, could lead to some extensive continuity of care problems.

Among other things, VA would have to determine some way to ensure that no veteran falls through the cracks when going from the department to a local provider.

Further, it would be absolutely critical that patient records be transferable among all providers so that all information is provided to all involved healthcare givers. With respect to H.R. 2192, "Providing for VA Ombudsman," the VFW is supportive of the intent of this act. We only question whether it's feasible for a single office or entity to gather together and properly coordinate so much information.

Be that as it may, there is definite need for additional assistance for veterans in this complex system.

The VFW supports H.R. 2219, the "Veterans Suicide Prevention Hotline Act." We understand, however, that the VA is in the process of establishing a similar hotline. So it may be necessary to determine how much overlap there is between the programs. It is clear, however, that the program would be beneficial.

The VFW supports H.R. 2378, which would establish a program of financial assistance to help veterans and their families from slipping back into homelessness.

The VFW offers our strong support for H.R. 2623 that would exempt patients seeking hospice care from paying copayments. This is a compassionate idea that relieves a burden on the veteran and their loved ones at a most critical time.

Thank you, Mr. Chairman, for my testimony.

[The prepared statement of Mr. Cullinan appears on p. 76.]

STATEMENT OF BARRY HAGGE

Mr. HAGGE. Good morning Mr. Chairman, Ranking Member Miller, and Members of this Subcommittee. Thank you for giving Vietnam Veterans of America the opportunity to offer our comments on several veterans' health-related bills that are up for discussion here today.

All of these bills, with the possible exception of H.R. 1853, are extremely important. And with a few reservations, they are worthy of your consideration and certainly our support.

I note that while we have not adopted an official position on H.R. 1925, we do not object to it.

The topic of accessibility to VA medical services for veterans who live in rural areas has been percolating of late. We believe that H.R. 2005 offers pragmatic solutions to address the problems of access to healthcare experienced by too many rural veterans.

The bill would increase travel reimbursement for veterans who travel to VHA facilities to the rates paid to Federal employees.

The current reimbursement rate was established decades ago and does not adequately compensate for the costs of gasoline, "wear and tear" on the vehicle and increased insurance that may be necessary in order to travel to distant medical centers.

In the same vein, the grant program for rural veterans' service organizations to develop transportation programs could be an innovative way to strengthen community resources that may already assist with veterans' travel needs.

The establishment of centers of excellence for rural health research, education, and clinical activities, another component of this

bill, should fill a gap in VA healthcare and should lead to innovation in long-distance medical and telehealthcare.

These centers have brought the synergies of clinical, educational, and research experts to bear in one site. Such centers have allowed VA to make significant contributions to the field of geriatric medicine and mental illnesses.

It would require demonstrations of rural treatment models. Demonstrations on treating rural veterans' populations would be extremely useful in assessing effective ways to offer healthcare to individuals who are generally poorer, more likely to be chronically ill, and almost, by definition, more likely to have challenges in access to regular healthcare.

And establishing partnerships with the Indian Health Service and with the Department of Health and Human Services should also add to greater cooperation and collaboration in meeting the needs of rural veterans.

We would caution, however, that we would not like to see these demonstration projects exploring more opportunities to do widespread contracting out of veterans health services. Demonstration models should be assessed according to a number of outcomes such as quality of care, cost, and patient satisfaction and the results reported back to Congress.

H.R. 1448, the "VA Hospital Quality Report Card Act of 2007," is a quality control measure that would help with accountability and issues regarding follow-up care and timely visits.

It would require the VA to provide grades for its medical centers on measures such as effectiveness, safety, timeliness, efficiency, patient"centeredness," and equity. Health-care quality researchers have long thrived trying to objectively define some of these measures.

As members of this Subcommittee are aware, the VA has a number of performance measures it regularly assesses in order to reward its medical centers and network directors among others. Some of these outcomes, such as immunizations for flu, foot care and eye care for diabetics, set the benchmark for care in the community.

In addition to these internal performance measures, VHA voluntarily submits to Joint Commission on Accreditation of Healthcare Organization, Commission on Accreditation of Rehabilitation Facilities, and managed care quality review standards.

VVA understands the importance of quality measurement. There is an expression with which we agree, and it's called "What's measured, matters."

We also agree that VA officials should be held to the highest degree of accountability, and whatever measures are available to allow this to better occur, we wholeheartedly endorse.

However, before enacting this clearly well-intended legislation, we could require significant retooling of quality measurement systems in the VA. The Committee should hold a hearing to identify the gaps and deficiencies in current performance and quality measurement systems.

It would also be useful to understand how report cards would be used and reported to improve VHA processes and performance rewards. Would poor grades be dealt with by changes in manage-

ment? By withholding bonuses to senior executives? With more funding? How would good grades be rewarded?

Such questions should be addressed before requiring a significant new quality measurement program to be installed.

Again, VVA appreciates the opportunity to testify before this Subcommittee, and we thank the Chairman for the opportunity.

[The prepared statement of Mr. Hagge appears on p. 77.]

Mr. MICHAUD. I would like to thank all the panelists once again for your testimony, and we appreciate all the work that you are doing and have done as it relates to fighting for healthcare services for our veterans. We really appreciate it. You represent your organizations very well.

I only have a couple of questions. The first one to Mr. Blake. You were talking about Mr. Salazar's bill. You mentioned that we ought to wait and see what happens with the Office of Rural Health, which was enacted in the 109th Congress. How long should we wait for that office to get up before we start, you know, taking steps?

A lot of bills that we have heard today, a lot of bills that we heard earlier, dealt with access issues. If the VA would move forward, whether it is the Office of Rural Health, whether it is the CARES process, we would not see a lot of these bills if they were doing the job that they should be doing.

And quite frankly I have a problem with this Congress, because of the funding issues, but hopefully we will be addressing that later on today. Mr. Blake?

Mr. BLAKE. Mr. Chairman, I would say that I guess on some level you kind of answered the question for me. I would say that they—it should have been done in January. When the bill was enacted in December, they should have gotten it up and going right away, and we haven't seen any sign. I mean, maybe they have, but we haven't seen any real sign that they have done anything with that office yet. And maybe the VA will be able to testify to the—what the office is doing now when they have the opportunity.

Short of that, I mean, I couldn't give you a timeframe to say, well, let us give them six more months and act. I understand all of the members frustration, and given that you created an office that doesn't seem to be doing anything, I don't necessarily blame you for taking action.

But we don't want to jump over that hurdle without giving an office that is directed with this responsibility the chance to come up with something.

Mr. MICHAUD. Thank you very much.

My next question goes to Mr. Atizado, and it relates to, once again, Mr. Salazar's bill dealing with the increase in mileage reimbursement.

I know the DAV has vans that help veterans with getting to VA services and facilities. My question is where are you on your vans? Is there a need for more vans? Do you think that this might be a way to help hold down costs by getting more veterans to utilize the vans?

Mr. ATIZADO. Well, thank you for the question, Chairman Michaud. The DAV transportation network obviously cannot provide its services to all veterans who need it. Every year we have

requests from our local chapters requesting additional vans for the network, and the way that it is structured, it is actually structured for services in—basically in concentric circles outside the facility. And when we map that out across the Nation, there are some gaps out there.

What we would like to see is that, as I had mentioned in my testimony, the moneys, the funds that are going to go into this program, are going to come from the medical care services account, which as we have noted earlier, has experienced some shortages, and we have always advocated for additional funding in those accounts.

In fact, our resolution speaks to that about the beneficiary travel pay. That is these funds are to be used out of that—out of that account for which—for either one of these programs, that it be done efficiently, effectively, and without duplication of services.

Mr. MICHAUD. Could you provide for the Subcommittee what these are as it relates to the gaps that you have talked about as far as getting vans?

Mr. ATIZADO. Sure. We would most certainly love to work with the Subcommittee on that. We will give you that answer for the record.

Mr. MICHAUD. Great. Thank you very much. Mr. Salazar?

Mr. SALAZAR. Thank you, Mr. Chairman.

I believe that most of you understand that what we are trying to do here is to create a quality—some kind of semblance of the fact that 40-some percent of most veterans are coming from rural communities, and we need to address the needs and the shortfalls.

You know, the study that I related to, it talked about how healthcare or basically veterans health was in poor shape in rural communities, and that is basically what our intent is with this legislation.

In reference to the reimbursement rate, this is only relative to those traveling 100-mile radius, over 100-mile radius. In my district, many veterans have traveled 250 to 300 miles to get access to healthcare.

So I understand the situation, but I also hope that you can understand that we have to continue fighting for rural veterans, because I think they are the ones that lack access. Thank you, Mr. Chairman.

Mr. MICHAUD. Mr. Hare?

Mr. HARE. Thank you, Mr. Chairman. Just a comment to you, Mr. Blake, and then a couple of questions.

I do share with you this concern of the contract out of the one-size-fits-all for folks, and I would like to say I want to get—I want us to be very careful that we do not hurt our veterans while we are trying to help. So I share with you that concern, and I think that is something that we need to be taking a look at.

I would like to ask you, Mr. Hollingsworth, with regard to H.R. 2378. In your testimony you urged Congress to provide priority assistance to the Department of Health and Human Services, as opposed to creating a new program.

Now, I was wondering why you think that would address the problem better?

Mr. HOLLINGSWORTH. Well, I think it is a good—it is a fair question. We struggled with this bill internally, and I think our overall concerns are clearly we want to help those at risk. Clearly we want to help homeless veterans not become homeless.

But I think we are dealing with the reality of limited financial resources for a lot of things. We want to maintain true to the mission of VA with regards to providing priority service healthcare to those injured in the line of duty and service.

And I think our overall fear, quite frankly, is what we didn't want to see happen is to create a voucher program within the Department of Veterans Affairs for low-income veterans.

Mr. HARE. Thank you. I appreciate that. Just one other question for—that I have.

Mr. Atizado, regarding H.R. 2173, to increase the funding for the VA, can you tell me a little bit more about the concerns that you have for the bill and how you think it would affect the VA and the current VA system?

Mr. ATIZADO. I'm sorry, Congressman.

Mr. HARE. That is okay.

Mr. ATIZADO. If you could repeat the question.

Mr. HARE. Sure.

Mr. ATIZADO. Because I had to look up what the bill was.

Mr. HARE. I was just wondering if you could tell me on H.R. 2173, the bill to increase the funding for the VA for mental health services, could you tell me a little bit more about the concerns that you had with the bill and how it would affect the current VA system?

Mr. ATIZADO. I thank you for that question it actually deals with the issue—it is a two-prong issue. Right now VA has the authority to contract services.

Our concern isn't what the quality of care providing community mental health clinics. Our concern is how this legislation implements services to be provides through community mental health clinics.

The two-prong issue is how it requires VA to contract these services, as opposed to using its current statutory authority to make discriminate use of limited resources to contract care.

The second concern we have is how VA actually provides contract care. There are some issues such as care—coordination of care, getting veterans out to seek care in the private sector and then back into the healthcare—the VA healthcare system, to ensure that VA's holistic care of a disabled veteran is, in fact, intact.

When a Veteran leaves the VA healthcare system to seek care outside, it is subject to issues that VA has addressed and is considered high quality such as patient satisfaction, medical and medication errors, patient safety issues.

So we would like to make sure that these veterans who receive care outside the VA healthcare system, come back in to enjoy what has been called the best healthcare system at least in the Nation.

Mr. HARE. I just want to conclude, Mr. Chairman, by saying that—to all the panelists, I have only been here for going on 6 months now that the great thing is to see that the pieces of legislation, the numbers of this legislation coming out for veterans, I think that is a wonderful thing.

And I appreciate all of you and what you do. And I look forward to working with you, because I certainly have no quorum of wisdom on all these bills. And it is good to hear from the people that you represent with what you think is right about these bills, what you think is wrong about them. I think it helps us to put together a better bill.

And I just want to compliment all of you for—and thank you for taking the time, but also compliment you on what you do to—for representing the people that you do each and every day.

So I was look very much forward to working with you on that. Not just these bills, but other bills, the assured funding and some other things as we go down the path.

So with that, Mr. Chairman, I give it back.

Mr. MICHAUD. Dr. Snyder?

Mr. SNYDER. I don't have any questions. Thank you all for being here.

Mr. MICHAUD. Ms. Brown?

Ms. BROWN OF FLORIDA. Yes. I just have a couple of questions, Mr. Chairman, thank you.

Mr. Hollingsworth, can you expound a little bit more about the report card? You say a lot of the information is available, but it seems to be scattered, and difficult to use. Can you expound upon that a little bit more?

Mr. HOLLINGSWORTH. As I indicated in my testimony, the VA does track and report on quite a few statistics and quality of care initiatives.

I can speak very specifically to the combined assessment program, because I have actually had some personal dealings in that area. And it is a very thorough review. The assessment team will go into the facility. It is generally supposed to be, to the best of my knowledge, unannounced, and they do kind of the top-to-bottom review. And it looks at everything from patient care to patient safety issues.

And they issue a report, and generally within that report, not only are there discrepancies listed, but they recommend courses of action to fix those discrepancies. And they provide a period of time for the VA to come back and fix those.

So I guess the only thing I am saying is that we would encourage—you know, there are numerous programs in place, and we would encourage Congress to continue to hold VA accountable for those programs in those reports.

You know, last but not least, and I forget the exact numbers and the statistics, but I would encourage this Committee to possibly take a look at formally.

There are a lot of reports the VA puts together. Okay? And it costs a lot of time, money, and resources, and many of these reports their time may have come and gone.

So we are leery about mandating the fact that you are going to formally institute something for VA to do something when they are going to take manpower, resources to put together these things and provide it to Congress when, in fact, it just may become another program that is there.

Ms. BROWN OF FLORIDA. Thank you.. Mr. Blake, you mentioned the hotline. You had some concerns about that. Could you expound on that a little bit?

Mr. BLAKE. Well, after listening to some of the discussion this morning about what the VA is doing with their own internal hotline versus this outside entity, I thought the discussion was interesting in that Mr. Moran suggested that these are different types of people providing, you know, an outside service.

And the VA, as I understand it, is going to staff their hotline, and maybe I am incorrect, with clinical professionals and individuals who work in the mental health field. And not to suggest that those aren't the right people, but this secondary hotline maybe provides a different perspective.

Now, I have to reiterate our point that we made that you can't just stick anyone behind—on the other end of the receiver and have them answering phone calls, particularly for this population of veterans.

But the shared perspective of a veteran, I think, is important. Understanding that they have to have some kind of—I don't want to say expertise maybe, but some kind of formal training in understanding how to handle these types of individuals.

I mean, most of the hotlines for special needs like that are volunteers that don't necessary—aren't necessarily clinical professionals as well. And it provides some perspective that might provide balance to what the VA is doing internally.

Ms. BROWN OF FLORIDA. My last question concerns not the reimbursement, the cost, but about moving forward and permitting another program.

I am thinking that we need to be considering how we can pool resources and other ways to get people to the different facilities, as opposed to what is wrong here. Everybody wants to drive their own car. I understand that, but that is part of our problem.

With gasoline being $3.00-plus a gallon, we have got to come up with some alternative ways to move people. And it seems to me it could be scheduling, working together, and more vans, more car pools. What are your ideas?

Mr. HOLLINGSWORTH. Well, from AMVETS perspective, we have testified in the past and will continue—rural healthcare and in under served areas, it is a real issue. And it is a problem. I think all of the veteran organizations know that.

You know, the Secretary of Veterans Affairs does have the authority in some cases to contract out. You know, we walk a fine line, because, you know, from an AMVETS perspective, we want to maintain the integrity of the Veterans' Affair system. But at the same time, we want to provide rural veterans in underserved areas healthcare.

So we would encourage the Secretary to continue to contract out. However, we, obviously, hope he uses that authority judiciously where applicable.

Ms. BROWN OF FLORIDA. Mr. Chairman, I have a couple more. I want to see if he can answer my question.

Mr. BLAKE. I just wanted to kind of reiterate our point about the travel reimbursement rate. I think most of the organizations here, if not all of them, principally believe that if you had a reasonable

travel reimbursement rate, you might do away with some of the complaining that veterans have about access in rural areas. That is not to say it solves the problem entirely. That certainly doesn't.

But a lot of the problem that veterans have that live in rural areas is they have to foot a large part of the bill out of their own pocket just to get the care from a VA facility. Yes, some veterans have to drive 250 miles. Well, that is expensive, because it is a tank of gas.

But in a lot of cases they foot the bill for a hotel, because they probably have to stay somewhere overnight if they have to travel that far, eating, and all those types of things. And 11 cents to the mile just doesn't get it done when addressing that concern.

So we think that some of those concerns would be offset if they knew that they weren't going to have to foot the bill out of their own pocket. Now again, some rural access issues are broader than that. Some of them are just—but an area that are clearly under served as a whole.

That is not just the VA. I mean, there are a lot of areas across the country that are under served for healthcare in general. So—and I think that is another issue that falls in line with that as well.

Ms. BROWN OF FLORIDA. Thank you, Mr. Chairman.

Mr. MICHAUD. Maybe we could get railroad access to some.

Ms. Brown of Florida. We will work it out.

Mr. MICHAUD. The Chairwoman chairs the Railroad Subcommittee on Transportation. Mr. Miller?

Mr. MILLER. No questions.

Mr. MICHAUD. Once again, I thank the panel for your testimony this morning, and we look forward to continue to work with you as we deal with veteran issues. Thank you.

And the last panel that we have this afternoon is Dr. Michael Kussman who is the Under Secretary for Veterans Health Administration, who is accompanied by Walter Hall who is the Assistant General Counsel for the Department of Veterans Affairs.

I want to thank both of the gentlemen for coming today, and I turn it over to you, Dr. Kussman. I want to congratulate you for no longer acting as the Under Secretary of Health, and now that you are no longer acting, hopefully we will see good, strong results, particularly as it relates to the Rural Healthcare Office.

STATEMENT OF HON. MICHAEL J. KUSSMAN, M.D., MS, MACP, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER A. HALL, ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. KUSSMAN. Thank you Mr. Chairman and Mr. Ranking Member, and other Members of the Subcommittee.

When you were talking about no longer being acting, I want to assure you that I am now going to pretend to be the Under Secretary of Health.

Thank you for inviting me here today to present the Administration's views on the nine bills affecting the Department of Veterans Affairs health programs.

As you mentioned, sir, with me today is Walter A. Hall, Assistant General Counsel.

As you already did, Mr. Chairman, I don't have to request that the written statement be submitted for the record, because you all did that.

Mr. Chairman, I am going to focus on my remarks on five of the bills, but I would like to state from the beginning, VA does not oppose the intent of any of the bills under consideration.

In some cases, the VA's current efforts meet or exceed the requirements of the bill and in others, some additional work is needed to allow the Congress and the VA to best serve our Nation's veterans.

And our request would be that we could continue to partner with you and the staff to get the best bills possible.

Mr. Chairman, H.R. 1925 would require the Secretary to establish a separate "Veterans Integrated Services Network" for the Gulf Coast region.

While VA certainly desires to serve all our veterans, we find at this point, on the basis of information that we have, no justification for establishing a separate VISN for a service area driven by the workload needed to make such a significant organizational change cost-effective.

Current facilities and referral patterns provide the best access for the veterans on the Coast using the combined efforts of VISNs 7, 8 and 16 who—which are—work very well together to provide the care for veterans living in the area.

H.R. 2005 is intended to improve the VA's ability to meet the healthcare needs of rural veterans. The VA recently established the Office of Rural Health, which is charged with determining how we can best continue to expand access to care.

And the Office of Rural Health is developing a strategic plan for operations that there is consideration for a proposal to create new research centers.

We would request that the Congress wait until these assessments are complete before requiring further action Moreover, while we recognize the significant increase in fuel prices, beneficiary travel payments are paid to a limited category of eligible veterans out of funds appropriated for healthcare for all the veterans.

Our initial estimates project that the bill would cost potentially and approximately up to $7 billion over the next ten years. At present, that cost would have to come out of medical care services.

H.R. 2173 would amend VA's authority readjustment counseling while permitting the Secretary to enter into contracts with community mental health centers for the provision of mental health services.

I have to admit that I have been a little bit confused by the discussion, because the bill talks about veterans health centers, not the VA in general contracting for care. The Vet Centers currently have authority to contract with community mental health agencies for the provision of readjustment counseling services.

For veterans with more complex mental health needs, the veterans—Vet Centers routinely refer them to the VA medical facilities.

This provision, if it really was intended for the Vet Centers to contract out for the full services of mental health, would blur the

distinction between the VA's readjustment counseling and more sophisticated mental health services.

Readjustment counseling is a special, more than medical community based counseling service that creates—that treats veterans and family members under the bereavement counseling to help them make a successful readjustment from combat to civilian life.

VA mental health is a medical care service provided by VA mental—medical centers for enrolled veterans. We already have the authority to outsource and contract if for care, and it is very clear that my guidance is that there are only two ways that you can do this. Let me make it three, but one is unacceptable.

One is that you—we have an obligation to provide whatever services are necessary for the veterans consistent with out benefit package. That we can either do it in-house, and if we can't have the resources, you don't have the infrastructure, then we are obligated to buy it. In other words, contract with it.

The third thing is not to do it, and that is totally unacceptable.

H.R. 2219 would require the Secretary to establish a national toll-free hotline for suicide prevention, staffed by peer-to-peer counselors.

Mr. Chairman, as you already know and has been mentioned already, VA's already developing a comprehensive program for suicide prevention, including a national 24-hour toll-free hotline.

The VA plans to staff the hotline with VA mental health professionals who may access the electronic health record of the callers and can work with local facility suicide prevention coordinators to provide immediate and provide more comprehensive care.

H.R. 2378 intends to prevent low-income veterans in permanent housing from falling back into their former homeless condition.

The VA generally supports H.R. 2378, but we strongly recommend the bill be modified to allow VA to establish additional criteria to ensure that this program reaches veteran families requiring additional support to end their homelessness.

There was one bill, the 2623, the "Hospice Care Bill" that I don't know exactly what happened in the process. I did not provide comments on that either in written or verbal, but I would be happy to answer any questions about it. But we didn't develop a formal response to that bill.

[Comments for H.R. 2378 and H.R. 2623 were provided by the U.S. Department of Veterans Affairs on August 19, 2007, and appear on p. 91.]

I am pleased to answer any questions you or any of the other members may have, Mr. Chair.

[The prepared statement of Hon. Kussman appears on p. 80.]

Mr. MICHAUD. I have a few questions. What have you provided to the Subcommittee dealing with Ms. Watson's bill as far as training. Looking at PVA's testimony, they had mentioned that they had talked to one of the VA chiefs and were told that the officers received training primarily on how to handle veterans aged 60 to 70 years old. I want to know if you could provide to the Subcommittee what other requirements for the officers as far as training goes.

[The FY 2007 Basic Police Officer Training Course Syllabus and Training Schedule from the U.S. Department of Veterans Affairs

Law Enforcement Training Center, North Little Rock, Arkansas, is being retained in the Committee files.]

Mr. MICHAUD. Another issue talked about—a report on the reports. I think it is important that we have reports. But, I am concerned about the redundancy and how we can streamline that process.

Regarding testimony the VA does a good job on a lot of its programs, but I can see the frustration that people might have in trying to access the system.

It is my hope that the VA will look at how it can improve access to programs, such as through a computer and telephone system. Did you want to comment on that?

Dr. KUSSMAN. Yes, sir. I would be happy if I could, if I could remember all the questions you had.

But first and foremost, as was mentioned, all our VA police are VA employees by statute. They are not contracted. There may be some confusion. I think that there is some contracting for guards, but not for the police themselves.

If I may just take a minute. Clearly, the description of what happened to Jose Medina is unacceptable, and all I can say as the leader of the VHA, that is unacceptable. And we apologize for whatever happened or anything veteran who is inappropriately treated by any employee in our system, much less the police.

Now, we—in the hiring our VA police, there is an extensive training program done even before they get to the ability to work. There is an 80-hour basic injury level of training course at whatever medical center they are going to be employed on. And then a 200-hour residential basic police office training course at our law enforcement training center, I think, that is in Little Rock, Arkansas. And we have been lauded by much of this training.

Title 38, U.S. Code, section 902, requires VA to create regulations with respect to training department police officers, with particular emphasis on situations involving patients.

The specific question that you had, it was alluded to that the training was only for people over 60. I have to go back and look at that, but clearly our job is to take care of the full depth and breadth of veterans, with specific emphasis on adjustment reactions in mental health and people who may or may not be acting in a way that is not normal the way they act because they are ill. And that is something that all medical employees have to do.

Whether it is a policeman or anybody else is that people don't necessarily act the way they might in the department store versus—or a bank versus when they come into mental—for medical services, because that is the problem. They are coming for medical services.

Much of the training, there is a 17.5 hour block of training in behavioral science, which includes training on mental illness——

Mr. MICHAUD. Instead of going through that whole thing——

Dr. KUSSMAN. Okay.

Mr. MICHAUD [continuing]. Could you provide that for the Subcommittee?

[The following was subsequently received:]

By statute, the Secretary is required to provide VA Police Officers with training that emphasizes effective management of situations involving patients. To carry out

that mandate, VA provides specialized training to VA Police Officers in dealing with disruptive and other unusual behaviors, key portions of which are taught by VA psychologists. VA officers must successfully complete:

- An 80-hour basic entry level training course at their Medical Center;
- A 200-hour residential basic police officer training course at the VA Law Enforcement Training Center in Little Rock, Arkansas;
- A 17.5-hour block during their residential basic officer training in Behavioral Science (including topics such as mental illness, communications/conflict management, verbal judo, crisis intervention/conflict resolution, and the dynamics of the suicidal individual); and
- A biannual refresher training program.

Dr. KUSSMAN. Sure.

Mr. MICHAUD. I know my time is up.

Dr. KUSSMAN. Okay. I am sorry. Just—okay.

Mr. MICHAUD. But the other issue you could look at that we are dealing with today is the budget. It is a very robust budget for the VA system, and our problem, when you look at the bills that you mentioned earlier, a lot of these issues could have been dealt with if the VA had the budget and moved forward, whether it is the CARES program or other access issues.

I am also looking at how we can help save costs. A good example, is the dental area.

For example when you go to the VA for dentures or you need amalgam fillings, it depends on whether the VA gets it. If you go to the dentist, the dentures tend to cost twice as much, as much as $600.00 or more if you went—than if you went to a denturist. Likewise, if you go to a dentist and they decide to fill a filling with a white filling versus an amalgam filling. The white tends to be a lot more expensive and it doesn't last as long.

So hopefully the VA is looking at ways where they might be able to save money, and it might make the system more effective. I will ask other members to ask that question, and we will go a second round if we have time.

Mr. Miller?

Dr. KUSSMAN. So you—there was one—on the last part of your question about the ombudsman?

Mr. MICHAUD. Yes

Dr. KUSSMAN. Yes.

Mr. MICHAUD. Excuse me.

Dr. KUSSMAN. And, obviously, in intent, that is a great idea, and it really depends on what type of veteran you are talking about. Whether it is the more routine veteran that is getting out, using the Benefits Delivery at Discharge (BDD) process, the Transition Assistance Program (TAP) process, and all those things. That is where a lot of that counseling goes.

But we realize that people who are injured in service, particularly with TBI and more severe injuries, needed a lot more care. And as you know, we have had our benefits counselors and case managers get deeply involved with these VA facility. They wrap themselves around, try to communicate with them, make sure everybody knows that their benefits are. Military people who are in our four Polytrauma Centers to help on the reverse way of making sure that people get help if they are worried about the Medical Evacuation Proponency Directorate (MEPD) process.

We also, as you know, just put in place a program of transition patient advocates that are going to glom themselves on, on a one-on-one basis with people who are in the Walter Reeds of Bethesda and Brooks, and help them longitudinally as they go through the process but not give up on them. They are going to have cell phone contact. They are going to picked by where the patient would generally want to go and will keep in contact with them over a period of years.

Mr. MICHAUD. Thank you. Mr. Miller?

Mr. MILLER. Thank you very much, Mr. Chairman. Doctor, good to see you.

Dr. KUSSMAN. Nice to see you, sir. Thank you.

Mr. MILLER. I look forward to working with you. I did put the chart back up so you could refer to the VISN in the Gulf Coast Region.

You stated in your testimony that there was not sufficient workload to make an organization change, create a new Gulf Coast VISN. Could you give me some type of idea of what you consider as sufficient workload?

Dr. KUSSMAN. The information that I have, and, sir, I would have to go back and validate it and discuss with you further, but the information that I have is that in 2005, there were 88,000 enrollees in the area that you are describing, with 281,000 veterans of which 88,000 were enrolled with us.

