

LEGISLATIVE HEARING ON H.R. 2790, H.R. 3458,
H.R. 3819, H.R. 4053, H.R. 4107, H.R. 4146,
H.R. 4204, AND H.R. 4231

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, JANUARY 17, 2008

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

The Subcommittee met, pursuant to notice, at 10:01 a.m., in Room 340, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Snyder, Hare, Miller, Moran.
Also Present: Representative Brown-Waite.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. Why don't we get started. It is my understanding we have votes at 11:30, so we will try to move this along so we can hear everyone.

I would like to thank everyone for coming here today. Today's legislative hearing is an opportunity for Members of Congress, veterans, the U.S. Department of Veterans Affairs (VA) and other interested parties to discuss recently introduced legislation that comes under this Subcommittee's jurisdiction.

I do not necessarily agree or disagree with the bills before us today, but I believe that it is an important process, that we encourage a frank discussion of new ideas. We have eight bills before us today. I look forward to hearing the testimony on these bills.

And I would turn it over to Mr. Moran if he has an opening statement.

[The prepared statement of Chairman Michaud appears on p. 32.]

OPENING STATEMENT OF HON. JERRY MORAN

Mr. MORAN. Mr. Chairman, thank you very much. I am happy to serve as the acting Ranking Member until Mr. Miller arrives, and I am interested in hearing the testimony from our colleagues on a variety of issues affecting veterans across the country.

And I am of the opinion that oftentimes we get some of our best ideas in this Committee by listening to colleagues who do not serve with us on the House Veterans' Affairs Committee, and I welcome the two gentlemen that are with us already this morning and look forward to hearing what they have to say.

I thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much.

I now would like to recognize Mr. Hare who also serves as a member of this Committee and a very strong advocate for our veterans.

Mr. Hare.

STATEMENTS OF HON. PHIL HARE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS; HON. STEPHANIE HERSETH SANDLIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA; HON. ZACK SPACE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO; AND HON. SHELLEY MOORE CAPITO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

STATEMENT OF HON. PHIL HARE

Mr. HARE. Good morning. Thank you, Mr. Chairman. Thank you for holding this hearing today, and I am pleased to provide testimony in support of H.R. 2790, the bill I introduced to elevate the current Physician Assistant (PA) Advisor to the Veterans Affairs Under Secretary of Health to a full-time Director of PA Services in the VA's Central Office.

I would like to thank my colleague, Representative Jerry Moran, for his leadership with me on this bill, as well as Chairman Filner, and Representatives Berkley, Corrine Brown, and Doyle for joining us as cosponsors of the bill.

PAs have long been a critical component in providing care in the Veterans Health Administration (VHA) with nearly 1,600 PAs currently employed, many of whom are Reservists, Guardsmen, and veterans. While the PA advisor position has been valuable in establishing guidelines for utilizing PAs, we do see unnecessary restrictions on PA use, and too many problems still exist.

I do not believe that Congress' original intent for a position has been fulfilled. Confusion still exists about the medical services PAs can provide from facility to facility.

VA facilities are telling PAs that they cannot and will not hire PAs and, most critically, the PA advisor has been excluded from critical planning and policy development.

These issues not only hinder the ability of PA advisors and PAs currently employed by the VA, but they also discourage PAs from even entering the VA system.

Without the PA advisor being able to fully perform his or her role in the full-time Director position, the VHA is missing a clear opportunity to improve the quality of healthcare for our veterans. Quite simply, this is a position that needs to be made permanent and be based on the VA's Central Office.

The lack of establishing the Director position ignores a valuable resource in improving care, prevents improvements in the recruiting and retention of the PA workforce, and disregards utilizing a critical aspect of the VHA workforce.

Considering the fact that nearly 40 percent of all VA PAs are projected to retire in the next 5 years, the VA is in danger of losing its PA workforce unless some attention is directed toward the recruitment and retention of this critical group.

One of the biggest challenges currently facing future PAs in the VA system is their exclusion from any recruitment and retention efforts or benefits.

The VA designates physicians, nurses as critical occupations and so priority and scholarships and loan repayment programs go to these critical occupations. However, the PAs have not been designated as a critical occupation, so no monies are directed their way.

This is despite the fact that the VA has determined PAs and Nurse Practitioners (NPs) to be functionally interchangeable and equal in the work that they perform. Many of these problems could be addressed by a Director of PA Services.

H.R. 2790 would legitimize and recognize the role PAs play by creating a permanent Director that would serve as a clear voice in strategic planning, policy, and staffing development initiatives, as well as an advocate for the physician assistants.

The VA's position on my bill is that the status quo is working just fine and that no change is necessary. I strongly disagree with that position. The VA prefers a field-based position and thinks that only 75 percent of the individual's time is necessary to devote to PA patient-care issues in the VA.

However, even though the VA opposes this legislation, VHA Under Secretary for Health, Dr. Kussman, said he intended to make the PA advisor a full-time position in the VA's Central Office.

There is no significant cost to elevating and relocating this individual position. This change is common sense and it promotes quality medical care for our veterans.

This bill is supported by the American Academy of Physician Assistants (AAPA), the Veterans of Foreign Wars, the Disabled American Veterans, Vietnam Veterans of America, the Blinded Veterans of America, and the Veterans' Affairs Physician Assistant Association.

I would like to thank all the Veterans Service Organizations (VSOs) for their support in this legislation and particularly thank the AAPA for their dedication on this issue.

I thank you, Mr. Chairman, for giving me the opportunity to be here this morning to testify on this critical piece of legislation.

Mr. MICHAUD. Thank you very much, Mr. Hare.

And we have had a request from one of the cosponsors of this legislation to speak who also sits on the Committee. So if there is no objection, Mr. Moran.

Mr. MORAN. Mr. Chairman, thank you, and I am pleased to join my colleague, Mr. Hare, as an original cosponsor of H.R. 2790, and am pleased to support the testimony that he provided this morning.

I suspect that the Department of Veterans Affairs will testify that this legislation is not necessary, but that is certainly not what I am hearing from my Kansas physician assistants, and very much hope that we can see this bill's passage.

I represent one of the most rural congressional districts in the country and I know in healthcare that our physician assistants are some of our most valuable resources in trying to meet the healthcare needs of Kansans who live in those rural communities.

And I know that that can be equally as true in the VA, and I have been an advocate for our Community-Based Outpatient Clin-

ics (CBOCs) and our physician assistants who are providing tremendous services to veterans through the outpatient clinics.

I also know that medical institutions like Cleveland Clinic, Mayo Clinic, M.D. Anderson Cancer Clinic at the University of Texas, and others have Directors of PA Services to make sure that they employ the PAs in an integrated way into their healthcare delivery system. And I believe that the VA can utilize the same technique to provide a stronger voice for our PAs in making healthcare policy.

It makes sense to me to give the PAs a stronger voice and invite their participation among the healthcare professions that have full-time Directors or consultants within the VA already at the Central Office, our social work, nursing, pharmacy, psychology, dentists, and dietitians. This just makes a lot of sense to allow the physician assistants the same kind of opportunity.

And I thank Mr. Hare for his leadership on this issue, and thank the Committee for allowing me to speak.

Mr. MICHAUD. Thank you very much, Mr. Moran.

I now would like to ask unanimous consent that Ms. Brown-Waite be invited to sit at the dais for this Subcommittee hearing.

Ms. BROWN-WAITE. Thank you, Mr. Chairman.

Mr. MICHAUD. Hearing no objections. It is so ordered.

I would now like to recognize Zack Space who is also another strong advocate for our veterans in this Nation. I want to thank you for presenting your legislation and look forward to your testimony.

Mr. Space.

STATEMENT OF HON. ZACK SPACE

Mr. SPACE. Thank you, Chairman Michaud, Ranking Member Miller, and Members of the Subcommittee, for holding today's hearing and including H.R. 3819, the "Veterans Emergency Care Fairness Act." I am grateful for the opportunity to discuss this bill.

In March, I received a letter from Terry Carson who is Chief Executive Officer (CEO) of Harrison Community Hospital in Cadiz, Ohio, a small critical care facility in rural Harrison County. Mr. Carson wrote to me about a problem he was experiencing at his small hospital when providing emergency care for veterans.

In late May, Senator Sherrod Brown of Ohio and I held a joint field hearing on the issues facing rural veterans, and Mr. Carson participated as a witness to share his experiences.

Mr. Carson explained that currently the VA reimburses non-VA hospitals for emergency care provided to veterans up to the point of stabilization. Once the patient is deemed stable enough to transfer, he or she is moved to a VA hospital. Oftentimes that is several hundred miles away from hospitals in rural areas of our country.

The problem Mr. Carson brought to my attention is that oftentimes veterans experience a waiting period for a bed in a VA hospital. During this limbo, the VA is not required to reimburse the private hospital for care. Meanwhile, people like Mr. Carson feel morally obligated to continue care despite the fact that they cannot count on reimbursement.

And it should be emphasized that many of the small hospitals, not just in southeastern Ohio but throughout the country, are oper-

ating on very, very narrow profit margins. So it is an economic burden as well.

The “Veterans Emergency Care Fairness Act” closes this loophole by requiring the VA to cover the cost of care while a transfer to a VA hospital is pending and if the private hospital can document attempts to transfer the patient.

Senator Brown introduced an identical companion bill on the Senate side and that has already advanced out of the full Committee. Senator Brown and I believe this legislation is a reasonable solution for the VA, private hospitals, and most importantly our Nation’s veterans.

I have received support for this legislation from people all across the country who have found either themselves or a loved one caught in this hospital limbo. Additionally, the Ohio Hospital Association and the Air Force Sergeants Association have written letters of support which I can submit for the record today.

This bill is a very good example of how our system of representational democracy is supposed to work. The constituent contacts his member of Congress. The member listens, and a legislative fix is found.

I am proud to have had a chance to advocate for Mr. Carson, and I hope you will join me in recognizing his efforts and the efforts of those veterans that his hospital cares for by supporting H.R. 3819.

And, again, I thank you for the opportunity.

[The letters from the Ohio Hospital Association and the Air Force Sergeants Association appear on p. 73.]

Mr. MICHAUD. Thank you very much, Mr. Space.

And now I would like to recognize Mrs. Hersetth Sandlin for her piece of legislation. I want to also thank her for her long-time support for our veterans’ issues and for being a long-time member of this Committee.

STATEMENT OF HON. STEPHANIE HERSETH SANDLIN

Ms. HERSETH SANDLIN. Thank you, Mr. Chairman. Good morning to you and to the Ranking Member and other Members of the Subcommittee. I want to thank you for having today’s hearing and I appreciate the opportunity to be here to discuss with you the “Women Veterans Healthcare Improvement Act.”

This bill, H.R. 4107, which I introduced last fall along with Congresswoman Brown-Waite of Florida, will expand and improve Department of Veterans Affairs healthcare services for women veterans, particularly those who have served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

I would like to thank the Disabled American Veterans (DAV) for their support in helping craft this important bill. And I would also like to thank the Veterans of Foreign Wars of the United States of America (VFW) for their endorsement of the legislation.

As you know, more women are answering the call to serve and more women veterans need access to services that they are entitled to when they return from their deployments or separate from service and return to civilian life.

With increasing numbers of women now serving in uniform, the challenge of providing adequate healthcare for women veterans is more considerable than ever. In the future, these needs likely will

be significantly greater with more women seeking access to care for a more diverse range of medical conditions.

In fact, more than 1.7 million women nationally are military veterans. More than 177,000 brave women have served our Nation in Iraq and Afghanistan since September of 2001, and nearly 27,000 are currently deployed in these wars.

By August of 2005, 32.9 percent of women veterans who had served in OIF or OEF had received VA healthcare. By the end of the following year, that number had increased to 37 percent. And as the VA compiles the final data for 2007, the percent is expected to increase again.

And according to the VA, the prevalence of potential post traumatic stress disorder (PTSD) among new OEF/OIF women veterans treated at the VA from fiscal year 2002 to 2006 has grown dramatically from approximately 1 percent in 2002 to nearly 19 percent in 2006.

So the trend is clear, but not surprising. More women are serving in our Armed Forces, including the National Guard and Reserves. More women are being deployed overseas and more women veterans need access to healthcare services. So clearly we must do everything we can from a public policy standpoint to meet the new challenge that this trend presents.

The "Women Veterans Healthcare Improvement Act" calls for a study of healthcare for women veterans who served in OIF and OEF, a study of barriers to women veterans seeking healthcare at the VA, enhancement of VA sexual trauma programs, enhancement of PTSD treatment for women, expansion of family counseling programs, establishment of a pilot program for childcare services, establishment of a pilot program for counseling services in a retreat setting for women veterans, and the addition of recently separated women veterans to serve on advisory committees.

We must ensure that the VA is positioned to provide adequate attention to women veterans' programs so quality healthcare and specialized services are available equally for both women and men.

I believe this bill will help the VA better meet specialized needs and develop new systems to better provide for the quality healthcare of women veterans, especially those who are returning from combat who were sexually assaulted or who need childcare services, especially in order to better access the healthcare services provided by the VA.

So, Mr. Chairman, Ranking Member Miller, again, thank you for inviting me to testify, and I look forward to answering any questions that you or other Members of the Subcommittee may have.

[The prepared statement of Congresswoman Herseth Sandlin appears on p. 33.]

Mr. MICHAUD. Thank you very much.

I have also had a request of one of the original cosponsors to speak on this bill, Ms. Brown-Waite.

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. Thank you, Mr. Chairman and Mr. Ranking Member Miller.

When I tour the hospitals in my district, whether it is St. Petersburg, Tampa, or Gainesville, one question I always ask when I see

women veterans there waiting is, how is the care. Do you think you are getting the same services.

And particularly in the area of mental health, women have told me, no, they do not believe they are getting the same services. And we might ask why.

When a woman comes back from the military, very often she has family at home, children, and it is the caregiver in her that she takes care of the children, takes care of the house, might have a job that she goes to.

And the trauma of having been at war or having been perhaps sexually assaulted does not really come back until later because the female physiology is a whole lot different.

This bill, I think, will go a long way toward making sure that our female veterans are receiving all of the care that they need and the care that is necessary and tailored to them.

You know, the specific healthcare needs of female service-members and veterans are sometimes overlooked by the Department of Defense as well as Department of Veterans Affairs. This bill will go a long way toward making sure that we have evidence-based treatment that women need to get the help to help them recover from whether it is sexual assaults or trauma of the war.

Thank you, Mr. Chairman, and I yield back and certainly commend Ms. Herseth Sandlin for putting together this bill. And I am sure you hear the same story from women veterans. And thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much.

And the last bill for the first panel is H.R. 3458, introduced by Ms. Moore Capito.

Ms. CAPITO. Thank you.

Mr. MICHAUD. Thank you for coming this morning. Appreciate it.

Ms. CAPITO. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you for your interest in veterans' issues as well.

STATEMENT OF HON. SHELLEY MOORE CAPITO

Ms. CAPITO. Thank you. Thank you for giving me the honor of presenting this to the full Committee. I appreciate that. I want to thank the Ranking Member as well.

May I submit my full statement for the record, and I am going to speak very briefly because I have to be on the floor. So if you saw me looking panicked, that was my problem.

My issue is rural veterans. I represent a State, West Virginia, which I have in my research material shows that over 14 percent of West Virginians are veterans living in my State.