Mr. MILLER. So you are saying—my question is not——

Mr. SNYDER. I was not sure of his answer. Is the number he is giving in the new area that he wanted——

Mr. MILLER. You can't—I mean, you—I mean——

Dr. KUSSMAN. Okay.

Mr. SNYDER. Yeah, that is what I figured.

Mr. MILLER. My first question is what do you consider an adequate workload, a sufficient workload? Looking at this chart, it is very clear that there are two VISNs that are absolutely covered up. One is 16; one is eight.

Obviously, a lot has changed since the inception of the VISN, and I think the Gulf Region is the concept works, and, obviously, because we took two and we fold them into one, there is flexibility in doing what needs to be done.

Clearly, you can look and see that VISN 16 has three times the number of Gulf veterans as VISN two, five, or 19. My question is at what time would the enrollment be too high that you would look at splitting? Splitting, not combining, but splitting this?

Dr. KUSSMAN. That actually is a very good question, and I don't think we have a criteria for that. And we certainly should look at it.

[The following was subsequently received:]

Question: For the record, "the opportunity for VA to look closer at the numbers" of VISN 16, particularly how many veterans it has relative to other VISNs and whether that should be reconfigured.

Response: Currently, we have no data to support an additional VISN in the Gulf Coast Region. The size of the area proposed for a VISN does not have the workload needed to be cost effective, nor to require that level of management. This area has only 88,583 enrollees and 281,476 veteran population in 2005, with the 2025 projections at 94,779 enrollees (a 7% increase) and 223,598 veteran population (a 21% decrease). The smallest VISN currently has at least 200,000 enrollees and over 500,000 veteran population.

This area has one hospital, the Gulf Coast Veterans Healthcare System in Biloxi, Mississippi, and no tertiary care facility. The Gulf Coast area has four operational Community Based Outpatient Clinics (CBOCs) in Panama City, Pensacola, Dothan, and Mobile, and one approved to open in the next year in Jackson County, Florida. In addition, there are sharing agreements in place at three major military installations in Pensacola, Ft. Walton, and Panama City for inpatient and other healthcare services as needed.

Each of the other 22 VISNs has at least four hospitals, with at least one providing tertiary care, and at least 15 CBOCs to manage the services and healthcare for veterans. With only one facility in the Gulf Coast, there is no need for Network Management. In addition, balancing the budget, opening new programs, and making large capital investments, among others, will be difficult at best. The Gulf Coast area does not have a tertiary care facility and as is the current practice, patients would still be referred to the closest tertiary care facility—Birmingham, Alabama; Jackson, Mississippi; or Gainesville, Florida.

The current facilities and referral practices in this area provide access for veterans. VISNs were originally created around referral patterns and geographic boundaries. In addition, VISNs work together along their borders to ensure access to healthcare for veterans in those areas. The Gulf Coasts region is one area where VISNs seven, eight, and 16 have worked together to manage care for veterans in the area. VA has no plans at this time to add an additional Network for this region.

Mr. Miller. What catches me by surprise with a visual such as this, that is it is very, very clear that there are some areas I would say are underserved or under worked.

Now, they won't say that, and I would never impute that or imply that, because they are all overworked. However, if the folks in VISN two, five, and 19 are overworked, then eight and 16 are really overworked.

I would like for the record the opportunity for VA to look closer at the numbers, and if it is time to realign the whole network, fine. I am looking obviously at the veterans in the Gulf Coast Region, but it may be other regions as well.

Another thing, on a personal note if I may, Public Law 109–461 required a report not later than 180 days after enactment on the option of construction of a VA medical center in Okaloosa County. We are upon that date. In fact, it may even be next week. My question is are we going to meet that deadline, and when can we see a copy of the report?

Dr. KUSSMAN. Sir, we working on it, and let me get back to you exactly when we will get that report to you.

[The "Report to Congress on Options for the Construction of Department of Veterans Affairs Medical Center in Okaloosa County, Florida," dated June 26, 2007, is being retained in the Committee files.]

Mr. MILLER. Okay. Thank you.

Mr. MICHAUD. Mr. Salazar?

Mr. SALAZAR. Thank you, Mr. Chairman. And, Dr. Kussman, thank you for being here, and I understand the issues that you face with VA funding. And I can assure you that this Congress is trying to do everything they can to provide these funds that are badly needed for veterans.

Can you tell me what model you use to estimate the $7 billion that you talked about that it would cost VA for mileage reimbursement?

Dr. KUSSMAN. I would have to go back to policy and planning and resource managers, and I will get you an answer. I don't have it at the tip of my tongue about how they develop the estimation.

[The following was subsequently received:]

Question: What was the methodology used to determine the $7 billion cost for beneficiary travel in Section 2 of HR 2005, the Rural Veterans Health Care Improvement Act of 2007?

Response: (16, 10A5, 17) Beneficiary travel is a discretionary program with funding coming directly from the annual VA healthcare appropriation. Funds expended for beneficiary travel decreases those available for direct medical care. The Secretary is required to undertake a yearly evaluation of the program in order to determine whether VA has sufficient funds to continue to provide veteran transportation benefits and whether any rate changes should occur. Given the unprecedented rise in veteran patient workload and the associated demand for limited VA medical care resources, the current reimbursement rates of .11 mile for travel relating to medical care and .17 mile when a veteran is recalled to redo a portion of a C&P examination that were established in 1979 have been maintained. Note: Under current law, when the beneficiary travel rate is adjusted, the deductible is adjusted proportionately to the adjustment.

The proposed legislation requires VA to reimburse veteran mileage at the same rate as that of federal employees. It would also pay a subsistence amount (e.g. meals, lodging) at the same rate as a federal employee for that locality. Cost determination data is presented below.

Cost Analysis: H.R. 2005, Section 2, changes the method of determining the mileage reimbursement rate of the VA Beneficiary Travel Program by equating it to that received by Federal employees as well as provides for a subsistence rate equal to that of a federal employee. The following provides a 5-year and 10-year estimate of the cost that would result from enactment of the proposed bill.

Fiscal Year	Estimated Reimburseable Mileage*	Payment Rate**	Increased Cost (Millions)
2008	675,363,636	.375	$253
2009	776,668,181	.40	$311
2010	893,168,408	.425	$380
2011	1,027,143,669	.45	$462
2012	1,181,215,219	.475	$561
5-Year Total			$1,967
2013	1,358,397,502	.50	$679
2014	1,562,157,127	.525	$820
2015	1,796,480,696	.55	$988
2016	2,065,952,800	.575	$1,188
2017	2,375,845,720	.60	$1,426
10-Year Total			$7,068

May not add up due to rounding

*Estimated 15% increase in mileage per year
**Federal Rate minus current .11 mileage rate

Methodology: Number of miles for FY 2008 is based upon projected expenditures for Budget Object Code (BOC) 2120, "Beneficiary Travel-Mileage" from the first half of FY 2007. **Note:** *While VA does pay 17 cents per mile for recalls due to the need to redo a portion of a C&P exam this is considered to be relatively rare, therefore the 11 cents per mile rate is used to determine base miles).*

Projected expenditures for FY 2007 are a 15% increase over FY 2006, and based upon continued increase in the number of veterans accessing VA healthcare it is estimated that this mileage rate increase will continue. Base Federal employee rate of 48.5 cents per mile is current rate. For the past 10 years there has been an annual average 2.5 cents per mile increase to the Federal employee rate, thus the rate changes noted.

A subsistence rate adjustment has not been included since meals and lodging is estimated to have minimal impact due to current operations of only paying when hotel or other VA lodging is not available and the trip requires an overnight stay. VA usually pays actual charges in this event for lodging and meals.

Mr. SALAZAR. I would appreciate that very, very much. And as far as the office that was established in January, the Office of Rural Health Care, could you also provide to this Committee an assessment as to what you have done to date in the last 6 months?

Dr. KUSSMAN. Yes, sir. Thank you for the question. As you know, we owe you a response in September of 2007, a written response about what progress has been made in the Office of Rural Health.

Right now it has been stood up under the auspices of the Office of Policy and Planning under the direction of the Assistant Deputy Under Secretary for Health, Pat Vandenberg. This is a good place for this office, because it is involved with the office that does projections on workload, access, CARES, and the Milliman Model.

Right now, Peter Sellick is in charge of that office, and they are looking at some strategic recommendations. At the same time, they are in the process of hiring a full-time director and establishing the necessary staff. So we will have a report for you.

Mr. SALAZAR. So we still do not have a director, and we still are not fully staffed?

Dr. KUSSMAN. Right. That is correct.

[The U.S. Department of Veterans Affairs, Veterans Health Administration, submitted the following report on January 10, 2008,*"Plan to Increase Access to Quality Long-Term Care and Mental Health Care for Enrolled Veterans Residing in Rural Areas,"* which appears on p. 96.]

Mr. SALAZAR. One other question, Doctor. You talked a little bit about the Centers of Excellent and your objection to us directing you to establish the Centers of Excellence; is that correct?

Dr. KUSSMAN. I——

Mr. SALAZAR. Could you tell us what your objection is to this?

Dr. KUSSMAN. Yes, sir. I will try. By the way, I was accused last year when I was here as being "Dr. No." I don't—I would like to be "Dr. Yes."

But to answer your specific question, we are not—I am not—I don't think anybody is against the Centers. The question is is there five, or four, or three that would be needed, and I think that is what we would hope that the Office of Rural Health, approaching the appropriate experts and everything, would recommend of how many or whatever that we need of these centers, because I think they are valuable centers.

Mr. SALAZAR. But would you also agree that it is really up to members of Congress to request from you that these offices wouldn't just be established on one coast or the other and forget about middle America?

And, you know, I think that is one of our reasons for trying to move this legislation forward so that we can basically make these Centers of Excellence, you know, located in—so that they address the needs of middle America as well, like Colorado, or Montana, or South Dakota.

Dr. KUSSMAN. Yes, sir. I wouldn't take exception. I don't recall that the legislation prescribed where they would be, but I don't dis-

agree with you. It ought to be in areas that have the most need for the research and development of things related to rural health.

Mr. SALAZAR. Thank you. I yield back.

Mr. MICHAUD. Mr. Hare?

Mr. HARE. Thank you, Mr. Chairman. Thank you for coming today, Dr. Kussman. Just three questions, I guess. One on H.R. 2623, the—which prohibits the collection of copayments for the hospice care.

I was wondering if the VA has a position on that or——

Dr. KUSSMAN. Well, as I mentioned earlier, I apologize. For some reason we didn't get that bill to put together an official policy. But in the past, and as we have done already with certain segments, we understand the need for that.

And I don't want to prejudice the ability to look at the legislation, but it is clearly something that we need to look at.

Mr. HARE. Thank you. The other one is on H.R. 2219, the "Veterans Suicide Prevention Hotline." I was wondering if you could just maybe update me on the status of the—of this project that you have.

Specifically, when you expect it to be up and running, the qualifications of the people who are staffing the hotline, and does the VA plan on advertising this resource, so that the veterans have an understanding that it is there or their families have an understanding that it is there to be used? And if so, how are you going to do that?

Dr. KUSSMAN. Well, yes, sir. Obviously, any suicide is one too many, and our goal is to be as aggressive as we can. And we put together a very aggressive suicide prevention program, including having suicide coordinators at every facility, and this is another aspect of that, training all our people to know about how to look for and treat, even non-mental health people.

The intent here, this will be established fully by the end of September of this year, and that we believe, after much discussions and everything—and by the way, the Joshua Omvig bill actually drove saying—we were doing this before that, but it was consistent with the bill, that said that they would be mental health professionals.

And so our intent is to have the most sophisticated responses available to people when they call in, especially that they have access to the medical records if they weren't a veteran that we had never seen, so that they would be able to know about the veteran and assess the patient, because they would have the information. And then be able to coordinate directly with the suicide coordinators and the clinical people who are actually taking care of this person.

Mr. Moran's point is well taken, and I think that it is something that we want to look at in balancing this, because there are veterans who don't like to use the system. That is what the Vet Centers, the readjustment counseling centers, are so valuable for.

So I think that this is just another thing that we need to work together to decide what was the best way to do this. But having two hotlines, I am not sure how productive that would be.

Mr. HARE. How do you plan on advertising this so the veterans can call in? The other question I had was for those who are staffing

the hotline, what qualifications they had to have in order to be there?

Dr. KUSSMAN. With all our communication efforts with our newspapers and information papers at the facilities, we will do everything we can to make sure that people and their families know.

Clearly when people transition out of the military, they will know as well as all the other veterans. Our intent is to have fully trained psychiatrists or psychologists available to provide that service.

Mr. HARE. Do you have—just one last question. Is there a guesstimate, if you will, on how many veterans or families who would utilize this hotline during the course of the year? I am thinking several thousand.

Dr. KUSSMAN. Well, I am sorry. I don't know. We can look at per capita things that have happened in other hotlines, and presume that that would be——

Mr. HARE. Would you—would you expect the numbers would be significant or your thought maybe even?

Dr. KUSSMAN. I don't know if they would be higher than we thought, but I think that we need to do it even if it is small numbers.

Mr. HARE. I agree. All right. Thank you. I yield back, Mr. Chairman.

Mr. MICHAUD. Dr. Snyder?

Mr. SNYDER. Thank you, Mr. Chairman. Dr. Kussman, I—is it Kussman or Kussman?

Dr. KUSSMAN. I think my father who is deceased would say it was Kussman, but everybody says Kussman. So I have been called worse.

Mr. SNYDER. There was a San Diego Padre ballplayer named Kussman. I don't know if you——

Dr. KUSSMAN. It is K-O-O-S.

Mr. SNYDER. If I call you Koosman, I will harass you for your batting average.

Dr. KUSSMAN. I don't see well enough.

Mr. SNYDER. Regarding—Mr. Miller had to leave, but in regard to this VISN issue, you know, part of VISN 16 includes Arkansas. And I have not heard much. You try to reach out a little bit on Mr. Miller's bill, and I have heard many complaints either way about how the lines have been drawn.

I do have some concerns though that if we were to start drawing these lines by statute, and regarding seeing some benefit to doing that, and we changed the lines. And so I would hope that you would take into consideration Mr. Miller's concerns about those areas and waiting on the veterans. And I think it has been growing. And I hope we take a very formal look at this.

And it may well be that in Arkansas we should also be concerned. Maybe there is an additional benefit to our veterans to have a smaller number of them under that administrative umbrella. I don't know what is magic, but I don't think Moses had golden tablets that said, what the most efficient number of enrollment is, this number versus a smaller number.

It doesn't follow beyond that because you have a larger number. You can be more efficient. I would assume that the staffing would reflect the numbers of veterans, and those kinds of issues.

But I hope you will formally look at that, and get that evaluation back to us, because——

Dr. KUSSMAN. Yes, sir.

Mr. SNYDER [continuing]. It has been a while since we took a look at it administratively.

The second question I want to ask, but I share your concerns about the dental hotlines. So many years ago was that before I ever got into medicine and practiced medicine, staffing hotlines, you really do get a lot of kinds of calls that come into the different hotlines.

But there are—every once in a while, there is one that really is a major problem and how that call is handled can make a huge difference in that person's life for better or worse. And I share your concern about who we would have on the hotline, and then like the real hotline. I think there could be some real confusion.

I think, ultimately what everyone wants is that there be a place that people can go when they really are having a problem. If everything else is broken down, hopefully they are calling their health professionals or before they reach the hotline, but I share your concern.

The issue of contracting out service in rural areas, about half my district is—would be considered rural, if not a little bit more. A great expanse of Arkansas are considered rural. We are very pleased with our VA system, the healthcare system in Arkansas.

One of the things I like about it is if something goes wrong, I can pick up the phone or my staff can pick up the phone and go straight to a VA employee and say, "Fix this." When things are contracted out, that is not so easy to do. You have people who have contractual responsibilities, which is different than having responsibilities to a member of Congress. I remember my office sent you a letter. We faxed it yesterday afternoon. If you haven't seen it, we have an issue going on now with regard to the seat back business in my district. I know we are hearing about veterans.

But my specific question is, if they can provide the best care, more power to them. The problem is, I also noticed reports—especially reports out of Eureka, California, that they were rejected for a contract out there. We have had some indication that one of the VA's out there said they were real concerned about the company. That they decided to reject that contractor.

But now we have got them in another VISN. That people may have a different set of information. How much information is shared when you have these kinds of—when you use this kind of contractor? How much information is shared amongst the decision-makers, so that we are sure that the experience is good or bad and the contractors in one area that they reach out to other areas? How is that information shared so we know that they work on the same basis, and don't have to rediscover?

Dr. KUSSMAN. Thank you for the question. I have not seen the facts, so I apologize. But I think that the point is very well taken. Obviously is what do we learn from one place to another.

You know, the old adage, you have seen one VA, you have seen one VA, is not what I believe. We have to have standards and consistency in the deliver.

I have no idea why that Eureka, California, contractor was rejected. There could be a lot of reasons. If it was truly the quality of care, then we certainly should be able to track that, because what brought in all the other sea box that they may be contracted around the country.

So I think we certainly have to look at that, and see if how we transmit information related to good contracts or bad contracts.

Mr. SNYDER. The number of contracts contracted is certainly going down. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you. Ms. Brown.

Ms. BROWN OF FLORIDA. Thank you. Mr. Chairman, I don't have all of the details right before me, but in the last couple of days there was a news report. It indicated that veterans, over the last, I think it said 10 years, were twice as likely to commit suicide than people who were non-veterans.

And I guess in response to that and other issues, the Department has indicated that they are going to hire 153 prevention counselors at all of the veteran centers.

My question lies—and I am not one for contracting out, but perhaps in a situation like this, it would be better, because I don't know what the cost is to hire 153. But how would those people who can't be available 24 hours help all the veterans. This would be the opportunity to work with some organizations and other groups to have people available and training in coordination.

I just don't know how it is going to work. Can you expound upon that?

Dr. KUSSMAN. Yes, ma'am. We are constantly looking at our mental health processes, suicide, PTSD, whatever it is.

Ms. BROWN OF FLORIDA. Are you familiar with the study that I am talking about?

Dr. KUSSMAN. I am aware of it. I haven't read the study specifically. The subject matter experts are looking at that to determine, because a lot of times the small numbers, and it is hard to know for sure what was in the report. I am not debunking the report at all.

I mean, I—but the ones—the counselors we were talking about are suicide coordinators to make sure that the facilities have all the programs and processes in place. That the staff is educated in things of that sort.

I have put in place a new policy related to mental health. That when somebody surfaces, that they need to be evaluated within 24 hours of what it is. Now, obviously, if a suicide, you can't even wait 24 hours, but we have people on call 24 hours a day. And we will make that the standard in our facilities.

So if somebody calls, again, and they call the hotline, that hotline has the way of getting to wherever the geography if the person will tell us. Sometimes they call and won't tell you where they are, and you have got to look at the call—caller ID and see the area code.

But if somebody comes to the emergency room or somebody knows about it, we have people on call 24/7 to come in and assess

that person, because you have to take every person who says, "I think I am going to do something bad to myself," seriously.

Thank God most of them don't do it. But there are enough that do that we have an obligation to try to intervene to the maximum extend possible.

Ms. BROWN OF FLORIDA. One follow up. You indicated in your written testimony you generally support most of the bills, but under the area of permanent housing for the homeless vets, why would clinical indicators be a reason to deny permanent housing?

I felt that if we are looking at veterans, there is going to be a big increase in funds to deny a program to staffing issues is kind of—is very unacceptable to me. And I would like for you to be "Dr. Yes."

Dr. KUSSMAN. Or "Maybe Could Be." I don't know. But in truth, I don't think we are against the permanent housing. I think what we were saying is that we support the bill. It would be a better bill for us if we could add some of these clinical services that are there.

For instance, we would want to know what—if there was a history of mental illness, whether there was a history of substance abuse, demonstrated significant impediments to holding a job, whether there was social dysfunction in the family. All those things would make it better for us to be able to provide services.

Ms. BROWN OF FLORIDA. Well, would you work with us as we move forward——

Dr. KUSSMAN. Yes.

Ms. BROWN OF FLORIDA [continuing]. With the bill and my staff to make sure that we include those areas that you think would make it better?

Dr. KUSSMAN. Yes, sir. And I think as the Chairman knows, I would like to do that in all the different bills, because I think we agree in principle as I said. We just want to maximally affect what we can do, and not, perhaps, get someplace where we are duplicating what we are doing.

But our effort is to take care of veterans.

Ms. BROWN OF FLORIDA. I know you know that there is a lot of frustration——

Dr. KUSSMAN. Right.

Ms. BROWN OF FLORIDA [continuing]. With us, because we all care about the veterans, and it is just—it seemed to be not working for them.

Dr. KUSSMAN. Right. It——

Ms. BROWN OF FLORIDA. And they are very frustrated, and they get on us. And then we have to get on you.

Dr. KUSSMAN. Yes, ma'am, I understand that. I have been sworn in since the 30th of May.

Ms. BROWN OF FLORIDA. All right, "Dr. Yes."

Mr. MICHAUD. Just a follow up. I think it was Mr. Hare's question and others about hospice. I believe that was actually requested from the VA back in the 2006 budget.

Just one last question, and we'll take questions in writing. It gets to questions asked earlier about the Office of Rural Health. You had mentioned you had not hired a director or anyone in that office.

Dr. KUSSMAN. I have to go ask Matt about that. I think that they have, but I don't want to give you the wrong information. Let me get back to you on that, whether they have actually hired any specific—they have a lot of detailed work out to hire the people. I don't know if anybody has actually been brought on.

As you know, there some challenges sometimes when we want to go hire somebody. It has got to go through all the process that can take months.

Mr. MICHAUD. Again, it would be interesting to know, and particularly for the director of Rural Health, who that individual might be and what you are looking for in that individual. I would hate to have someone from Boston or Los Angeles or Chicago. But I would like to have somebody who really understands and has a mindset of problems that people are facing in rural areas.

Dr. KUSSMAN. Yes, sir. And there is a job description that is established. I would be happy to try to get it to you.

[The job description for the *Program Analysis Officer, Office of the Assistant Deputy Under Secretary for Policy and Planning, Veterans Health Administration, U.S. Department of Veterans Affairs,* appears on p. 103.]

Mr. MICHAUD. Great. Once again, I want to thank the panel for your testimony today and we look forward to continue working with the VA as we move forward in this upcoming Congress. Thank you very much.

Dr. KUSSMAN. Thank you, Mr. Chairman.

The hearing is adjourned.

[Whereupon, at 12:41 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of the Honorable Michael H. Michaud, Chairman, Subcommittee on Health

Today's legislative hearing will provide Members of Congress, veterans, the VA and other interested parties with the opportunity to discuss legislation within the Subcommittee's jurisdiction in a clear and orderly process.

While I may not necessarily agree or disagree with the bills before us today, I do believe that this is an important process that will encourage frank discussions and new ideas.

We have ten bills before us that seek to improve healthcare for the nation's veterans, and I look forward to hearing the views of our witnesses.

I also look forward to working with everyone here to continue to improve the quality of care available to our veterans.

There are two draft discussions that are not before us today. There is a discussion draft on homelessness, and a discussion draft on mental health services. Congressman Patrick Murphy of Pennsylvania has also introduced H.R. 2699. I ask that the members of the third panel, the VSOs, and the fourth panel, VA, provide comments and views on these three items for the record once they are made available. We would like your written comments submitted to the Committee by June 21st, 2007.

Prepared Statement of the Honorable Jeff Miller, Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman.

I appreciate your holding this legislative hearing and welcome the opportunity to discuss the ten different legislative proposals before us today. I would like to offer brief introductory remarks, and note that I have introduced two of the bills and will expand on these bills, H.R. 1925 and H.R. 2623, at the appropriate time.

As we evaluate this legislation, it is important to consider that the demand for veterans' healthcare is increasing and will continue to grow. While there may be some areas that will see a decrease in the veteran population, other areas, including my own Florida district, are experiencing a large increase in the veteran population. In fact, in the past 10 years, the number of veterans living in FL CD 1 has grown more than 30% and is among the top 10 districts in the United States for growth of veterans since 2000.

I'd like to thank my colleagues, Dr. Kussman and all of the veteran service organization representatives for their commitment to join us today to discuss these very pertinent issues affecting our Nation's veterans.

Thank you, Mr. Chairman, I yield back.

Prepared Statement of the Honorable Stephanie Herseth Sandlin, a Representative in Congress from the State of South Dakota

Chairman Michaud and Ranking Member Miller, thank you for allowing me to be here to discuss the Services to Prevent Homelessness Act, a bill which I introduced on May 17, 2007, to provide supportive services for very low-income veterans.

The U.S. Census Bureau estimates that 1.5 million of our nation's veterans live in poverty, including 702,000 veterans with disabilities and 404,000 veterans in-households with children. 634,000 of the 1.5 million poor veterans live in extreme poverty. These poor veterans face residential insecurity due to their low-income levels or their past episodes of homelessness. They also face health and vocational challenges and access barriers to supportive services, which limit their ability to sustain housing and maintain independence from more-costly public institutional care and

support. These poor veterans may benefit from flexible and individualized support services provided in home-based settings.

The Services to Prevent Veterans Homelessness Act would authorize the Secretary of Veterans Affairs to provide financial assistance to nonprofit organizations and consumer cooperatives to provide and coordinate the provision of supportive services that addresses the needs of very low-income veterans occupying permanent housing. The financial assistance shall consist of per diem payments for each household provided supportive services.

Supportive services that may be offered include physical and mental health, case management, daily living, personal financial planning, transportation, vocational counseling, employment and training, education, assistance in obtaining veterans benefits and public benefits, child care, and housing counseling.

Veteran subpopulations expected to benefit from the program include veterans transitioning from homelessness to permanent housing, poor disabled and older veterans requesting supportive services in home-based settings, and poor veterans in rural areas with distance barriers to centrally located services.

While federal programs exist to help create veterans homeownership, there is no national housing assistance program targeted to low-income veterans. Permanent housing opportunities for veterans ready for independent living are limited. In addition, the VA currently is not permitted to provide grants to create affordable permanent housing, and the resources that are available for providers are inadequate and highly sought after by competing housing projects.

Thank you again for allowing me to be here. I look forward to continuing to work with the Chairman and Ranking Member to support efforts to meet the housing assistance needs of our Nation's low-income veterans through the establishment of a permanent housing assistance program for low income veterans.

I would be happy to answer any questions you may have.

Statement of the Honorable Ciro D. Rodriguez, a Representative in Congress from the State of Texas

Chairman Michaud, Ranking Member Miller, and distinguished Members of the Subcommittee. Thank you for the opportunity to speak before you in support for an issue near and dear to my heart. H.R. 2173, a bill I introduced with my friend and colleague Congresswoman Napolitano, provides for the increase in capacity for mental health services through contracts with qualified community mental health centers.

Recent surveys show that one in eight returning Iraqi war veterans report symptoms of post traumatic stress disorder (PTSD). The same studies also report high incidence of major depression and anxiety disorders among returning members of Army and Marine combat units. As a Member of this Committee, we have long identified mental health services as a major issue facing returning soldiers as well as at the Veterans Administration (VA).

Experts note that the manifestation of clinical symptoms of PTSD and other mental health disorders often occurs over several years. With the increase of active duty, guardsmen and reservists returning from combat, the necessary capacity to provide mental health services is relatively unknown. It is difficult to know if our large number of returning veterans will need mental health services beyond what the VA is capable of providing.

My bill, H.R. 2173, authorizes the VA to contract with community mental health centers to increase their capacity. In my opinion the need has outpaced the capacity for the VA to provide mental health services in outpatient clinics. Contracting out to community mental health centers is already been done successfully in some states and could serve as a model for VA-wide implementation.

Mr. Chairman, in my previous career, I worked in the mental health field as a social worker. I am fully aware of the great service provided by community mental health centers. If there is any doubt of the quality of care they provide, I can tell you of the hundreds of families whose lives have been changes by the treatments received during my professional career in the field. But don't take my word for it. Each year, community health centers give nearly 6 million children, adults, and families in communities across the country the chance to recover and lead productive lives. Our returning soldiers deserve the same opportunity.

As I mentioned before, it is clear that our soldiers are returning with an increased need for mental health services, but after this long war, it is unclear what the VA's capacity to fulfill this need will be. It is my hope that H.R. 2173 can provide the

VA with the tools to continue to provide top notch mental health services to veterans in their own communities.

Mr. Chairman, I would like to again thank you and the Members of this Subcommittee for the opportunity to speak on this bill. I urge the Members to support this important legislation. Thank you and I would gladly answer any questions you may have.

Statement of the Honorable James P. Moran, a Representative in Congress from the State of Virginia

Mr. Chairman, members of this Subcommittee, I want to thank you for holding this important hearing today and commend the Subcommittee for the work that it has already undertaken on behalf of our Nation's veterans.

The problem of suicide among our veterans is one of the most serious issues that we have to address as we care for our older veterans and prepare for a new generation of returning soldiers.

The Centers for Disease Control recently released a troubling statistic: Each year, approximately 115,000 veterans attempt suicide. This accounts for nearly 20% of all suicide attempts, yet, the veteran population only accounts for 11% of the entire population.

The disproportionate prevalence of suicide among veterans suggests that, in addition to our overall national strategy on suicide prevention, particular attention must be paid to preventing suicide among this special population.

Unfortunately, I expect this trend to continue as more of our brave men and women return from multiple deployments with the symptoms of post-traumatic stress disorder, or PTSD. As we have learned, a staggering 20% of soldiers returning from Iraq are experiencing depression, sleep deprivation, anxiety and other symptoms of PTSD.

I am proud that this Congress has already acknowledged the growing problem of PTSD and dedicated substantial resources to it. Still, I believe, as scientific evidence suggests, that as our returning soldiers are increasingly susceptible to PTSD, they are at an elevated risk for suicide attempts.

My bill, the "Veterans Suicide Prevention Hotline Act of 2007", would create a 24-hour national toll-free hotline to assist our Nation's veterans in crisis. It would be staffed predominantly by veterans, trained to appropriately and responsibly answer calls from other veterans. This hotline would follow the models of the National Suicide, Sexual Assault and Domestic Violence hotlines, where volunteers trained in active listening and crisis de-escalation respond to a variety of crisis calls.

I believe that this cultural competency—the ability to connect to another veteran who understands best what the caller may be experiencing—can make a real difference in crisis counseling. It is difficult to connect on this level with anyone else, even trained doctors or other professionals.

To build this capacity nationwide, my bill calls for a 3-year, competitively awarded grant for $2.5 million in the next three fiscal years. The funding will be made available to a qualified non-profit crisis center to establish, publicize, and operate the hotline, including developing curricula to train and certify volunteers.

We have reached out the Department of Veterans' Affairs and are encouraged that the VHA is undertaking new efforts to establish a suicide hotline and address mental health needs. Their plan is to divert callers from the National Suicide Prevention Hotline to a VA facility, staffed by doctors, psychologists and other certified counseling professionals.

On the surface the VHA's effort may appear duplicative of my proposal, but there are some very important differences that I feel need to be highlighted.

First, my legislation requires that the people answering the phones, those dealing directly with the veterans, are veterans themselves. There are times when speaking with someone who has the cultural competence and empathy to really understand the experiences of veterans in crisis can help make the difference between successful integration into mental health treatment and failure to reach a veteran in dire need of services.

Second, The VHA has many responsibilities for providing the highest quality of healthcare for our veterans. However, they have experienced stretched budgets and staffing shortages in recent years. Because the demands placed on any veterans' hotline may be great as our Nation redeploys from Iraq in the future, I have concern that the VHA may not have the capability and commitment to the hotline that a non-profit organization dedicated to suicide prevention as its sole purpose might be able to provide.

Third, there are times when a person in crisis doesn't want to talk to a doctor—they want to talk to a volunteer. Mentally ill individuals all face societal stigma associated with seeking care. Research from the Air Force's suicide prevention efforts suggests that this is perceived to be even more profound in the military and veteran communities. Fear of "the system", of an unfriendly mental health establishment, and of potential job-related consequences keep many from seeking care.

One of the motivations behind the National Suicide hotline and this bill is to give people in crisis another option—an anonymous hotline that can respond to their immediate crisis.

To conclude, our vets deserve as much support when they return from combat as they receive while in battle. Too many of our veterans are struggling to make the difficult adjustment back to society and need someone they can talk to, someone who's walked a mile in their shoes.

This legislation will offer a caring voice at the end of the line when it feels like there's no where else to turn.

Statement of the Honorable Diane E. Watson,
a Representative in Congress from the State of California

Thank you Mr. Chairman for holding today's hearing, and letting me speak about my bill, H.R. 1853—The Jose Medina Veterans Affairs Police Training Act. I believe this legislation is vital to protect our heroes who have sacrificed their minds and bodies to protect our freedoms.

Mr. Chairman, too many veterans are suffering from mental health problems after returning from combat, and they are not receiving the proper treatment they deserve. Congress has a responsibility to provide quality healthcare for our veterans. We must analyze every aspect of services associated with the treatment of Post Traumatic Stress Disorder, or PTSD, for our vets.

I have introduced H.R. 1853—The Jose Medina Veterans Affairs Police Training Act, a bill that would force the Department of Veterans Affairs to better prepare its police force to interact with patients and visitors at VA medical facilities who suffer from mental illnesses.

Jose Medina is a constituent of mine. He is a Vietnam veteran who suffers from PTSD. In January 2006, Mr. Medina was assaulted by two West Los Angeles VA police officers who kicked him and forced him to the ground after he isolated himself and fell asleep in a hallway at a VA Medical Center in Los Angeles.

After a physical altercation ensued, this fifty-six year old veteran was forced to lay face down on a hospital floor. The officers injured Mr. Medina, and after the altercation they did not allow him to use the hospital's emergency room. Instead, the officers handcuffed him and detained him for an hour, before sending him home with a loitering ticket. This is not the way we should be treating veterans who have served and protected this country.

What bothers me the most is that when you see someone sitting on a hospital floor, one would think law enforcement and hospital staff would ask the individual if they were all right, or in need of assistance. Instead, in this case, Mr. Medina was mistreated. This is happening to too many of our brave veterans.

As we look to the future, thousands of veterans will be entering the VA healthcare system. We must ensure that the VA has the ability to administer quality healthcare services to veterans that suffer from mental illnesses. With over 20% of the one and a half million veterans that served in Iraq or Afghanistan showing signs of PTSD, we do not want any of them to endure what Mr. Medina had to endure.

Mr. Chairman, the Veterans Administration believes this legislation is unnecessary, but the story of Jose Medina and other veterans from around the country who have contacted my office with similar problems has proven to me that this training is indeed necessary. As Congress debates funding strategies and timelines for our military missions, we must not forget that not only do we need our vets to have the resources for the battlefield; they must also be treated with dignity and respect once they resume their lives after combat. We must ensure that this happens!

Mr. Chairman, I thank you for the opportunity to address your committee, and I urge the members of the committee to support H.R. 1853.

Statement of the Honorable John T. Salazar,
a Representative in Congress from the State of Colorado

Thank you Mr. Chairman.

Mr. Chairman, I'm pleased to bring H.R. 2005 to the Subcommittee this morning, and I look forward to the discussion on this important legislation.

The Rural Veterans Healthcare Improvement Act seeks to improve healthcare services to veterans living in rural areas.

A study of more than 767,000 veterans by researchers working for the Department of Veterans Affairs shows vets in rural areas are in poorer health than vets living closer to cities.

The VA found that the health of rural veterans still persisted, even after researchers adjusted for socioeconomic factors such as race, education or employment status.

It was identified in the study, that *access* to care is a key factor.

The study suggested, that in addition to establishing more clinics in rural areas, VA should consider coordinating services with Medicare or other healthcare services based in rural areas.

As a way to begin addressing some of these issues, the Veterans Benefits, Health Care, and Information Technology Act of 2006, which passed at the end of the 109th Congress, created the Office of Rural Health within the VA.

Dr. Kussman's testimony will tell you that the VA is opposed to this legislation because the Office of Rural Health is charged with these tasks. . . .

I would like to make the point that even though Congress directed VA to establish this office, it has yet to be implemented.

This new office, when the VA does decide to set it up, needs support, direction, and resources in order to fulfill its mission of coordinating care to this vital constituency.

The Rural Veterans Healthcare Improvement Act of 2007 would task the Director of the Office of Rural Health with developing:

- demonstration projects
- centers of excellence
- a transportation grant program

and the bill would also more fairly reimburse veterans in rural areas for the traveling expenses they incur when driving long distances to VA medical facilities.

Mr. Chairman . . . with both an ailing veteran population to care for, and a new generation of veterans returning from service in Iraq and Afghanistan, we immediately need to address access to care issues for our rural vets.

It is estimated, that nearly 45% of all new recruits are coming from Rural America, and with a large percentage of this war burdened by our national Guard, that number is only going to increase.

Many vets must travel hundreds of miles to access the medical care we've promised and they do so almost entirely at their own expense.

Currently, we reimburse veterans at a rate of $0.11 cents per mile, a rate that has not increased since 1978.

In 1978 . . . the average price of gasoline was $0.63 cents. I don't have to remind the Committee of the price of gasoline today.

This legislation would increase the reimbursement rate to $0.48 cents per mile, the same rate paid to federal employees.

This legislation also establishes a transportation grant program called VetsRide.

VetsRide encourages Veterans Service Organizations to develop innovative transportation options to vets in rural areas.

With a grant up to $50,000, a VSO could purchase a van, or find other ways to assists veterans with travel to VA medical centers.

This bill also establishes Centers of Excellence to research ways to improve care for rural veterans. These centers would be based at VA Medical Centers with strong academic connections.

The outcome of these Centers would be the development of specific models to be used by VA in providing health services to vets in rural areas.

The Rural Veterans Healthcare Improvement Act also tasks the Office of Rural Health with following their studies own advice.

It develops demonstration projects that would examine the feasibility of expanding care in rural areas through partnerships.

Partnerships between the VA; Centers for Medicare and Medicaid Services; and the Department of Health and Human Services through critical access hospitals and community health centers.

Demonstration projects would also be carried out in partnership with the Indian Health Service to improve healthcare for Native American veterans.

In 2003, the VA entered into a Memorandum of Understanding with these departments to encourage partnerships just like these, however 4 years have passed without accomplishment and our vets have suffered.

Mr. Chairman . . . We must explore every option, to ensure that the healthcare services we promised to our veterans are delivered.

The Rural Veterans Healthcare Improvement Act of 2007 aims to improve one of the greatest problems that plague the VA system.

I am proud of the bipartisan work that has gone into this bill and the forty co-sponsors that share these goals.

Thank you Mr. Chairman. I'm happy to answer any questions the Committee might have.

Statement of the Honorable Jeff Miller,
a Representative in Congress from the State of Florida

Mr. Chairman, thank you for considering H.R. 2623. This bill would prohibit the collection of co-payments for all hospice care furnished by the Department of Veterans Affairs (VA).

VA offers a complement of hospice and palliative care options as part of the comprehensive heath care benefit provided to all enrolled veterans. Hospice and palliative care is a continuum of comfort-oriented and supportive services provided across settings, including hospital, extended care facility, outpatient clinic and private residence.

Under current law, a veteran receiving hospice care in a nursing home is exempt from any applicable copayments. However, if the hospice care is provided in any another setting, such as in an acute-care hospital or at home, the veteran may be subject to an inpatient or outpatient primary care copayment.

Essentially, VA's current policy penalizes a veteran who chooses to remain at home for their hospice care or out of medical necessity receives hospice care in an acute care setting.

Mr. Chairman, this legislation would correct this inequity by exempting all hospice care provided through VA from copayment requirements.

This bill is important to ensuring that every veteran's preference for end-of-life care is provided in an equitable and compassionate manner.

I appreciate the opportunity to testify on H.R. 2623, and will be happy to answer any questions on the bill.

H.R. 1925

Thank you, Mr. Chairman.

Nearly 12 year ago, the VA's Veterans Integrated Service Network, or "VISN," plan was set in motion as a way to make the large VA healthcare network more attuned to the needs of its patients. For certain, VA provides some of the best care in this nation. The VISNs were implemented as a way to maintain the high quality of care while allowing more regional management so that the central office in Washington did not unnecessarily micromanage the day-to-day aspects of healthcare delivery.

The VISN network has enjoyed its successes in providing better access and more patient-centered care. However, there is room for improvement, and the Gulf Coast region of our nation is an area where such improvement is needed. Having already seen a consolidation of two VISNs since their creation, it is clear that flexibility within the VA healthcare system is necessary. My bill, H.R. 1925, would create a VISN specifically targeted to improving the delivery of healthcare to the large and ever-increasing population of veterans living in the Gulf Coast—a "Gulf Coast VISN."

A new Gulf Coast VISN would create a healthcare network that could better respond to the unique needs and problems facing veterans in the area. The area involved covers the coastal counties just west of Tallahassee, Florida over to the Louisiana state line, an area home to few VA clinics and lacking hospitals providing inpatient care. It is an area identified by the CARES report as underserved, and its unique geographical location is no doubt part of that reason. Most of the area that would make up the Gulf Coast VISA is in the region where VISN eight meets VISN 16. VISN eight encompasses the rest of the state of Florida. VISN 16, the largest single VISN in the country, reaches all the way west past Houston, Texas, and all the way up through Oklahoma.

Looking at the map, you can see how this largely rural region can get overlooked in such a huge VISN with major metropolitan areas. The more than 300,000 veterans that would be directly served within this VISN do not want their access to care overlooked—and that has happened for far too long. With even basic outpatient

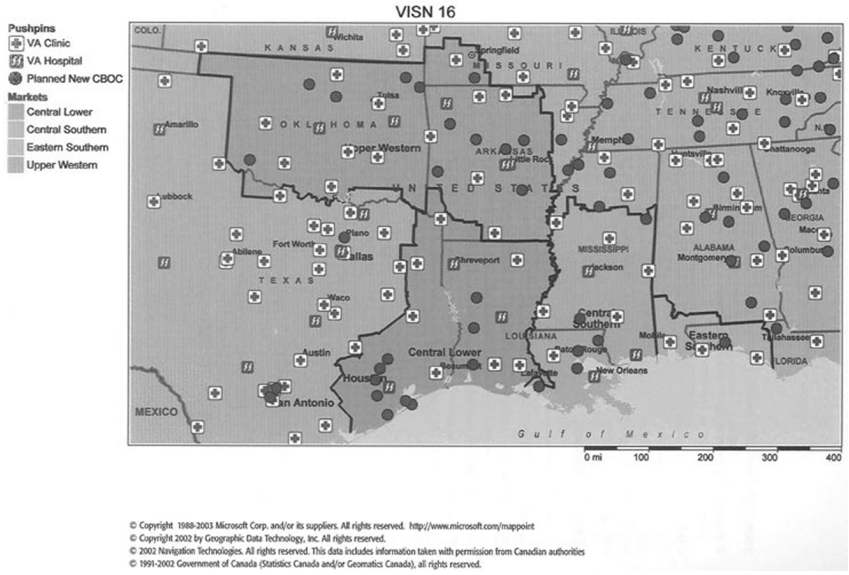
care being difficult for many to obtain, it is time to ensure that the Gulf Coast's veterans are provided the full range of services they have earned.

There are several reasons why I see this bill as being successful. With an increased focus on the unique, shared needs for veterans in the area, the Gulf Coast VISN director could take great advantage of the sharing opportunities with the Department of Defense (DoD) that are available in that region. The Gulf Coast is home to multiple DoD installations, and while a few joint VA/DoD facilities exist now, there is a tremendous opportunity for expanding this relationships to deliver a wider range of healthcare services.

The VISN system was founded on good principles to improve access and quality of care by eliminating the inefficiencies of a centralized bureaucracy and promoting a local, patient-focused system of healthcare delivery. However, it is not perfect, and with the findings of the CARES Commission as well as the simple fact that veterans in the Gulf Coast area have to drive upward of three hours in many instances to receive inpatient care, it is abundantly clear that improvements are still needed. I feel the creation of a Gulf Coast VISN can do just that. Its implementation would be neither costly nor particularly difficult. In addition, the bill would give VA the authority to decide on the location of the VISN headquarters.

The GulfCoast's veteran population clearly deserves more timely access to VA healthcare. Creating a Gulf Coast VISN would be a significant step toward providing that access.

Thank you, Mr. Chairman, for considering this important legislation and I am pleased to answer any questions on the bill.



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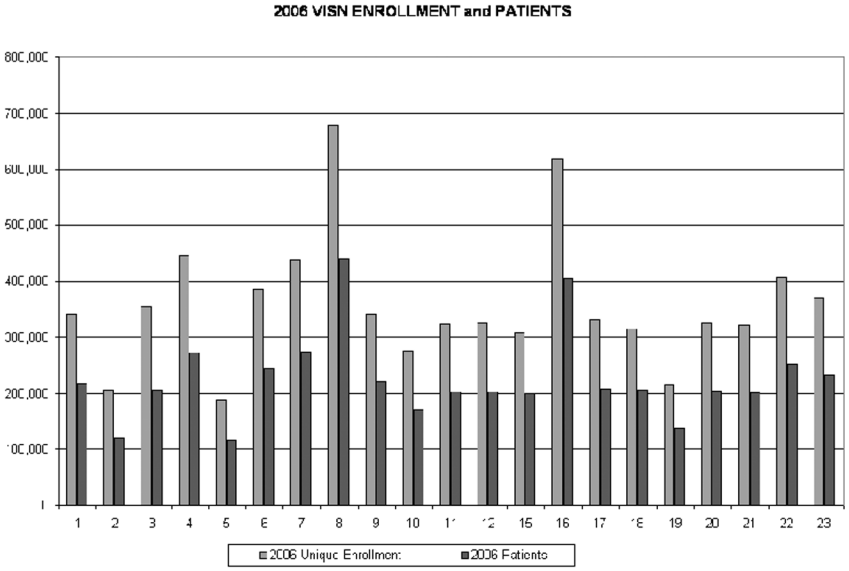

Statement of the Honorable Paul W. Hodes,
a Representative in Congress from the State of New Hampshire

Thank you Chairman Michaud and Ranking Member Miller for holding this important hearing today. I appreciate the opportunity to testify today about H.R. 2192, the bipartisan bill I introduced establishing an Office of the Ombudsman in the Department of Veterans' Affairs. I would also like to thank Chairman Filner for his support of the bill.

I recently visited Walter Reed Army Medical Center with the Oversight and Government Reform Committee. I talked with soldier after soldier about the problems they experienced transitioning out of active duty and into the VA. Veterans in my district have repeatedly told me their compelling stories of the great difficulties and challenges they have faced in understanding and receiving all the benefits and services to which they are entitled.

The Ombudsman's Office should serve as the outreach master office—a coordinating and coordinated center for benefits and health information services available both within and outside of the VA.

I am not interested in creating another meaningless layer of bureaucracy. Instead, I would like the Ombudsman's Office to become a one stop shop for veterans, a CENTCOM for veterans' benefits information.

I applaud the VA for their hard work in providing information that veterans need. The VA has numerous hotlines and support services available to veterans. I've counted 10 different 1–800 numbers on the VA's website to help with different types of benefits—one for disability pension, another for healthcare benefits, another for life insurance, etc.

While the VA provides veterans benefits and service information, the veterans may not know where they put their informational pamphlets 6 months or 1 year down the road when they have a question or a problem.

Veterans are falling through the cracks and do not know where to turn.

The Office of the Ombudsman would provide a focal point of information within the VA. The Ombudsman's Office should be a one stop shop of information and resources. The Office should head up the advocacy and information campaigns that the VA already has in place, and consolidate the information services with one 1–800 number to address all the veterans' needs and complaints.

For a veteran who has just returned from active duty in OIF (Operation Iraqi Freedom) or OEF (Operation for Enduring Freedom) with Traumatic Brain Injury, it would be a whole lot simpler and easier to have only one office to call to receive the information he or she needs. The VA has a patient advocacy program for health-

care, but a lot brave men and women need help with loans for their homes and schooling too. They should not have to run around asking the same ten questions to ten different offices. The Ombudsman's Office can help the veteran figure out the all the services in the benefits system, not just healthcare, and not just disability ratings.

I have reviewed the testimony of the esteemed panelists, the VA and VSOs. Just in the six testimonies that specifically discussed the Ombudsman's Office, the panelists referred to fourteen different programs both within and outside of the VA that veterans could turn to for help with benefits coordination. These fourteen programs are extremely important to our veterans and providing specialized services. But, as a healthy Member of Congress and not a PTSD patient or an ailing elderly veteran, I am even confused about which programs to use and under which circumstances.

Mr. Chairman, I am not trying to make redundant services. The Veterans Administration provides advocacy and resources, VSOs provide advocacy and resources.

I would, however, like to work with the Honorable Members of the Committee to mold the Office of the Ombudsman into a viable, helpful resource for veterans. I believe that this consolidation of various information sources into a coordinated center of information will help make sure the veterans receive the care they need and cut through the seemingly endless amounts of bureaucratic red tape.

Thank you again for giving me the opportunity to testify before the Subcommittee on Health today. I look forward to working with the Committee to help veterans understand and access the benefits they deserve.

Statement of the Honorable Nita M. Lowey,
a Representative in Congress from the State of New York

I want to thank the Committee for holding this hearing today and for considering the VA Hospital Quality Report Card Act of 2007. I introduced this legislation in an effort to provide increased disclosure and accountability in the VA hospital system, and ultimately increase the quality of care for the men and women who have served in the Armed Forces.

The treatment provided to our veterans is not a partisan or political issue, and I am pleased that this legislation is cosponsored by some of my Republican colleagues.

I believe we can all agree that quality care initiatives and public disclosure should not end when an individual leaves active military service. In fact, the quality of care for those who have bravely served our Nation should be of the highest standard possible.

To achieve that goal we must have a clear picture of the quality of care provided by the Veterans Administration, and this information must be continually assessed and updated. As we learned with Walter Reed Army Medical Center, a facility that once defined excellence may not do so in the future without constant internal assessments.

My legislation would require the Department of Veterans Affairs to establish a formal Hospital Report Card Initiative and publish reports on individual hospitals' level and quality of care. The resulting report cards would: provide clear outcomes data to be used for peer review and quality improvement; galvanize hospitals to make changes by creating public accountability; and provide our veterans with the information they need to make sound healthcare decisions. Several states, including Pennsylvania, New York, California, Florida and Illinois, have already implemented Hospital Report Card Initiatives.

A March 2007 Veterans Administration report exposed major deficiencies in the physical conditions in many veterans' facilities.

In this report, the VA Hudson Valley Health Care System, which serves over 25,000 veterans throughout my district and the surrounding areas, was cited for ceiling mold, suicide hazards in the psychiatric ward and cosmetic deficiencies. I'm going to repeat one part of that because I think it underscores the level of neglect seen throughout the VA healthcare system—suicide hazards in a psychiatric ward, an area in hospitals that most certainly should limit the ability of an individual to harm him or her self.

Dr. Michael Kussman, Under Secretary for Health at the VA, previously stated, "VA facilities are inspected more frequently than any other healthcare facilities in the nation." If this is true, the Department should have no problem complying with the requirements of this legislation.

If we are serious about ensuring a seamless transition between DOD-provided healthcare and VA-provided healthcare, we must have an accurate assessment of

the VA system, and the VA Hospital Quality Report Card Act of 2007 would provide just that.

I thank the Members of the Subcommittee once again for this hearing and I look forward to working with each of you to provide our veterans with the level of healthcare worthy of their service and dedication to our country.

Statement of Shannon Middleton, Deputy Director for Health, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's view on the several pieces of legislation being considered by the Subcommittee today. The American Legion commends the Subcommittee for holding a hearing to discuss these very important and timely issues.

H.R. 1448, VA Hospital Quality Report Card Act of 2007, seeks to establish the Hospital Quality Report Card to ensure quality measures data on the Department of Veterans Affairs (VA) hospitals are readily available and accessible.

The state of VA healthcare/medical facilities are an important issue for The American Legion. Each year the organization is mandated by resolution to conduct a series of site visits to various VA medical facilities and submit a report to the President, Congress and VA.

The bill is similar in scope to our report—**A System Worth Saving**. Periodic assessments would enable VA to get a clearer picture of its system-wide needs and assist lawmakers in determining adequate funding for the VA healthcare system.

H.R. 1853, Jose Medina Veterans Affairs Police Training Act of 2007, seeks to ensure that VA police officers receive training on interacting with visitors and patients suffering from mental illness at VA medical facilities. The American Legion has no official position on this issue, but hopes that VA is training all of its employees to interact with veterans and their families in the dignified, respectable manner in which they deserve.

H.R. 1925, A Bill to Direct the Secretary of Veterans Affairs to Establish a Seprate Veterans Intergrated Service Network (VISN) for the Gulf Coast Region of the United States, would mandate that the Secretary create a VISN that would encompass several counties in the states of Florida, Alabama and Mississippi. The American Legion has no position on this issue.

H.R. 2005, Rural Veterans Health Care Improvement Act of 2007, addresses many issues affecting veterans who reside in rural areas. It seeks to increase the beneficiary travel rate to make it equivalent to the rate provided to federal employees; establish centers for rural health research, education, and clinical activities; offer transportation grants for service organizations that assist rural veterans; and explore alternatives to improve transportation to medical facilities for rural veterans. The American Legion fully supports the provisions in this bill.

Beneficiary travel pay has not been increased from its current rate since 1978. The price of gasoline has steadily increased since the $0.11 per mile rate was established, creating a financial hardship for veterans who have to travel long distances for care, or those who have limited financial resources.

Since service-connected veterans and other veterans authorized beneficiary travel only receive $0.11 per mile are subjected to a $6 per trip deductible not to exceed $18 per month—this amount does very little to defray the cost of travel. Eligible veterans are not reimbursed at a reasonable level for costs incurred to visit a VA medical facility for service-connected or other authorized care and treatment.

There are no provisions in law that VA must increase the per mile travel authorization on a regular basis. The beneficiary travel program is discretionary and the Secretary of Veterans Affairs is required to review the program annually to determine the Department's ability to maintain the program and its ability to increase the reimbursement rate for eligible veterans. The Secretary has determined that it is necessary to maintain the current reimbursement rate in order to allow the VA healthcare system to accommodate the increasing patient workload.

The lack of a consistent and reliable mechanism to periodically adjust the rate authorized for beneficiary travel creates an injustice and an unfair economic burden for many veterans. The American Legion believes that mandatory funding for VA healthcare would allow the Secretary to provide adequate healthcare without inversely affecting programs designed to mitigate the cost of accessing that care.

Establishing centers for rural health research, education, and clinical activities would afford VA the opportunity to build strategies to improve its system of care

for rural veterans, as well as educate and train healthcare professionals on health issues prevalent in specific rural veteran populations.

Offering transportation grants for veterans' service organizations that assist rural veterans and exploring alternatives to improve transportation to medical facilities for rural veterans would make accessing care easier for those who are not financially able to travel to facilities, especially those who, due to their physical condition, are not able to make extremely long trips in 1 day. If more transportation options became available, it may also improve coordination of care for those who have to travel distances for special services, especially in the unavailability of a family care giver.

H.R. 2172, Amputee Veteran Assistance Act, would require that VA's orthotic-prosthetic laboratories, clinics, and prosthetists are certified by either the American Board for Certification in Orthotics and Prosthetics or the Board of Orthotics and Prosthetic Certification. It is The American Legion's understanding that VA's ortho-prosthetic labs/clinics are accredited and each has at least one orthotist that has certification which is how the labs were able to gain accreditation. The orthotists and prosthetists are being trained on latest prosthesis at Walter Reed, so they can be knowledgeable about the prosthetics being given to returning soldiers. They also participate in focus groups with veterans' service organizations, and OIF veterans. Furthermore, VA already contracts with non-Department entities when the medical facility is not capable of providing the service or the veteran lives too far away and patients are given information about their prosthetic choices.

H.R. 2173, Seeks to Amend Title 38, United States Code, to Authorize Additional Funding for the Department of Veterans Affairs to Increase Capacity for Provision of Mental Health Services Through Contracts with Community Mental Health Centers, and for Other purposes. The American Legion believes that VA should contract with community providers only when it is unable to provide needed services to the veteran, if travel for the veteran would be a danger to his or her health, or if the veteran resides in a rural area. As long as VA healthcare remains discretionary, VA will always struggle to obtain sufficient funding to provide access to quality care for eligible veterans seeking care in VA facilities. Assured (mandated) funding would provide a method to provide dependable, stable and sustained funding for veterans' healthcare. The American Legion believes that Congress should designate assured funding for VA medical care; continue to provide discretionary funding, as required, to fully operate other programs within the Veterans Health Administration's budgetary jurisdiction; and provide, if necessary, supplemental appropriations for budgetary shortfalls in VHA's mandated and discretionary appropriations to meet the healthcare needs of America's veterans.

H.R. 2192, A Bill to amend Title 38 USC, to establish an Ombudsman within the Department of Veterans Affairs, would designate an Ombudsman to serve as a liaison for veterans and their families to guarantee the receipt of VA healthcare and benefits. The American Legion supports the provisions of this bill. Establishing a point of contact to work with families to ensure that veterans receive all benefits, to which he or she is entitled, based on his or her unique situation, would reduce the stress and frustration associated with navigating the complex VA healthcare and benefits system.

H.R. 2219, Veterans Suicide Prevention Hotline Act of 2007. The American Legion has no position on this issue.