And I am very concerned with the traumatic brain injury (TBI) issues that many veterans in many rural States and across the Nation are dealing with and making sure that they are able to access the kind of care that they need and deserve. And I think the Chairman shares the same, I know, issue.

My bill basically introduces five pilot projects where the Secretary would pick five States that do not have the traumatic brain injury centers in their States and designates a case manager for the TBI victims in the State that would be able to follow their cases through their treatment.

And it also opens up the possibilities of using local providers, whether it is a CBOC or a local provider, to help that veteran. I mean, you can imagine having an injury such as this and then to actually see the physician, you might have to travel 8 or 9 hours by car makes it very difficult to do it on a regular basis and certainly in some cases almost impossible.

So this is what the bill asks for. It asks for a pilot study of five States. It asks for a case manager for each State to specifically deal with this issue. This was brought to light for me from the Office of Rural Health at West Virginia University who deals with rural healthcare in the State of West Virginia quite frequently.

It also asks for a report back to Congress every year to see how the needs of rural veterans are being met who unfortunately are suffering from the results of traumatic brain injury.

I thank the Chairman. I thank all the Members of the Committee. It is an important issue across the country. And as I was reading through my background material, I guess I did not realize that rural States really provide a relatively larger majority of men and women to our military than some of our metropolitan areas. And we want to see that they are able to access the care. Thank you.

[The prepared statement of Congresswoman Moore Capito appears on p. 33.]

Mr. MICHAUD. Thank you very much.

Are there questions for any of our first group of panelists?

[No response.]

Okay. Hearing no questions, we will dismiss the first panel.

I would like to ask the second panel to come forward. I would like to thank the second panel. We are looking forward to hearing your testimony. And we will start off with Mr. Boswell.

STATEMENTS OF HON. LEONARD L. BOSWELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA; HON. STEVE KAGEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN; AND HON. MICHAEL M. HONDA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

STATEMENT OF HON. LEONARD L. BOSWELL

Mr. BOSWELL. Well, thank you, Mr. Chairman, Mr. Miller, and all of you on the panel. Good to see you and I appreciate the hard work you are doing for veterans. Thank you so very, very much.

I would just like to make a couple points here. I know you are very busy, but some say that suicide is an epidemic, which is sweeping through our veteran population. And for too long, suicide among veterans has been ignored. I feel that now is the time to act.

We can no longer be afraid to look at the facts and the sad fact is we are missing adequate information on the number of veterans who commit suicide every year.

Probably all of you, all of us could tell or make reference to how a person or someone in our own acquaintance had a mental health problem and it was not dealt with and oftentimes just kind of swept under the rug and looked at as a sign of weakness. And that time has to be gone, has to pass.

I was shocked as I am sure many of you were when I saw a *CBS Evening News* report focusing on veteran suicide. They found that in 2005, over 6,200 veterans committed suicide, 120 a week.

The report also found that veterans were twice as likely to commit suicide as nonveterans. And these are very devastating circumstances.

However, the data collected did not come from the Department of Veterans Affairs, but rather from individual States. That is why I introduced H.R. 4204, the "Veterans Suicide Study Act," to direct the Secretary of Veterans Affairs to conduct a study on the rate of suicide among our Nation's veterans.

I believe it is imperative we have the facts on this terrible problem if we are to effectively treat our veterans as they return home.

While I am pleased that the "Joshua Omvig Veterans Suicide Prevention Act" is now law, we need to continue to get all the facts on suicide among our veterans in order to better treat them as they return home.

I implore this Committee and Congress to act swiftly on H.R. 4204 so we can ensure we have the data we need to treat our Nation's heroes. This is an issue important to veterans and their families in Iowa and across our Nation.

And I would like to thank you, Mr. Chairman, for allowing me this time, and I would be glad to answer any questions you might have.

But a thought comes to me and I know we have talked to several of you about the "Suicide Prevention Act." But at some point, we want to measure, and how are we going to measure if we do not have some data? You know, is it effective? Maybe we need to go in and adjust that as we work with it or whatever we might need to do.

So I feel like we need to have this information and then we can make comparisons as we see whether we have been effective or not. We have to take care of our veterans. And I know every one of you are committed to that as well. Thank you very much.

[The prepared statement of Congressman Boswell appears on p. 34.]

Mr. MICHAUD. Thank you.

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. May I make a statement real quick?

Mr. MICHAUD. Okay. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

Mr. Boswell, I salute you on bringing this bill, H.R. 4204, the "Veterans Suicide Study Act," forward. I am probably not going to be able to stay past 10:30 and I just want whoever is here from VA to hear this from me beforehand.

All I hear on this particular piece of legislation H.R. 4204, is why we cannot do it and why it is not the right piece of legislation. I would like to see VA get with the sponsor. Let us see if we can fix the language and come out with a piece that says "we can" instead of "we cannot."

Mr. Boswell.

Mr. BOSWELL. Well, I am not stuck on authorship. I want something to happen. You can make it a Committee bill for all I care. I want something to happen.

Mr. MILLER. This will be the Boswell bill, I am sure, but I want VA to let us get this thing moving forward.

Mr. BOSWELL. Thank you.

[The prepared statement of Congressman Miller appears on p. 32.]

Mr. MICHAUD. Thank you, Mr. Miller.

Mr. Kagen.

STATEMENT OF HON. STEVE KAGEN

Mr. KAGEN. Thank you, Mr. Chairman. I really appreciate the opportunity to provide these few minutes to present H.R. 4231, which is entitled the "Rural Veterans Mental Health Improvement Act."

I will review with you some of the facts you are already aware of. We have all become aware that mental health conditions affect many of our soldiers. And as a physician, I can tell you that the brain is still a vital organ in the human body. We ought to do everything we can to protect it and to heal it.

There are 9 million veterans who live in rural regions in America. And only one out of three of these veterans are receiving the medical benefits that they have already earned.

To say it another way, two-thirds of rural veterans when they come home do not get their medical benefits for reasons that are becoming apparent more and more every day.

Fifteen percent of veterans who have served in Iraq and Afghanistan now suffer from PTSD, post traumatic stress disorder, but barely of those who have already been diagnosed receive the care that they require.

When people come home from overseas and combat, they have higher rates of divorce and this affects not just our families but our communities because when our soldiers are wounded mentally, they are unable to perform at work. They lose their jobs, lose their incomes, and all of our communities lose their tax base as a result.

It is not a surprise to anyone that an early and accurate diagnosis of any medical condition saves lives and saves human tragedy. And that is what we must accomplish by serving all of our veterans, especially those who live in rural areas.

What H.R. 4231 seeks to do is to make it easier for affected patients to receive the care they have earned, first by providing an accurate diagnosis from a qualified mental health specialist at a VA medical center or clinic. Secondly, for those patients who are affected and diagnosed as having a mental condition, they need to receive care as soon as possible and as close to home as possible.

For those patients who live more than 30 miles away from a VA medical center, H.R. 4231 seeks to create a voucher system where each affected veteran would receive a voucher, receive the care, the expert care they need from qualified specialists close to home. If it is close to home, they are going to have a higher probability of receiving the care that they need.

We know from our common experience as Congressmen and women that if it is close to where we are, we are much more likely

to get there to that event or to that, shall we say, fundraising opportunity.

The third thing H.R. 4231 seeks to do is to guarantee that the families who are also affected by the post traumatic stress disorder, by drug and alcohol addictions that occur in such affected veterans, that the family gets the counseling and care that they require to help keep them together.

I am proud to say that my wife, Gayle, who was President of the Congressional Spouse Association for the class of 2006, has made a marriage between United Way and the National Military Family Association to create access to a telephone number that will help rural veterans and those in the cities to get the care and the benefits that they have already needed.

But we have to do more. This Congress can do more. And H.R. 4231 seeks to do just that. It is a pilot program. It is something that we can measure and monitor to guarantee to push our affected veterans into the care that they really require.

If we fail to do this, if we turn our back on the needs of our veterans now, especially those mental impairments, the wounds that you will never see, we will be failing to do our complete job.

And I thank you again for the time that you have provided to me. I will submit my written statement to your official records, and I am open to any questions that you may have.

Mr. MICHAUD. Thank you very much, Mr. Kagen.

Are there any questions from the Committee?

Mr. Hare.

Mr. HARE. No questions, Mr. Chairman, except to say to my two friends, Mr. Boswell and Mr. Kagen, I think both bills have a tremendous amount of merit. And I know how hard you have worked on this issue of suicide among veterans.

And, Mr. Boswell, I will tell you that anything I can do to assist you on this I will, and I am proud to be on the bill with you.

And, Mr. Kagen, let me just say I come from a very rural area too, in west central Illinois with all or parts of 23 counties. I do not think we ought to be hung up on who they are talking to, if it works for them, and they can stay close to home. Their families can go with them.

I have had veterans that have had to travel 2½ hours by van, get out of the van, go in, and literally sit for 2, 2½ hours waiting to be seen for something. And, quite frankly, they just give up and leave.

And I think it is incumbent upon us and this Congress to make sure that any veteran, any place, just because you live in a rural area, you have problems too. These people have served. I think we have an obligation to give them the type of care and the access to the care that they deserve.

So I commend you both for your pieces of legislation and hopefully down the road, we will see this become law because to do anything less, I think, really dishonors the service that these people have put in for this Nation.

So I want to just thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much.

I want to thank this panel as well. And the last member of the panel, Mr. Honda, who is presenting H.R. 4146, thank you very much for joining us today and we look forward to your testimony.

STATEMENT OF HON. MICHAEL M. HONDA

Mr. HONDA. Thank you, Mr. Chairman, and thank you for this opportunity. I would like to thank the leadership of this Committee for holding this hearing and inviting me to testify before the Subcommittee. I really do appreciate the opportunity to share my thoughts on veterans' emergency services and reimbursement.

In the 109th Congress, I introduced legislation which would amend the "Millennium Healthcare Act" and provides that the VA should cover an uninsured veteran's emergency healthcare cost before and after stabilization if no VA hospital bed is available at a geographically accessible VA facility.

It is a problem that I have been facing with our constituents in my district since I have been on the Board of Supervisors.

As the Subcommittee knows, I reintroduced this bill as H.R. 4146 right before Veterans Day last year. And the need for this legislation was brought to my attention by again a constituent, Robert Dahlberg, who is a Vietnam-era veteran. I would like to read a detailed account of what happened to Robert and why he contacted me. I will be very brief.

"About 2 years ago, after my helicopter crashed while fire fighting in northern California, I went to register for my veteran's medical benefits. And as I was signing up at the VA, I asked a lot of questions to understand what my obligations were in order to get the care.

At one point, I heard the words, and then you will need to get yourself once stabilized to a VA hospital, and these words alarmed me.

And after further investigation, that was it. Even if I had a heart attack and was stabilized at a non-VA hospital, it was my responsibility to get myself to a VA hospital. The VA requirements to get one's self to a VA hospital after stabilization is at best a joke and could financially devastate veterans of all ages and family status, leaving them destitute with a huge bill from the non-VA hospital. And to me, this is unconscionable."

The unintended loophole created by the "Millennium Healthcare Act" can leave veterans in a financial disaster. The problem, if nothing is done, is likely to grow as veteran ranks swell with servicemen and women returning from the wars in Iraq and Afghanistan.

Mr. Chairman and Committee Members, we, as legislators, must fix this loophole. We have a responsibility to our veterans to do so. We owe them a debt of gratitude for their service and it is inexcusable for us to allow this loophole to even exist.

It is an unnecessary burden for our returning veterans, Mr. Chairman. This important fix will save many veterans a great deal of grief and we should not stand by idly as more veterans are served absurd inordinate hospital bills because of this situation, especially as VA hospitals reduce the number of beds they have available.

American Veterans (AMVETS) and the American Legion support this bill, along with some Members of this Committee such as Ms. Ginny Brown-Waite and Mr. John Hall. I appreciate the bipartisan support this bill has received and urge the Committee to fix this problem with the health and financial stake of our veterans in mind.

Again, I thank you, Mr. Chairman, for this opportunity, and am willing to answer any questions.

Mr. MICHAUD. Thank you very much, Mr. Honda.

Are there any questions?

[No response.]

We are letting you off easy today. Thank you very much. We really appreciate your testimony.

And as staff is preparing the table for panel three, there is one more piece of legislation that was introduced by Ms. Berkley. It is H.R. 4053. She is not able to be here, but it is my understanding that Mr. Hare will present that legislation.

Mr. HARE. Thank you, Mr. Chairman. I will be very brief. And I thank you and I thank my friend, Mr. Moran, for allowing me to speak on this bill this morning.

Unfortunately, Ms. Berkley could not be here today to talk about her bill. As a cosponsor of her legislation, I would just like to say a few words in support of it.

Nationally, one in five veterans returning from Iraq and Afghanistan suffers from post traumatic stress disorder. Twenty-three percent of members of the Armed Forces on active duty acknowledge a significant problem with alcohol use. It is vital that our veterans receive the help that they need to deal with these conditions.

Ms. Berkley has introduced legislation which aims to improve the treatment and services provided by the Department of Veterans Affairs to veterans with post traumatic stress disorder and substance abuse disorders by establishing national centers of excellence on PTSD and substance abuse disorders and expanding the assistance of mental health services for families of veterans, among other initiatives.

As a cosponsor of the "Mental Health Improvements Act," I feel this bill takes a step in the right direction in providing our veterans with the care that they have earned.

I thank you very much, Mr. Chairman, for allowing me to read this into the record on behalf of Ms. Berkley. And it is my sincere hope that we will get bipartisan support on this vital piece of legislation from the Committee. Thank you, Mr. Chairman.

[The prepared statement of Congresswoman Berkley appears on p. 66.]

Mr. MICHAUD. Thank you very much, Mr. Hare.

Any questions for Mr. Hare?

[No response.]

Thank you.

So I would invite the third panel to come on up. And as they are coming up, it will be Joe Wilson who represents the American Legion, Joy Ilem who represents the Disabled American Veterans, Christopher Needham, the Veterans of Foreign Wars, and Richard Weidman who represents the Vietnam Veterans of America (VVA).

I would like to thank all of you for coming here this morning to give your testimony on the piece of the legislation that we just heard. And we will start with Mr. Wilson and move on down the table.

Mr. Wilson.

STATEMENTS OF JOSEPH L. WILSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION DIVISION, AMERICAN LEGION; JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; CHRISTOPHER NEEDHAM, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND RICHARD F. WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

STATEMENT OF JOSEPH L. WILSON

Mr. WILSON. Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for this opportunity to present the American Legion's views on legislation being considered by the Subcommittee today.

The American Legion commends the Subcommittee for holding a hearing to discuss these important and timely issues.

In regards to H.R. 2790, although the American Legion has no specific official position on this issue, we believe VA should do everything in its power to improve access to its healthcare benefits to include providing adequate funding to support programs within the VA medical system.

In regards to H.R. 3458, the American Legion favors the intent of this bill to create a pilot program that would train and assign specified VA case managers for veterans diagnosed with TBI, or traumatic brain injury, and residing in rural areas.

However, we would encourage the implementation of this program to every venue nationwide thereby ensuring across-the-board quality and adequate healthcare.

In regards to H.R. 3819 and also H.R. 4146, the American Legion supports provisions to allow VA to pay for emergency room care at non-VA facilities. We believe this would prevent any delays in treating life-threatening injuries or illnesses for veterans not in close proximity to a VA facility.