H.R. 2378, Services to Prevent Veterans Homelessness Act. This bill aims to establish a financial assistance program to facilitate supportive services for very-low income veteran families to assist them in ending their chronic homeless state and to prevent chronic homelessness.

Enactment of this legislation will enable funding to provide much needed supportive services to veterans and their dependents. It takes into account that the VA Grant and Per Diem (GPD) program can only provide services to veterans and fills a much-needed gap of caring for their dependents..

The American Legion fully supports this bill in its effort to assist homeless veterans. We applaud that the bill recognizes that families also suffer alongside the veteran struggling with homelessness.

The American Legion supports the efforts of public and private sector agencies and organizations with the resources necessary to aid homeless veterans and their families. The American Legion supports proposals that will provide medical, rehabilitative and employment assistance to homeless veterans and their families.

Currently, the VA has no authority to provide grant funding to create affordable permanent housing units for low-income veterans and those who have completed their transition programs. Veteran service providers must compete with other housing projects for limited HUD funding, and constantly search for additional funding sources to provide this housing option.

This legislation will be in addition to the VA Grant and Per Diem program, but will enable the mechanism of funding supportive services to become more streamlined.

Homeless veteran programs should be granted full appropriations to provide supportive services such as, but not limited to outreach, healthcare, habilitation and rehabilitation, case management, daily living, personal financial planning, transportation, vocational counseling, employment and training, and education.

Veterans need a coordinated effort that provides secure housing and nutritious meals; essential physical healthcare, substance abuse aftercare and mental health counseling; as well as personal development and empowerment.

Veterans also need job assessment, training and placement assistance. The American Legion believes all programs to assist homeless veterans must focus on helping veterans reach their highest level of self-management.

The most effective programs for homeless and at-risk veterans are community-based, nonprofit, veteran-staffed groups. It is critical that community groups continue to reach out and help to provide the support, resources and opportunities most Americans take for granted.

Homelessness impacts every community in the nation. Approximately 200 community-based veterans' service organizations across the country have successfully reached homeless veterans through specialized programs. Veterans who participate in these programs have a higher chance of becoming productive citizens again.

A full continuum of care—housing, employment training and placement, healthcare, substance abuse treatment, legal aid, and follow-up case management—depends on many organizations working together to provide services and adequate funding. The availability of homeless veteran services, and continued community and government support for them, depends on vigilant advocacy and public education efforts on the local, state and federal levels.

The FY 2006 Department of Veterans Affairs Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) report estimates that nearly 200,000 veterans are homeless at any point in time. Prior reports state that one out of every three homeless men sleeping in a doorway, alley or box in our cities and rural communities has put on a uniform and served this country. According to the February 2007 Homeless Assessment Report to Congress (U.S. Department of Housing and Urban Development 2007) veterans account for 19% of all homeless people in America.

For FY 2006, The VA Health Care for Homeless Veterans (HCHV) reports that 101,182 homeless veterans are enrolled in their programs. Community-based organizations are attempting to assist the overwhelming remainder of veterans who are homeless.

In addition to the complex set of factors affecting all homelessness (the extreme shortage of affordable housing, livable income, and access to healthcare), a large number of displaced and at-risk veterans live with lingering effects of Post Traumatic Stress Disorder (PTSD), substance abuse, and a lack of family and social support networks. Many times these veterans have mental health disorders related to their honorable service to their country, are unable to compensate for their condition. They unfortunately deteriorate to unrecognizable individuals compared to their pre-military experience.

Operation Iraq Freedom and Operation Enduring Freedom (OIF/OEF) veterans are at high risk of becoming homeless. Combat veterans of OIF/OEF and the Global War on Terror who need help—from mental health programs to housing, employment training and job placement assistance—are beginning to trickle into the nation's community-based homeless veterans' service organizations. Already stressed by an increasing need for assistance by post-Vietnam Era veterans and strained budgets, homeless services providers are deeply concerned about the inevitable rising tide of combat veterans who will soon be requesting their support.

Since 9/11, nearly 800,000 American men and women have served or are serving in a war zone. Rotations of troops returning home from Iraq are now a common occurrence. Military analysts and government sources say the deployments and repatriation of combat veterans is unlike anything the nation has experienced since the end of the Vietnam War.

The signs of an impending crisis are clearly seen in VA's own numbers. Under considerable pressure to stretch dollars, VA estimates it can provide assistance to about 100,000 homeless veterans each year, only 20% of the more than 500,000 who will need supportive services. Hundreds of community-based organizations nationwide struggle to provide assistance to as many of the other 80% as possible, but the need far exceeds available resources.

VA's HCHV reports 1,049 OIF/OEF era homeless veterans with an average age of 33 years young. HCHV further reports that nearly 65% of these homeless vet-

erans experienced combat. Now receiving combat veterans from Iraq and Afghanistan daily, the VA is reporting that a high percentage of those casualties need treatment for mental health problems. That is consistent with studies conducted by VA and other agencies that conclude anywhere from 15 to more than 35% of combat veterans will experience some clinical degree of PTSD, depression or other psychosocial problems.

Homeless veteran service providers' clients have historically been almost exclusively male. That is changing as more women veterans and women veterans with young children have sought help. Additionally, the approximately 200,000 female Iraq veterans are isolated during and after deployment making it difficult to find gender-specific peer-based support. Access to gender-appropriate care for these veterans is essential.

More women are engaging in combat roles in Iraq where there are no traditional frontlines. In the past 10 years, the number of homeless women veteran has tripled. In 2002,the VA began a study of women and PTSD. The study includes subjects whose PTSD resulted from stressors that were both military and non-military in nature. Preliminary research shows that women currently serving have much higher exposure to traumatic experiences, rape and assault prior to joining the military. Other reports show extremely high rates of sexual trauma while women are in the service (20–40%). Repeated exposure to traumatic stressors increases the likelihood of PTSD. Researchers also suspect that many women join the military, at least in part, to get away from abusive environments. Like the young veterans, these women may have no safe supportive environment to return to, adding yet more risk of homeless outcomes.

"Homeless providers continue to report increases in the number of homeless veterans with families (i.e., dependent children) being served at their programs. Ninety-four sites (68 percent of all sites) reported a total of 989 homeless veteran families seen with Los Angeles seeing the most families (156). This was a 10-percent increase over the previous year of 896 reported families. Homeless veterans with dependents present a challenge to VA homeless programs. Many VA housing programs are veteran-specific. VA homeless workers must often find other community housing resources to place the entire family—or the dependent children separately. Separating family members can create hardship." (FY 2006 VA CHALENG report)

Homeless veteran service providers recognize that they will have to accommodate the needs of the changing homeless veteran population, including increasing numbers of women and veterans with dependents. In conclusion, The American Legion supports the provisions in H.R. 2378 which will be helpful in addressing the issues of homeless veterans.

H.R. 2623, Seeks to amend title 38, United States Code, to prohibit the collection of copayments for all hospice care furnished by the Department of Veterans Affairs. The American Legion is continuing to study the bill and will provide an addendum to this testimony to the Committee.

Again, thank you Mr. Chairman for giving The American Legion this opportunity to present its views on such important issues. We look forward to working with the Subcommittee to address these and other issues affecting veterans.

Statement of Kimo S. Hollingsworth,
National Legislative Director, American Veterans (AMVETS)

Mr. Chairman and Members of the Subcommittee:

I am pleased to offer testimony on behalf of American Veterans (AMVETS) regarding pending health legislation before this Subcommittee. AMVETS appreciates the Subcommittee's work to ensure the Department of Veterans Affairs can fulfill its obligation to provide healthcare and other health related services to veterans.

Mr. Chairman, some of the issues relevant to today's hearing are extremely important to returning veterans from Operations Iraqi Freedom and Enduring Freedom. Specifically, suicide prevention, mental health funding, and access to healthcare in rural or underserved areas. These issues were identified and highlighted at the AMVETS sponsored "National Symposium for the Needs of Young Veterans" in Chicago, Illinois last year. More than 500 veterans, active duty and National Guard and reserve personnel, family members and others who care for veterans examined the growing needs of our returning veterans. With regards to today's legislative agenda, AMVETS would like to offer the following observations.

H.R. 1448 would establish a Hospital Quality Report Card Initiative in order to report on healthcare quality in the Department of Veterans Affairs Hospitals. The Government Performance and Results Act, Public Law 103–62, requires that agen-

cies develop measurable performance goals and report results against these goals. In the President's Fiscal Year 2008 budget request, VA focuses on the Secretary of Veterans Affairs priority of providing timely and accessible healthcare that sets a national standard of excellence for the healthcare industry. VA generally tracks the timeliness of care in two broad areas—primary and specialty clinic appointments. Over the next year, the percent of appointments scheduled within 30 days of the desired date is expected to reach 96% for primary care appointments and 95% for specialty care appointments.

In July 2005, the VA Office of Inspector General (OIG) reported that VHA's scheduling procedures needed to be improved and issued eight recommendations. As of September 2006, five of the eight recommendations for improvement remained open and AMVETS encourages the Department to implement the remaining recommendations. The Department has tracked and monitored the quality of care at VA facilities since the early seventies through comprehensive quality management (QM) programs. Furthermore, Public Laws 99–166 and 100–322 require the VA OIG to oversee VA QM programs at every level and a large part of the VA Office of Inspector General Combined Assessment Program (CAP) reviews focus on quality, safety and timeliness of VA healthcare. Mr. Chairman, AMVETS supports efforts to improve VA healthcare and supports the intent of H.R. 1448. However, we believe this legislation would mandate a duplicative effort as many of the items to be reported in a report card are already reviewed and reported through the VA QM and CAP programs.

H.R. 1853 would direct the Secretary to ensure the Department of Veterans Affairs police officers receive training to interact with visitors and patients at medical facilities who are suffering from mental illness. VA police officers already receive some degree of training in interacting with individuals with potential mental illnesses and mandating this training will codify an existing practice. AMVETS supports the intent of the bill.

H.R. 1925 would direct the Secretary of Veterans Affairs to establish a separate Veterans Integrated Service Network (VISN) for the Gulf Coast Region of the United States. Mr. Chairman, Public Law 104–204 directed VA to implement a more equitable resource allocation system that was to *reflect, to the maximum extent possible, the Veterans Integrated Services Network developed by the Department to account for forecasts in expected workload and to ensure fairness to facilities that provide cost-efficient healthcare; and . . . ways to improve the allocation of resources so as to promote efficient use of resources and provisions of quality healthcare . . .* Obviously the Veterans Equitable Resource Allocation (VERA) model is designed to bring consistency, fairness and stability to the VA funding process. This in turn is dependent upon the VISN model.

The Capital Asset Realignment for Enhanced Services (CARES) was supposed to be a system-wide process to prepare the VA for meeting the current and future healthcare needs of veterans. CARES addressed the appropriate clinical role of small facilities, vacant space, the potential for enhanced use leases and the consolidation of services and campuses. To date, it is the most comprehensive analysis of VA's healthcare infrastructure conducted. The CARES made some very specific recommendations with regards to healthcare infrastructure, to include areas of the Florida Panhandle and the Gulf Coast.

Overall, AMVETS supported the CARES process and we believe Congress should consider the CARES recommendations in deliberations about VA infrastructure to include deliberations about the current VISN model. AMVETS would like to note that VA adopted the VISN model in 1995. Considerable time has elapsed since implementation of the VISN model and there clearly have been demographic changes within the general population that would most likely include changes to the veteran population.

H.R. 2005 would seek to improve healthcare for veterans living in rural areas, to include providing an increase in the travel reimbursement and establishing centers of excellence for rural health research, education and clinical activities. AMVETS continues to support an increase to the travel reimbursement rate for our veterans. The VA beneficiary travel program was intended by Congress to assist veterans when trying to access VA healthcare. The mileage reimbursement rate is currently fixed at 11 cents per mile; however, current law limits the actual reimbursement with a $3.00 per trip deductible capped at $18.00 per month. The Secretary of Veterans Affairs has the authority to make rate changes to these rates, but changes have not been adopted in more than 30 years. Obviously the price of owning and operating a vehicle has risen dramatically during this time period. AMVETS believes it is now time for Congress to act by mandating a realistic reimbursement rate for the VA beneficiary travel program.

Regarding the delivery of rural healthcare, an important issue brought forth at the "National Symposium for the Needs of Young Veterans", Sections 212 and 213 of Public Law 109–461 are specifically targeted at advancing the healthcare needs of veterans in rural areas. VA is mandated to establish an Office of Rural Health within the Veterans Health Administration (VHA). The office is charged with improving VA healthcare for veterans living in rural and remote areas. Among other provisions, the law requires an extensive assessment of the existing VA fee-basis system of private healthcare, and eventual development of a VA plan to improve access and quality of care for enrolled veterans who live in rural areas. AMVETS would encourage Congress to fully fund the Office of Rural Health and allow VA to conduct the mandated assessment.

H.R. 2172 would require VA orthotic-prosthetic laboratories, clinics and prosthesists to be certified by either the American Board for Certification in Orthotics and Prosthetics or the Board of Orthotics and Prosthetic Certification. Mr. Chairman, the VA already receives certification from these agencies and we support the certification process. AMVETS does have concern with the section of the bill that would require the VA to enter into contracts for service and repair of prosthetic devices with non-department entities. This provision would create a "sole-source" contract, and AMVETS would oppose this provision.

H.R. 2173 would authorize additional funding to allow VA to enter into contracts with local or community health centers. Mr. Chairman, as we are all aware, there is a large number of National Guard and reserve units that have deployed or will be deployed into a theater of combat operations. Many of these units and personnel are from areas of the country that do not have VA healthcare or VA healthcare services readily available. AMVETS continues to support the Secretary of Veterans Affairs in his authority to contract out for medical and healthcare services when/where applicable and also supports additional funding for these services.

H.R. 2192 would establish an Ombudsman within the Department of Veterans Affairs to act as a liaison for veterans and their families with respect to the receipt of healthcare and benefits administration. The VA has a long history of special efforts to bring information on VA benefits and services to active duty military personnel. These efforts include counseling about VA benefits through the Transition Assistance Program (TAP), a nationally coordinated federal effort to assist military men and women to ease the transition to civilian life through employment and job training assistance. A second component of the program, the Disabled Transition Assistance Program (DTAP), helps separating servicemembers with disabilities.

VA also has launched special efforts to provide a "seamless transition" for those returning from service in Operations Iraqi Freedom and Enduring Freedom. Internal coordination was improved and efforts currently focus on reducing red tape and streamlining access to all VA benefits. Each VA medical facility and benefits regional office has identified a point of contact to coordinate activities locally to help meet the needs of these returning combat servicemembers and veterans. In addition, VA increased the staffing of benefits counselors at key military hospitals where severely wounded servicemembers from Iraq and Afghanistan are frequently sent. AMVETS does not oppose legislation to establish an Ombudsman within the VA.

H.R. 2219 would direct the Secretary to award a grant to a private, nonprofit entity to establish, publicize and operate a national toll-free suicide prevention telephone hotline targeted to and staffed by veterans of the Armed Forces. Mr. Chairman, the Department of Veterans Affairs Office of Inspector General recently reported that veterans returning from Iraq and Afghanistan are at increased risk of suicide because Veterans Administration health clinics do not have 24-hour mental healthcare available. Many facilities lack 24-hour staff, adequate screening for mental problems, or personnel who were properly trained.

The report also concluded that VA clinics and military hospitals must improve their sharing of health information, particularly for patients who might return to active-duty status and that VA should loosen criteria for inpatient PTSD care. Currently only veterans with "sustained sobriety" get treatment. It is AVMETS' understanding that the VA Undersecretary for Health, concurs with findings and recommendations, and that VA has recently installed suicide prevention coordinators in each medical center to better develop prevention strategies. AMVETS supports the Undersecretary in this endeavor; however, AMVETS would oppose efforts by Congress to mandate the Secretary of VA to enter into contracts with a private entity for these services and believes that the Secretary must continue to have flexibility in how he implements these services.

H.R. 2378 would establish a financial assistance program to facilitate the provision of supportive services for very low-income veteran families in permanent housing. We continue to urge Congress to provide resources and oversight on homeless veterans programs and veterans who may be at risk. With regards to the establish-

ment of a financial assistance program for very low-income veterans, AVMETS would urge Congress to provide veterans priority assistance through the Department of Health and Human Services as opposed to creating a new program within the Department of Veterans Affairs.

Mr. Chairman, this concludes my testimony.

Statement of Adrian M. Atizado,
Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman, Ranking Member Miller and other Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this important legislative hearing of the Subcommittee on Health of the Committee on Veterans' Affairs. DAV is an organization of 1.4 million service-disabled veterans, and along with its auxiliary, devotes its energies to rebuilding the lives of disabled veterans and their families.

You have requested testimony today on ten bills primarily focused on healthcare services for veterans under the jurisdiction of the Veterans Health Administration (VHA), Department of Veterans Affairs (VA). Your staff indicated two additional draft bills would be considered but we did not receive those two bills in time to include them in this testimony. With exception to the aforementioned draft legislation, this statement outlines our positions on all of the proposals before you today. The comments are expressed in numerical sequence of the bills, and we offer them for your consideration.

H.R. 1448—The VA Hospital Quality Report Card Act of 2007

H.R. 1448 would establish a "hospital report card" covering a variety of activities of inpatient hospital care occurring in the medical centers of the Department. We support this bill, because it is consistent with trends occurring in private sector healthcare. We believe that veterans under VA care have the same rights as private sector patients to review the quality and safety of the care they receive while hospitalized. We do note, however, that the purposes of this bill do not cover the grand majority of overall patient care workload in VA healthcare, namely primary (outpatient) care and extended care services provided in VA's nursing home care units and its various contracted programs. Nevertheless, this is a good bill and one that is supported by DAV. We do note for the Committee's purposes, that the term "VA hospital" was supplanted by the term "VA medical center" in prior legislation. You may wish to consider conforming this bill accordingly, should the Committee decide to approve and report it.

H.R. 1853—The Jose Medina Veterans Affairs Police Training Act of 2007

H.R. 1853 would require the Secretary of Veterans Affairs to ensure that officers of the VA police service be trained with respect to officers' interactions with veterans possibly suffering from mental illnesses. While DAV does not have a resolution dealing with this issue, we consulted with the National Alliance for Mental Illness (NAMI) and its NAMI Veterans Council, an advocacy group that, like DAV, is deeply concerned about VA mental health programs and veterans who benefit from them. NAMI fully supports the concept of adequate training being provided to VA police, who are sworn federal police officers charged with providing physical and personal security at all VA healthcare facilities. We concur with NAMI's views on this issue. We would suggest that the bill be amended, however, to ensure that properly credentialed mental health practitioners (principally those whom VA employs within the VHA to care for veterans with mental illnesses) be designated as training resources for the purposes of this bill.

H.R. 1925—To direct the Secretary of Veterans Affairs to establish a separate Veterans Integrated Service Network for the Gulf Coast region of the United States

H.R. 1925 would establish a 22nd Veterans Integrated Service Network (VISN) in the western Panhandle of Florida, far south Alabama, and eastern Mississippi, within 1 year of date of enactment.

DAV does not have a resolution from our membership addressing this issue. It should be noted however, that the bill raises valid questions on the relevance and effectiveness of current VISN boundary alignments. These VA jurisdictional lines have been in place with only one adjustment for the past 12 years. These boundaries were generally formed based on veteran patient care referral patterns established in the eighties, and it should be recalled that VA has revolutionized its patient care system over the past dozen years.

It is unclear if VA has reviewed whether the current alignment is optimal or may need adjustment. Also, it should be noted that some parts of the geographic area encompassed by the bill's intent is still in transition in terms of VA physical assets, with no major affiliated VA medical centers and only one significant VA facility in Florida, the Pensacola Outpatient Clinic, one in Alabama, the Mobile Outpatient Clinic and one Mississippi VA medical center, in Jackson. Distances and access to these facilities is challenging for the veterans of the region, especially for specialized VA services that had generally been provided by the New Orleans, Louisiana VA facility until Hurricane Katrina destroyed it in 2005. It is also important to note that the Florida Panhandle area is not a part of VISN eight, constituting the remainder of the State of Florida excepting a few counties along its northern border. With most of this area now embedded within VISN 16, the VA system's largest VISN (encompassing parts of eight States), the proponent of this bill makes a valid argument that perhaps a new alignment is in order.

H.R. 2005—Rural Veterans Health Care Improvement Act of 2007

Section 2 of this bill would improve reimbursement rates for veterans for their travel expenses related to VA medical care. It would reimburse veterans at the same rate paid to federal employees, by increasing it from 11 cents per mile to 48.5 cents per mile.

For several years, we have urged VA to correct the inequity in its travel reimbursement program and include a line item in the budget to make a fair adjustment in travel pay while retaining sufficient funding for direct medical care. Given the cost of transportation in 2007, including record-setting gasoline prices, a reimbursement rate unchanged since 1977 pales in comparison to the actual cost of travel. Adequate travel expense reimbursement is directly tied to access to care for many veterans and not a luxury.

The VA beneficiary travel program is intended by Congress to assist veterans in need of VA healthcare to gain access to that care. While the mileage reimbursement rate is currently fixed, actual reimbursement is limited by law with a $3.00 per trip deductible capped at $18.00 per month. The mileage reimbursement rate has not been changed in almost 30 years, even though the VA Secretary is delegated authority by Congress to make rate changes when warranted. The law also requires the Secretary to make periodic assessments of the need to authorize changes to that rate. Unfortunately, no Secretary has acted to make those changes, despite the obvious need to update the rate of reimbursement to reflect rises in travel and transportation costs.

DAV Resolution No. 212 is a longstanding resolution supporting repeal of the beneficiary travel pay deductible for service-connected veterans and to increase travel reimbursement rates for all veterans who are eligible for reimbursement. Additionally, we support legislation that has been introduced in Congress to repeal the mandatory deductible and increase the rate veterans are reimbursed for their authorized travel to and from VA services. We believe the House and Senate bills titled the "Veterans Travel Fairness Act," offer a fair and equitable resolution to this situation which we have been concerned for many years. We urge this Subcommittee to approve and enact legislation this year to reform the VA beneficiary travel program.

Section 4 of this measure would establish a grant program to provide innovative transportation options to veterans in remote rural areas. The bill tasks the Director of VA's Office of Rural Health to create a program that would provide grants of up to $50,000 to veterans' service organizations and State veterans' service officers to assist veterans with travel to VA medical centers and to improve healthcare access in remote rural areas. The bill authorizes $3 million per year for the grant program through 2010.

In 1987, the DAV, in coordination with VA's Voluntary Service program, began buying and donating vans to VA for the purpose of transporting veterans to receive VA medical care. Since that time, the DAV National Transportation Network has become a very significant and successful partnership between VA and DAV. We have donated 1,959 vans to VA facilities at a cost exceeding $39 million. Since its inception, these vans, their DAV volunteer drivers and medical center volunteer transportation coordinators have transported more than 10 million veterans over 397 million miles. We plan to continue and enhance this program, not only because the VA beneficiary travel rate is so low, but also we have found our transportation network serves as a truly vital link between rural veterans and crucial VA healthcare. Its absence would equate to the actual denial of care for eligible veterans because many of them have no means to substitute. Although as an organization, the DAV does not accept federal funds such as the grant program; however, knowing first hand the value and effectiveness of such a program, we would not oppose this section of the bill.

Section 3 of this bill would establish at least one and no more than five Centers of Excellence to research ways to improve care for rural veterans. The centers would be based at VA medical centers with strong academic connections. The Office of Rural Health would establish between one and five centers across the country with the advice of an advisory panel.

Existing VA research, education clinical centers, and various centers of excellence have proven to be a valuable resource to educate sick and disabled veterans as well as VA healthcare providers on new and effective treatment regimes. We are hopeful the proposed Rural Health Research, Education and Clinical Care Centers will strive to strike the balance we seek when providing better outreach and high quality VA medical care to veterans residing in rural and remote areas.

To examine alternatives for expanding care for rural veterans, section 5 of this measure would require the VA to conduct demonstration projects through the recently created VA Office of Rural Health to establish partnerships between the VA, Centers for Medicare and Medicaid Services, and the Department of Health and Human Services to coordinate care in critical access hospitals and community health centers. In addition, VA would be required to expand coordination with Indian Health Service for Native American veterans, and a report to Congress on these test projects would be due in 2 years.

While these initiatives are laudable, we recommend the VA office of Rural Health be given ample opportunity to discharge the responsibilities specified by Congress in Public Law 109–461 which would include developing, refining, and promulgating policies, best practices, lessons learned, and innovative and successful programs to improve care and services for veterans who reside in rural areas of the United States. In addition, we urge this Subcommittee to provide oversight and urge the Department of proceed with expeditious implementation by the Department.

H.R. 2172—The Amputee Veteran Assistance Act

This measure seeks to improve VA's prosthetics programs by requiring all VA orthotic/prosthetic laboratories and clinics to be certified by either of the two leading boards in these fields, the American Board for Certification in Orthotics and Prosthetics or the Board of Orthotics and Prosthetic Certification, within 5 years of the enactment of this bill, and allow disabled veterans to obtain new devices and seek care for the repair and servicing of their existing prosthetic devices from outside the VA system when VA facilities are unable to perform the required service or repairs due to a lack of technology or capability or when a suitable VA facility is not within a 55 mile radius.

The bill would also require a complete review and a report to Congress by VA of its prosthetic laboratories and clinics to determine the need to modernize such facilities to ensure that the VA is capable of servicing and repairing the most technologically advanced prosthetic devices. Also, VA would be required to complete a review and a report to Congress on VA prosthesists to determine what kinds of training and education will be needed to ensure that its prosthesists have the required knowledge to service and repair the latest prosthetic devices.

The DAV agrees that the Department's prosthetics program should be able to provide all necessary prosthetic services, devices, and supplies for the proper treatment of service-connected disabled veterans. We believe much of the bill's requirements are already being addressed and implemented by VA. We are concerned however, with the bill's requirement for VA to enter into one contract with one non-VA entity to repair and service prosthetic devices in certain circumstances. In addition to the arbitrary nature of a 55-mile radius as a requirement to contract for the service and repair of prosthetic devices, VA currently utilizes numerous service and repair contractors to allow a more personalized and convenient care to veteran in need of prosthetic and orthotic devices.

H.R. 2173—To amend title 38, United States Code, to authorize additional funding for the Department of Veterans Affairs to increase the capacity for provision of mental health services through contracts with community mental health centers, and for other purposes

This measure would allow the VA to provide mental health services through contracts with community mental health centers, and authorizes appropriations of $150 million from fiscal years 2008 through 2010 for such contracts.

First and foremost, DAV's position on contracted or fee-based care is well known. We believe that VA purchased care is an essential tool in providing timely access to quality medical care. Current law limits the indiscriminant use of VA purchased care to specific instances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all enrolled veterans and to promote effective, high quality care for veterans, especially those disabled in military service

and those with highly sophisticated health problems such as blindness, amputations, spinal cord injury or chronic mental health problems.

Second, as VA's contract workloads have grown significantly at a cost of about $3 billion each year, it has not been able to monitor this care, consider its relative costs, analyze patient care outcomes, or even establish patient satisfaction measures for most contract providers. This measure does not include provisions to address our concerns that VA has no systematic process for contracted care services to ensure that:

- care is safely delivered by certified, licensed, credentialed providers;
- continuity of care is sufficiently monitored, and that patients are properly directed back to the VA health-care system following private care;
- veterans' medical records accurately reflect the care provided and the associated pharmaceutical, laboratory, radiology and other key information relevant to the episode(s) of care; and
- the care received is consistent with a continuum of VA care.

Any bill seeking to contract for care outside VA without addressing these concerns would essentially shift medical resources and veterans from VA to the private sector to the detriment of the VA healthcare system and eventually sick and disabled veterans themselves. VA operates under constant pressure to do more with less and we believe the expansion of the current form of VA contracted care would benefit some veterans at the cost of eroding VHA's patient resource base, undermine the Department's ability to maintain its specialized service programs, and endanger the well-being of veteran patients under care within the system.

We are concerned that this bill does not provide any consideration for judicious use of contract care nor does it address our concerns regarding the lack of a systematic process for contract care. Such a measure could place at risk VA's well recognized qualities as a renowned and comprehensive direct provider of healthcare.

H.R. 2192—To amend title 38, United States Code, to establish an Ombudsman within the Department of Veterans Affairs

This measure would require VA to assign an Ombudsman to act as a liaison for veterans and their family members to navigate the VA healthcare and benefits system. We appreciate the intent of this bill; however, we believe VA has taken actions to address these issues by providing assistance and outreach to newly returning veterans through a cadre of case managers, transition patient advocates, patient representatives, peer counselors, suicide prevention coordinators, and other special purpose assistance to guide veterans through the VA healthcare benefit systems.

VA's actions noted above raise questions concerning the purposes of the proposed Office of the Ombudsman, given the fact that some of these positions have only recently been filled or that VA is in the midst of recruiting or training personnel to fill these positions. We urge the Subcommittee to provide oversight on the effectiveness of these new programs before authorizing the additional Office as proposed by this legislation.

H.R. 2219—Veterans Suicide Prevention Hotline Act of 2007

This measure would require the VA to award a grant to a private, nonprofit entity to establish and operate a national toll-free suicide prevention hotline. It would establish a 3-year authority for this program, at a cost of $7.5 million, to be paid from VA's Medial Services Appropriation.

There is already in existence a federally funded 24-hour, toll-free suicide prevention service comprised of over 120 individual crisis centers across the country. This service is available to all persons in need or in suicidal crisis. Individuals seeking help can call the National Suicide Prevention Lifeline (NSPL) at 1–800–273–TALK (8255). From the toll free number, they will be seamlessly routed to the certified provider of mental health and suicide prevention services nearest to the call of origination.

We agree with testimony provided by Mr. Jerry Reed, Executive Director of Suicide Prevention Action Network USA (SPAN USA), before the Senate Committee on Veterans' Affairs on May 23, 2007, that we could build upon what Congress has already funded with the NSPL.

As it was pointed out during that hearing, once a veteran in need calls the number, an option could be provided for that veteran to be transferred to a VA call center if the individual wants the services and support of the VHA. We also agree that the VA should be providing up-to-date information to non-VA crisis centers on all VA suicide prevention counselors, hospitals, medical centers, outpatient clinics, and peer support groups and, where appropriate, this national network of crisis centers should reliably transfer cases to the VHA call center. It is our understanding that

VHA's mental health program office is discussing the possibility of joining the existing system rather than mounting an independent VA suicide prevention service. We concur with that concept and urge VA to move forward in lieu of Congress passing this bill.

H.R. 2378—Services to Prevent Veterans Homelessness Act

This bill would direct the VA to provide financial assistance for supportive services for very low-income veterans' families in permanent housing. Under the bill VA would provide grants to certain eligible entities such as private nonprofit organizations or consumer cooperatives to provide various supportive services.

The DAV supports the intent of the bill to better address homeless veterans' needs, and to help them move toward independent living. Furthermore, unlike the companion bill in the Senate, this measure authorizes appropriation and does not divert resources from VA's medical care account. However, as well-intentioned as this measure may be, we are concerned that a grant under which healthcare and counseling services would be provided by private providers versus VA providers raises questions about cost, quality, continuity and safety similar to our views on other proposals with these goals.

H.R. 2623—To amend title 38, United States Code, to prohibit the collection of copayments for all hospice care funished by the Department of Veterans Affairs

VA is the only public healthcare system that charges copayments to hospice patients, and the DAV is greatly concerned particularly as the number of veteran deaths has been increasing to a current average of 1,800 per day. Congress initially addressed this issue, but only to a limited extent. section 204 of Public Law 108–422, the Veterans Health Programs Improvement Act of 2004, exempted veterans who receive hospice care from the requirement to pay copayments, but only if the hospice care were being provided at a nursing home.

The DAV recommends the fulfillment of Congress's original intent in Public Law 108–422 by exempting veterans from paying copayments when they receive VA hospice care in any authorized setting. We thank Ranking Member Miller for introducing this measure and Chairman Michaud for including it in today's hearing, which seeks to prohibit the collection of copayments for all hospice care furnished by the VA.

Veterans are subject to inpatient copayments if they seek inpatient hospice care at facilities without nursing home beds, or if the hospice care must be provided in an acute care setting as a result of clinical complexity. Moreover, veterans choosing to remain at home for their hospice care are subject to outpatient primary care copayments. While the DAV supports H.R. 2623, we recommend that its scope be broadened to include exempting veterans from copayments for hospice care provided in any treatment setting by amending section 1710 of Title 38 United States Code.

Mr. Chairman, again, the members and auxiliary of DAV appreciate being represented at this hearing today, and I appreciate being asked to testify on these bills. Mr. Chairman, this concludes my testimony. I and other members of the DAV Legislative Staff will be pleased to make ourselves available to you and your staffs for further discussion of our positions on any of these issues, in hopes of working toward compromise on measures that we can eventually support. I will be pleased to respond to any of your or other Committee Members' questions.

Statement of Carl Blake, National Legislative Director, Paralyzed Veterans of America

Mr. Chairman and members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to testify today regarding the proposed legislation. We appreciate the fact that you continue to address the broadest range of healthcare issues possible to best benefit veterans. We particularly support any focus placed on meeting the complex needs of the newest generation of veterans, even as we continue to improve services for those who have served in the past.

H.R. 1448, THE "VA HOSPITAL QUALITY REPORT CARD ACT"

Although PVA has no objection to the requirements for a Hospital Quality Report Card Initiative outlined in this legislation, we remain concerned that this wealth of information will go unused. Collecting this information and assessing it without acting on any findings from that information would serve no real purpose. We would

hope that the congressional committees will use this information published in these reports each year to affect positive change within the VA. However, we must emphasize that additional resources should be provided to allow the VA to properly compile this information as we believe that this could be a major undertaking.

H.R. 1853, THE "JOSE MEDINA VETERANS AFFAIRS POLICE TRAINING ACT"

PVA supports H.R. 1853, the "Jose Medina Veterans Affairs Police Training Act of 2007." H.R. 1853 will compliment the training that is currently in place for VA police officers. Some of the current personnel in the VA police force nationwide may have little or no specific training to work with emotionally distressed veterans. A majority of VA officers must deal with veterans with various degrees of emotional problems. In conversations with some of the VA officers at the VA Headquarters here in Washington, D.C., they have informed us that they have been told to be ready to deal with the large number of new veterans returning from the Iraq and Afghanistan war who may have significant mental health problems.

The current style of conduct as a VA officer is considered "situational enforcement". While regular law enforcement officers take action upon a violation of the law, VA police officers evaluate a given situation to determine if the situation presents a danger to veterans, medical staff, other individuals, or the officer. If the situation is or could become harmful to individuals who are present, or to government property, the VA officer then takes action.

All new officers receive initial training at the VA police officers training academy. After that training any future training is at the discretion of the Chief of Police at each VA location. The Chief will decide what training is required and how much training each officer receives. One VA Chief we spoke with told us that his officers receive training primarily on how to handle veterans age 60 to 70, as that is the age group of most veterans that they see at the VA medical center.

PVA believes that VA police officers across the system should have mandatory, standardized, training to help them address the new challenge of dealing with the newest generation of veterans, along with the older veteran population. This bill would certainly support this idea ensuring that specific training to help VA police officers understand how to best handle the new Iraq and Afghanistan veterans and how to accommodate them as they come to the VA for services.

H.R. 1925 (New VISN in the Gulf Coast Region)

PVA opposes H.R. 1925, a bill that would establish a new Veterans Integrated Service Network (VISN) in the Gulf Coast region. This would encompass counties in Florida, Alabama, and Mississippi. PVA has serious concerns about the precedent that this legislation would set. The VA currently uses the VISN structure as a management tool for the entire VA healthcare system. It makes no sense for the Congress to legislate how the VA should manage its system. Furthermore, this sets a dangerous precedent whereby any member could decide that a VISN, or some similar network structure, should be redrawn in such a way to support his or her own district.

However, we certainly believe that the current network alignment could be reassessed and possibly realigned. There is certainly nothing that suggests that 21 service networks is the optimal structure. But where does the VA draw the line when establishing its healthcare system structure? With the current 21 VISN's, the VA seems to do a good job of managing a massive healthcare system.

H.R. 2005, THE "RURAL VETERANS HEALTH CARE IMPROVEMENT ACT"

PVA generally supports H.R. 2005, the "Rural Veterans Health Care Improvement Act." This bill would enhance the implementation of the rural health requirements of P.L 109–461 enacted last year. However, we still have some concerns about how best to address the needs of veterans who live in rural areas. PVA recognizes that there is no easy solution to meeting the needs of veterans who live in rural areas. These veterans were not originally the target population of men and women that the VA expected to treat. However, the VA decision to expand to an outpatient network through community-based outpatient clinics reflected the growing demand on the VA system from veterans outside of typical urban or suburban settings.

PVA fully supports the provisions of this legislation which would align the mileage reimbursement rate afforded to eligible veterans with the rate that all federal employees get when they are on travel. It is wholly unacceptable that veterans have to live with the 11 cents per mile reimbursement rate that the VA currently provides when all federal employees receive 48 cents per mile. In fact, PVA believes

that some of the difficulty in providing care to veterans in limited access areas, specifically rural areas, might be eliminated with a sensible reimbursement rate. We believe that veterans would be less likely to complain about access issues as a result of their geographic location if they know that they will not have to foot the majority of the travel expense out of their own pocket. This is a change that has been long overdue, and we urge the Subcommittee and all of Congress to take immediate action to correct this inequity.

We also support the creation of rural health research, education, and clinical care centers. These centers would essentially serve as centers-of-excellence for rural healthcare. This could allow the VA to address the needs of rural veterans through broad application of the "hub-and-spoke" principle. This is the same structure utilized in the spinal cord injury service. A veteran can get his or her basic care at a community-based outpatient clinic (spoke). However, if the veteran requires more intensive care or a special procedure, he or she can then be referred to the larger rural research, education, and clinical care center (hub). This would ensure that the veteran continues to get the best quality care provided directly by the VA, thereby maintaining the viability of the system. It will also allow the VA to develop excellence within the actual VA healthcare system, instead of farming out these services to the private sector. Likewise, PVA supports the provisions to allow for transportation grants to veterans service organizations to assist veterans access the VA healthcare system. We are all familiar with the success of the Disabled American Veterans' (DAV) van program that provides transportation to medical facilities for disabled veterans who have appointments. This provision would further support similar programs and allow other organizations to play an equally useful role.

PVA has concerns about the demonstration projects that will establish partnerships between the VA and the Centers for Medicare and Medicaid Services to seek care in critical access hospitals or at community health centers. Principally, we believe that this legislation is "jumping the gun" by getting ahead of the Office of Rural Health, which is responsible for determining if solutions, such as this proposed demonstration project, are feasible. We think that this new office in the VA should be given time to do its job before Congress begins legislating solutions to the problems with rural healthcare for veterans. This is certainly not to say that Congress should not pressure the VA to get the office operating expeditiously.

Although we do not necessarily have a problem with the reporting requirements contained in the legislation, they seem to be redundant. PVA believes that similar requirements were placed on the VA with the creation of the Office of Rural Health in legislation enacted during the 109th Congress. We do not see the need for this requirement if the new office at VA will be fulfilling this task once it gets up to speed anyway.

H.R. 2172, THE "AMPUTEE VETERAN ASSISTANCE ACT"

PVA has serious concerns about the provisions of this proposed legislation. PVA strongly opposes the provision of Section 2 of H.R. 2172 that would allow the VA to contract for service and repair of prosthetic devices. We interpret this legislation to mean that the VA can contract with a single entity to provide these services and repairs. This is absolutely a bad idea. By using a single entity, the pool of devices and services available will be severely limited.

A one-size-fits-all approach to prosthetics cannot be applied. As an example, prosthetics departments that serve PVA members needing wheelchairs often, if not always, contract with several different vendors to provide those wheelchairs. Because every PVA member, and every disabled veteran for that matter, is different, the equipment they need varies. Although an Invacare power chair may be suitable for one spinal cord injured veteran, a different spinal cord injured veteran might be better served by a Jazzy chair. Two uniquely different veterans cannot be expected to use the same equipment simply because it might streamline processes for the VA. We believe that giving the VA the authority outlined in this provision would have a significant negative impact on the severely disabled veterans who are the highest users of VA prosthetics services.

PVA has no objection to the provision of the legislation that would require certification of VA orthotic-prosthetic laboratories with the American Board for Certification in Orthotics and Prosthetics or the Board of Orthotics and Prosthetic Certification. However, we believe that the VA already meets these requirements, but if this provision will reinforce this action, then we have no problem with it.

H.R. 2173 (Mental Health Services)

PVA opposes H.R. 2173 which would authorize VA to contract with community mental health centers to meet the needs of veterans dealing with mental illnesses.

As we testified earlier this year, we oppose any effort to allow the VA to contract out care when it can do a better and more cost effective job in its own system. Furthermore, by allowing the VA to send these veterans out of the system to receive their care, it effectively relieves itself of the obligation it has to these men and women. The VA must be appropriated adequate funding (steps that are finally beginning to take place) and it must be provided in a timely manner if it is going to have any chance of meeting these veterans needs.

Moreover, Congress must continue to conduct aggressive oversight to ensure that funding specifically allocated for mental health initiatives is properly spent. As explained in the Government Accountability Office (GAO) report of November 2006, the VA did not allocate all of the funding it planned to commit in FY 2005 for new mental health initiatives, nor did it spend all of the funds planned for FY 2006. VA must be held accountable to ensure that it lives up to the goals established in its National Mental Health Strategic Plan. Until such time as the VA meets these goals, the burden for mental healthcare should not be shifted to the community.

H.R. 2192 (VA Ombudsman)

PVA supports H.R. 2192, a bill that would establish an Office of the Ombudsman in the VA. We believe that this office could certainly improve the transition of service members and their families from the Department of Defense to the VA. The office can be an important information tool for the VA. We do find it unfortunate, however, that such an office would be necessary as the VA as whole should be responsible for fulfilling this role through outreach.

H.R. 2219, THE "VETERANS SUICIDE PREVENTION HOTLINE ACT"

The incidence of suicide among veterans, particularly Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans, is a serious concern that needs to be addressed. PVA principally supports this legislation. Any measure that will reduce the incidence of suicide among veterans is certainly a good thing.

However, we must emphasize a couple of important points. First and foremost, there need to be absolute standards established that ensure that the individuals staffing this hotline are adequately trained to handle the complex issues associated with individuals contemplating suicide. We certainly support the idea that this service should be staffed by veterans, but they must have the proper training to deal with these cases. Simply having the shared experience of military service is not enough. This legislation seems to address this concern, but the VA cannot be let off the hook for ensuring that this is handled properly.

Secondly, clear steps for referral into VA mental health clinics and other VA facilities with related services must be outlined. The private entities responsible for the operation of the suicide prevention hotline must understand how to refer veterans dealing with these problems into programs that will provide the services they need. These services are essential to helping the veteran overcome the suicidal feelings he or she may be dealing with.

H.R. 2378, THE "SERVICES TO PREVENT VETERANS HOMELESSNESS ACT"

PVA has no objection to the provisions contained in the proposed legislation. Clearly, the most important factor in combating the problem of homelessness among veterans is preventing homelessness in the first place. This legislation would seem to accomplish that task by offering financial assistance to organizations or entities that provide permanent housing and support services to very low income veteran families. In the mean time, we believe that additional resources should be invested in programs that actually target veterans and their families who are experiencing homelessness as well. With more than 200,000 veterans on the street on any given night, it is time to make real, meaningful efforts to end this problem.

H.R. 2623

PVA fully supports H.R. 2623, a bill which would prohibit the VA from collecting copayments from veterans receiving hospice care whether in an inpatient or outpatient setting. As we recall, the VA actually supported similar legislation during the 109th Congress. This legislation only makes sense as it will align with current statute that prevents VA from collecting copayments from veterans receiving hospice care in a nursing home setting.

We look forward to working with the Subcommittee to develop workable solutions that will allow veterans to get the best quality care available. I would like to thank

you again for allowing us to testify on these important measures. I would be happy to answer any questions that you might have.

Statement of Dennis M. Cullinan, Director,
National Legislative Service, Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THIS COMMITTEE:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify before you today on a wide range of important veterans healthcare bills.

H.R. 1488, THE VA HOSPITAL QUALITY REPORT CARD ACT

The VFW is pleased to support the VA Hospital Quality Report Card Act, legislation that would require VA to develop and implement a system to measure data about its healthcare facilities.

This data would be of great service. It would allow veterans to compare the quality of service VA provides, letting them make informed judgments about their healthcare. It would allow VA to identify areas of improvement, and it would provide essential data for Congress to better use its essential oversight authority.

H.R. 1853, THE JOSE MEDINA VETERANS AFFAIRS POLICE TRAINING ACT

The VFW supports this legislation which would require VA police officers to undergo training on how to deal with patients and visitors who are suffering from mental illnesses.

Given the large numbers of returning veterans who are suffering from mental illnesses of various degrees, extra training for VA employees on how to deal with these patients is entirely appropriate. This is especially true for those patients who are vulnerable and suffering the most. The extra training will ensure that wounded warriors are treated with dignity and respect.

H.R. 1925

The VFW has no objection to H.R. 1925, legislation that would establish a new Veterans Integrated Service Network (VISN) in the Gulf Coast Region. The regions in this area share many similar geographic things in common and, perhaps, aligning them all in one vision will allow them to better serve the veterans' population.

H.R. 2005, RURAL VETERANS HEALTH CARE IMPROVEMENT ACT

The VFW is pleased to support the Rural Veterans Health Care Improvement Act, legislation that aims to solve one of the greatest problems facing the large number of veterans who live in remote locations: access to care. It aims to improve services including transportation for disabled vets, research and partnerships with small communities.

It would require VA to create centers of excellence for rural healthcare veterans and to establish a grant program for groups that help transport veterans from rural areas. It also includes a provision that would create demonstration projects for potential partnerships with local hospitals and community health centers, as well as for Native American veterans.

We are strongly supportive of section 2, which would increase the mileage reimbursement rate veterans receive for their travel expenses related to VA healthcare to the rate provided to all federal employees. The current deductible for travel expenses is so limiting that most veterans receive little, if any, compensation for their travels. With so many veterans facing drives of hundreds of miles for even basic care, this is clearly the right thing to do.

H.R. 2172, AMPUTEE VETERAN ASSISTANCE ACT

The VFW is supportive of H.R. 2172, a bill to require that all Department of Veterans Affairs orthotic-prosthetic laboratories, clinics, and prosthesists are certified by either the American Board for Certification in Orthotics and Prosthetics or the Board of Orthotics and Prosthetic Certification. However, the VFW is not sure if changing the rules of VA's prosthetic program is needed, and we have concerns that the certification requirements that would affect all service and repair programs for prosthetics and orthotics is necessary.

VA continues to be on the forefront of advancement in this most important area, allowing hundreds of our wounded warriors the ability to regain their mobility or to become whole.

We are also concerned that some efforts to create a certification process could lead toward a standardization process that aims for one-size-fits-all solutions, instead of a personalized approach necessary to deal with each veteran's particular disability. Medical decisions must be made on the individualized needs of a veteran and what works best.

H.R. 2173

We support the intent of this legislation, which would allow the VA secretary to enter into contracts for service with community mental healthcare centers, but we do have some concerns.

With the number of returning service members who are suffering from mental health conditions, it is clear that VA can and must do more. VA has made great strides from where they were a few years ago in providing care, but the system is far from perfect. This legislation aims to fill in the gaps, by allowing VA to utilize local resources, presumably in places where there are gaps in the availability of care—whether through a high demand or a dearth of providers.

We remain concerned, however, with an over-reliance on contract care. Especially in the mental health area contract care could lead to some extensive continuity of care problems. Among other things, VA would have to determine some way to ensure that no veteran falls through the cracks when going from the department to a local provider. Further, it would be absolutely critical that patient records be transferable among all providers so that all information is provided to all involved healthcare givers. We have concerns, given VA's state-of-the-art medical records, that this is feasible in dealing with the private sector.

We need to do more for these wounded warriors, but we need to make sure that what we're doing really is in their best interest.

H.R. 2219, VETERANS SUICIDE PREVENTION HOTLINE ACT

The VFW supports this legislation which would establish a grant program to an organization to staff and run a suicide prevention hotline targeted and staffed by veterans and armed forces personnel.

We understand that VA is in the process of establishing a similar hotline, so it may be necessary to determine how much overlap is between the programs. It is clear, however, that the program would be beneficial.

This is a critical issue, especially with the difficulties so many of our men and women who have worn the uniform are facing. Anything we can do to extend a helping hand, especially when they are suffering and in a time of such need, is essential.

H.R. 2623

The VFW offers our support for this legislation, which would exempt patients seeking hospice care from paying copayments. This is a compassionate idea that relieves a burden on the veteran and their loved ones at a critical time.

This concludes my testimony and I will be happy to respond to any questions you may have.

Statement of Barry Hagge, National Secretary, Vietnam Veterans of America

Good morning, Chairman Michaud, Ranking Member Miller, and members of this Subcommittee. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to offer our comments on several veterans' health-related bills up for discussion here today.

All of these bills, with the possible exception of H.R. 1853, are extremely important. With a few reservations, they are worthy of your consideration and our support.

The topic of accessibility to VA medical services for veterans who live in rural areas has been percolating of late. We believe that **H.R. 2005, the "Rural Veterans Health Care Improvement Act of 2007,"** offers pragmatic solutions to address the problems of access to healthcare experienced by too many rural veterans. The bill would increase travel reimbursement for veterans who travel to VHA facilities to the rates paid to federal employees. The current reimbursement rate was es-

tablished decades ago and does not adequately compensate for the costs of gasoline, "wear and tear" on the vehicle or increased insurance that might be necessary in order to travel to distant medical centers. In the same vein, the grant program for rural veterans' service organizations to develop transportation programs could be an innovative way to strengthen community resources that may already assist with veterans' travel needs.

The establishment of centers of excellence for rural health research, education, and clinical activities, another component of this bill, should fill a gap in VA healthcare and should lead to innovation in long-distance medical and telehealthcare. These centers have brought the synergies of clinical, educational and research experts to bear in one site. Such centers have allowed VA to make significant contributions to the fields of geriatric medicine and mental illness. It would require demonstrations of rural treatment models. Demonstrations on treating rural veteran populations would be extremely useful in assessing effective ways to offer healthcare to individuals who are generally poorer, more likely to be chronically ill, and almost, by definition, more likely to have challenges in access to regular healthcare.

And establishing partnerships—with the Indian Health Service and with the Department of Health and Human Services—also should add to greater cooperation and collaboration in meeting the needs of rural veterans.

We would caution, however, that we would not like to see these demonstration projects exploring more opportunities to do widespread contracting out of veterans' healthcare services. Demonstration models should be assessed according to a number of outcomes such as quality of care, cost, and patient satisfaction and the results reported to Congress.

H.R. 1448, the "VA Hospital Quality Report Card Act of 2007," is a quality control measure that would help with accountability and issues regarding follow-up care and timely visits. It would require the VA to provide grades for its medical centers on measures such as effectiveness, safety, timeliness, efficiency, patient-"centeredness," and equity. Health-care quality researchers have long thrived trying to objectively define some of these measures.

As members of this Subcommittee are aware, the VA has a number of performance measures it regularly assesses in order to reward its medical center and network directors, among others. Some of these outcomes, such as immunizations for flu, foot care and eye care for diabetics, set the "benchmark" for care in the community. In addition to these internal performance measures, VHA voluntarily submits to Joint Commission on Accreditation of Healthcare Organization, Commission on Accreditation of Rehabilitation Facilities, and managed care quality review standards.

VVA understands the importance of quality measurement; there is an expression with which we agree: "What's measured, matters." We also agree that VA officials should be held to the highest degree of accountability, and whatever measures are available to allow this to better occur we wholeheartedly endorse. However, before enacting this clearly well-intended legislation, which could require significant retooling of quality measurement systems in the VA, the Committee should hold a hearing to identify gaps and deficiencies in current performance and quality measurement systems. It would also be useful to understand how report cards would be used and reported to improve VHA processes and performance rewards. Would poor grades be dealt with by changes in management? By withholding bonuses to senior executives? With more funding? How would good grades be rewarded? Such questions should be addressed before requiring a significant new quality measurement program to be installed.

H.R. 1853, the "Jose Medina Veterans Affairs Police Training Act," would require VA police to receive training in interacting with patients and visitors with severe mental illness. Most VA police are in daily contact with veterans with mental illness, often dealing with stressful situations that are liable to exacerbate symptoms. Sensitivity training in confronting any individuals in crisis could potentially assist officers in peacefully de-escalating or defusing volatile situations, thus avoiding the use of force.

VVA does not have a position on **H.R. 1925**, which would establish a Gulf Coast Veterans Integrated Service Network.

H.R. 2172, the "Amputee Veterans Assistance Act," would require that all VA orthotic-prosthetic laboratories, clinics, and prosthesists are certified by either the American Board for Certification in Orthotics and Prosthetics or the Board of Orthotics and Prosthetic Certification. We endorse this bill because, very simply, as more and more catastrophically wounded veterans are returning home minus arms and legs, it is incumbent on us to ensure that they are receiving quality prosthetics and orthotics.

The VA already has the authority to contract with community mental health providers; however, under the strain of thousands of returning troops in need of mental health services, the VA is struggling to implement provisions of its mental health strategic plan, including providing "round-the-clock" access to care. The funding authorized in **H.R. 2173** for the provision of mental healthcare from community providers—$50 million—would greatly assist the VA in filling the programmatic gaps it recognized in both its strategic plan and in its budget submission for FY 2008.

Community mental health providers should be selected based on quality of care indicators such as compliance with standards for either the facility or its clinical personnel (what credentials/training are required for the clinical personnel?) Standards for community providers should be no less rigorous than those required for similar VA facilities. And the VA must provide vigorous oversight of the care these community facilities provide veterans.

We should also note that mental health providers across the country are eager to assist returning veterans in dealing with their demons. Passage of 2173 should help give them the opportunity.

VVA endorses **H.R. 2192**, which would establish an Office of the Ombudsman within the Department of Veterans Affairs. Although most of the duties of an ombudsman are the responsibility of program managers and assistant secretaries, veterans and their families who are sometimes frustrated by bureaucratic runarounds or non-answers often encountered at VA medical centers or regional offices will have a champion—if H.R. 2192 is enacted and sufficiently funded.

VVA very much supports **H.R. 2219, the "Veterans Suicide Prevention Hotline Act of 2007,"** which would authorize and fund the establishment of a national toll-free suicide prevention hotline. As many of those in this room are aware, up to one-third of the thousands of veterans of the fighting in Iraq and Afghanistan have screened positive for mental illness. As more of these veterans return home from ongoing deployments in Southwest Asia, the acute symptoms of these illnesses, including post-traumatic stress disorder, depression and anxiety, are likely to manifest resulting in more preventable losses of life.

In a report published last month (May 10, 2007), the VA's Office of Inspector General recommended that VA provide such a hotline (VA OIG Report No. 06–03706–126). The VA's response indicated that the Veterans Health Administration's Office of Mental Health Services was developing a hotline that would be rolled out November 30, 2007 and fully implemented by January 30, 2008. Enacting this legislation will better ensure that the VA meets these goals.

The provision should assure that contracted services for the hotline call for a minimum percent of vets hired—including veterans who have recently returned from deployments abroad—over and above the 3% required for government contracts.

VVA supports, too, **H.R. 2378**, the "Services to Prevent Veterans Homelessness Act." If veterans at risk of becoming homeless can be identified and assisted before they are turned out of their apartment, if they can be given the modest assistance they need to maintain their independence, if they have access to the supportive services they need to maintain their dignity, it is entirely possible that hundreds will be saved from having to live with no permanent address, and no roof over their head.

That some 200,000 military veterans, including growing numbers of men and women who served in Iraq and on the "Global War of Terror" are homeless is a national scandal. It should shock you into action. And indeed, Congress has responded, but often with too little in the way of resources that can make a real difference.

VVA supports the provisions in **H.R. 2623** that would prohibit the collection of copayments for all hospice care furnished by the VA. Hospice care is a service that allows individuals with terminal illness to reject extraordinary measures for prolonging life and, instead, accept "comfort care." The last year of life is known to be far more expensive than those that precede it. It is unfortunate, then, to penalize veterans and their families by charging co-payments for hospice care when those same veterans might have elected to receive, free-of-charge, acute, in-patient care that was far more expensive and ultimately fruitless. The VA should be encouraging its patients to prepare living wills and advanced directives that specify their choices for end-of-life care and educate veterans with terminal illness about hospice. Relieving veterans of copayments for hospice care seems one means to better ensure that they are able to choose hospice for their end-of-life care.

Members of this Subcommittee, VVA welcomes your comments and your questions.

Statement of the Honorable Michael Kussman, M.D., MS, MACP, Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs

Good Morning Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to present the Administration's views on nine bills that would affect Department of Veterans Affairs (VA) programs that provide veteran healthcare benefits and services. With me today is Walter A. Hall, Assistant General Counsel. Mr. Chairman, with the exception of section 2 of H.R. 2005, VA has not had sufficient time to prepare cost estimates for the bills on today's agenda. As soon as these become available, we will supply them for the record. In addition, with the short time available to prepare for this hearing, we were not able to provide views on all of the bills reflected on the agenda. We can provide those views for the record.