We also support H.R. 4146 because H.R. 4146 would alleviate the hardship or burden of veterans paying out-of-pocket expenses unfairly incurred, which is also due to unavailable beds at VA facilities.

In regards to H.R. 4053, according to the Diagnostic and Statistical Manual of Mental Disorders IV, post traumatic stress disorder always follows a traumatic event that causes intense fear and/or helplessness in an individual. Typically the symptoms develop shortly after the event, but may take years. Psychological care is considered the most effective means of treatment for PTSD.

In addition to treatment for PTSD, other mental health conditions such as acute reaction to stress and abuse of drugs or alcohol require much attention. Due to the increasing numbers of veterans seeking care at VA medical facilities to include those from the Gulf

War era and OEF/OIF, the American Legion supports a bill to further improve treatment and services provided by the VA to our Nation's veterans.

In regards to H.R. 4107, the American Legion supports this bill to include sections 101 to 103 and sections 201 to 206. In addition, we support expansion and improvement of healthcare services to all veterans.

And regarding H.R. 4204, the American Legion receives contact from actual veterans who disclose their need for immediate help due to their thoughts of harming themselves. As the number of calls to suicide prevention call centers increase, the need for more suicide prevention counselors throughout the VA medical centers is warranted.

The American Legion supports continued studies on suicides among veterans. In a proactive effort, these findings must be readily communicated to suicide prevention divisions to increase the prevention of potential tragedies.

In regards to H.R. 4231, according to research conducted by the Department of Veterans Affairs, one in five veterans nationwide who enroll to receive VA healthcare reside in rural areas. The American Legion believes no veteran should be penalized or forced to travel long distances to access quality healthcare because of where they choose to live.

Furthermore, all care, to include pilot programs, should include outreach to every rural venue in which veterans reside. The American Legion favors the intent of this bill to create a pilot program that would accommodate veterans residing in rural areas.

However, we would encourage the inclusion of every Veterans Integrated Service Network (VISN) across the country as well as a more condensed pilot program than the above mentioned.

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 Committee in continuing the enhancement of access to quality care for all veterans.

[The prepared statement of Mr. Wilson appears on p. 35.]

Mr. MICHAUD. Thank you.

Ms. ILEM.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Mr. Chairman and Members of the Subcommittee. We appreciate being invited to testify at this legislative hearing today.

The first measure under consideration, H.R. 2790, would establish the position of Director of Physician Assistant Services as a full-time position within the VA Central Office. We believe PAs are a critical component of VA healthcare and urge the Subcommittee's approval of this measure.

H.R. 3458 would require VA to establish a rural pilot program of VA case-managed traumatic brain injury care. The bill would require the pilot program be conducted in consultation with the VA Office of Rural Health and includes protections to ensure rural veterans with TBI receive sufficient care from competent, trained providers.

This measure is consistent with recommendations of *The Independent Budget* related to VA care coordination of fee-basis and contract care, rural healthcare services, and TBI. Therefore, we have no objection to its enactment.

H.R. 3819 would require the VA to reimburse for emergency treatment provided in a non-VA facility until an eligible veteran is transferred to VA. In accordance with the mandate from our membership, DAV supports this bill to improve reimbursement policies for non-VA emergency healthcare services.

We believe H.R. 4146 is intended to achieve the same purpose as the bill just mentioned. However, based on our analysis, we recommend the Subcommittee to proaction on this measure and instead favorably report H.R. 3819.

DAV supports H.R. 4053, a bill to establish new and enhanced treatment programs for post traumatic stress disorder and substance abuse disorder with a special regard for the treatment of veterans who suffer from these co-morbid conditions.

It would also provide VA new authority to treat OEF/OIF veterans and their families for combat readjustment problems.

We appreciate the emphasis in section 201 of the bill which includes provisions for peer counseling and outreach, requires VA referral and coordination with the Office of Rural Health, while ensuring that private providers are properly trained and compliant with VA standards.

However, we continue to have concerns about contracting with non-VA providers for specialized PTSD treatment and other combat readjustment issues.

H.R. 4107 is a comprehensive measure aimed at evaluating the unique needs of women veterans including those who served in Operations Iraqi and Enduring Freedom and improving VA's healthcare and mental health services for women veterans.

This legislation is consistent with recommendations from the research, experts in women's health, *The Independent Budget*. And, therefore, we support this measure and urge the Subcommittee to recommend its enactment.

H.R. 4204 would require VA to conduct a study on the number of veterans' suicides since 1997. DAV supports this bill, but recommends including other relevant measures in the legislation that could help reduce veterans' suicide as outlined in our written statement.

H.R. 4231 would establish a 5-year mental health services pilot program in seven specific VA networks in which veterans would be issued vouchers for private mental health services at VA expense for up to 1 year.

We have a number of concerns about this measure, specifically that it lacks contract care coordination features that we believe are essential to the protection of veterans' health and the long-term maintenance of veterans' health services.

Additionally, under this measure, a veteran who receives care in the community without connection to VA loses the many safeguards built into the system for their protection including VA's electronic medical record, evidence-based medicine, patient safety programs, and most importantly VA's expertise in combat-related

mental health readjustment services. For these reasons, we cannot support this measure.

As a community, all of us are concerned about rural veterans' access to care including mental health and readjustment services, especially for our newest generation of war veterans.

However, DAV wants to ensure that veterans receiving contract care through VA are treated in accordance with VA's internal standards of care.

VA has developed a national mental health strategic plan to deploy new mental health programs, ramp up existing specialized services for PTSD and substance abuse treatment, and hire new staff.

Additionally, last year, Congress mandated VA, through its Office of Rural Health, to take specific steps to improve rural veterans' access to care including assessing fee-basis programs and developing a plan to improve access and quality, meeting mental health needs, and conducting an extensive rural outreach program to OEF/OIF veterans and their families.

Implementation of VA's mental health strategic plan in conjunction with the mandate to the Office of Rural Health should create greater access to mental health services for all rural veterans.

Prior to final consideration of this bill, we urge the Subcommittee to request the mandated reports from VA's Office of Rural Health to see what progress has been made thus far. In our opinion, these reports should provide essential information on how to best develop a comprehensive solution and meet rural veterans' mental health and other healthcare needs.

Mr. Chairman, that completes my statement, and we thank you for the opportunity to testify.

[The prepared statement of Ms. Ilem appears on p. 38.]

STATEMENT OF CHRISTOPHER NEEDHAM

Mr. NEEDHAM. Mr. Chairman and Members of the Subcommittee, the VFW thanks you for the opportunity to testify today.

There is a wide range of healthcare legislation before us and the common theme through most of them is access. VA provides first-rate, high-quality healthcare to thousands of veterans every day, but barriers to care remain, whether that is for a veteran living in the country far from a VA clinic, for a woman veteran unsure of her entitlement to healthcare, or for a wounded warrior suffering from TBI who is finding that VA is not yet providing the range of treatment he or she needs.

Today's hearing addresses some of those barriers and we are generally supportive of all of the bills. Because of time considerations, I will limit my remarks to a few of them. Our full comments can be found in our written statement.

The first two bills concern a number of our members. H.R. 3819 and 4146 would close the loophole that is costing a number of our veterans thousands of dollars out of their own pocket for emergency care. This especially affects veterans who live in rural areas far away from VA clinics.

Under current law, VA can pay for emergency treatment for a veteran who goes to a non-VA facility under certain circumstances and must be an enrolled veteran who uses the system and who

does not have any other form of insurance. It is a safety net for those who otherwise would have no emergency care.

The wrinkle occurs in that once the veteran is stabilized, he or she must be transferred to a VA facility. There have been cases, though, where VA is unable to accept the veteran. Maybe VA cannot provide the type of care that the veteran needs or maybe there are not any beds available.

Whatever the reason, when VA refuses to accept a patient, they also refuse to pay for the care. This is wrong and defeats the purpose of that safety net.

We strongly urge the Committee to close this loophole to ensure that veterans are not penalized for VA's inability to adequately care for them.

The VFW urges passage of H.R. 4107, the "Veterans Emergency Care Fairness Act." This comprehensive bill would authorize a number of important studies on the healthcare needs of women veterans, especially those returning from Iraq and Afghanistan.

The current conflict is one of a true front line, exposing all to the hazards of combat. The study in section 101 would look at the healthcare needs of returning female servicemembers not just for the short term but also the long term. With the new type of conflict they are facing, it is essential that we stay on top of any potential health problems that may arise.

We also welcome the assessment from section 102 of that bill, which would require VA to study barriers to care that may prevent women veterans from receiving healthcare on par with what men receive. It may be a matter of not enough outreach or substandard gender-specific care. Regardless, it is important to find these reasons out so that VA can correct them, especially as the number of women veterans continues to rise dramatically.

Another bill we support is H.R. 2790, which would create a full-time Director of Physician Assistants at VA's Central Office. VA is the largest employer of PAs in the country with around 1,600 of them providing essential care to veterans. Around one-quarter of all primary care patients are seen by PAs making them a critical component of the healthcare delivery system.

Because of this, they should have a voice in the process and a full-time Director would allow PAs to take part in VA's strategic planning committees.

Finally, I would make a note on the contracting provisions on a few of the bills, notably H.R. 4231 and H.R. 3458.

It is our goal that VA develops the in-house expertise to provide the full range of treatment and recovery for all veterans, especially our wounded warriors. These brave men and women are likely going to be with the VA for the rest of their lives and the system must adapt to their needs.

VA has made great strides to improve their services, but they are not all the way there yet. These men and women cannot afford to wait for VA to develop these in-house systems. They need treatment now.

For that reason, we support the proposals of these bills to contract for care. As always, we would urge strong oversight of these programs to ensure that they really are meeting the needs of our

veterans and that they are complying with VA's clinical, safety, and privacy protocols.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or the Members may have.

[The prepared statement of Mr. Needham appears on p. 44.]

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. Mr. Chairman, thank you for the opportunity to appear here today. There are a number of bills, so I will try to move very quickly.

H.R. 2790 addresses a problem that should have been solved by VA several years ago. We have great hope that Secretary Peake and the new General Counsel are going to change the attitude regarding some laws that they do not like as just cute ideas advanced by the Congress and actually follow through in congressional intent on statutes put in place that are passed by the Congress and enacted by the President's signature.

To make the PA advisor a full-time position in Central Office and as part of the strategic planning committees only makes sense.

One of the places where VA is falling down now and even by their own admission is rural healthcare. We know that a great number of those serving today come from areas that are not in proximity to one of the VA hospitals which generally are located in major population centers.

PAs came about as a profession largely to serve rural areas and other underserved communities. And this ought to be exploding as opposed to being diminished.

There are a number of things that we would recommend in addition to early passage of this legislation. First is to end what is often a hostile work environment toward PAs not just at the national level, but at the local level and ensuring that they are on the VA committees and on par with nurse practitioners.

Secondly, that their scope of practice be no less than that which is accorded in the United States Army and the other military services. In many cases, it is more narrow at the VA.

And the third thing is to create a scholarship program for returning Navy corpsmen and Army medics to become PAs in the VA system. It is akin to the nursing scholarships. It needs to be done. It needs to be done now with a nationwide effort in order to utilize these extraordinary experiences of these men and women who have served in combat and served well.

VVA strongly supports the bill as written, but urges that you take some additional steps here, Mr. Chairman.

H.R. 3458 is the pilot program for the provision of traumatic brain injury care. Something has to be done in order to serve these rural vets when it comes to TBI. But I would join the DAV and my colleagues at the table in making sure that we do not contract out and then that is it, that these people are competent, that they know how to deal with veterans and other problems. It is not uncommon for people who have TBI to have PTSD at the same time, which may or may not be diagnosed.

In terms of the numbers of people, last May, there was a survey done out at Fort Carson and they found 19 percent of OIF/OEF returnees had undiagnosed TBI. These were not people in med halls

or in the hospital. These were just troops in the Garrison. So it is a huge problem and we do need to follow through with it.

We would, however, suggest that you make a number of changes to require frequent substantive input by the veterans service organizations as part of the legislation, frequent reporting to this Committee and other accountability mechanisms to ensure that this does not go awry.

Often good ideas get twisted and we would bring to your attention Project Hero having to do with the effort to rationalize the contracting out of care.

H.R. 3819, the "Veterans Emergent Care," just makes great sense and we are very much in favor of ending what is often an ugly, protracted, and unsuccessful effort on the part of veterans who have to use emergency service not in VA in order to get reimbursed or face financial ruin.

H.R. 4053, the "Mental Health Improvement Act," we are very much in favor of. A lot of the problems at VA, however, we would point out have been, in mental health in particular, have been because they do not have the organizational capacity and the resources in order to do what is done and, therefore, cause distortion in the system.

The distortions in the system and the reduction of 10,000 physicians post 1996, during the flat-line period 1996 to 1999, caused great distortions in the system and nowhere more than in substance abuse. And in substance abuse, some VISNs, it was practically wiped out. And whatever resources they had were shifted into primary care for mental class vets. This needs to be restored. It is a resource problem in addition to a focus problem.

And, once again, for any of the legislation that you pass, we encourage you strongly to build in more accountability mechanisms, et cetera.

For H.R. 4107, we are very much in favor of this. We have been talking about the need for VA to gear up for women veterans since the beginning of the war. We would suggest you make it clear in that there has to be a full-time women's coordinator at each one of the VA medical centers across the country. More cases than not, it is an ancillary duty.

Further, there should be expansion at the major medical centers who see a good number of women into a free-standing women's clinic. And that will help solve the problem having to do with women seeking help for Military Sexual Trauma (MST). Nobody knows why anybody goes to the women's health clinic at Washington, D.C., and that should be the model. And I would encourage the Committee Members to visit it.

The last is H.R. 4146. VVA supports this bill. Excuse me. It is not the last. And H.R. 4204. There is a suicide study that VVA has informed staff has been done at VA, but it has not been released. It is in peer review for publication now, but there is no reason why the staff cannot get a confidential briefing and certainly the Members get a confidential briefing on the results of this study done by VA.

In regard to suicide among all veterans or certainly among Vietnam veterans, National Vietnam Veterans Longitudinal Study (NVVLS) is currently still not done even though it was supposed

to be delivered to the Congress 2½ years ago. And we would encourage following through on that because one of the things that will show up is the suicide rate of the last generation, major generation of combat veterans and, therefore, give us some sense about what is likely to happen in the future with OIF/OEF veterans.

Our best defense against suicide is a vet center system that is more robust than it is today. It is a great system. The Vet Centers work, but there is just flat not enough staff. These are our forward aid stations and that is where a veteran and/or her family, his or her family is more likely to go than to a VA hospital because it is in the community. We need to expand the vet center system number of staff.

There was \$17 million provided and a supplemental passed, enacted on March 7th. It did not reach the readjustment counseling service until mid-August when it was too late to get anybody on-board much less spend the \$17 million, so they spent it on other services.

This is the kind of decision on the part of VA that is simply short-sighted and needs to be, if it requires specific legislation to require them to come up to a certain Full Time Equivalent (FTE) level and readjustment counseling service, then we encourage you to do so if, in fact, it will not be reasonable.

Thank you very much, and I appreciate your indulgence for going over time on my summary, sir.

[The prepared statement of Mr. Weidman appears on p. 49.]

Mr. MICHAUD. Thank you very much, each of you, for your testimony today.

As you know, we have been focusing a lot on mental health issues, and TBI, and rightfully so. We have several pieces of legislation before us today.