H.R. 1448—VA Hospital Quality Report Card Act of 2007

Mr. Chairman, I will begin by addressing H.R. 1448. This bill would require VA to establish a Hospital Quality Report Card Initiative ("Initiative") to, among other things, help inform patients and consumers about the quality of care in VA hospitals. Under the Initiative, the Secretary would be required to publish, at least biannually, reports on the quality of VA's hospitals that include quality-measures data that allow for an assessment of healthcare effectiveness, safety, timeliness, efficiency, patient-centeredness; and equity.

In collecting and reporting this data, the Secretary would have to include very extensive and detailed information (i.e., staffing levels of nurses and other healthcare professionals; rates of nosocomial infections; volume of various procedures performed, hospital sanctions and other violations; quality of care for specified patient populations; the availability of emergency rooms, intensive care units, maternity care, and specialty services; the quality of care in various hospital settings, including inpatient, outpatient, emergency, maternity, and intensive care unit settings; ongoing patient safety initiatives; and, other measures determined appropriate by the Secretary). VA would be allowed to make statistical adjustments to the data to account for differences relating to characteristics of the reporting hospital (e.g., size, geography, and teaching status) and patient characteristics (e.g., health status, severity of illness, and socioeconomic status). In the event VA makes such adjustments, there would be a concomitant obligation to establish procedures for making that data available to the public.

The bill would require the Secretary to disclose the entire methodology (for the reporting of the data) to all organizations and VA hospitals that are the subject of any information prior to making such information available to the public. Each report submitted under the Initiative would have to be available in electronic format, presented in an understandable manner to specified populations, and presented in a manner that allows for a comparison of VA's hospital quality with local hospitals or regional hospitals. The Department would also need to establish procedures to make these reports available to the public, upon request, in a non-electronic format (such as through a toll-free telephone number).

In addition, H.R. 1448 would require the Secretary to identify and acknowledge the analytic methodologies and limitations on the data sources used to develop and disseminate the comparative data and to identify the appropriate and inappropriate uses of such data. The bill would further mandate the Secretary, on at least an annual basis, compare quality measures data submitted by each VA hospital with data submitted in the prior year or years by the same hospital to identify and report actions that would lead to false or artificial improvements in the hospital's quality measurements.

This measure would further require the Secretary to develop and implement effective safeguards to: protect against the unauthorized use or disclosure of VA hospital data reported under this measure; protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective VA hospital data; and ensure that identifiable patient data is not released to the public. In addition, the Secretary would need to evaluate and periodically report to Congress on the effectiveness of this initiative and its effectiveness in meeting the purposes of this Act. And such reports would have to be made available to the public. Finally, this legislation would direct the Secretary to use the results of the evaluations to increase the usefulness of this initiative.

H.R. 1448 would authorize to be appropriated to carry out this section such sums as may be necessary for each of Fiscal Years (FY) 2008 through 2017. The effective date for this bill and its requirements would be 18 months after the date of the bill's enactment.

Mr. Chairman, VA supports the intent of this bill but opposes the bill as written. H.R. 1448 is too prescriptive in its requirements, and much of the information that would be required by H.R. 1448 is already available through other avenues, such as The Joint Commission's (previously known as the Joint Commission on Accreditation for Healthcare Organizations) website that provides standardized comparative data in a form that has been tested for consumer understandability and usefulness. Moreover, VA is in the process of compliance with Executive Order 13410, which requires transparency of quality measures in Federal healthcare programs. We would welcome the opportunity to meet with the Committee members to help them understand what is available already, how the members might better access the information, and how we can help veterans and the public better access that information.

H.R. 1853—Jose Medina Veterans Affairs Police Training Act of 2007

H.R. 1853 would require the Secretary to ensure, not later than 8 months after the date of enactment, all VA police officers receive training on how to interact with visitors and patients at VA medical facilities who have, or who exhibit symptoms of, mental illness. The purpose for this mandate is the bill's express finding that there has been, and will continue to be, an increase in the incidence of post-traumatic stress disorder (PTSD) among veterans who served in past and present combat theaters and thus in their concomitant need for VA mental health treatment and services.

We do not support H.R. 1853 because it is unnecessary. By statute, the Secretary is already required to provide VA Police Officers with training that emphasizes effective management of situations involving patients. To carry out that mandate, VA provides specialized training to VA Police Officers in dealing with disruptive and other unusual behaviors. VA officers also must successfully complete an 80 hour basic entry level training course at their medical centers as well as a 200 hour residential basic police officer training course at the VA Law Enforcement Training Center. Included in the residential course is a 17.5 hour block of training in Behavioral Science that includes such topics as introduction to mental illness, communications/conflict management, verbal judo, crisis intervention/conflict resolution and the dynamics of the suicidal individual. Much of this training is taught by VA psychologists. Moreover, VA officers must also complete a biannual refresher training program.

H.R. 1925—VISN for Gulf Coast Region

H.R. 1925 would require the Secretary to establish, not later than 1 year after enactment, a separate "Veterans Integrated Services Network ("VISN") for the Gulf Coast region of the United States. This new VISN would be comprised of specified counties located in Florida, Alabama, and Mississippi.

VA does not support H.R. 1925. We find no justification for establishing a separate VISN for a service area that does not have the workload needed to make that organizational change cost-effective or to require that level of management. The current facilities and referral patterns in this area provide the best access for the veterans. VISNs were originally created around referral patterns and geographic boundaries. In addition, VISNs work together along their borders to ensure access to healthcare for veterans in those areas. The Gulf Coast region is one area where VISNs seven, eight and 16 have worked very well together in managing care for veterans in the area. Therefore, VA sees no reason to add an additional Network for this region.

H.R. 2005—Rural Veterans Health Care Improvement Act of 2007

H.R. 2005 is intended to improve VA's ability to meet the healthcare needs of rural veterans. section 2 of this bill would amend VA's beneficiary travel program by requiring VA to pay or reimburse eligible veterans at the same per diem rates and mileage rates that apply to Federal employees using privately owned vehicles for official travel.

Section 3 would require the Secretary, through the Director of the Office of Rural Health, to establish up to five Rural Health Research, Education, and Clinical Centers of Excellence ("Centers"). The bill sets forth detailed requirements that would govern the Secretary's designation and placement of such Centers. It also would limit designation of Centers to those facilities found by a peer review panel to meet the highest competitive standards of scientific and clinical merit and also found by the Secretary to have met the requirements specified in the legislation.

Section 4 would require the Secretary to establish a grant program for State Veterans' Service Agencies and Veterans' Service Organizations for purposes of providing veterans living in remote rural areas with innovative means of travel to VA medical centers (and to assist them with their other medical care needs). A grant

awarded under this section could not exceed $50,000. Grant recipients would not be required to provide matching funds as a condition for receiving a grant. This section would require the Secretary to prescribe regulations to implement this program and also authorize to be appropriated $3 million for each of FYs 2008 through 2012 to carry out this program.

Section 5 would require the Secretary, through the Director of the Office of Rural Health, to carry out demonstration projects to examine alternatives for expanding care to veterans in rural areas. In so doing, the Secretary would be required to establish partnerships with the Department of Health and Human Services (HHS) to coordinate care for veterans in rural areas at both critical access hospitals and community health centers. VA would also be obliged to coordinate with HHS' Indian Health Service to expand care for Native American veterans.

The bill would institute annual reporting requirements, the first of which would have to include the results of the statutorily mandated assessment of VA's fee-basis program on the delivery of care to veterans residing in rural areas, along with the results of VA's extensive outreach program to OEF/OIF veterans living in rural veterans.

Mr. Chairman, while we appreciate the impetus for H.R. 2005, we do not support the bill. In accordance with Congress' mandate in the "Veterans Benefits, Health Care, and Information Technology Act of 2006," VA recently established the Office of Rural Health (ORH) within the Veterans Health Administration. Part of that office's charge is to determine how we can best continue to expand access to care for rural veterans. Presently, ORH is developing a strategic plan for operations and is considering a proposal to create new research centers. We would request the Congress wait until these assessments are complete before requiring action in this area. We will keep the Committee abreast of ORH's activities and findings as available.

VA is working closely with other organizations in a variety of areas, including outreach, clinical care, education, expanded services, care coordination, and telemedicine, to improve the quality of healthcare available to those living in rural areas. The Department of Health and Human Services (HHS) and the Department of Veterans Affairs (VA) signed a Memorandum of Understanding (MOU) in February 2003 to encourage cooperation and resource sharing between the Indian Health Service (IHS) and the Veterans Health Administration (VHA) to deliver quality healthcare services and enhance the health status of American Indian and Alaska Native (AI/AN) veterans. VHA's Office of Rural Health (ORH) has also established a working relationship with and sought consultation from HHS's Office of Rural Health. As the office matures, VHA's plan is to work closely with HHS to maximize the opportunities in a range of areas including education, training, research, and access. Therefore, a Congressional mandate to encourage cooperation with HHS and IHS is not necessary.

Moreover, while we acknowledge there has been a significant increase in fuel prices, beneficiary travel payments are paid out of funds appropriated for healthcare treatment and services. In our view, VA should use medical care funds for furnishing direct patient care in the manner that best serves the most veterans. It is also important to note that increasing the beneficiary travel payment and reimbursement rates would benefit only the limited categories of veterans who are eligible for those benefits e.g., veterans whose travel is in connection with treatment for a service-connected disability. For that reason, the amendments to the beneficiary travel program that are set forth in H.R. 2005 may not advance the Congress' general objective of improving access to care for rural veterans.

We further note that the travel benefits program for Federal employees is distinct and on the whole inapposite to VA's beneficiary travel benefits program. It is unclear, based upon the text of the bill, if the limitations and conditions on Federal employee eligibility for travel pay would be applied to veterans. Federal employees do not automatically qualify for reimbursement of expenses they incur while on official travel. They must meet certain criteria to be eligible for such reimbursement, particularly in connection with the use of a privately owned vehicle. The criteria and conditions for reimbursement that apply to Federal employees (e.g., travel order) would not be appropriate to patients traveling to VA facilities for care and treatment, and transposing such a system would prove to be very complex and difficult to manage. VA estimates the cost of section 2 of H.R. 2005 to be $253 million for FY 2008 and $7 billion over a 10-year period.

H.R. 2172—Amputee Veteran Assistance Act

Mr. Chairman, the next bill on today's agenda is H.R. 2172. This bill would require the Secretary to ensure, not later than 5 years after enactment, that all VA orthotic-prosthetic laboratories and clinics are certified by either the American

Board for Certification in Orthotics and Prosthetics or the Board of Orthotics and Prosthetic Certification.

This bill would also require the Secretary to seek to enter into a contract with a non-VA entity for the service and repair of a prosthetic device for a veteran in the following situations:

- If the Secretary determines that VA facilities are unable to perform the necessary service or repair due to a lack of technology or for any other reason that the Secretary determines prevents such service or repair in a timely manner; or
- The veteran in need of such service or repair resides at a distance greater than 55 miles from the nearest suitable VA facility capable of furnishing the service or repair.

The bill would further require the Secretary to develop and carry out a plan to inform disabled veterans at least twice a year of the technological advances made in the field of prosthetics. The above-discussed contracting and information related requirements would both have to be implemented not later than 6 months after the date of the bill's enactment.

Additionally, H.R. 2172 would require the Secretary to conduct and complete a review of all VA orthotic-prosthetic laboratories and clinics to ensure that the Department is capable of serving and repairing the most technologically advanced prosthetic devices. Such review would need to be conducted and completed not later than one year after the bill's enactment. No later than 6 months after completion of that review, the Secretary would need to submit a report to Congress on the Secretary's findings and any recommendations to address deficiencies in capability that were identified during the mandated review.

Finally, no later than 1 year after the bill's enactment, this bill would require the Secretary to conduct and complete a review of VA's prosthetists and orthotists to determine what level and kinds of training and education will be needed to ensure they are qualified to service and repair the most technologically advanced prosthetic devices. No later than 6 months after that review is completed, the Secretary would be required to submit a report to Congress on the Department's findings and any recommendations to address identified deficiencies in education, training, or qualification.

VA does not support H.R. 2172 because it is unnecessary. VA's policies already meet or exceed the requirements in the bill. In 2003 VA mandated all prosthetic and orthotic laboratories be accredited by the American Board for Certification in Orthotics and Prosthetics or the Board of Orthotics and Prosthetic Certification. Today, all 58 of our laboratories are accredited and we require all contractors be accredited by these organizations as well. As a prerequisite of attaining accreditation, each facility had to employ at least one certified Prosthetist/Orthotist to oversee all work. Today, 131 out of our 186 prosthetists/orthotists are certified and we are actively encouraging all staff to attain this certification. Both ABC and BOC require all certified practitioners maintain certification through 5-year cycles of continuing education units, including education in new and emerging technology. VA will continue to conduct site visits to all prosthetic and orthotic laboratories to ensure they meet quality standards and maintain their accreditation.

VA uses over 600 non-department entities for fabrication, service and repair of prosthetic devices. Veterans will continue to have their choice of contracted providers, including the VA. VA is informing veterans of new developments with Open Forums, routine newsletters and press releases, and a dedicated web link devoted to the care and treatment of amputees.

As a technical matter we point out that H.R. 2172 would amend chapter 31 of title 38, United States Code, which governs vocational rehabilitation benefits administered by the Veterans Benefits Administration, not chapter 17 of the same title, which governs the provision of healthcare benefits, including prosthetic care and services.

H.R. 2173—Authorization for Vet Centers to contract for Mental Health Services

will now discuss H.R. 2173. This bill would amend VA's readjustment counseling authority in 38 U.S.C. § 1712A to permit the Secretary to enter into contracts with community mental health centers (deemed qualified by the Secretary) for the provision of mental health services as part of VA's readjustment counseling program.

VA does not support H.R. 2173. Currently, VA's authority to provide mental health services to veterans receiving readjustment counseling services under section 1712A of title 38, United States Code, is limited to mental health services that are necessary to facilitate the successful readjustment of a veteran to civilian life and

limited to the provision of counseling, training and mental health services described in 38 U.S.C. §§ 1782 and 1783 (bereavement counseling) for the veteran's immediate family members. It is not clear if the bill, in creating a new subsection wholly unrelated to the existing provisions governing VA's contracting authority under section 1712A, means to encompass mental health services beyond those currently authorized and those which have traditionally been provided under VA's readjustment counseling mission (in contrast to VA's clinical mission).

As already alluded to, Vet Centers currently have authority to contract with private sector community mental health agencies for the provision of readjustment counseling services and related mental health services. For more complex mental health needs, Vet Centers readily refer patients to VA medical facilities. Furthermore, H.R. 2173 would obfuscate and blur the special service mission of the Vet Centers as defined by law. These services are deliberatively set apart from medical facilities to promote more than medical readjustment services for combat veterans in an easy to access, community-based setting.

H.R. 2192—Establishement of Office of Ombudsman within the Department

H.R. 2192 would establish an Office of the Ombudsman (herein referred to as the "Office") within the Department and require the Secretary to designate an Ombudsman to carry out the duties of the Office. The Ombudsman would act as a liaison for veterans and their family members with respect to the receipt of healthcare and benefits administered by VA.

This measure would also require the Secretary to ensure the services of the Office are available to all veterans and their family members and would further direct the Secretary to make available to each veteran, and to the family members of all veterans, information on contacting and using the services of the Office. Lastly, H.R. 2192 would authorize the disclosure of information provided by veterans or their family members only to the extent necessary to carry out the duties of the Office.

VA does not support H.R. 2192. Of particular concern is the provision that would authorize the Ombudsman to act as a liaison for veterans and their family members with respect to the receipt of healthcare. VHA has instituted a variety of measures to support our patients and their families, including appointing patient advocates in our Medical Centers, benefits counselors, OEF/OIF Coordinators, and Transition Patient Advocates for those seriously injured in combat. Vet Center counselors also contribute to resolving situations on behalf of veterans. VSO representatives, likewise, serve ably as counselors and mentors and many State Departments of Veterans Affairs contribute in this area. VBA has also has extensive initiatives and programs aimed at assisting claimants with respect to receipt of benefits, including the Transition Assistance Program (TAP), the Benefits Delivery at Discharge (BDD) Program, and expanded outreach to veterans, dependents, and survivors. Adding another layer of oversight and involvement could create a confusing situation for patients and families, who might become unsure whom to consult. A new Office of the Ombudsman could also produce confusion within VA in terms of assignments and responsibilities, since the bill, as written, does not delineate between the role the new Office would fill vis-à-vis other offices within VA.

H.R. 2219—Veterans Suicide Prevention otline Act of 2007

Mr. Chairman, H.R. 2219 would require the Secretary to award one grant for a period of not more than 3 years to an eligible entity to establish, publicize, and operate a national toll-free telephone number to serve as a suicide prevention hotline targeted to, and staffed predominately by, veterans of the Armed Forces.

Under H.R. 2219, the grantee would be required to perform the following functions:

- enter into a contract with a telecommunication carrier for the use of such a national toll-free number;
- select; train; and supervise personnel to answer incoming calls and to provide counseling and referral services to callers;
- ensure that sufficient staffing is provided so that the hotline services are available to callers at all times;
- assemble and maintain a current database of information to be used to refer callers to local service providers and of information about the availability of shelters for homeless callers;
- publicize the hotline to potential callers; and
- certify the capacity of, and provide supplemental training for, any local crisis center operating as a subcontractor of the grantee.

H.R. 2219 would further provide that to be eligible to receive the grant under this section, a private, nonprofit entity would have to prepare and submit a detailed ap-

plication to the Secretary addressing a number of specified areas. The selected grant recipient would, in turn, be required to submit an annual report to the Secretary, in the form and with such information as the Secretary may require. The grantee would have to include in that report the volume of calls to the hotline, the demand for specific types of referrals, and the number of trained volunteers answering the hotline. Finally, payments awarded to the grantee would be subject to annual approval by the Secretary and to the availability of appropriations for each FY.

For purposes of the grant award, H.R. 2219 would authorize to be appropriated $2,500,000 each year for FYs 2008, 2009, and 2010.

VA does not support H.R. 2219. VA is already developing a comprehensive program for suicide prevention including a national 24 hour toll-free hotline. The services under development in VA are more comprehensive that those proposed in H.R. 2219. VA is proposing to administer the services with VA mental health professional staff, not outside contractors, to provide mechanisms for accessing the electronic health records of veteran-callers as part of the response to crisis calls, and to establish strong interactions between the national hotline and the suicide prevention coordinators in each medical center to provide for continuity of care. While we respect the idea of peer-to-peer counseling, which is employed with great effectiveness in our Vet Centers, VA believes it is more appropriate from a clinical standpoint to staff VA's national hotline with trained healthcare professionals.

H.R. 2378—Services to Prevent veterans Homelessness Act

H.R. 2378 is a measure intended to prevent low income veterans transitioning to, or residing in, permanent housing from falling back into their former homeless condition. Subject to the availability of appropriations provided for the bill's purpose, H.R. 2378 would require the Secretary to provide financial assistance to eligible entities to provide and coordinate the provision of supportive services for very low-income veteran-families occupying permanent housing or transitioning from homelessness to permanent housing. The bill would further require the Secretary to establish a formula for determining the rate of payments to be made to eligible entities providing supportive services under this section. The rate would have to be adjusted at least annually to reflect changes in the cost of living. In calculating the rate payment formula, the Secretary would be authorized to consider geographic cost of living variances, family size, and the cost of services provided.

To be eligible to receive funding, H.R. 2378 would require eligible entities to submit a detailed application to the Secretary. This bill would also authorize the Secretary to give preference to an entity providing or coordinating the provision of supportive services for very low-income veteran families who are transitioning from homelessness to permanent housing.

This measure would require the Secretary to provide training and technical assistance to entities receiving payments under this program on the planning, development, and provision of supportive services to the targeted families. Such assistance could be provided either directly, or through grants or contracts with appropriate public or nonprofit private entities.

As to funding, H.R. 2378 would make available out of the amounts appropriated for medical care $25 million for each of FYs 2008, 2009, and 2010, of which not more than $750,000 could be used to provide technical assistance.

VA generally supports H.R. 2378 but we strongly recommend that the bill be modified to allow VA to establish additional criteria, specifically clinical indicators, to ensure this program reaches veteran families requiring additional support to end their homelessness. H.R. 2378 would require additional staffing resources for VHA's Homeless Program Office in the Office of Mental Health Services.

This concludes my prepared statement. I would be pleased to answer any questions you or any of the members of the Subcommittee may have.

Statement of Andy Behrman, Chair, Rural Health Policy Board, National Rural Health Association

It is my distinct pleasure to submit my comments for the record in regard to H.R. 2005, the Rural Veterans Health Care Improvement Act of 2007. As the Rural Health Policy Board Chair for the National Rural Health Association (NRHA), and as a veteran, I have long been an advocate for appropriate change and improvement to our VA healthcare delivery system. It is a priority for me and a priority for the NRHA.

The NRHA is a national nonprofit, non partisan, membership organization whose mission is to improve the health of rural Americans and to provide leadership on

rural health issues. The members of the NRHA have long maintained concern for the health and mental healthcare needs of rural veterans.

The members of the National Rural Health Association (NRHA) have maintained a special concern for the health and mental healthcare needs of rural veterans for many years. NRHA was one of the first non-veteran service organizations to develop a policy statement on rural veterans and this policy work is evidence of our memberships' concern for rural veterans.

Since our Nation's founding, rural Americans have always responded when our Nation has gone to war. Whether motivated by their values, patriotism, or economic concerns, the picture has not changed much in 230 years. Simply put, rural Americans serve at rates higher than their proportion of the population. Though only 19% of the nation lives in rural areas, 44% of U.S. Military recruits are from rural America. And nearly one-third of those who died in Iraq are from small towns and communities across the nation.

There is a national misconception that all veterans have access to comprehensive care. Unfortunately, this is simply not true. Access to the most basic primary care is often difficult in rural America. Combat veterans returning to their rural homes in need of specialized care due to war injuries (both physical and mental) likely will find access to that care extremely limited. What this means, is that because there is a disproportionate number of rural Americans serving in the military, there is a disproportionate need for veteran's care in rural areas.

Additionally, we must all be mindful of long-term needs. While the NRHA is pleased that both the House and Senate FY 2008 budgets call for greater increases in VA medical care spending than in past years, long-term healthcare planning is critical. The wounded veterans who return today won't need care for just the next few fiscal years, they will need care for the next half century.

In my testimony to the Committee on April 18, 2007, I presented recommendations that NRHA believes to be prudent in terms of developing a new approach to serving our rural veterans. These recommendations include:

1. Increasing Access by Building on Current Successes

Community Based Outreach Centers (CBOCs) open the door for many veterans to obtain primary care services within their home community. Additionally, Outreach Health Centers meet the needs of many rural veterans. NRHA applauds the success of these programs and supports their expansion.

2. Increasing Access By Collaborating with Non-VHA Facilities

Many rural veterans cannot access VHA care simply because VHA facilities are too far away. Linking the quality of VA services with rural civilian services can vastly improve access to healthcare for rural veterans. As long as quality standards of care and evidence-based medicine guide treatment for rural veterans, the NRHA supports collaboration with:

- *Federally Qualified Community Health Centers.* These centers serve millions of rural Americans and provide community-oriented, primary and preventive healthcare. And, most importantly, are located where rural veterans live. A limited number of collaborations between the VHA and Community Health Clinics already exist and have proven to be prudent and cost-effective solutions to serving eligible veterans in remote areas. These successful models should be expanded to reach all of rural America.
- *Critical Access Hospitals.* These facilities provide comprehensive and essential services to rural communities and are specific to rural states. If these facilities are linked with VA services and models of quality, access to care would be greatly enhanced for thousands of rural veterans.
- *Rural Health Clinics.* These clinics serve populations in rural, medically underserved areas. In many rural and frontier communities, these clinics are the only source of primary care available.

3. Increasing Traumatic Brain Injury Care

Currently, it appears that Traumatic Brain Injury (TBI) will most likely become the signature wound of the Afghanistan and Iraqi wars. Such wounds require highly specialized care. The current VHA TBI Case Managers Network is vital, but access to it is extremely limited for rural veterans—expansion is needed.

4. Targeting Care to Rural Veterans

A. ***Needs of the Rural Family***. Rural veterans have an especially strong bond with their families. Returning veterans adjusting to disabilities and the stresses of combat need the security and support of their families in making their transitions back into civilian life. The Vet Centers do a tremendous job

in assisting veterans, but their resources are limited. The NRHA supports increases in funding for counseling services for veterans' and their families.

B. ***Needs of Rural Women Veterans***. More women serve in active duty than at any other time in our Nation's history. And more women are wounded or are war casualties than ever before in our nation's history.

Targeted and culturally competent care for today's women veterans is needed. Rural providers should also be trained to meet the unique needs of rural, minority, and female veterans.

5. Improving Office of Rural Veterans

The NRHA calls on Congress and the Veterans Administration to fully implement the functions of the newly created Office of Rural Veterans to develop and support an on-going mechanism to study and articulate the needs of rural veterans their families.

We are grateful to Mr. Salazar for introducing HR 2005 and are grateful for the Committee's consideration of the bill. This legislation provides important relief for rural veterans and clearly addresses our second and fifth recommendations. We hope the Committee will consider this as a strong and positive step toward addressing the many challenges—especially access challenges—faced by rural veterans.

To that end, we hope that this Committee will also address other ways to improve access to healthcare for our rural veterans. While the VA has provided outstanding service to our veterans over the years (and I have been one of those recipients), the need to increase access to services has become a major concern to the VA, and a critical concern to veterans living in rural communities throughout the United States.

Efforts to increase service points for rural veterans have, in large part, been hindered by the VA Administration itself. The VA has thwarted attempts to collaborate with organizations that are located where rural veterans reside (such as community health centers, critical access hospitals, and rural health clinics) because of a false assumption that quality of care standards in rural communities are inferior. To the contrary, the standards of healthcare in rural America are high. In fact, community health centers, for example, have been rated as the number one most efficient and effective program in all of HHS. CHS must meet the highest standards of care, and in many cases, they musts also be Joint Commission accredited. All facilitates must meet federal standards of care.

We must never forget that many veterans forgo care entirely because of access difficulties to VA facilities. Often, however, local quality care is available within a veteran's own community. In many cases, these rural centers, as well as critical access hospitals and rural health clinics, are the only providers in a large geographic area. Our goal is not to mandate care to our veterans, but to provide them a choice, a local choice. We applaud Congressman Salazar and this Committee for taking steps toward providing our honored veterans with such a choice.

Thank you again for this opportunity. The NRHA looks forward to working with you and this Committee to improve rural healthcare access for the millions of veterans who live in rural America.

Statement of the Honorable Silvestre Reyes,
a Representative in Congress from the State of Texas

Chairman Michaud, Ranking Member Miller, and distinguished members of the Subcommittee, I would like to thank you for the opportunity to testify before you in support of my bill HR 2172 the Amputee Veteran Assistance Act. As a veteran and former member of this Committee, many of you know me well and are aware of my commitment to Veteran issues. Today as Chairman of the Intelligence Committee and a member of the Armed Services Committee much of my time is devoted to ensuring that our troops have the necessary equipment and timely intelligence they need to fight the wars in Iraq and Afghanistan and to return home safely. However, I believe it is also critically important that our troops have confidence that if they are wounded in battle that they will be cared for in a manner that reflects the great sacrifices they have made for our country.

The wars in Iraq and Afghanistan are placing great strain not only on our armed forces but on the Veterans Administration (VA) as well. The VA has not experienced this level of casualties since the Vietnam War. Despite the committed work of many healthcare professionals within the VA, the system is having a tough time dealing with this new influx of wounded veterans, while addressing the needs of our others veterans who honorably served in previous conflicts.

As you know, since the beginning of the wars in Iraq and Afghanistan, more than 500 of our brave men and women in the armed forces have suffered major amputations resulting from wounds and injuries received in combat. Many of them have suffered multiple amputations. Our wounded servicemen and woman are now receiving world-renowned care and access to some of the most modern prosthetic technology available under the Department of Defense (DOD) healthcare system. Some of our amputee soldiers have even been able to return to duty. However, others, because of their own unique situations, are transitioning to the VA, a system they will be part of for the rest of their lives. I want to assure that the VA is well prepared to provide service and care for their advanced prosthetic devices. Some recent amputee veterans and veteran support groups have expressed reservations that the VA is currently too focused on convalescent care and does not have the resources and training to help these wounded men and women return to the active lives they led before their wounds.