So I would like to ask each of you what type of legislation would you like to see come before the Subcommittee that is not included in what we saw today. Is there anything that we are missing? I will start with Mr. Wilson.

Mr. WILSON. Nothing I see at this time, Mr. Chairman.

Ms. ILEM. I think the measures that are before the Committee are some of the most very important things that we are hearing about today. And I think it is a good start. I cannot think of anything right offhand that could be added additionally at this time.

Mr. NEEDHAM. I think I would agree with what Mr. Weidman had to say concerning sort of the Vet Centers. I agree with him that they do seem to sort of be a really effective tool in terms of dealing with mental health. Particularly, I know from reading VA's prepared statements, they were concerned about some of the family provisions in some of the bills before us today in discussing how they overlap with what Vet Centers are doing.

We are particularly concerned about some of the effects of mental health problems on the families. And so if Vet Centers are the way to go, then it would definitely be something we would need to take a little closer look at.

Mr. WEIDMAN. We ask that you specifically require that the Special Committee on PTSD have VSO access to attend their meetings and constituent input on some kind of a basis, and further that you follow through on requiring VA to set here to sunshine good gov-

ernment standards with the seriously mentally ill advisory committee and that that also, the entire thing, be open.

Dr. Kussman, his response when we have requested that is that they cannot carry on candid discussions with anybody there from the outside. Our response back to that is that just means you are saying things that you cannot stand in the light of day.

And, frankly, he should not be saying those things if they cannot stand up in the light of day. And so we would request that you take those two steps.

The other thing is something that we have discussed before, sir, and that has to do with taking a military history as part of the computerized patient treatment record. We have empty promises for years upon years and different Under Secretaries and different Directors of Clinical Care.

And in point of fact, the new system that they are designing does not have in there the taking of a military history, branch of service, when did you serve, where did you serve, what was your Military Occupational Specialty (MOS), and what actually happened to you and utilization of that through clinical reminders in the diagnosis and treatment process.

If they will not do it on their own within the next very short period of time, then we ask that the Committee pass legislation, which incidentally was passed by the House in 2000, that requires them to do so. The Senate did not pass it at that time. We have talked to the Senate and believe they would be amenable to passing such a provision today. It only makes good sense.

When you ask any of your constituents, or tell any of your constituents, that when people go to a VA hospital, they do not ask completely what did you do in the war, dad, what did you do in the war, mom, and use that in the diagnosis and treatment modalities, people look at you blankly and say, but is that not what we are paying for. And the answer is yes, that is what we are paying for.

And that is the whole purpose of having a specialized VA system. But if you do not take the military history, then you are going to miss things like, for instance, TBI, post traumatic stress disorder, tropical parasites, and endemic diseases whether it is southwest Asia or southeast Asia or Korea, or wherever it might be.

The point is that the primary purpose of having a separate VA hospital is to have a veterans' healthcare system, not a general healthcare system that happens to be for veterans. It is both in the long run cost effective, but it is also cost efficient in the long run because you will have better diagnoses and treat people.

Ms. ILEM. Mr. Chairman?

Mr. MICHAUD. Very good point. Yes.

Ms. ILEM. If I may, I did think of a couple of things as the discussion continued. One would be touching on the family issues, the caregiver issues related.

I do not think that that is something that has been completely fully discussed within the Subcommittee as yet and those that are really caring for our most seriously wounded and perhaps some additional services for them and benefits.

Also, on the mental health side, substance abuse disorder from talking to so many OEF/OIF veterans, we believe that is really

going to be a critical issue. We would like to hear more from VA about, through its mental health strategic plan, number one, what is the implementation phase of that plan and how quickly is it moving in terms of the substance abuse programs that they have promised that they are putting online and ramping up.

And one last thing was the mild TBI issue. Although there is, you know, much care and discussion about the severe TBI and lots of bills that have been introduced regarding that issue, the mild TBI issue from mental health providers and psychiatrists within the VA, I believe that that is going to be such a critical piece of the undiagnosed milder TBI that is still coming out within mental health problems.

So we would like to see about, you know, what VA is doing in terms of its treatment plan, its strategic plan for those veterans and to really be able to catch them. Thank you.

Mr. WILSON. Mr. Chairman, I cannot help but speak on this critical issue as it is progressing very rapidly. On behalf of the American Legion, my concern involves the connection between research and the critical divisions within the VA medical center.

During the American Legion's 2007 site visits to polytrauma centers, the staff inquired about research being conducted in the area of traumatic brain injury. The researcher had no response to the question. To be more specific, in one of the main polytrauma centers visited, was a brain research chamber. The researcher was asked how their research served the clinic side of the VA medical center, still, no response. In conclusion, there should be an inquiry to assess whether or not there is complete communication and interaction between research and clinical divisions throughout the VA medical center system.

Mr. MICHAUD. Thank you very much.

Mr. Hare.

Mr. HARE. Thank you. Nothing, Mr. Chairman.

Mr. MICHAUD. Okay. Well, once again, I would like to thank each of you for your testimony today and look forward to working with you as we move forward with these pieces of legislation.

Mr. WEIDMAN. Thank you, Mr. Chairman.

Mr. MICHAUD. The last panel today is Dr. Cross who is the Principal Deputy Under Secretary for Health, and he is accompanied by Walter Hall who is the Assistant General Counsel.

I want to thank you, Dr. Cross, for coming here today. I look forward to hearing your comments and to you answering the Committee's questions. So without any further ado, I will turn it over to you, Dr. Cross.

STATEMENT OF GERALD M. CROSS, M.D., FAAFP, PRINCIPAL DEPUTY 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. CROSS. Good morning, Mr. Chairman and Members of the Subcommittee, and thank you for inviting me here to present the Administration's views on several bills that would affect the Department of Veterans Affairs.

And, of course, joining me today is Walt Hall, Assistant General Counsel.

And I would like to request that my written statement be submitted for the record.

Mr. MICHAUD. Without objection.

Dr. CROSS. Given the breadth of issues covered in these bills, I will simply highlight a few key issues. We would welcome the opportunity to brief the Committee and provide technical assistance on any of the issues that we discuss today including our PTSD, suicide, and outreach programs among others.

Mr. Chairman, VA strongly supports H.R. 3819. Effective reimbursement or payment of emergency treatment has been an issue of longstanding concern to the Department. H.R. 3819 more appropriately resolves important billing issues than does H.R. 4146 and properly places the financial onus on the Department.

VA believes H.R. 4204, H.R. 3458, and sections of H.R. 4107 are unnecessary given VA's current efforts which I would be delighted to discuss with the staff.

Specifically we do not believe the study required in H.R. 4204 on veterans' suicide rates would generate the information that would further our understanding of how to effectively screen and treat veterans who may be at risk of suicide. In fact, certain requirements mandated by the bill make its implementation unfeasible.

Similarly, H.R. 3458 is unnecessary as VA has developed and implemented a number of recent traumatic brain injury initiatives including programs addressing case management. This bill would potentially fragment care for veterans in the greatest need of receiving healthcare in a well-coordinated, continuous manner.

And since the bill was introduced, each VA facility has established an OIF/OEF case management program for severely injured OIF/OEF members.

VA also created the Care Management and Social Work Service to ensure that each VA facility has an appropriate treatment team caring for these veterans.

Mr. Chairman, VA believes the studies recommended in sections 101 through 103 and sections 201 through 203 of H.R. 4107 would prove costly and duplicate current efforts. Regarding Title 1, VA's strategic healthcare group for women veterans already studies and uses available data to assess the needs of women veterans and has developed a variety of mechanisms already to improve their care.

For example, VA funds Drs. Donna Washington and Elizabeth Yano who were examining access for women veterans and how staffing issues impact quality.

In response to Title 2, VA prepares our clinicians through multiple venues in identifying and treating military sexual trauma, utilizing evidence-based psychotherapies for mental health conditions and counseling women veterans in our Vet Centers.

VA generally opposes H.R. 4053 and H.R. 4231. H.R. 4053 is the companion bill to Senate bill 2162, which the Department discussed with your Senate colleagues in October.

While we appreciate the intent of the bill, we cannot support its approach of mandating forms of treatment, treatment settings, and composition of treatment teams.

VA does not support the Title 4 of H.R. 4053 because it is unclear how these readjustment and transition assistance services are intended to differ from or interact with the readjustment counseling services and related mental health services already available to our veterans and their families through our Vet Centers.

This provision would not effectively enhance current activities and has serious potential to create confusion and disruption for both VA and for our beneficiaries.

We strongly oppose H.R. 4231 as presently drafted without exception. A recommendation for a veteran's receipt of mental health counseling services by a non-VA provider should be made only by appropriate departmental mental health professionals. This ensures a continuum of care for the veteran, reduces the potential for self-referrals or conflicts of interest by participating providers, and supports appropriate coordination and oversight of all medical services furnished to the veteran.

Mr. Chairman, this concludes my prepared statement, and Mr. Hall and I are prepared to answer your questions.

[The prepared statement of Dr. Cross appears on p. 53.]

Mr. MICHAUD. Thank you very much.

You heard the testimony of the previous panels and some of the discussion about how the VA has done their own suicide study.

Is that something you are willing to share with the Committee?

Dr. CROSS. Yes, sir.

Mr. MICHAUD. And is that complete now or is it—

Dr. CROSS. I understand it is being submitted for publication.

Mr. MICHAUD. Okay.

Dr. CROSS. But, you know, we can brief you on it.

Mr. MICHAUD. Okay. Also, Mr. Weidman mentioned the Special Committee on PTSD and having VSOs be more involved in the process and he talked about the Deputy Secretary as well.

Why is the VA reluctant to get more involvement and have open discussions with the VSOs?

Dr. CROSS. To tell you the truth, Mr. Chairman, that is a new issue for me and I need to go check on it and find out what the background is on that.

But I do want to say this. We meet with our VSO colleagues frequently in small groups, in large groups. We share information. We share papers. We have excellent personal relationships in terms of the mission that we have to carry out.

And it is my intent and I believe it is all of our intent to share whatever information, to coordinate with them as closely as possible and to do so more than perhaps ever done before.

Mr. MICHAUD. We also heard, and I agree with the comment, about Vet Centers. They do an outstanding job in a lot of the rural areas and they deal with a lot of issues of mental health.

One of the issues that we have heard from VSOs, and a lot of the bills that are referred to us are introduced because veterans in rural areas are still not getting the healthcare that they need. And I think part of it is underfunding of the VA which hopefully the last budget will—I know that it definitely will help out.

What are you doing to make sure that the Vet Centers get the resources as quickly as they can to take care of the veterans in the rural areas?

Dr. CROSS. Here is what we are doing. We are expanding them. And I was surprised at the testimony earlier because we are opening more and more Vet Centers, expanding them into other areas. We are adding staff to our Vet Centers.

And by the way, I have a representative from the Vet Centers here with me today. And I would recommend that, you know, if anyone wants to talk afterwards or at some other time, we can arrange a definitive briefing on that.

Mr. MICHAUD. I would like to know where you are beefing up the Vet Centers with additional staff, what are the vacancies, or if all the current positions are filled, as well as the new Vet Centers that you are planning to open. A lot of the bills we are seeing, directly go back to that particular area.

Dr. CROSS. Mr. Chairman, we would be absolutely happy to provide you with that. And I would like to highlight that we are adding staff. We are making sure that we have an environment in our Vet Centers as welcoming to women veterans. We are adding more female staff specifically to our Vet Centers to support that.

We are changing the very way we construct our Vet Centers to make sure that that environment is conducive to both males and females. We want them to feel like this is their home and that they are welcome there.

We are expanding. We will get you that list, show you where they are at, show you what our plans are.

[The list of Vet Centers was included in a News Release from the Department of Veterans Affairs, dated July 9, 2008, which appears on p. 74.]

Mr. MICHAUD. Great. And it was mentioned this morning when you look at the Office of Rural Health and that, as you well know, has been a big issue with a lot of us on this Committee, that office getting up and running.

And have they made any reports or any recommendations on how we should be moving forward in rural health areas and when will those be available for the Committee?

Dr. CROSS. We are keeping them busy as bees. They are wonderfully motivated. It is a young staff who are very engaged, who consider this their passion, their mission. They are working on papers. They are working on proposals.

What they are doing is very interesting. I wanted to tell you their strategic direction. It is not so much to create entirely new programs, but what they wanted to do, and this is brilliant on their part, is to go look at all the programs that the VA already has and to reconfigure some of those programs, to readjust them to better serve veterans in the rural environment. So not just start from zero, but to take what we have already gotten built from that and adjust that to make it more effective for our rural veterans.

Mr. MICHAUD. And have they come up with any recommendations so far?

Dr. CROSS. Absolutely. They have drafted plans. They have already been to my office.

Mr. MICHAUD. And since they have been in your office, have you acted upon the plans?

Dr. CROSS. We are working on acting on the plans, giving them money to move those initiatives forward in substantial amounts.

Mr. MICHAUD. I would like to also see exactly what they are recommending if it would be possible.

Dr. CROSS. Mr. Chairman, we would love to brief you on that.

Mr. MICHAUD. Because I think that that is a very important issue, and a lot of the concerns that we hear as Members of Congress deal with a lack of service or access to that care in rural areas. So I think it is very important that we get as much information as possible and that the VA acts upon it, but also one of the problems that we see is lack of communication a lot of times that causes a lot of problems. And it is important for not only elected officials, but also the VSOs, to be involved in the process and that they know what is happening out there so we can move forward.

My last question deals with Mr. Hare's bill. How can this be effectively accomplished if a Director of Physician Assistant Services is not located at the VA's Central Office?

Dr. CROSS. We have a PA advisor. He works in a very similar manner to our other advisors, for instance, for infectious disease, cardiology, podiatry, orthopedic surgery, and so forth.

We are field based. That was the way it was originally designed because we thought it added credibility to the position, that they are still engaged in the practice and advise us.

We did increase his percentage of time that he works with the Central Office from half time to three-quarters which is typical for what we do with others as well, in the ones I just mentioned.

Having said that, we are flexible. I would rather that you did not mandate this for the following reason: When the current advisor who I work with very closely leaves at some point in the distant future, we will be recruiting for another advisor. I would like to recruit nationwide and for the best one I can find.

Quite frankly, sometimes getting people to come and move to Washington is a challenge for us. And if I restrict it to those who can only come to Washington, we have had people in the past for many different positions, not just PAs, say thank you, but no.

And so I am willing to show flexibility on that, and I understand the concern. I understand the concern from the PA group. And I met with them personally and I am willing to show some accommodation.

Mr. MICHAUD. Okay. Thank you.

Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

Thank you, Doctor, for coming this morning. I just have four questions for you, two regarding H.R. 2790 and then two on H.R. 4053.

What will the cost estimate be for the Director of PA Services if you were to include the offset that would come from eliminating the PA advisor role?

Dr. CROSS. It is a relatively small amount. I do not know the number offhand.

Mr. HARE. So it would not be a significant amount of—

Dr. CROSS. The money is not an issue.

Mr. HARE. There are a large number, as you know, of VA-employed PAs that are veterans, some estimates are as high as 32 percent. And many are active members in the Guard and Reserve units and with important military medical experience.

I am wondering what is being done about recruitment and retention of this occupation in terms of getting people to come in and to do this.

Dr. CROSS. Let me say right from the start we tremendously value our physician assistants. They are part of the team. And our current advisor has been in so many meetings, it would be hard to count in terms of our policy and particularly those policies relevant to what they do and what we all do.

You noted something earlier. I think you listed the number of PAs at 1,600 plus. When I came in, it was upper 1,400 or 1,500. We have increased the numbers. I heard somebody say that the number had gone down. It is actually going in the other direction as I understand it.

So they are part of the team. We are increasing their numbers as we are increasing the numbers for others as well.

Mr. HARE. Well, maybe if you could just spend a second or two talking about how you do the recruitment, I mean in terms of getting people to come in and do these.

Dr. CROSS. We go out to events. We advertise. We have a group in New Orleans, an office there that puts out our announcements.

Mr. HARE. Just a couple questions on H.R. 4053. A lot of us, I mean, you have heard I know a lot of discussion about rural districts and I have a very rural district in west central Illinois. I have all or part of 23 counties.

Could you explain what the VA does when veterans who live in rural areas and they have this lack of access to mental health services through the VA, is there something in place to try to be able to bring those veterans in and to get the treatment that they need, because to be honest with you, I hear that all the time?

I had instances where veterans were telling me that they have to get into a van, and not just for mental health services, but in general. Even for a chest x-ray, we have veterans that are going 2½ hours in a van to get a chest x-ray and having to wait when they get there for tremendous periods of time and they just, quite frankly, Doctor, give up and say "I am not doing this again," you know, "I can't do this."

So I am wondering if you would maybe be able to tell me, particularly in the mental health area, but also generally how we address this in your opinion.

Dr. CROSS. I agree with what you said and the premise of your statement, I think, is correct. It is a challenge in the rural environment to provide all the medical services that might be needed in that environment.

So here is what we are doing. We have taken rather dramatic action and have much more planned. First of all, you have heard about the Office of Rural Health that is helping to organize this. But here are some of the things that we have done, and I want you to be proud of this because it is an aggressive effort. Lots of time, money, people are devoted to this.

In the past about a year and a half, 2 years, we have added over 3,700 mental health staff in the VA. I think that is absolutely phenomenal. That includes 147 addiction therapists, 343 psychiatrists, 720 psychologists, 1,024 social workers. And we are distributing

those across the Nation including where we can into the rural environments.

We are opening more community-based outpatient clinics, and I think you are all well aware of those and when we opened them because it is quite a big deal.

But going beyond that, sometimes our community-based outpatient clinics can create satellite sites where they can operate out of and we are doing that more and more, part-time places where they can get into the smaller communities and address the needs of our veterans.

But two other things I wanted to tell you about particularly. We do not want the patient to have to come to the big medical center unless they really have to. And one of the things they have to come to us most often for is medicine. And so we have arranged to send it to their home and we have arranged through the computer process or the phone process so that they can call up and get their refills through that mechanism.

And we are doing one other thing, which is absolutely wonderfully innovative, secure messaging. We have a pilot project starting now and this was really directed at the rural environment, but to others as well, but particularly the rural environment, how to get a question asked, that information, that personal touch from your doctor, your PA, nurse practitioner.

And we were concerned that e-mail was not secure enough. Secure messaging will allow us to do that. We are starting the pilot project. They can submit the question and we will help them get the answer back. Better than a phone system because when you call up, you have to go through the phone system. The doc might not be available right at that time. The doc might call them back later. The patient might not be home at that time.

This will work much better, I think. And so many more of our people, our veterans now have some form of computer access, either in the home or in a library nearby where they might be able to use this.

There are so many things that we can do for the rural environment. I think we should be excited about this. We should see this as an opportunity and grab hold of it. And we have lots of ideas that we can talk to you about on this.

Mr. HARE. Thank you, Doctor.

Thank you, Mr. Chairman.

Mr. MICHAUD. Dr. Snyder.

Mr. SNYDER. Thank you. I am sorry I was late. The Armed Services Committee was having a hearing going on at the same time.

But I just had one general question as I have flipped the material. It seems like we have several instances here in your discussion of some of these bills' proposals in which you feel that the veterans healthcare system is already providing the services.

Do you think that we have a gap in the awareness that Committee Members have or are we aware of gaps in our own particular areas that generally you do not see across the country or are we not spending enough time just trying to understand everything that you all have going on in this dynamic situation? We are treating more and more people coming back from Iraq and Afghani-

stan with, you know, the number of wounded and folks we are treating, counseling.

Where do you think the gap is as you see members, good faith members, good members coming forward with bills that you do not think that there is a need for? Where do you all see the gap?

Dr. CROSS. I really appreciate that question because that is exactly how I feel and many of us because Congress has been good to us, and the Administration has been good to us, in terms of getting us more resources and doing more things in the past several years.

Let me give you an example, and this is why I am so anxious to volunteer, that we and my staff gathered here today have times outside the hearing to meet with your staff to explain some of this in great detail because we are doing many things that often we do not have time to really express in the hearing environment.

On the Women's Health Act, for instance, so many of these things we think are great ideas and really support them except we are already doing them. I'll give you an example.

The proposal for a long-term study on health. Well, we started it in 2007. It is a VA initiated, 10-year longitudinal epidemiological surveillance on the mortality and morbidity of OIF/OEF veterans, including women veterans. With the interest of Congress, we are quite willing to also expand the sampling that we do in regard to women veterans. And they said that we should go out and look at some of the gaps or services that we provide to women veterans. Well, we agree and we are already doing it. The VA contracted for a national survey of women veterans in fiscal year 2007, a structured survey based on a pilot survey originally conducted in VISN 21. We will examine the barriers to care and the access to care and we will include women of all areas of service and include veterans who never even utilize VA care.

Just two examples. When I read through these proposals, I thought, well, many of these are good ideas except, and particularly in the TBI, we are already there. In some cases, the proposal here was to do things, which is actually less than we are anticipating doing on our own.

One of the proposals was in regard to a \$50 million expenditure related to PTSD. Our mental health enhancement fund last year, which was heavily for PTSD and heavily for substance abuse and similar things, was \$307 million.

So I would really appreciate the opportunity to show what we have done recently because some of these things may not have caught up with general knowledge as to what we are doing. And I think that we should be proud of that.

Mr. SNYDER. Thank you.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much.

Just a couple of quick questions. I know you are going to provide the position counts, what have you, for the Vet Centers. But for the Office of Rural Health, are all those positions filled in that particular office?

Dr. CROSS. I think there is a GS14 coming in 2 weeks that we are waiting for.

Mr. MICHAUD. Okay. Now, then they will be completely filled?

Dr. CROSS. Well, we just started the office in, you know, really September officially, although we were working on it before. I expect the office will change and expand.

Mr. MICHAUD. You mentioned a longitudinal study, and I know we have heard quite a bit from the Vietnam Veterans of America as far as their longitudinal study that has never been completed.

Do you know where that is in the process? Does the VA plan to move forward with that study?

Dr. CROSS. Truthfully, Mr. Chairman, I am not an expert on that. I would rather get my experts together and give you a detailed briefing rather than try and wing it in this environment.

Mr. MICHAUD. I appreciate that because I am sure we will be hearing more about that study again. So I would like to know and try to move it forward if at all possible.

So, once again, I would like to thank you very much, Dr. Cross, for coming in today, Mr. Hall. I look forward to the followup answers to our questions. Look forward to working with you as we move forward in making sure that our veterans of this great Nation of ours are taken care of in a timely and an appropriate manner. So, once again, thank you for your testimony.

The hearing is adjourned.

[Whereupon, at 11:32 a.m., the Subcommittee was adjourned.]

A P P E N D I X

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

I would like to thank everyone for coming today.

Today's legislative hearing is an opportunity for Members of Congress, veterans, the VA and other interested parties to discuss recently introduced legislation within the Subcommittee's jurisdiction in a clear and orderly process.

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

We have eight bills before us today.

I look forward to hearing the views of our witnesses on these bills before us.

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

Prepared Statement of Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman.

I appreciate your holding this legislative hearing to start the New Year.

Currently we have over 265,000 servicemembers deployed overseas in the Global War on Terror. These men and women and their families expect and should know that when they return home their service and sacrifice will be honored and supported with benefits and health care services tailored to meet their needs.

Today we will look at eight different bills that have been introduced to improve the way we deliver health care to our Nation's veterans.

I want to thank my colleagues who have brought forth these legislative proposals and for joining us to provide testimony on their respective bills.

The first bill on the agenda, H.R. 2790, would elevate the Physician Assistant position Congress established seven years ago to a full-time Director of Physician Assistant Services. It was introduced in a bipartisan manner by Phil Hare and Jerry Moran. The Physician Assistant profession has a strong relationship with the military, as it originated with medical corpsmen who wanted to transform their military medical training into the civilian health care field. And, it is important that we encourage VA to foster the recruitment and retention of these important health care providers.

Two bills we will consider, H.R. 3819 and H.R. 4146, would amend current law to clarify VA requirements for the reimbursement and payment of emergency medical care for veterans in a non-VA medical facility. A veteran enrolled in VA health care should never be subject to post-emergency treatment costs for any emergency health related situation and I strongly support a legislative change to correct any ambiguities that exist in current law.

We will also consider a number of bills that seek to create new authorities for new programs, research and studies for veteran patients with a traumatic brain injury; mental health concerns, including PTSD and substance use disorder; and to meet the specialized needs of women veterans. The Fiscal Year 2008 Consolidated Appropriations Act provided VA with significant new funds targeted to addressing the provision of care for these emergent needs. As we examine these measures, it is important that we keep in mind the importance of developing solutions that are principle centered, patient centered and complement rather than replicate existing authorities and ongoing efforts.

I look forward to a very productive discussion on legislation that would ensure our wounded warriors receive the best and most advanced medical care that is available.

Again, I thank all of our witnesses and those in the audience who have chosen to participate in today's hearing.

Thank you, Mr. Chairman, I yield back my time.

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

Good morning, Chairman Michaud and Ranking Member Miller. Thank you for holding today's hearing. I appreciate having the opportunity to be here to discuss the Women Veterans Health Care Improvement Act.

The Women Veterans Health Care Improvement Act (H.R. 4107), which I introduced on November 7, 2007, along with Rep. Brown-Waite, will expand and improve Department of Veterans Affairs health care services for women veterans, particularly those who served in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF).

I would like to thank the DAV for their support in helping craft this important legislation. I would also like to thank the VFW for their endorsement of the bill.

As you know, more women are answering the call to serve, and more women veterans need access to services that they are entitled to when they return. With increasing numbers of women now serving in uniform, the challenge of providing adequate health care services for women veterans is overwhelming. In the future, these needs will likely be significantly greater with more women seeking access to care and a more diverse range of medical conditions.

In fact, more than 1.7 million women nationally are military veterans. More than 177,000 brave women have served our Nation in Iraq and Afghanistan since September 2001 and nearly 27,000 are currently deployed in these wars.

By August of 2005, 32.9% of women veterans who had served in OEF/OIF had received VA health care. By the end of the following year (2006) that number had increased to 37%. As the VA compiles the final data for 2007—the percent is expected to have increased again.

And according to the VA, the prevalence of potential PTSD among new OEF/OIF women veterans treated at VA from fiscal year 2002–2006 has grown dramatically from approximately one percent in 2002 to nearly 19 percent in 2006.

So the trend is clear, but not surprising: More women are answering the call to serve . . . and more women veterans need access to services that they are entitled to. Clearly, we must do everything we can from a public policy standpoint to meet this new challenge of women veterans.

The Women Veterans Health Care Improvement Act calls for a study of health care for women veterans who served in OIF and OEF, a study of barriers to women veterans seeking health care, enhancement of VA sexual trauma programs, enhancement of PTSD treatment for women, expansion of family counseling programs, establishment of a pilot program for child care services, establishment of a pilot program for counseling services in a retreat setting for women veterans, and the addition of recently separated women veterans to serve on advisory committees.

The VA must ensure adequate attention is given to women veterans' programs so quality health care and specialized services are available equally for both women and men. I believe my bill will help the VA better meet the specialized needs and develop new systems to better provide for the health care of women veterans—especially those who return from combat, who were sexually assaulted, or who need child care services.

Chairman Michaud and Ranking Member Miller, thank you again for inviting me to testify. I look forward to answering any questions you may have.

**Prepared Statement of Hon. Shelley Moore Capito,
a Representative in Congress from the State of West Virginia**

Good day, Chairman Michaud and Ranking Member Miller and the members of the Subcommittee. I want to first take this opportunity to thank you sincerely for holding this hearing on this Veteran's TBI pilot program bill. In doing so you are demonstrating to our brave men and women in the Armed Services your commitment and concern for their well-being. You are also demonstrating to the American people, and your constituents that you are sincere about upholding the promise made to these young men and women by their country.

As the Subcommittee is already aware Traumatic Brain Injury has become one of the signature injuries of the Middle Eastern theatre of the War on Terror. TBI

is a multifaceted injury with a wide range of severity and a wide spectrum of symptoms. Many sufferers require in-home care and extensive treatment and rehabilitation.

Symptoms of mild cases of TBI include persistent headaches, ringing in the ears, sleep disturbances, and chronic dizziness. In the more severe cases symptoms of TBI include loss of consciousness, personality changes, seizures, slurred speech, debilitating weakness or numbness in the extremities, loss of coordination, increased confusion, restlessness, and/or agitation. Many returning veterans also suffer from PTSD which commonly accompanies TBI. These symptoms can compound duress, and will also complicate recovery.

You may recall the story of a Sergeant David Emme, of the U.S. Army. Sergeant Emme's convoy came under an IED attack. Emme suffered a textbook case of TBI. Although he was conscious on and off for 10 days after the attack he could not recall what happened until he woke up at Walter Reed after having been transferred from Iraq. What Emme suffered could be likened to the recovery of a stroke victim. He had to relearn names, and redevelop cognitive abilities like talking. Emme noted being horribly confused and disoriented during the first few days of his recovery in which he confused nurses and doctors for CIA agents.

According to the Defense and Veterans Brain Injury Center, in just 2003 TBI comprised up to 20% of all surviving casualties. I will remind you 2003 saw the fewest U.S. military deaths in Iraq (486 deaths) and saw little over half the deaths of the next most violent year (822 deaths in 2006). We can only conclude that this percentage has increased with the prominence of IED attacks as the preferred method of attack of insurgents.

As of January 5th, according to the Department of Defense, 28,870 members of the Armed Services have been wounded in Iraq. Twenty percent of that number is 5,774, therefore at an absolute minimum almost 6,000 returning veterans suffer from some form of TBI.

Currently the VA only has four treatment centers that specialize in treatment for battle related TBI: Richmond, VA, Tampa, FL, Minneapolis, MN, and Palo Alto, CA. In June of 2006 the National Rural Health Association gave testimony on the need for intensive treatment for geographically isolated veterans suffering from TBI. The testimony also emphasized the importance of Community Based Outreach Centers and local care facilities in providing the intensive treatment needed to overcome TBI.

What my bill proposes is a five year pilot program run by the Secretary of the VA with the Office of Rural Health. The program will be run in five States selected by the Secretary. For the VA hospitals in these five States case managers will be assigned to any recovering TBI sufferer receiving treatment at a VA facility. In carrying out the pilot program, the Secretary is directed to provide training at Department of Veterans Affairs medical facilities located in the selected States for the case managers who are assigned to individuals diagnosed with TBI.

The Secretary will also coordinate with non-Department medical facilities located in the selected States to provide the appropriate training necessary to manage the rehabilitation and treatment of TBI sufferers. Also the Secretary must determine an appropriate ratio of TBI patients to each case manager to ensure the patients receive proper and efficient treatment.