During her testimony before the Senate Committee on Veteran Affairs last March, Major Tammy Duckworth, an Iraq war amputee and Director of the Illinois Department of Veteran Affairs, spoke about her difficulties transferring from the DOD healthcare system to the VA. She noted that the care she received as an inpatient at Walter Read Army Medical Center was exceptional, but her experiences with her local VA prosthetic facility were less positive. She pointed out that the VA prosthetics departments were "many decades behind" in technology and that VA staff, while eager to be helpful, lacked the knowledge and training to treat amputees at high tech levels set at Walter Reed and other major DOD healthcare facilities.

The Amputee Veteran Assistance Act is an important step toward addressing some of these shortcomings in the VA system. I would like to emphasize that this bill is not an indictment of the VA. The VA has played an important role in research and development in the field of prosthetics for many decades and should be commended for its efforts. Instead, it is a step toward giving VA personnel the training and resources they need to do their jobs better, while addressing the immediate concerns of our amputee veterans. It is my hope that this bill will help create a more personalized approach for our veterans. The field of prosthetics is as much of an art as it is a science. Each amputee veteran is a unique case with his or her own specific needs. My bill is not an attempt to create a "one size fits all" solution but to better prepare the VA to address a wide range of demands and give our amputee veterans greater options in the mean time.

This legislation will require that all VA prosthetic facilities and prosthesists be certified within 5 years by either the American Board for Certification in Orthotics and Prosthetics or the Board of Orthotics and Prosthetic Certification. Many of the VA facilities and prosthesists are already board certified but some are still lagging behind. It also allows amputee veterans to seek care for the repair and servicing of prosthetic devices from outside the VA system when VA facilities are unable to perform the required service or repairs or when a suitable VA facility is not available within a 55 mile radius. The VA will also be required to conduct a study to provide recommendations on modernizing its facilities and training its prosthesists so that it will be able to address the high tech needs of these amputee veterans. This report will allow us to get a better handle on what kind of resources the VA will need to address these problems. It also requires the VA to implement a plan to inform amputee veterans twice a year about the latest innovations in the field of prosthetics. Advances in the field of prosthetics continue rapidly and many amputee veterans may not be aware of some of the new options out there for them.

I know you will all agree that providing for our brave men and women in uniform who have sacrificed so much for our great nation is imperative. Today we have an opportunity to demonstrate to our disabled veterans our firm commitment to providing them with all possible means for living a full and rewarding life. Thank you for giving me the opportunity to testify before the committee. I will be pleased to answer any questions you might have.

United States Ombudsman Association
Des Moines, Iowa, 50325
June 13, 2007

Hon. Michael H. Michaud
Chairman, Subcommittee on Health
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Representative Michaud:

On behalf of the United States Ombudsman Association (USOA), thank you for your invitation to comment on H.R. 2192, proposed legislation to establish an ombudsman within the Department of Veterans' Affairs.

I have served as President of the USOA for 2 years and am the Deputy Ombudsman in the State of Iowa—Office of Citizens' Aide/Ombudsman. My short curriculum vitae is appended.

The USOA, a non-profit association, does not receive any federal funds and does not participate in any federal contract or grant, nor has it done so for the previous two fiscal years.

Founded in 1977, the USOA is our Nation's oldest and largest organization of ombudsmen working in government to address citizen complaints. The membership of the USOA includes practicing ombudsmen at all levels of government, some of whom have general jurisdiction over multiple agencies and subject matters, and others who have jurisdiction over a specified subject matter or agency. (Detailed information regarding the USOA can be found at the Association's website: http://www.usombudsman.org/.)

As a matter of good public policy, the USOA supports the establishment of independent ombudsman offices for the investigation and resolution of complaints involving administrative agencies in government at all levels. An ombudsman can serve as an independent office not only to address individual concerns, but also to identify systemic problems and recommend improvements in policies, practices, and procedures. An ombudsman can also help in the important effort to provide public and, indeed, legislative oversight of administrative agencies in government.

From this perspective we have reviewed the proposed legislation and offer these comments.

Key to the ability of an ombudsman to function effectively is independence. An ombudsman whose position, budget, staff, and investigations can be controlled or supervised by persons who (or whose actions or decisions) may be the subject of an investigation is not independent and will not be perceived as being independent. To the extent possible, an ombudsman should be structurally separated from the entities that are subject to the ombudsman's review or investigations. An ombudsman should be free to hire and fire staff, within the larger employment structure, manage the budget, select and prioritize the issues to be investigated and determine how they should be investigated. This independence allows the ombudsman to act and to be viewed by the public as acting as an impartial official who reports findings and recommendations based on objective review of the facts and the applicable law.

Structural Location

H.R. 2192 establishes the ombudsman *within* the Department of Veterans' Affairs. The USOA believes that the best way to make an ombudsman independent is by situating the ombudsman's office in the legislative branch of government. If that arrangement is not feasible, then we believe that everything reasonably possible should be done to maximize an ombudsman's independence within the branch of government or agency where the office is situated.

Appointment, Supervision, Term, and Removal

H.R. 2192 provides for the Secretary of the Department to designate the ombudsman. It does not specifically state to whom the Ombudsman reports for supervision or direction on job duties. Assuming that the ombudsman reports to the Secretary, the USOA believes that can compromise the independence of the ombudsman because the Secretary sets policies and makes decision relevant to the Department's programs and is the person ultimately accountable for decisions made by departmental staff. The ombudsman needs to be able to function without fear or concern that shat he/she says in regards to supervisory officials might affect his/her job.

For this reason, the USOA believes it would be best for the ombudsman to be appointed by Congressional action. If that is not feasible, an alternative is for the om-

budsman to be appointed by the President, with the advice and consent of the Senate (like an Inspector General) or a Congressional Committee.

Furthermore, the term of the office should be set in such a manner that it does not coincide with administrative terms of office. In addition, removal or dismissal from office within the term should be limited to "just cause," with relevant definitions specified in the legislation.

We urge inclusion of these provisions under subsection (a) to reinforce the independence of the ombudsman.

Ombudsman's Staff

Based on the experience of USOA members, we recommend a provision for the ombudsman to appoint at least a deputy or assistant ombudsman, to maintain consistent functioning of the office, in the event the ombudsman is absent or the position is vacant.

Authority to Investigate

Subsection (b), pertaining to duties of the office, states only that the ombudsman "shall act as a liaison for veterans and their family members." One of the hallmarks of an ombudsman function is the authority to investigate the agency which it oversees. The proposed legislation is silent in this regard. The USOA recommends that specific language be included in the legislation granting the ombudsman the authority to investigate complaints related to the healthcare program and benefits administered by the Department.

Authority to Access Information

H.R. 2192 is also silent regarding the ombudsman's ability to gather relevant information, including information which may be confidential by law. The duty to investigate ought to include the authority to have access to information and to issue subpoenas when necessary. While usually an ombudsman will be able to obtain information from an agency on an informal basis, there may be instances when the agency may resist or deny information. Therefore, we recommend adding such a provision regarding this authority. In addition, the provision may require the ombudsman to keep confidential any information which is confidential by law.

Authority to Issue Public Reports

Another important function that is also missing from H.R. 2192 is the authority to report the investigative findings and recommendations for improvements. Since ombudsmen do not have enforcement authority they rely on the ability to persuade an agency to take corrective action. The option to publicly criticize an agency enhances that ability. In addition, public reports can educate and inform those interested in or affected by the issues involved. An ombudsman cannot be effective without the duty to investigate and report. In addition, the ombudsman should submit an annual report to Congressional members and other officials with policy and operational oversight over the Department of Veterans' Affairs.

We recommend adding these duties to subsection (b) of the proposed legislation.

Confidentiality and Immunity

Subsection (d) provides for information provided to the ombudsman by veterans or their family members to be disclosed only as necessary to carry out the duties of the office. We recommend expanding this provision to grant the ombudsman immunity from being compelled to testify or produce complaint and investigative records in any legal proceedings, except as necessary to enforce or defend the authority of the office.

Closing

Thank you for allowing the USOA this opportunity to comment on the proposed legislation. We applaud your consideration of creating the ombudsman function, in the interest of improving the delivery of necessary services to our veterans and their families.

Sincerely,

Ruth Cooperrider
President
United States Ombudsman Association, and
Deputy Ombudsman
State of Iowa—Office of Citizens' Aide/Ombudsman

U.S. DEPARTMENT OF VETERANS AFFAIRS
Washington, DC.
August 19, 2007

The Hon. Bob Filner
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This letter is in response to your invitation to submit for the record the Department's views on two discussion drafts and H.R. 2623 and H.R. 2699. We received these legislative items too late to address them in the statement we submitted to the Subcommittee in connection with the June 14, 2007, legislative hearing.

Discussion Draft on Readjustment Counseling Services and Mental Health

Section 1 of this discussion draft would require the Secretary to establish a program to provide readjustment counseling and mental health services to eligible veterans through contracts with community mental health centers. Eligible veterans would include combat-theater veterans who seek VA care within the 2-year period after their discharge or release from service, who served in Operational Enduring Freedom or Operation Iraqi Freedom, and who reside in an area where the Secretary has determined the Department is incapable of providing readjustment and mental health services.

This provision would cover community mental health centers which: (1) meet qualification standards determined by the Secretary; (2) require appropriate staff to complete a VA clinical and cultural training program; and (3) employ a qualified veteran for the duration of the contract. These centers would also be required to submit information relating to the program's workload to the Secretary on an annual basis.

Section 1 would further require the Secretary to establish a program to provide support and assistance to the immediate family members of eligible veterans. Such assistance would include the provision of education materials and classes on mental health issues (including signs and symptoms of post traumatic stress disorder). This provision would also require the Secretary to provide individual counseling and mental health services (up to 2 years) to immediate family members, if requested.

Section 1 would also require the Secretary to establish a 5-year pilot program in at least four Veterans Integrated Service Networks (VISNs) to provide confidential readjustment counseling and mental health services to combat theater veterans at non-VA facilities. Under the pilot program, veterans would receive a voucher, coupon, or card that could be used to receive five visits with any provider on a Department-approved list.

For the reasons discussed below, the Department opposes section 1. First, it would blur the distinction between VA's readjustment counseling services and mental health services and work at cross-purposes with the existing programs. Additionally, these services are authorized by separate authorities and employ different eligibility criteria. These benefits should not be coupled because they are conceptually and operationally very distinct areas of treatment.

VA's authority to furnish readjustment counseling services includes authority to furnish limited mental health services necessary for effective treatment of the veteran's readjustment problems. Vet Centers provide professional treatment for combat-related Post Traumatic Stress Disorder (PTSD), depression, and substance abuse and, if necessary, refer the veteran to VA facilities for treatment of additional or more complex mental health needs. VA's readjustment counseling services encompass many other unique social and psychological readjustment services separate from mental health services. Readjustment counseling is considered to be a special, "more-than-medical," community-based counseling service providing an array of services to combat theater veterans to facilitate a successful readjustment from combat to civilian life. Vet Centers also have authority to furnish limited counseling, education, and training services to the veteran's immediate family members when such services are needed for the effective treatment and readjustment of the veteran. Family readjustment services include outreach, early intervention educational services, and family counseling. Family counseling is provided through the Vet Centers to treat any psychological, social or other military-related readjustment problems of the veteran whether those problems are service connected or not. We note that family services currently provided through Vet Centers are available throughout the life of the veteran. section 1 would provide individualized counseling and

mental health services for immediate family members for no more than 2 years, a significant reduction of the current benefit.

Comprehensive mental health services are furnished as medically needed to all enrolled veterans, regardless of combat-status, as part of VA's standard medical benefits package. VA already has authority to furnish certain family members with counseling, training, and education services. However that authority is extremely limited by statute and extends only to those family members of veterans receiving treatment for a service-connected condition. That authority also requires a nexus between the services furnished to the family members and the effective treatment of the veteran.

While we certainly appreciate that a veteran's family member may have his or her own mental health needs apart from the veteran's, we believe it is beyond the Department's statutory mission to furnish treatment or services to family members whose individual mental health needs are unrelated to the Department's ability to effectively treat the veteran.

Second, VA already has authority to contract for both readjustment counseling services and mental health services. Currently, VA contracts for readjustment counseling and related readjustment services with private sector community mental health agencies and other professional entities. We see no justification for limiting the entities with which VA may contract for these services, as the bill would do. Of note, most of our contract providers are located in rural areas. In providing mental health services, VA collaborates with publicly supported clinics in furtherance of VA's Mental Health Strategic Plan. Several existing contracting related authorities can be used to ensure a veteran receives needed mental health services if VA cannot timely provide the needed services in a timely manner. In this regard, section 1 is duplicative of VA's existing contract authorities and on-going activities.

Third, section 1 is not necessary because Vet Centers already provide veteran-peer outreach and counseling. In 2004, VA began an aggressive outreach effort, which included the hiring of combat-theater veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) to provide outreach services and peer-counseling to their fellow veterans. To date, the Vet Center program has hired 100 OEF and OIF outreach workers.

The Vet Center program is also undergoing the largest expansion in its history. The planned expansion complements the efforts of the Vet Center outreach initiative, discussed above, by ensuring sufficient staff resources are available to provide the professional readjustment services needed by the new veterans as they return home. In fiscal year (FY) 2006, VA announced plans for establishing two new Vet Centers in Atlanta, Georgia, and Phoenix, Arizona, and augmenting staff at 11 existing Vet Centers, bringing the current number of Vet Centers to 209. In February 2007, VA announced plans to increase the number of Vet Centers to 232 and augment the staff at 61 existing Vet Centers. The following communities will be receiving new Vet Centers: Montgomery, Alabama; Fayetteville, Arkansas; Modesto, California; Grand Junction, Colorado; Orlando, Fort Meyers, and Gainesville, Florida; Macon, Georgia; Manhattan, Kansas; Baton Rouge, Louisiana; Cape Cod, Massachusetts; Saginaw and Iron Mountain, Michigan; Berlin, New Hampshire; Las Cruces, New Mexico; Binghamton, Middletown, Nassau County and Watertown, New York; Toledo, Ohio; Du Bois, Pennsylvania; Killeen, Texas; and Everett, Washington.

In May 2007, VA announced a plan to add 100 new staff positions to the Vet Center program in FY 2008. Together with the 100 OEF and OIF outreach specialists hired in FY 2004 and 2005, these program expansions represent an increase in Vet Center staffing by 369 positions since 2004, a 39% increase.

Fourth, while well-intended, the pilot program required by section 1 could result in harm to a participating veteran. In most cases, five sessions is too few to ensure an adequate course of evidence-based treatment is delivered safely and effectively. A participating veteran may believe, in error, that upon completing the fifth visit that he or she has received a full course of treatment and no longer requires further assistance from the Department. The draft bill's arbitrary limit of five visits could create an unreasonable expectation on the part of the patient that he or she should be able to resolve their readjustment or mental health problems in that timeframe.

Moreover, the pilot program would fragment care and impede VA's ability to ensure veterans in the program receive the benefits of continuity of care. In sharp contrast, VA-furnished readjustment services and mental health services are delivered in a manner promoting the veteran's continuity of care. Under the readjustment counseling program, VA conducts site-visits to contract providers to verify the quality of readjustment counseling services being rendered to veterans. With respect to mental health services currently provided through Department medical facilities, these services are fully integrated. Of utmost importance, the patient's medical data

are maintained in the VA's electronic health record system, which further helps prevent fragmentation and ensure continuous high-quality care.

Finally, the Vet Center program reports the highest level of veteran satisfaction recorded for any VA program. For the last several years, over 99% of veterans consistently using the Vet Centers reported satisfaction with services received and indicated they would recommend the Vet Center program to other veterans. In view of the Vet Center's authorities and accomplishments, we oppose section 1 because it would amend the Vet Center program in a way that adds no value and results in substantial confusion between these benefits and those separately furnished under VA's mental health programs.

Section 2 of this discussion draft would authorize the Secretary to make a grant to a qualified entity to conduct workshop programs in the performing arts, public speaking, writing, and culinary arts to further the readjustment of veterans. Qualified entities would include a nonprofit private entity with expertise in conducting workshop programs or one that the Secretary determines has a program that is likely to improve the readjustment of veterans. A grant under this section could not exceed $100,000 for any calendar year and would need to be used exclusively for the benefit of veterans. section 2 would also authorize $2 million to be appropriated to carry out this section each fiscal year.

VA does not support section 2. It is not clear what appropriation it is intended that VA use for this authority. We would oppose using medical care funds for services that would not constitute medical care.

Second Discussion Draft on Programs for Homeless Veterans

Homeless Providers Grant and Per Diem Program

Section 1 would amend the Department's Homeless Providers Grant and Per Diem Program (the "Program") by requiring the Secretary to furnish funding assistance to grantees on an annual basis; currently the grantees receive per diem payments based on the provider's daily cost of care. It would also require the Secretary to annually increase the annual rate of payment to reflect anticipated changes in the grantee's cost of furnishing services and to take into account the cost of providing services in a particular geographic area. section 1 would further authorize the Secretary to establish a maximum annual amount that could be paid to a provider under the Program. Currently, the statutory cap on the per diem amount is the same that applies to per diem payments made to State homes.

Section 1 would also eliminate the current requirement that VA adjust the per diem rate to exclude other sources of income a provider receives for the purpose of furnishing services to homeless veterans. However, section 1 would permit the Secretary to continue collecting such information as needed to determine the provider's cost of care. section 1 would also allow grantees to use VA payments to match, or in combination with, other payments or grants for which the grantee is eligible.

The Department does not support section 1 in its entirety. Although payment on an annual basis would appear to ease the administrative burden of calculating daily per diem rates, it would not offer any incentive to providers for maintaining the census and level of services throughout the year for which the funding amount is awarded. Providing the grantee with an annual lump-sum payment would lessen a provider's accountability concerning the use of VA grant funds. This concerns us greatly. Also, this measure is unnecessary because the Department recently modified its system for determining per diem rates under the Program. This should make it much easier to determine the per diem rates and alleviate the administrative workload for both VA and the grantee.

However, VA supports the provision in section 1 that would establish a maximum rate that could be paid to grantees, VA's grant program for State homes and the grant program for homeless providers are too dissimilar to justify linking the maximum payment level as is currently done by statute. And VA has no objection to eliminating the requirement to adjust a grantee's per diem payment by excluding other sources of income from the provider's estimated daily cost of care. We note, however, that this provision would not prohibit a provider from receiving payments from VA and other sources that together exceed the grantee's actual cost of providing care or services to homeless veterans. We would therefore recommend that section 1 be modified to prevent a grantee from being able to receive more than 100 per cent of its actual daily cost of care.

The Department estimates the total cost of section 1 to be $88,388,137 for fiscal year 2008 and $1,479,329,118 over a 10-year period.

Dental Benefit for Homeless Veterans

Section 2 would eliminate the current requirement that in order to receive one course of dental services an eligible veteran must also be receiving care or services

for a period of 60 consecutive days in one of the specified treatment settings (domiciliary care, care in a therapeutic residence, community residential care, care from a grantee under the Program).

VA strongly opposes section 2. Without the 60-day treatment requirement, there is no means to ensure the homeless veteran gets his or her other medical needs addressed. The availability of the dental benefit often provides the only opportunity to connect a homeless veteran to other VA programs that can provide the veteran with more vital care. Also, a single course of dental care in the absence of other medical services does little to help homeless veterans lift themselves from their plight. Most homeless veterans suffer from substance or alcohol abuse problems and/or serious mental health conditions. These conditions make it difficult, if not impossible, for them to find and keep permanent housing and to secure gainful employment. If these veterans receive not only the one-course of dental care services but also medical services to help them rise above their homelessness, everyone's interests are served. VA data support this position: homeless veterans have a better rate of treatment success and experience longer stays in permanent housing if they complete their residential treatment programs. We therefore find no justification for changing the current program eligibility criteria,

The Department estimates the cost of section 2 to be $8.1 million for fiscal year 2008 and $98.1 million over a 1 a-year period.

VISN Staffing

Section 3 would require the Secretary to ensure that each VISN office assigns at least one full-time employee of the Veterans Health Administration (VHA) to oversee and coordinate VA's programs for homeless veterans. VA regards section 3 as unnecessary. VHA has already assigned a full-time employee to coordinate homeless veterans programs in every VISN and has fully funded those positions.

Grants to Repair and Replace Homeless Providers' Facilities

Section 4 would authorize the Secretary to make emergency grants, pursuant to criteria and requirements prescribed by the Secretary, to entities receiving grants under the Homeless Providers Grant and Per Diem Program for the purpose of repairing or replacing a grantee's facility that is damaged or destroyed by a major disaster.

VA supports section 4. Grantees receiving VA grants and per diem for furnishing care to homeless veterans under the Program lost their capacity to continue providing care and services (including transitional beds) in the aftermath of Hurricane Katrina. Desperately trying to find beds for their displaced veterans, the grantees whose facilities were damaged turned to VA for additional assistance. To assist them, VA had to rely on other departments which administer Federal laws and regulations managing the Federal response to disasters and national emergencies. This situation resulted in delays, which in turn lengthened the time displaced homeless veterans had to survive without services previously furnished by the grantee. All-but foremost the displaced homeless veterans previously served by the grantee—would benefit if VA were able to provide financial assistance to grantees in these types of catastrophic situations more quickly. However, we note that if a grantee's facility cannot be replaced or repaired, VA would still not have authority to award grants out-of-cycle to maintain capacity in the area(s) affected. We note that the costs for emergency activities of this nature are not typically available within existing funding levels.

Pilot Program for Permanent Housing

Section 5 would require the Secretary to conduct a 5-year pilot program to award grants to public or nonprofit entities with established single-room occupancy facilities for the purpose of (1) acquiring and operating single-room occupancy housing solely for the benefit of homeless veterans and (2) providing rental assistance on behalf of homeless veterans. Section 5 would also establish detailed reporting requirements and authorize $10 million for fiscal year 2008 and each subsequent fiscal year to carry out this pilot program.

VA does not support section 5. As a general matter, VA's statutory mission appropriately does not encompass permanent housing for homeless veterans. In our view, section 5 is a measure far better suited to the expertise, capacity, and mission of the Department of Housing and Urban Development. If enacted, VA estimates the cost of section 5 to be $5 million in fiscal year 2008 and $93 million over a 10-year period.

H.R.2623 Elimination of Co-payments for Hospice Care

H.R. 2623, as ordered reported, would exempt a veteran who is receiving inpatient or outpatient hospice care from all copayment requirements that would otherwise apply.

We support this measure.

H.R. 2699 amendments to VA's Homeless Providers Grant and Per Diem Program

Elimination of Adjustments to Per Diem Rate

Section 1 would repeal the requirement that the Secretary adjust the amount of per diem payable to a grantee under the Homeless Providers Grant and Per Diem Program by excluding income the grantee receives from other sources to provide services to homeless veterans. We refer the Committee to our comments on the discussion draft bill that included a similar provision and our concern that a grantee could receive more than 100% of its cost of care.

Demonstration Program for Members of the Armed Forces

Section 2 would require the Secretary to conduct, through September 3D, 2011, a demonstration program (at a minimum of three sites) for the purpose of identifying active duty members who are at risk of becoming homeless after they are discharged or released from service. The Secretary would also be required to provide (directly or by contract) referral, counseling, and supportive services to service members participating in the demonstration program. section 2 would also require the Secretary of Veterans Affairs to consult with the Secretary of Defense (and other appropriate officials) in developing the criteria for inclusion in the demonstration program. Finally, section 2 would authorize $2 million to be appropriated to carry out this demonstration project.

VA does not support section 2. There exist no reliable criteria for identifying which active duty members are at risk of becoming homeless once they leave the military, nor is there any reliable means for developing such criteria. VA could not carry out such a program.

Referral and Counseling Demonstration Program

Section 3 would expand. from 6 to 12, the number of sites participating in the Department of Labor's on-going demonstration program of furnishing referral and counseling services to veterans at risk of becoming homeless upon their release from certain institutions (e.g., penal institutions and long-term mental health facilities). section 3 would also eliminate this program's demonstration status and authorize it through September 30, 2011.

We defer to the views of the Secretary of Labor, who administers this program. We are aware, however, that this demonstration program has been very successful at reducing recidivism rates among the participating veterans and we therefore applaud Labor's success with this program.

Grants for Staffing Service Centers

Section 4 would permit service centers receiving grants under the Homeless Providers Grant and Per Diem Program to use those funds to meet mandated staffing levels. VA has no objection to section 4.

Domiciliary Care

Section 5 would require the Secretary to take appropriate actions to ensure that the domiciliary care programs of the Department are adequate to meet the capacity and safety needs of women veterans. VA does not support section 5 because it is unnecessary. The Department has on-going efforts to ensure the domiciliaries are able to meet the unique needs of women veterans and to ensure their privacy and safety while in that setting. Finally we note that the measure would also eliminate the authorization for appropriations for fiscal years 2003 and 2004 currently found in law. That authorization does not expire as may be suggested by the caption for section 5.

The Office of Management and Budget advises that there is no objection to the transmittal of this letter in regard to the program of the President.

Sincerely yours,

R. James Nicholson
Secretary

U.S. Department of Veterans Affairs
Washington, DC.
January 10, 2008

The Hon. Michael H. Michaud
Chairman
Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the requirements of section 212(c) of Public Law 109461, enclosed is the Department of Veterans Affairs' (VA) plan to improve access to quality long term care and mental health services for veterans residing in rural areas.

Similar letters have been sent to other leaders on the House and Senate Committees on Veterans' Affairs.

Sincerely yours,

James B. Peake, M.D.
Enclosure

Department of Veterans Affairs
Veterans Health Administration

Plan to Increase Access to Quality Long-Term Care and Mental Healthcare for Enrolled Veterans Residing in Rural Areas

January 2008

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I. *INTRODUCTION*

On December 22, 2006, the Information Technology Act of 2006, Public Law 109–461, was signed into law. Section 212 of this law established the Office of Rural Health (ORH) and, among other things, requires the Director of the Office of Rural Health to develop a plan to improve the access and quality of care for enrolled veterans in rural areas.

Specifically, section 212(c) states the plan shall include:

(l) Measures for meeting the long-term care needs of rural veterans; and
(2) Measures for meeting the mental health needs of veterans residing in rural areas

This plan addresses the specific actions underway in regards to mental health (MH) and long-term care (LTC). The plan includes a systematic evaluation of the current state of MH and LTC service provided by the Veterans Health Administration (VHA) and presents a strategy to increase access, either by enhancing existing services or developing new initiatives, to further advance access to quality MH and LTC services for veterans residing in rural areas.

II. *BACKGROUND*

A. *The Office of Rural Health (ORH)*

VA's Office of Rural Health was established in March 2006, in compliance with P.L 109–461 section 212 § 7308(c) under the VHA Office of the Assistant Deputy Under Secretary for Health (ADUSH) for Policy and Planning.

The mission of the office is to promulgate policies, best practices and innovations to improve services to veterans who reside in rural areas of the United States. The office is accomplishing this by assessing the delivery of services with a range of VHA program offices to ensure the needs of rural veterans are being considered as program development and implementation takes place. As a program office, the role of the ORH is to provide policy, guidance, and oversight within VHA to enhance the delivery of care by creating greater access, engaging in research, promulgating best practices and developing sound and effective policies to support the unique needs of enrolled veterans residing in geographically rural areas.

As specified in the Public Law, one of the key responsibilities of ORH is to conduct, coordinate, promote, and disseminate research into issues affecting veterans who reside in rural areas. With a strong collaboration between ORH and internal VHA program offices, ORH is also responsible to develop, refine, and promulgate policies, best practices and innovations to improve services. ORH will translate lessons learned into policy and facilitate broader execution through Patient Care Services (PCS).

B. *Definition of Urban/Rural/Highly Rural*

There is no single, universally preferred definition of *rural* that is used across either government or private sector agencies.[1] Currently, more than 15 definitions of *rural* are used by Federal programs. The two most commonly used classification systems are from the U.S. Census Bureau and the Office of Management and Budget. In order to be consistent with most commonly used definitions, VHA adopted a census bureau based classification system, where our definitions are:

Urban: A veteran (or clinic) located in a Census defined urbanized area.

Rural: A veteran (or clinics) not designated as urban.

Highly Rural: A veteran (or clinic) that is defined as rural and located in counties with less than 7 civilians per square mile.

For this plan, the term *rural* will refer to both *rural* and *highly rural* populations.

C. *Demographics*

The Census Bureau estimates approximately eight percent of the general population are veterans. In FY 2006, the Veterans Health Administration (VHA) had almost 7.9 million enrollees and served about 4.8 million unique patients. In fiscal year 2006, VHA identified approximately 39% (1,878,624) of the veteran patients served resided in rural areas and another one and six tenths percent (79,464) resided in highly rural areas. Of our enrollee population, approximately 36% (2,850,173) resided in rural areas and 1.5 percent (118,685) resided in highly rural areas (Attachment A).

D. *Current Services*

Long-Term Care (LTC)

Health care services, both within and outside VA, exist along a continuum consisting of: (1) ambulatory care, which is predominantly offered as primary care

[1] Choosing Rural Definitions. March 2007. Rural Policy Research Institute Issue Brief. Mueller, et. al.

(through Geriatric Primary Care or Geriatric Evaluation and Management programs when available) with use of urgent care and referrals for specialty services; (2) acute care which encompasses hospital-based acute and intensive/critical care; and (3) long-term care. Long-term care is a spectrum of medical and non-medical services provided for a prolonged period of time, to eligible persons with chronic, disabling conditions, delivered in institutional and non-institutional settings and can be either provided, purchased, or coordinated by VA. VHA provides long-term care through programs managed by the Office of Geriatric and Extended Care (GEC) and the Office of Care Coordination (GCC).

The GEC provides oversight for the majority of VHA's LTC programs. While LTC services are provided to veterans of all ages, the elderly comprise a major proportion of those needing LTC (two-thirds of the population using VHA LTC are over the age of 75). These LTC programs provide a continuum of increasingly resource-intensive services ranging from outpatient Geriatric Primary Care to institutionalized nursing home care. Veterans can receive services in one or more of VHA's LTC care programs concurrently based on need.

Veterans whose care needs exceed the resources for continued support in the home may require placement in settings where professional staff on site can support necessary self-care and health needs: VA operated nursing home care units, VA contracted community nursing homes, and the State Veterans Homes provide this form of long-term care. A final form of long-term care is offered to those whose disease process is anticipated to result in death. Palliative care focuses on the comfort-physical, mental, and spiritual-of-patients. The most well known form of palliative care is hospice, which is palliative care provided when death is expected in 6 months or sooner. VA provides hospice and palliative care in a continuum of environments, both institutionally and in-home care, as well as linking with community services through participation in Hospice-Veteran Partnerships to improve veterans' access to community hospice care in rural areas.

VHA's strategic direction since the enactment of the Veterans Millennium Health Care and Benefits Act, P.L. 106–117 (Nov. 30, 1999), has been to develop and offer community and home-based alternatives to nursing home care. When veterans are unable or limited in their ability to come to a VA facility for care, this strategic direction is to bring care closer to the veterans and to enhance the veteran's ability to remain in his or her customary place of residence. To meet this need, VA has several non-institutional programs, including Home Based Primary Care (HBPC), which provides comprehensive longitudinal care by an interdisciplinary team in the homes of veterans with complex chronic disabling disease. Additional initiatives to increase rural veterans' access to care include establishing satellite HBPC programs at remote sites such as Community Based Outpatient Clinics (CBOC) and an expansion of the Office of Care Coordination's Care Coordination Home Telehealth (CCHT) program into 155 VA facilities and clinics nationwide. CCHT uses home telehealth technologies to enhance and extend care and case management in the home for veteran patients with chronic diseases. These veterans are monitored at home using telehealth technology that transmits vital sign measurements and symptoms to a VA care coordinator. CCHT reduces clinical complications, increases access to care when it is needed, and prevents or delays elderly veterans from being admitted into long-term institutional care.

Other non-institutional LTC services that are available include, but are not limited to, Community Residential Care (including Medical Foster Home), Adult Day Health Care, Homemaker/Home Health Aide, outpatient respite services, and purchased skilled home care. To develop future opportunities for greater access to care for veterans, collaborations with other Federal entities such as the Administration on Aging, Indian Health Service, and the Health Resource Services Administration have been established.

Mental Health

Comprehensive and effective mental healthcare is a top priority for VA. VA is making changes to address veterans' needs and is investing significantly to improve access to mental health services for veterans residing in rural areas and throughout the country. Mental health services are available at all VHA outpatient clinics either from primary care staff, who are trained to manage many common mental health problems, or from mental health specialists, who can manage a full range of mental healthcare needs. VA also provides readjustment services through the Vet Center program, which is designed to provide quality readjustment counseling and some related mental health services, for combat veterans and family members (to the extent necessary for successful readjustment for the veteran).

The advancement of technology has increased the range of specialty mental health services that can be provided in rural areas, creating greater access for these vet-

erans. VA's Office of Care Coordination (OCC), in collaboration with the Office of Mental Health Services (OMHS), has developed telemental health programs, which involve the use of health information and telecommunications systems to enable delivery of care when veteran patients and clinicians are separated by geographical distance. Telemedicine equipment has been deployed to VA facilities and their corresponding CBOCs, thus building an infrastructure to provide expert telemental healthcare where direct access to mental health specialists is unavailable. The advantages of telemental health are that it improves access to mental health services, reduces the need for travel by patients and is associated with preliminary evidence that it reduces the "no show" rate in clinics.

Additionally, VHA has implemented care coordination home telehealth (CCHT) to support the care of veteran patients with chronic mental health conditions in their homes and local communities. Another example of VA telemental health programs is the collaboration with the Indian Health Service where VA provides services on several reservations.

VA OMHS is also meeting the needs of rural veterans through the pilot implementation of the Mental Heath Intensive Case Management—Rural Access Network for Grouth Enhancement (MHICM–RANGE) program, where VA provides community based support for veterans with severe mental illness. Other programs include the use of referrals for fee-based mental health services in Community Mental Health Centers and a program that sends VA mental health providers to Community Mental Health Centers where they can use laptop computers for Computerized Patient Record System (CPRS) access. Still other efforts include integrating psychologists into the Home Based Primary Care program and adding mental health professionals to the staffs of CBOCs.

III. *PLAN*

The Office of Rural Health (ORH) has collaborated with an array of subject matter experts within VHA program offices to develop a plan to improve access to quality mental health and long-term care for veterans residing in rural areas. This plan takes the results from an internal programmatic assessment and either expands current services to increase focus on rural veterans or identifies new initiatives to meet the long-term care and mental health needs of rural veterans. The performance period is FY 2008.

A. ***Goal:*** To increase access to quality mental health and long-term care services for veterans residing in rural areas.

B. ***Long-Term Care Initiatives***

1. Expand access to VA's innovative non-institutional LTC services for veterans residing in rural areas by supporting the Office of Geriatrics and Extended Care (GEC) and the Office of Care Coordination (OCC) in implementing additional programs that serve rural veterans. Programs include:

   a. Home Based Primary Care (HBPC)
   b. Care Coordination Home Telehealth (CCHT)
   c. Medical Foster Home program

   Milestone: During FY 2008 establish CCHT programs in all 21 Networks and at most facilities

2. Conduct a baseline assessment of the average daily census (ADC) in non-institutionalized settings for veterans residing in rural areas for the following programs:

   a. Home Based Primary Care (HBPC)
   b. Care Coordination Home Telehealth (CCHT)
   c. Medical Foster Home program

   Milestone: Completion of baseline by 4th Quarter, FY 08 and completion of plan by 1st Quarter FY 09

3. Fund at least two studies or demonstration projects that address issues of long-term care, institutional or non-institutional, access or quality for veterans residing in rural areas.

   Milestone: Develop a Request for Proposals (RFP) and select projects by 4th Quarter, FY 08

4. Create an Office of Rural Health Web site to give veterans greater access to information and research.

Milestone: 4th Quarter, FY 08

5. Establish a Rural Health National Advisory Committee (RHNAC) to examine ways to improve and enhance VA services for enrolled veterans residing in rural areas through evaluation of current program investment, policy, and barriers to providing services as well as the development of strategies to improve services. The RHNAC will be comprised of experts within the federal, non-federal, academic, and veteran community.

   Milestone: Charter developed by 3rd Quarter, FY 08

6. Develop strategies and incentives to support recruitment and retention of staff to provide geriatric care in rural settings, including those stationed on a full-time basis within rural settings, those who rotate between facilities, and those utilizing telehealth services for care delivery.

   Milestone: Ongoing activity in FY 08

C. *Mental Health Initiatives*

1. Expand the Mental Health Intensive Case Management-Rural Access Network Growth Enhancement (MHICM–RANGE) pilot program into additional rural areas where need is identified.

   Milestone: 3rd Quarter, FY 09

2. Increase the capacity to provide telemental health services from VA facilities over the FY 07 baseline.

   Milestone: Ongoing initiative, FY 08

3. Evaluate strategies and the feasibility of implementing VA collaborations with non-VA entities to expand telemental health linkages between VA providers and patients in community settings.

   Milestone: Assessment by 4th Quarter, FY 08

4. Through VHA's Strategic Planning process, assess rural geographic areas identified as underserved markets based on VHA's drive time access standards to primary care (which includes access to mental health services) and develop plans for addressing gaps in care.

   Milestone: 4th Quarter, FY 08

5. Require each VA medical center or clinic to develop plans for the delivery of VA mental health services by using on-site providers, telemental health, referral to other facilities, or referral to community providers as appropriate.

   Milestone: Implementation of plans by 4th Quarter FY 08

6. Assess the degree to which CBOCs defined as *rural* or *small* (<1500 unique veterans) provide timely delivery of mental health services completing an initial evaluation within 24 hours of veteran referral and for a full diagnostic and treatment planning evaluation for non-urgent cases within 14 days.

   Milestone: 4th Quarter FY 08

7. Develop metrics to serve as quality monitors for the delivery of mental health services in rural areas, in collaboration with mental health services.

   Milestone: Development of metrics by 4th Quarter FY 2008

8. Fund at least two studies or demonstration projects that address issues of mental healthcare, access or quality for veterans residing in rural areas.

   Milestone: Develop a Request for Proposals (RFP) by 4th Quarter, FY 08. Select and begin initiatives by 4th Quarter, FY 08

9. Create an Office of Rural Health Web site to give veterans greater access to information and research.

   Milestone: 4th Quarter, FY 08

10. Develop strategies and incentives to support recruitment and retention of staff to provide mental healthcare in rural settings, including those stationed on a full-time basis within rural settings, those who rotate between facilities, and those utilizing telemental health services for care delivery.

    Milestone: Ongoing activity in FY 08

11. Develop a Rural Health National Advisory Committee (RHNAC) to examine ways to improve and enhance VA services (including mental health services) for enrolled veterans residing in rural areas through evaluation of current program investment, regulatory policy, and barriers to providing services as well as the development of strategies to improve services. The RHNAC will be comprised of experts within the federal, non-federal, academic, and veteran community.

    Milestone: Charter developed by 3rd Quarter, FY 08

IV. *BARRIERS TO RURAL HEALTH CARE*

The ORH has systematically identified barriers to delivery of accessible high quality care in rural America. Initial findings include:

A. *Long-Term Care*

Meeting access and quality standards in rural areas is a challenge for both VA and non-VA healthcare systems. This is because rural veterans live farther from Veterans Administration Medical Center-based, tertiary care options (which are largely in urban areas in order to meet the needs of the larger concentrations of veterans), greater delay and disease exacerbation before care is accessed, less local availability to specialty and geriatrics expertise, and greater likelihood referrals to tertiary care centers will be unfulfilled. The intrinsic challenges of providing LTC in less populous areas and over wider geographic distances are exacerbated by the worsening undersupply of trained professionals that characterizes rural settings.

Additional challenges to rural, elderly veterans include: limited transportation services; frail, elderly primary care givers with few resources; preferential relocation to urban areas of younger family members who might otherwise provide non-professional support services and care giving; higher poverty rate; a lower level of awareness of those services that may be available, and more constricted financial resources.

B. *Mental Health*

The provision of mental healthcare in rural settings has historically been a challenge for all health systems and providers, including VA. While Community Based Outpatient Clinics (CBOCs) have been the anchor for VHA's efforts to expand access to veterans in rural areas, there are notable challenges in providing mental health services in rural communities, such as:

- Availability of qualified mental health professionals in small rural communities is often limited.
- Very small rural CBOCs may require mental health specialists too infrequently to justify even part-time on-site mental health staff. However, telemental health at remote clinics, where feasible, has proven to be convenient and is generally well accepted by veterans.
- VA salaries at times are not competitive in specific locations, both rural and urban.
- Transportation to and from CBOCs is problematic for many veterans living in sparse population areas. However, telemental health at remote clinics, where feasible, has proven to be convenient and is generally well accepted by veterans.
- VHA's CBOCs are complemented by contracts in the community for specialty services. The range of specialty care services is highly dependent on the services available in the local community.
- Constraints on the expansion of telehealth in VHA, as in all organizations, include clinical (e.g. clinician buy-in and training of clinicians), technical (e.g. interoperability of technologies, telecommunications bandwidth availability, a national video-telecommunications, and adequate scheduling systems) and business processes (e.g. clinical coding and reimbursement systems).

While these barriers exist, the ORH will leverage VA's capabilities and develop partnerships with governmental and non-governmental entities to provide the best solutions to the challenges that rural veterans face. Areas of focus include: tech-

nology expansion, transportation, research and evaluation, workforce recruitment and retention, and education and training. By using a data-driven decisionmaking and collaborative approach to develop policies and practices that expand and adapt current initiatives, as well as developing new models of care delivery, the ORH will improve access to high quality healthcare care for rural veterans.

V. *CONTINUOUS IMPROVEMENT*

VA's plan to increase access and quality mental health and long-term care services to veterans residing in rural areas will be implemented, evaluated, and undergo continuous improvement. Prior to implementation of initiatives outlined in the plan, the Office of Rural Health will consult with the Office of Geriatric and Extended Care, the Office of Care Coordination, and the Office of Mental Health Services within the Office of Patient Care Services, and other VA offices as appropriate, to assess feasibility and identify barriers that could affect the successful implementation of the initiatives.

Attachment A

Veteran Enrollee and Patients by Urban/Rural/Highly Rural Designations

Total Enrollees	Urban Enrollers	Rural Enrollees	Highly Rural Enrollees	Rural & Highly Rural Enrollees
7,848,282	4,879,424	2,850,173	118,685	2,968,858
100.0%	62.2%	36.3%	1.5%	37.8%

Total Patients	Urban Patients	Rural Patients	Highly Rural Patients	Rural & Highly Rural Patients
4,877,733	2,919,645	1,878,624	79,464	1,958,088
100.0%	59.9%	38.5%	1.6%	40.1%

Attachment B

VETERAN ENROLLEE DRIVE TIME ACCESS STANDARDS

Access standard for Primary Care (includes mental health).
Seventy percent of enrollees within a market meet the following drive time standards:
30 Min.—Urban
30 Min.—Rural
60 Min.—Highly Rural

Attachment C

Acronyms

ADC—Average Daily Census
CBOC—Community Based Outpatient Clinics
CCHT—Care Coordination Home Telehealth

CPRS—Computerized Patient Record System
GEC—Office of Geriatric and Extended Care
HBPC—Horne Based Primary Care
LTC—Long-Term Care
MH—Mental Health
MHICM-RANGE—Mental Health Intensive Case Management—Rural Access Network Growth Enhancement
NHC—VA Nursing Home Care
OCC—Office of Care Coordination
OMHS—Office of Mental Health Services
ORH—Office of Rural Health
PCS—Patient Care Services
RFP—Request for Proposals
RHNAC—Rural Health National Advisory Committee
VA—Department of Veterans Affairs
VHA—Veterans Health Administration

Program Analysis Officer
GS–340–15
Office of the Assistant Deputy Under Secretary for Health for Policy and Planning
Veterans Health Administration
Department of Veterans Affairs

Under the general guidance of the Assistant Deputy Under Secretary for Health (ADUSH) for Policy and Planning, incumbent provides leadership, advice and subject-matter expertise in tasks, projects and assignments related to rural health policy development, analysis, decision making, and implementation activities affecting the entire VA healthcare system. Incumbent serves as Director, Office of Rural Health.

Incumbent functions in a supervisory capacity in contributing to attainment of Department of Veterans Affairs (VA) and Veterans Health Administration (VHA) goals and objectives with regard to rural health. In this capacity, the incumbent works very closely with other key Departmental Officials on cross-cutting programs and issues and is responsible for the for the planning, direction, coordination, development, and implementation of rural health programs and projects.

DUTIES AND RESPONSIBILITIES

Directs and leads the development and implementation of the Veterans Health Administration Office of Rural Health to address healthcare needs of veterans in the rural and highly rural areas.

Researches, plans, develops, implements, and evaluates policy and programs to improve the access and delivery of healthcare services in rural and highly rural areas for the planning and implementation of appropriate healthcare to improve access and improve the quality of healthcare services and enhance the access and delivery of healthcare in rural and highly rural areas for veterans.

Addresses key issues, such as,

- improves communication and coordination among key VA health providers and medical administrators within and across the VHA and other government healthcare providers, such as, the DHHS in the rural and highly rural areas;
- enhances access to select services, (e.g., prescription drugs, non-emergency medical transportation, chronic disease management programs, mental health and long term healthcare);
- improves travel times and evaluates transportation needs;
- provides quality health assessment data to promote information-based health policy and planning; and
- Investigates and improves the capacity of VA rural and highly rural healthcare from infrastructure to staffing needs.

As the focal point within VHA and the Department for monitoring rural health issues and coordinating Department-wide efforts to strengthen and improve the delivery of veterans health services to populations in rural areas, the Director

- coordinates rural health activities within the Department;
- oversees the collection and analysis of information regarding the special problems and needs of rural healthcare providers;

- maintains a clearinghouse for the collection and dissemination of information and research related to veterans rural health services;
- manages rural health services outreach projects and network development, and support;
- conducts or provides contracts for the conduct of specific rural health studies and activities directed toward specific rural issues; and
- responds to inquiries on rural health matters from the Congress and the public and private sectors.

Directs the conduct of complex qualitative and/or quantitative analysis to assess patient care trends and anomalies in rural and highly rural settings.

Leads and coordinates technical, professional and administrative ad hoc teams established to conduct comprehensive studies on patient care in rural and highly rural settings; the conclusions of which are recommended to management for decisions, relative to the design and development of new, or the curtailment or modification of existing patient care delivery.

Serves as the primary link between the Assistant Deputy Under Secretary for Health (ADUSH) for Policy and Planning and other executive staff and key offices within the Veterans Health Administration (VHA), the Office of the Under Secretary for Health and other appropriate offices, congressional offices and Committees, and other Federal agencies, and a wide variety of external groups and organizations with regard to rural and highly rural health issues.

Counsels the ADUSH for Policy and Planning and key management in the development and implementation of policies, plans, guidelines, and proposals for patient care in rural and highly rural settings. He/she develops written documents for a wide range of matters, including the development or the implementation of policies, practices, or other operational and management activities. Conclusions, findings, recommendations and reports are in many instances used by top VA management to make management decisions and to develop policy.

Acts as a representative of the ADUSH for Policy and Planning on interpretation of policy, in public relations issues, and in reconciling conflicting interpretations and differences among the Rural and Highly Rural staff nation-wide.

Serves as a member of various Committees as designated by the ADUSH for Policy and Planning with Administrative and other key officials, other government agencies, and organizations outside the Federal Government and represents the ADUSH for Policy and Planning.

The incumbent plans, organizes, and carries through to completion program plans, program/policy analyses, data collection, legislative interpretation, and analytical studies involving Federal and VA programs and policies on patient care in rural and highly rural settings.

Coordinates special studies and projects with other agencies within the Department to ensure involvement of the appropriate Departmental officials, as well as involvement by outside groups. Provides technical and policy advice on healthcare financing and rural healthcare proposals reflecting the Administration's objectives and priorities.

Promotes effective communication and coordination of departmental activities with other Federal agencies and outside organizations. Communicates the policies and positions of the Department to governmental and private organizations concerned with the provision of veterans' healthcare in rural areas.

Explains a variety of policies and/or procedures to VA officials and resolves problems of a highly complex nature. May resolve issues independently or make recommendations for resolution. Coordinates critical and sensitive office correspondence with top management of the Department.

Directs comprehensive studies from which to analyze and evaluate the needs, strategic plans, and goals of the Office of Rural Health, and makes recommendations for new directions, initiatives, policies and procedures. S/he participates in senior management decisions regarding strategic planning and priority-setting for these activities.

Ensures coordination of reports, evaluations and follow up actions. Identifies deficiencies or problems and consults with the ADUSH for Policy and Planning for problem resolution

Supervises the staff of the Office of Rural Health. Plans and assigns work to be accomplished. Evaluates performance; gives instructions on work and administrative matters; interviews and selects candidates for subordinate positions; hears and resolves employee problems; and takes disciplinary measures and recognizes noteworthy contributions as warranted.

Identifies and makes provisions for the training of staff as needed. Assures that staff in the Office of Rural Health maintain state of the art knowledge in this pro-

gram area. Assures and oversees that staff are remaining current with the availability of relevant literature, and also with applicable regulations, manual, and other related policies. Maintains competency of self and existing staff and encourages use of resources and continuing education courses.

Performs other duties, as assigned.

SCOPE

The incumbent is a national level resource, responsible for directing and supervising the conduct of complex analysis, design, development, technical support work; providing assistance to VA Central Office and Field units throughout the VHA system; and utilizes existing tools and/or recommends the development of new processes and applications to troubleshoot problems and meet specified business needs, having a cross organizational affect on Department-wide administrative policies and programs, as they relate to providing medical services in an effective environment to veterans nationwide.

The incumbent will have expert knowledge of analytical and evaluative methods plus a thorough understanding of how regulatory or enforcement programs are administered to select and apply appropriate program evaluation and measurement techniques in determining the extent of compliance with rules and regulations issued by the agency, or in measuring and evaluating program accomplishments. This may include evaluating the content of new or modified legislation for projected impact upon the Agency's programs and resources.

EFFECT

The incumbent directs the completion of significantly complex administrative, technical and analytical projects such as qualitative and quantitative studies of patient care delivery in rural and highly rural settings; data analysis to determine customer satisfaction with care provided in rural and highly rural settings; development of tools and metrics to monitor the outcomes of newly established or implemented policies and procedures to enhance patient care in rural and highly rural settings. The work significantly affects Department-wide VHA business requirements, veterans using VHA medical facilities, stakeholders and end user customer satisfaction.

This incumbent will be skilled in planning, organizing, and directing team study work and in negotiating effectively with management to accept and implement recommendations, where the proposals involve substantial agency resources or may require change in procedures.

The incumbent will have a mastery of advanced management and organizational principles and practices along with a comprehensive knowledge of planning, program and budget regulations, guidelines and process, and thorough knowledge of the Agency's planning, acquisition, and management process to prepare long-range and short-range planning guidance in accordance with broad agency program policies and objectives.

ORGANIZATIONAL SETTING

The incumbent reports directly to the Director of Policy Analysis and Forecasting, an SES position and is accountable to the VHA Assistant Deputy Under Secretary for Health for Policy and Planning, who encumbers a SES Position.

SUPERVISORY & MANAGERIAL AUTHORITY EXERCISED

The incumbent directs and supervises a staff of highly analytical and technically skilled specialist, and professionals, which may include contract staff. Decides methodologies to use in achieving program objectives or to determine which goals and objectives to emphasize. In addition, he/she serves as an active team member for projects encompassing the development, maintenance and improvement of patient care in rural and highly rural settings.

The incumbent plans work to be accomplished by subordinates, sets and adjusts short-term priorities, and prepares schedules for completion of work; assigns work to subordinates based on priorities, selective consideration of the difficulty and requirements of assignments, and the capabilities of employees; gives advice, counselor instruction to employees on both work and administrative matters; evaluates subordinate performance and identifies developmental and training needs for employees, providing or arranging for needed development and training; finds ways to improve production or increase the quality of the work of subordinates and develops performance standards for supervised staff'; hears and resolves minor complaints from employees, referring group grievances and more serious unresolved complaints to a higher-level management; Prepares and updates position descriptions and performance plans for subordinate employees; interviews applicants, develops criteria for selection of best candidate and recommends or makes selection; and approves/

disapproves leave, makes work assignments, resolves work conflicts and implements established or management approved policies, as it relates to customer service and support.

PERSONAL CONTACTS

Nature of contacts: Contacts include VA program officials representing VACO VHA, Staff Offices, OI&T, VHA field offices, VA Medical Centers, VISN Offices, Congressional Offices, etc. Contacts also include communication media, consultants, affiliated universities, professional organizations and associations. Contacts take place in planned or unscheduled meetings, including presentations, conferences, hearings, etc. As requested, the incumbent prepares reports or responses for Congress, executive branch agencies such as the Office of Management and Budget, Agency for Health Care Policy and Research and foundations such as Academy Health, or media audiences, working through appropriate VA offices. Meets and addresses constituency, advocacy and national and local veterans groups, as well as Congressional staff and professional associations

Purpose of Contacts: Contacts are designed to meet several objectives, including: developing appropriate collaborative relationships for sharing information among colleagues and agencies with similar interests; communicating information about the Office of Rural Health's programs, plans, and strategies; obtaining information from well-known rural health experts; to influence managers or other officials to accept and implement findings and recommendations on organizational improvement or program effectiveness; and to effectively provide advice and counsel to management on the resolution of patient care in rural and highly rural settings problem issues. The incumbent may encounter resistance due to such issues as organizational conflict, competing objectives, or resource problems. He/she must be familiar with congressional and legislative activities bearing upon VHA Rural Health Care program activities.

DIFFICULTY OF TYPICAL WORK DIRECTED

The highest graded non-supervisor work directed, which requires at least 25% of this position's duty time, is GS–14 or higher, or equivalent.

The incumbent directs and supervises the work of approximately two subordinate employee's performing highly analytical, specialized, technical and administrative work.

This position manages through subordinate supervisors and/or contractors who each direct workloads comparable to GS–12 or higher.

Identifying the nature of issues or problems in planning, organizing, and determining the scope and depth of rural health studies, and discerning the intent of legislation and policy statement and how to translate the intent into program actions is extremely complex.

The incumbent provides high-level operational and program management leadership. The work is highly varied, visible, and subject to an exceptional level of scrutiny by stakeholders and advocacy groups within and outside the system.

TRAVEL

Position requires 25% overnight travel.

OTHER CONDITIONS

The attention paid to the Office of Rural Health is very significant. The incumbent must carefully coordinate the myriad efforts of the Office's diverse portfolio, ensuring attention to all these politically sensitive issues. All this must be accomplished in an environment of extraordinary oversight of activities by advocates within and outside the Department. The incumbent must deal with demands, expectations, and oversight at a very high level.

This work requires familiarity with a broad range of topics and current issues related to the provision and outcomes of rural healthcare, and to the conduct of research on those issues. This includes general knowledge of concepts and methods drawn from healthcare administration, scientific review and evaluation, public health, and other health organizations. The incumbent must be a critical thinker with excellent writing and organizational skills.

Requires expert level knowledge of the principles and practices of the following disciplines as they relate to rural health: healthcare management, resource management, and policy development, in order to provide consultation/advice to the ADUSH for Policy and Planning in healthcare administration and organizational management matters.

The incumbent is responsible for extensive coordination and integration of work efforts related to rural health policy development associated with a national healthcare delivery system. The incumbent makes major recommendations that have a di-

rect and substantial impact on current and future rural healthcare initiatives. The incumbent must be thoroughly familiar with the Department's programs, objectives, operations, and the interrelationships among these as well as those of other federal agencies, Congress, etc.

Mastery of program and organizational analysis principles, methods, practices and techniques; analytical methods; and interpersonal relations practices. Skill to apply this mastery in developing new methods and approaches in planning, integrating and evaluating rural health programs for the agency. Knowledge and skill to advise other specialists in and outside the agency, as well as top managers and decision-makers, on issues of developing, communicating, or enhancing program matters involving interaction with all of the agency's publics, both nationally and internationally.

Because of the sensitivity inherent in analyses and recommendations made by the VHA Office of Rural Health, the incumbent is expected to elicit a high and sustained level of collaboration and trust with VA program managers. The incumbent must also demonstrate marked qualities of diplomacy, patience, and persistence, professional deportment, and discretion suited to all levels of VA management. The incumbent develops and implements systems and processes to gather and analyze the information needed to make strategic and tactical decisions.

OTHER SIGNIFICANT FACTS

Customer Service: Incumbent meets the needs of customers while supporting VA missions. Consistently communicates and treats customers (veterans, their representatives, visitors, and all VA staff) in a courteous, tactful, and respectful manner. Employee provides the customer with consistent information according to established policies and procedures. Handles conflict and problems in dealing with the customer constructively and appropriately.

ADP Security: Incumbent protects printed and electronic files containing sensitive data in accordance with the provisions of the Privacy Act 1974 and other applicable laws, federal regulations, VA statutes and policy, and VHA policy. Employee protects the data from unauthorized release or from loss, alteration, or unauthorized deletion. Follows applicable regulations and instructions regarding access to computerized files, release of access codes, etc., as set out in the computer access agreement that the employee signs.

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