For a State in which no Department of Veterans Affairs medical facility is easily accessible, the Secretary can enter into a contract with a private health care provider located in that area for which the provider will be reimbursed. The Secretary is responsible for reporting to those providers the most recent and up to date information on the TBI patients they are treating.

Finally, the Secretary of Veterans Affairs shall submit to Congress an annual report on the pilot program.

In summation I would like to express my gratitude to the committee for allowing my testimony today, and for the opportunity for H.R. 3458 to be considered before the U.S. Congress. Again, I would like to acknowledge the committee's observation of the valiance and the sacrifices of the armed services. I am convinced by your actions that at heart you do have the best interests of veterans.

**Prepared Statement of Hon. Leonard L. Boswell,
a Representative in Congress from the State of Iowa**

Chairman Michaud, Ranking Member Miller and Members of the Committee, I would like to thank you for inviting me to speak before you today and for holding this hearing over many important pieces of veteran's health legislation.

Some say suicide is an epidemic which is sweeping through our veteran population. For too long suicide among veterans has been ignored; now is the time to act. We can no longer be afraid to look at the facts and a sad fact is we are missing adequate information on the number of veterans who commit suicide each year.

I was shocked, as I am sure many of you were, when I saw a *CBS Evening News* report focusing on veteran's suicide. They found that in 2005 over 6,200 veterans committed suicide—120 per week! The report also found that veterans were twice as likely to commit suicide as non-veterans. These statistics are devastating.

However, the data collected did not come from the Department of Veterans Affairs, but rather from individual States. That is why I introduced H.R. 4204, the Veterans Suicide Study Act to direct the Secretary of Veterans Affairs to conduct a study on the rate of suicide among our Nation's veterans. It is imperative we have the facts on this terrible problem if we are to effectively treat our veterans as they return home.

While I'm pleased that the Joshua Omvig Veteran Suicide Prevention Act is now law, we need to continue to get all the facts on suicide among our veterans in order to better treat them as they return home. I implore this Committee and Congress to act swiftly on H.R. 4204 so we can ensure we have the data we need to treat our Nation's heroes. This is an issue important to veterans and their families in Iowa and across our great Nation.

I would again like to thank members of this Committee for allowing me the time to speak and your diligence on this matter. I would be happy to answer any questions you might have.

**Prepared Statement of Joseph L. Wilson, Deputy Director,
Veterans Affairs and Rehabilitation Division, American Legion**

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on veterans' health care legislation being considered by the Subcommittee today. The American Legion commends the Subcommittee for holding a hearing to discuss these important and timely issues.

H.R. 2790, a bill to elevate the Physician Assistant (PA) Advisor to the VA's Under Secretary for Health to a full-time director, located in the VA's central office

P.L. 106-419 required the Department of Veterans Affairs (VA) to establish a PA (Physician Assistant) Advisor to advise on such PA issues as qualifications, clinical privileges, and scope of practice. Prior to the enactment of the law in 2000, VA had never had a PA advisor and the absence of a knowledgeable resource to advise on these issues resulted in unnecessary restrictions on PA ability to provide medical care to the veteran population. In the years since the PA advisor position was put into place, the VA PA population grew from 1,195 PAs to nearly 1,600 PAs—a 34-percent increase.

The VA's choice to implement the PA advisor provision as a part-time, field position has resulted in inconsistencies across VA medical facilities in their utilization of PAs. In one instance, the American Association of Physician Assistants was informed that a local facility determined that a PA could not write outpatient prescriptions, despite licensure in the State allowing prescriptive authority. Other PAs report that VA medical facilities will not hire PAs.

The Senate Appropriations Committee report on the Department of Veterans Affairs has included language recommending that the position be strengthened. In the 2002 report, the Senate expressed concern about the Veterans Health Administration's (VHA's) limitation of the PA advisor to a part-time position and encouraged the VHA to implement a full-time PA advisor in or around Washington, DC. Additionally, the Senate report urged the VHA to provide sufficient funding to support the PA advisor position.

Although The American Legion has no specific official position on this issue, we believe VA should do everything in its power to improve access to its health care benefits, to include providing adequate funding to support programs within the VHA, as well as establishing and maintaining an immediate accessible, relative continuum between VA Central Office (VACO) and VA medical centers and its attachments throughout the VHA.

H.R. 3458, a bill to direct the Secretary of Veterans Affairs to carry out a pilot program on the provision of traumatic brain injury care in rural areas

This bill directs the Secretary of Veterans Affairs to carry out a five-year pilot program, in five rural States, under which the Secretary trains and then assigns a specific VA case manager to each veteran diagnosed with traumatic brain injury (TBI), who is receiving care in a VA medical facility within that State.

The American Legion favors the intent of this bill to create a pilot program that would train and assign specified VA case managers for veterans diagnosed with TBI and residing in rural areas; however, we would encourage the implementation of this program to every venue nationwide, thereby ensuring across-the-board quality and adequate healthcare.

H.R. 3819, Veterans Emergency Care Fairness Act of 2007

This bill would require the Secretary of Veterans Affairs to reimburse veterans receiving emergency treatment in non-VA medical facilities for such treatment until such veterans are transferred to VA medical facilities, and for other purposes.

The American Legion supports provisions to allow VA to pay for emergency room care at non-VA facilities. We believe this would prevent any delays in treating life-threatening injuries or illnesses for veterans not in close proximity to a VA facility.

H.R. 4053, Mental Health Improvements Act of 2007

This bill seeks to improve the treatment and services provided by the VA to veterans with post-traumatic stress disorder (PTSD) and substance use disorders, and for other purposes.

Section 102 seeks to require the Secretary of VA to ensure that the following services be available at each VA medical center and Community-Based Outpatient Clinic (CBOC): short-term motivational counseling, intensive outpatient care, detoxification and stabilization, relapse prevention, ongoing aftercare, opiate substitution therapy, outpatient counseling, and pharmacological treatments to reduce the craving for drugs and alcohol. The American Legion believes this action would heighten assurance of continuous and consistent treatment to veterans nationwide.

Section 103 would require VA to ensure concurrent treatment for a veteran's substance use disorder and co-morbid mental health disorder by professionals proficient in treating substance use and mental health disorders. The American Legion has always held the position that veterans who succumb to alcohol or drug abuse caused by their service-connected disability are entitled to a level of compensation that reflects all aspects of their disability.

Section 104 seeks to mandate Vet Centers as an avenue to house peer outreach programs to re-engage veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) who aren't able to attend appointments for PTSD or substance use disorder. In this effort, The American Legion urges the Congress to authorize sufficient funding for programs, such as the aforementioned to adequately treat veterans suffering from PTSD and the effects of substance abuse.

Section 105 would require the VA to establish no less than six national centers of excellence on PTSD and substance use disorders, to provide comprehensive inpatient treatment and recovery services to veterans newly diagnosed with these disorders. While The American Legion applauds results that would be invoked by section 105, we also request that these centers of excellence be adequately placed to ensure veterans residing in rural areas of the country have access to treatment as well.

Section 106 seeks to require the VA to review all of its residential mental health care facilities, to include domiciliaries. This section includes an assessment of the aforesaid facilities, along with supervision and support provided throughout the entire Veterans Integrated Services Network (VISN); an assessment of the appropriateness of rules and procedures for the prescription and administration of medications to patients in such residential mental health care facilities; the ratio of staff members at each residential mental health care facility to patients at such facility; a description of the protocols at each residential mental health care facility for handling missed appointments; and recommendations by the VA for improvements as well.

The American Legion supports this section's request to provide up-to-standard inhabitable facilities, as well as adequate staff to ensure continuous and quality care for veterans.

Section 107 would provide for Title 1 of this bill to be enacted in tribute to Justin Bailey, an OIF veteran who died while under VA treatment for PTSD and a substance use disorder. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV, PTSD always follows a traumatic event that causes intense

fear and/or helplessness in an individual. Typically, the symptoms develop shortly after the event, but may take years. Psychological care is considered the most effective means of treatment for PTSD. In addition to treatment for PTSD, other mental health conditions, such as acute reaction to stress and abuse of drugs or alcohol, require much attention.

Due to the increasing numbers of veterans seeking care at VA medical facilities, to include those from the Gulf War era and OIF/OEF, The American Legion supports a bill such as H.R. 4053 to further improve treatment and services provided by the VA to our Nation's veterans. The American Legion also supports quality treatment and adequate supervision, to include that which would prevent such tragedies as Justin Bailey's.

H.R. 4107, Women Veterans Health Care Improvement Act

This bill seeks to amend title 38, United States Code, to expand and improve health care services available to women veterans, especially those serving in OIF/OEF, from the VA, and for other purposes. Section 101 discusses long-term study on health of women serving in OIF/OEF. This section would also require VA to adjoint with War-Related Injury and Illness Centers (WRIICs) and contract with outside organizations to conduct an epidemiologic study on the health effects of women who served in OIF/OEF. The American Legion concurs with the intent of this section due to the course of action in ascertaining the results of the study, which include collaborating with the Department of Defense (DoD) in acquiring relevant health care data, such as pre-deployment health and health risk assessments in conjunction with VA access to the cohort while they are serving in the Armed Forces.

Section 102 discusses study of barriers for women veterans to health care from the VA. The current Global War on Terror illustrates a few deficiencies in services provided for women veterans. Participation in OIF/OEF has obligated them to expand their military roles to ensure their own survival, as well as the survival of their units. They sustain the same types of injuries as their male counterparts. The American Legion supports studies to identify and alleviate barriers that hinder quality health care for all veterans, including women.

Section 103 discusses comprehensive assessment of VA's women's health care programs. The American Legion supports assessment of such programs as disease prevention, primary care, women's gender-specific health care, acute medical/surgical, and mental health treatment, domiciliary, rehabilitation and long-term care to ensure ongoing delivery of quality and adequate care to women veterans.

Section 201 discusses improvement of sexual trauma care programs of the VA. The American Legion supports improvement of VA's sexual trauma care programs, to include a comfortable atmosphere, which may encourage full disclosure of the veteran's traumatic event.

Section 202 discusses dissemination of information on effective treatment, including evidence-based treatments, for women veterans with PTSD. The American Legion supports the dissemination of information disclosing effective means of treatment for women and all veterans.

Section 203 discusses ensuring adequate provision of services for women veterans at VA Vet Centers. The American Legion supports adequate provision of services for women and all veterans at VA Vet Centers. This also includes effective communication with VA medical centers to adequately provide quality treatment for veterans requiring more complicated and/or long-term treatment.

Section 204 discusses a pilot program for childcare for certain women veterans receiving health care from facilities of the Department. The American Legion supports programs that allow flexibility for women and all veterans to obtain quality and adequate health care within the VHA.

Section 205 discusses a pilot program for women veterans newly separated from service for counseling in retreat settings. It is essential that appropriate treatment be provided to veterans who require special needs treatment.

Section 206 discusses the addition of recently separated women veterans to serve on advisory committees. It is essential that advisory committees represent the experiences of all veterans.

H.R. 4146, to amend title 38, United States Code, to clarify the availability of emergency medical care for veterans in non-Department of Veterans Affairs medical facilities

This bill seeks to amend title 38, United States Code (USC), to clarify the availability of emergency medical care for veterans in non-VA medical facilities. Currently, veterans who are diverted to non-VA medical facilities are unfortunately overwhelmed with hospital bills incurred from their stay at the respective facilities.

Section 1725 of title 38, USC, requires that non-facilities transfer the veteran to a VA facility following his or her stabilization.

However, when there are no accommodations available at a VA medical facility and the veteran has to remain at the non-VA facility, he or she incurs the cost of the emergency care from that point. Incurring costs for actions out of the veteran's control is inherently unconscionable. The American Legion supports provisions to authorize VA to cover the costs of emergency room care at non-VA medical facilities for veterans who are required to remain at these facilities due to unavailable space at VA medical facilities.

H.R. 4204, Veterans Suicide Study Act

This bill seeks to direct the Secretary of VA to conduct a study on suicides among veterans. The American Legion receives contact from actual veterans who disclose their need for immediate help due to their thoughts of harming themselves. As the number of calls to suicide prevention call centers increase, the need for more suicide prevention counselors throughout the VHA is warranted.

The American Legion supports continued studies on suicides among veterans. With a proactive stance in mind, we ask that these findings be readily communicated to suicide prevention divisions to increase the prevention of potential tragedies.

H.R. 4231, Rural Veterans Health Care Access Act of 2007

This bill creates a pilot program in seven geographically diverse VISNs across the country to provide veterans living 30 miles from a VA medical facility staffed by a licensed mental health professional with vouchers that can be used as payment in full for mental health services at a private, VA approved facility.

The aim of this bill is to also help veterans who require regular, long-term care and who live in areas that don't allow frequent trips to a VA medical facility. This would be especially intended to make counseling for PTSD, drug/alcohol abuse and families more accessible. Because treatment for a variety of mental conditions requires regular one-on-one sessions with a professional, we determined, with the input of veterans groups, that 30 miles was a reasonable distance. Many veterans are disabled or economically disadvantaged, meaning that a weekly trip for counseling appointments would be prohibitive or impossible. Thus, many vets who should be in counseling choose to forgo it.

According to research conducted by the VA, one in five veterans nationwide who enrolled to receive VA health care reside in rural areas. The American Legion believes no veteran should be penalized or forced to travel long distances to access quality health care because of where they choose to live. Furthermore, all care, to include pilot programs, should include outreach to every rural venue in which veterans reside.

The American Legion favors the intent of this bill to create a pilot program that would accommodate veterans residing in rural areas; however, we would encourage the inclusion of every VISN across the country, as well as, a more condensed pilot program than the above mentioned.

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 in continuing the enhancement of access to quality health care for all veterans.

**Prepared Statement of Joy J. Ilem,
Assistant National Legislative Director, Disabled American Veterans**

Mr. Chairman and other Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this legislative hearing of the Subcommittee on Health. DAV is an organization of 1.3 million service-disabled veterans, and devotes its energies to rebuilding the lives of disabled veterans and their families.

You have requested testimony today on eight bills primarily focused on health care services for veterans under the jurisdiction of the Veterans Health Administration (VHA), Department of Veterans Affairs (VA). This statement submitted for the record relates our positions on the proposals before you today. Our comments are expressed in numerical sequence of the bills.

H.R. 2790—To amend title 38, United States Code, to establish the position of the Director of Physician Assistant Services within the Office of the Under Secretary of Veterans Affairs for Health

The VA is the largest single federal employer of Physician Assistants (PA), with approximately 1,600 full-time equivalent employee (FTEE) PA positions. In the VA health care system PAs are essential primary care providers for millions of veteran outpatient and inpatient encounters and work in ambulatory care clinics, emergency medicine, and 22 other VA medical and surgical subspecialties.

The passage of the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) directed the VA Under Secretary for Health to appoint a PA advisor to that office. Since that time VHA has assigned this duty to a PA as a part-time, field-based collateral position, in addition to their local clinical care duties. However, this important clinical representative has not been appointed to VHA's major health care strategic planning committees or been fully integrated into VHA policy and planning management and health care planning activities. Additionally, the PA advisor has not participated in establishing priorities or policies for the new Office of Rural Health, or been utilized for emergency management planning, even though 36 percent of all VA PAs are veterans or currently serve in the military Reserves or Guard forces. These experiences and perspectives of VA's PA workforce could bring vital information to a number of new initiatives for improving veterans health care, including services for our newest generation of war veterans returning from Operations Iraqi and Enduring Freedom (OIF/OEF).

The Independent Budget veterans service organizations, including DAV, believe that PAs are a critical component of VA health care delivery and urge that the Subcommittee report this bill that would legislatively mandate the Advisor position as a full-time Director of Physician Assistant Services within the office of the Under Secretary for Health in Washington, D.C.

H.R. 3458—To direct the Secretary of Veterans Affairs to carry out a pilot program on the provision of traumatic brain injury care in rural areas

This bill would require the VA to establish a five-State pilot program of VA case-managed traumatic brain injury (TBI) care in rural States, and would provide various protections to ensure rural veterans with TBI received sufficient care from competent, trained providers, whether in VA facilities or those with which VA contracted to provide necessary specialized services. VA would be required to assign a case manager to each TBI patient with a determination of an appropriate ratio of patients to each case manager.

The bill would require the pilot program be conducted in consultation with the VA Office of Rural Health established under Public Law 109-461. The bill would also require VA to distribute best practice information on the treatment of TBI to the VA facilities and private providers that would participate in this pilot program.

DAV has no objection to this bill since it is consistent with recommendations of *The Independent Budget*.

H.R. 3819—Veterans Emergency Care Fairness Act of 2007

This bill would amend the two existing authorities, sections 1725 and 1728 of title 38, United States Code, that determine the circumstances in which the Secretary may pay for expenses incurred in connection with an eligible veteran's authorized emergency treatment in a non-VA facility.

Under current law VA is authorized to pay for non-VA emergency treatment for a veteran's service-connected disability, a nonservice-connected disability aggravating a service connected condition, any condition of veteran who is rated permanently and totally disabled, or a veteran enrolled in VA vocational rehabilitation. However, expenses incurred after the period of medical emergency ends but before the veteran can be transferred to a VA or another Federal facility may not be reimbursed.

If enacted, this measure would require the Secretary of Veterans Affairs to reimburse a veteran for emergency treatment provided in a non-VA facility until such veteran is transferred to VA. In addition to applying the prudent layperson definition of "emergency treatment" under both sections, the bill intends to reverse the current VA practice of denying payment for emergency care provided to a veteran by a private facility for any period beyond the moment at which VA determines the veteran can be safely transferred. Specifically, it would amend the definition of reimbursable emergency treatment to include the time when VA or another Federal facility does not agree to accept a stabilized veteran who is ready for transfer from a non-VA facility, provided the non-VA provider has made reasonable attempts (with documentation) to effect such a transfer.

The DAV supports the intent of this bill which is in accordance with the mandate from our membership and consistent with the recommendations of *The Independent Budget* to improve reimbursement policies for non-VA emergency health care services for enrolled veterans.

H.R. 4053—Mental Health Improvements Act of 2007

This measure would establish new program requirements and new emphases on existing programs for treatment of post-traumatic stress disorder (PTSD) and substance use disorder—with special regard for the treatment of veterans who suffer from co-morbid associations of these disorders.

Title I—Sections 102–104 of the bill would require VA to offer a complete package of continuous services for substance use disorders, including counseling; intensive outpatient care; relapse prevention services; aftercare; opiate substitution and other pharmaceutical therapies and treatments; detoxification and stabilization services; and other services the Secretary deemed necessary, at all VA medical centers and community-based outpatient clinics (unless specifically exempted). The measure would require that treatment be provided concurrently for such disorders by a team of providers with appropriate expertise. This section guides allocation funding to facilities for these new programs, as well as how facilities would apply for such funding. Sections 105 and 106 would require establishment of not less than six new national Centers of Excellence on Post-Traumatic Stress Disorder and Substance Use Disorder, that provide comprehensive inpatient treatment and recovery services for veterans newly diagnosed with both PTSD and a substance use disorder. The bill would require the Secretary to establish a process of referral to step-down rehabilitation programs at other VA locations from a center of excellence, and to conduct a review and report on all of VA's residential mental health care facilities, with guidance on required data elements in the report.

Title II—Section 201 of the measure seeks to make mental health accessibility enhancements. This provision would require the establishment of a pilot program of peer outreach, peer support, readjustment counseling and other mental health services for OIF/OEF veterans who reside in rural areas and do not have adequate access through VA. Services would be provided using community mental health centers (CMHC) (grantee organizations of the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services), and facilities of the Indian Health Service, through cooperative agreements or contracts. This pilot program would be carried out in a minimum of two Veterans Integrated Service Networks (VISNs) for a three-year period. Provisions would require the Secretary to carry out a training program for contracted mental health personnel and peer counselors charged to provide these services to OIF/OEF veterans. All contractors would be required to comply with applicable protocols of the Department and provide, on an annual basis, specified clinical and demographic information including the number of veterans served.

Title III—Section 301 of the bill would establish a new, targeted research program in comorbid PTSD and substance use disorders, and would authorize \$2 million annually to carry out this program, through VA's National Center for PTSD. Title IV—Sections 401 and 402 of the measure seek to clarify authority for VA to provide mental health services to families of veterans coping with readjustment issues. The bill would establish a ten-site pilot program for providing specialized transition assistance in Vet Centers to veterans and their families, and would authorize \$3 million to be used for this purpose. Finally, provisions included in the measure would require a number of reports on these new authorities.

Current research highlights that OIF/OEF combat veterans are at higher risk for PTSD and other mental health problems, including substance use disorder, as a result of their military experiences. Mr. Chairman, like you, we are concerned that over the past decade VA has drastically reduced its substance abuse treatment and related rehabilitation services, and has made little progress in restoring them—even in the face of increased demand from veterans returning from these current conflicts. There are multiple indications that PTSD and readjustment issues, in conjunction with the misuse of substances will continue to be a significant problem for our newest generation of combat veterans; therefore, we need to adapt new programs and services to meet their unique needs. We are especially pleased with the provisions pertaining to mental health services for family members. The families of these veterans are suffering too, and are the core support for veterans struggling to rehabilitate and overcome readjustment issues related to their military service. We hope at the same time that previous generations of veterans and their families could also benefit from these newly proposed programs and services.

Although DAV has no approved resolution from our membership calling for a joint treatment program for PTSD and substance use disorders, we believe the overall

goals of the bill are in accord with providing high quality, comprehensive health care services to sick and disabled veterans. Additionally, the bill is consistent with recommendations in the forthcoming Independent Budget for fiscal year 2009. Thus, with only one exception, stated below, we believe these are very timely provisions, and we fully support them.

Our concern relates to Title II section 201 of the bill. We support the peer counseling concept it would authorize, but we continue to have concerns about contracting with non-VA providers to provide specialized PTSD treatment.

Although DAV believes that VA contract care is an essential tool in providing timely access to quality medical care, we feel strongly that VA should use this authority judiciously. Current law limits the use of VA purchased care to specific instances so as not to endanger the VA's ability to maintain a full range of specialized services for enrolled veterans and to promote effective, high quality care for veterans, especially those disabled in military service and those with highly complex health problems such as blindness, amputations, spinal cord injury or chronic mental health conditions. A major concern is that in most cases where VA authorizes care to veterans by contract providers VA has not established a systematic approach to monitor that care, or consider any alternatives to its high cost, has not analyzed patient care outcomes, or even established patient satisfaction measures. For several years, The Independent Budget has recommended VA make major improvements in its contract and fee-basis programs, but VA has yet to make any improvement.

DAV wants to ensure that all veterans receiving care from VA or through its fee basis or contract programs are treated in accordance with VA's standards. In its 2001 report, "Crossing the Quality Chasm: A New Health Care System for the 21st Century," the Institute of Medicine (IOM) put forward six aims that now underpin the standard of care for U.S. providers. The IOM aims are that health care will be safe (avoiding errors and injury), effective (based on the best scientific knowledge), patient-centered (respectful of, and responsive to patient preferences, needs and values), timely (reduced waiting time and harmful delay), efficient (avoiding waste), and equitable (unvarying, based on race, ethnicity, gender, geography, or socio-economic status). VA embraces the IOM aims and therefore should manage rural veterans' health care issues in a way that addresses all of the aims collectively.

VA also lacks an integrated approach to address the unique health care challenges of rural veterans, including OEF/OIF veterans living in rural areas. To remedy the gaps, VA should identify an effective and creative approach to make health care—including mental health care—available to our newest generation of wartime veterans irrespective of their locations of residence. VA should develop performance measures and quality standards to assess the care that is provided through contract or fee-basis arrangements. DAV believes that reform in rural, remote and frontier VA care can be achieved with the same overarching principles that have accompanied the transformation of the Veterans Health Administration (VHA) over the past decade. Necessary actions to achieve this reform would include:

- Issuance of clear VHA policy that local facilities and Networks, through their mental health leadership, are responsible for creating a VHA-sponsored system that provides a stipulated array of services reasonably accessible to as many rural veterans, including OEF/OIF veterans as possible who need these services.
- Provision of direct services wherever VHA has a large enough concentration of veterans needing such services, and has an existing VHA site of care. This would require VA to upgrade access to marital counseling and develop brief interventions for substance abuse—services that VHA does not make easily accessible in even some of its largest facilities.
- Contracting for care where there is not a large enough concentration of veterans needing readjustment counseling services, after local and Network leadership assess the availability and quality of alternative service providers (e.g. Vet Centers, State veterans services), including the availability and quality of services which could be purchased in the community, and assuring that a full array of services is made readily available.
- Oversight by Congress of this policy, with evidence that it is coordinated with the VHA Office of Mental Health Services and the newly established Office of Rural Health.

Mr. Chairman, VA has received significant new funds targeted to providing better access to mental health services to all enrolled veterans. VA has developed a national Mental Health Strategic Plan to deploy several new mental health programs, ramp-up existing specialized mental health services and hire new staff. VA should rapidly deploy those plans then determine the degree of unmet need in rural areas.

In that connection, in Public Law 109–461, sections 212 and 213, Congress mandated VA to take specific steps to develop innovative and successful programs to improve care and services for veterans who reside in rural areas; assess its fee-basis health care programs; and, develop a plan by September 30, 2007 to improve access and quality of care, including measures for meeting the mental health needs of veterans residing in rural areas. VA was also required by that Act to report to Congress not later than March 30, 2007 on the VA community-based outpatient clinics (CBOC) and other access points identified by the Capital Asset Realignment for Enhanced Services (CARES) May 2004 decision document, and to coordinate that report through the Office of Rural Health. Finally, VA must conduct an extensive outreach program to OIF/OEF veterans who reside in rural communities in order to enroll those veterans in VA health care during the existing two-year enrollment period after their release from active duty. In carrying out the program the Secretary is required to work with State agencies, community health centers, and rural health clinics, to increase awareness of veterans and their families about the availability of health care services provided by VA.

Again, we recognize and appreciate the emphasis placed on peer counseling, outreach and ensuring that non-VA providers are properly trained and compliant with VA standards, and coordination with VA's Office of Rural Health in this provision. As a community everyone is very concerned about rural veterans access to health care—including mental health and readjustment services, especially for our newest generation of OEF/OIF veterans. We ask the Subcommittee to request the above noted reports from the Office of Rural Health to see what progress VA has made in addressing the needs of rural veterans. This information will provide essential information on how to best develop a comprehensive solution and meet the health care and mental health needs of this population.

H.R. 4107—Women Veterans Health Care Improvement Act

Mr. Chairman, women veterans are a small but dramatically growing segment of the veteran population. The current number of women serving in active military service and its reserve and Guard components has never been larger and this phenomenon predicts that the percentage of future women veterans who will enroll in VA health care and use other VA benefits will continue to grow proportionately. Also, women are serving today in military occupational specialties that take them into combat theaters and expose them to some of the harshest environments imaginable, including service in the military police, artillery, medic and corpsman, truck-driver, fixed and rotary wing aircraft pilots and crew, and other hazardous duty assignments. VA must prepare to receive a significant new population of women veterans in future years, who will present needs that VA has likely not seen before in this population.

Title I, sections 101–103 of the bill would authorize and mandate longitudinal studies by VA in coordination with the Department of Defense (DoD) to evaluate the needs of women who are currently serving, and women veterans who have completed service, in OIF/OEF. Also, VA would be required to study and report existing barriers that impede or prevent women from accessing health care and other services from VA. Thirdly, this title would require VA to make an assessment of its existing health care programs for women veterans and report those findings to the Congress.

Title II, sections 201 and 202 would make improvements in VA's ability to assess and treat women who have experienced military sexual trauma (MST), and would mandate the use of evidence-based treatment practices and methods in caring for women veterans who suffer from post traumatic stress disorder (PTSD) related to MST and/or combat exposure. The Secretary would be required to ensure appropriate training of primary care providers in screening and recognizing symptoms of sexual trauma and procedures for prompt referral and require qualified MST therapists for counseling. Under this authority the Secretary would also be required to provide Congress an annual report on the number of primary care and mental health professionals who received the required training, the number of full-time employees providing treatment for MST in each VA facility, and the number of women veterans who had received counseling, care and services associated with MST.

Section 203 and 204 would require a study on the adequacy of care and counseling for women veterans in VA's existing Readjustment Counseling Service, through its Vet Center programs, and would authorize a pilot program of childcare reimbursement for certain women veterans to ensure they are able to avail themselves of VA's existing mental health and other specialized health care programs. Section 205 would establish a pilot program of counseling in retreat settings for recently discharged women veterans who could benefit from VA establishing offsite counseling

to aid them in their repatriation with family and community after serving in war zones and other hazardous military duty deployments.

Mr. Chairman, this comprehensive legislative proposal is fully consistent with a series of recommendations that have been made in recent years by VA researchers, experts in women's health, VA's Advisory Committee on Women Veterans, The Independent Budget, and DAV. Therefore, we support this measure and urge the Subcommittee to recommend its enactment.

H.R. 4146—To amend title 38, United States Code, to clarify the availability of emergency medical care for veterans in non-Department of Veterans Affairs medical facilities

Although less comprehensive, this bill is intended to achieve the same purpose as H.R. 3819, discussed above, to provide equity of reimbursement to veterans who receive emergency health care services through private providers under VA eligibility. DAV holds similar views on both bills, and therefore, supports the merit of this bill. While supporting the intent, we believe this bill may not offer a complete remedy to the conditions which prompted its introduction. Therefore, we recommend the Subcommittee defer action on this bill and instead favorably report H.R. 3819.

H.R. 4204—Veterans Suicide Study Act

This bill would require VA, in coordination with DoD, State public health offices and veterans agencies, and veterans service organizations, to conduct a study and report to Congress the number of veteran suicides that have occurred since 1997. Given DAV's testimony on this topic at the full Committee's hearing on December 12, 2007, we support the need for a study of suicide in the veteran population; however, DAV recommends the language of the bill be amended to include other relevant measures that could help reduce veterans' suicides, specifically—information about risk factors—including age and gender, combat service and co-morbid medical and behavioral health conditions.

VA should also invest in translational research on how to improve clinical techniques to prevent suicidal behaviors. Another area VA should address is the impact on families (including parents) after a veteran or military servicemember commits suicide and what these families may need in terms of continued mental health counseling and care, or other VA or DoD services. Currently neither VA nor DoD knows very much about impact on these families post-suicide, and to our knowledge no rigorous studies have been undertaken.

Most importantly, suicidal behavior can be controlled and monitored with readily available access to quality psychiatric care for those who may be at risk because of a variety of mental health conditions. Mental health professionals and suicidologists are well informed about techniques and treatments that can reduce suicidal behavior (most often a prelude to suicide attempts), including attentive primary health care and mental health screening, good psychological health care, early intervention in substance misuse or abuse, addressing of relationship and interpersonal problems, reduction in risk-taking behavior, crisis intervention, protective hospitalization, etc.

While DAV supports the need for data on suicide in the veteran population and appreciates the intent of this measure, we hope the Subcommittee will consider making amendments to this bill to address some of these additional needs.

H.R. 4231—Rural Veterans Health Care Access Act of 2007

This bill would establish a five-year mental health services pilot program in seven specific Veterans Integrated Service Networks (VISNs), in which veterans in need of mental health services, but who reside at least 30 miles from a VA medical facility that employs a full-time mental health professional, would be issued vouchers by VA to receive private mental health services at VA expense. Vouchers would expire six months after issuance but could be renewed for an additional six months on request of a veteran, if deemed appropriate by the Secretary of Veterans Affairs. VA would be required to maintain a list of participating private providers, including family counseling providers and a contractor's participation would hinge on agreement to accept VA's vouchers as payment in full. While the program would expire five years after commencing, the Secretary would be required to recommend whether the program should be extended or expanded at the time.

We have a number of concerns about this bill. The Independent Budget is clearly on record as opposed to vouchering, privatization and other initiatives that could endanger VA's capabilities and lack contract care coordination aspects that we see as essential to the delivery of high quality care for veterans and the long-term maintenance of veterans' health services.

Sick and disabled veterans need a strong and vibrant VA system, one that offers specialized services for the kinds of serious injuries and chronic illnesses endemic

to that population. Congress has historically agreed with this premise and in consequence authorized VA to build and sustain its specialized programs in spinal cord injury, blindness, prosthetics and sensory aids, amputation care and rehabilitation, and, importantly in this instance, care for the seriously mentally ill and other disabled war veterans with mental health readjustment issues including PTSD. We are sympathetic to the plight of veterans residing in remote and rural regions, but we believe the type of vouchering program envisioned by this bill lacks the essential component of VA-managed care coordination. We believe VA's Offices of Mental Health Services and Rural Health should identify unmet needs in mental health within the rural veteran population, then fashion programs or solutions to meet those needs. As stated previously in this testimony, Congress has provided VA resources to hire thousands of new mental health providers, and VA has informed us that over 3,500 have in fact been hired to date. These new employees, and a multiplicity of new VA mental health programs, and the mandate to the Office of Rural Health should create greater access to mental health services for rural veterans. We ask the Subcommittee to provide oversight and to request from VA its strategic plan to outreach and provide services to OIF/OEF veterans and other veterans living in rural areas.

We also call to your attention that under the bill, the decision on whether an eligible veteran would be in need of mental health counseling would be made by a "certified mental health professional" with no requirement that VA make or confirm that determination. We believe access to care and its quality, quantity and safety, should be closely controlled and monitored by VA. We are also concerned about the intent of the provision in section 3, subsection b(4) of the bill, that states an eligible veteran would need to "reside[] at least 30 miles from a medical facility of the Department of Veterans Affairs that employs a full-time mental health professional" (emphasis added). We interpret this provision to mean that if a veteran lives within 30 miles of a VA medical facility, and that clinic or medical center only has a part-time mental health professional, or more than 30 miles from a VA facility with a full-time mental health professional, the veteran would be eligible to seek care through the proposed voucher system without regard to whether that VA facility were able to provide an appointment in a timely manner. If a qualified VA provider is unable to provide the service a veteran needs, VA should make a determination that veteran's need for care dictates the use of a contract provider. In any case, we believe VA should identify an appropriate contract provider and make a prompt referral. However, we believe, to ensure a veteran has access to VA's full range of services, VA should always remain that veteran's care manager.

Mr. Chairman, DAV appreciates the opportunity to provide this written statement for the record and present our views on these bills. I will be pleased to respond to any questions you or other Subcommittee Members may have.

**Prepared Statement of Christopher Needham, Senior Legislative Associate,
National Legislative Service, Veterans of Foreign Wars of the United States**

Mr. Chairman and Members of the Subcommittee:

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 am pleased to be before you providing the organization's views on an array of health care legislation.

The majority of the bills before us today revolve around a central theme: access to care. Whether a rural veteran, a female veteran, or one of our heroic wounded warriors, there are gaps in the Department of Veterans Affairs' (VA) ability to provide first-rate care. The bills under consideration today aim to close those gaps, ensuring that all of our veterans are adequately cared for, which is a goal that all of us certainly share.

H.R. 2790

This legislation would create a full-time Director of Physician Assistant Services to report to the Under Secretary of Health with respect to the training, role of, and optimal participation of Physician Assistants (PA). We are pleased to support it.

Congress created a PA advisor role when it passed the *Veterans Benefits and Health Care Improvement Act of 2000* (P.L. 106-419). The law required the appointment of a PA advisor to work with and advise the Under Secretary of Health "on all matters relating to the utilization and employment of physician assistants in the Administration." Since that time, however, the Veterans Health Administration (VHA) has not appointed a full-time advisor, instead appointing a part-time advisor

who serves in the role in addition to his or her regularly scheduled duties while working in the field, far from where VA makes its decisions.

The current PA advisor role is likely not what Congress envisioned when it created the role, and the PA advisor has had little voice in the VA planning process; VA has not appointed the PA advisor to any of the major health care strategic planning committees.

With the role that PAs play in the VA health care process, it only makes sense to invite their participation and perspective. VA is the largest employer of PAs in the country, with approximately 1,600. They provide health care to around a quarter of all primary care patients, treating a wide variety of illnesses and disabilities under the supervision of a VA physician. Since they play such a critical role in the effective delivery of health care to this Nation's veterans, they should have a voice in the larger process. We urge passage of this legislation and the creation of a full-time PA Director position within the VA Central Office.

H.R. 3458

The VFW is certainly supportive of the intent of this legislation, which would create a pilot program to care for veterans suffering from traumatic brain injuries (TBI) in rural areas.

It is clear that VA needs to do a better job caring for our wounded warriors, especially for those who transition from the polytrauma rehabilitation centers, but also for those who suffered, but did not stay at those specialized clinics. As we learn more about TBI, we are also finding that veterans can suffer from it without having any apparent physical injuries, meaning there are likely larger number of veterans suffering from mild or moderate TBI—diagnosis can come later, but only if VA properly screens the veteran.

We have all seen the television reports and read the heart-wrenching stories about wounded warriors falling through the cracks. It is truly shameful that these brave men and women have had to suffer. We can and must do better.

This legislation acknowledges these problems, and works to correct some of them. It would create, in five rural States, a pilot program that would provide trained case managers to veterans suffering from TBI, and allow VA to contract for care in places where VA is unable to meet the demand for care. All are worthy goals.

We would ask, however, that the Committee be mindful of any potential overlap with the Wounded Warrior legislation that has been making its way through Congress as part of the National Defense Authorization. It is our understanding that the provisions, which earlier cleared both chambers of Congress, are noncontroversial and that they will likely be a part of any upcoming Defense Authorization bill.

As always, we would hope that VA would be able to develop the in-house experience to deal with all these problems, and we believe that this should remain VA's ultimate goal. In the meantime, there are hundreds of veterans with a demonstrated need who would benefit from the contracting care this legislation would provide. We cannot afford to wait; they must receive adequate care as soon as possible.

H.R. 3620

The VFW is pleased to support H.R. 3620, the Homecoming Enhancement Research and Oversight Act. This legislation calls for a comprehensive study on the physical and mental health care needs of OEF/OIF veterans, produced by DoD, VA and the National Academy of Sciences.

The study, which would consist of two major phases, would look at the key issues and unknowns confronting those who were deployed overseas as part of OEF/OIF. It would include a study of the effects of multiple deployments, the scope of traumatic brain injuries and their effects on the servicemember and his or her family, and the long-term impact of other war-related illnesses and disabilities such as post-traumatic stress disorder. Notably, the study would also assess the physical and mental health care needs of women veterans. We also appreciate the emphasis this legislation would place on families and the effects these illnesses and disabilities appear to have on them. With the large number of citizen soldiers fighting these conflicts, it is only proper to see how all are affected, because it is clear that it is not just the man or woman in uniform who suffers.

A study such as this is essential to allow VA and DoD to properly manage what appears to be a crisis in our returning veterans. This assessment would give the departments and policy managers a clear idea of what the problems are, allowing us to develop plans to treat the disabilities and impairments we are seeing. The studies that we have seen have hinted at the problem, and have shown us enough to make initial efforts at improving the care of these brave men and women. However, we can and must do more.

We must be proactive with our approach, and move forward. Proper study of the issues will allow VA and DoD to see if their programs are accurately meeting the needs of this deserving population of veterans, and will better allow us to prepare for their care into the future. There is plenty that we do not yet know about the needs of these veterans, and the more we find out, the better prepared we will be to fulfill this Nation's sacred obligations to her sick and disabled veterans.

H.R. 3819 and H.R. 4146

The VFW is pleased to offer our support for these two pieces of legislation that deal with an issue important to a number of our members. These two bills would close a loophole in current law that causes a number of veterans each year to be saddled with expensive hospital bills for care related to emergency treatment.

Section 1725 of title 38 authorizes VA to reimburse veterans for medical expenses related to emergency care at non-VA facilities if the veteran is enrolled and using the VA health care system, and if he has no other form of medical insurance. This is an important safety net for many veterans who have no other means to pay for potentially life-saving care.

Under that same section, the definitions in (f)(1)(C) create that loophole that harms veterans. Current law requires that the non-VA facility transfer the veteran to a VA facility when the veteran is stable. However, in areas, where there is no suitable VA facility or when the facility is unable to accept the patient, the veteran is forced to stay at the non-VA facility and VA makes no payment for that emergency care. In this case, VA's inability to adequately provide the care the veteran needs ends up costing the veteran thousands of dollars out of his or her own pocket, something that is unconscionable. Clearly, this unfair policy punishes veterans unfortunate enough to live in areas where no VA facilities are available or able to accept a veteran. The policy punishes them for something that is no fault of their own.

Both bills amend that section and close the loophole. H.R. 3819 goes a step further. It mandates that the Secretary provide reimbursement by striking the "may reimburse" from section 1725 (a) and replacing it with "shall reimburse." This would eliminate any potential for a weakening of the policy. H.R. 3819 also would amend section 1728 of title 38 to specify emergency care as a medical expense eligible for reimbursement to certain categories of service-connected veterans. While we support the concept, we would note that the Committee should carefully consider any externalities that could pop up from replacing "such care or services" with "emergency treatment," especially when section 1728(a)(1) already specifies that reimbursement is for "such care or services [that] were rendered in a medical emergency."

With that in mind, we would urge the Committee to swiftly approve legislation that would close this loophole so that VA can properly reimburse those veterans who would be unfairly penalized by the current law.

H.R. 4053

The VFW is happy to support the Mental Health Improvements Act, comprehensive legislation that aims to improve the level of mental health services that VA provides, especially with respect to PTSD and substance abuse disorders. This legislation acknowledges and aims to improve the treatment of what is sadly a growing problem among veterans, especially OEF/OIF veterans. As the findings of the bill note, a 2005 DoD study found a 23% rate of Active Duty personnel who acknowledge a significant problem with alcohol use.

Title I of the bill focuses on substance use disorders, especially in conjunction with PTSD and other mental health issues. It would require VA to provide treatment—including counseling, therapy, and detoxification services—for substance use disorders at each VA medical center and community-based outpatient clinic, although it gives the Secretary the authority to decide if services are not needed at a particular location.

Additionally, it would provide funding for services to veterans suffering from PTSD with substance use disorders. Notably, it would allow VA to conduct these services in concert with peer groups, but also families. This flexibility would allow VA to develop a program that best works for individual veterans, adapting it to the veteran's particular needs for the most effective results.

The legislation would also create six new centers of excellence within VA to address PTSD and Substance Use disorders. These centers would provide comprehensive inpatient treatment for those veterans most in need of help with these sometimes-debilitating diseases. We are especially appreciative of the proposal to require the creation of a referral process for when veterans are ready to leave the centers. This could help to eliminate the possibility of a veteran falling through the cracks,

ensuring that the veteran really does receive the additional care that they would need to recover and return to normal life.

The VFW also supports section 201 of the legislation, which would create a new pilot program of peer outreach and support to help provide readjustment counseling and other mental health services. With respect to the peer outreach and support, we believe that these types of therapies and support are often preferable to certain veterans. They may appear to be less formal and more casual, a style that may be conducive to more effective results among some veterans. We would hope that the results from the pilot program would lead to improvements in VA's overall mental health and readjustment programs.

Section 201 would also authorize VA to provide mental health care to veterans in rural areas through contracts awarded by the newly created Office of Rural Health. While ultimately, the VFW would like to see VA have the ability and capacity to provide the full continuum of care to all veterans within its systems, we support this measure as it fills a critical gap in service to those veterans who truly need it. We would urge, however, that VA and Congress provide strong oversight of these programs to ensure that they really are meeting the needs of our veterans, and that they are complying with all VA privacy and clinical protocols.

We also support Titles III and IV of the legislation. They would require an in-depth study of PTSD and substance use disorders and extend VA's Special Committee on PTSD through the end of 2012. I would also make a note of the meaningful change in section 401 of the bill, which would add marriage and family counseling to the list of services VA should offer. As we have seen with the current conflict, the range of mental health services veterans suffer from do not just affect the individual, but also their families. We must do better, if not just to help those family members who suffer silently outside of VA's normal range of treatment, but also to improve the home life of those veterans suffering, giving them stability and comfort in their home life. That stability is critical to the effective treatment of the veteran, and anything we can do to improve upon it, is something we must do.

We thank Ms. Berkley and the members of this Subcommittee who have signed on to this bill for supporting it, and we would urge its approval. It could really have a meaningful impact upon thousands of veterans suffering from the invisible wounds of war.

H.R. 4107

The VFW is pleased to offer our strong support for this legislation, which would expand and improve upon the health care services provided to women veterans. Female veterans from OEF/OIF are experiencing many types of conflict that previous generations did not. They are involved in a conflict with no true frontline and in a high-stress situation with almost no relent.

The difficulties they face, and the level of reported mental health issues that all OEF/OIF veterans have is itself a challenge for VA. It is essential that VA's strategies not be a one-size-fits-all approach, but one that adapts and provides our men and women with tailored programs to give them every chance to return to civilian life fully healthy. This is especially so for our women veterans, many of whom are facing unprecedented levels of stress and conflict, and who, when they return, enter a VA that is predominantly used to caring for male veterans.

VA has made great strides in the care provided to women veterans, but they can definitely do more. *The Veterans Emergency Care Fairness Act* would push VA even further along, and would address some of the most critical issues our female veterans face.

Title I of the bill would authorize a number of studies and assessments as to VA's capacity for care, but also for what the future needs of women veterans will be. Section 101 would create an essential long-term epidemiological study on the full range of health issues female OEF/OIF veterans face. This is critical because it is uncharted territory. With increasing numbers of women veterans in a hostile combat zone, there are higher rates of exposures and incidents that must be studied so that we know what health care issues will come up in the short- and long-term. There is much we do not know, and lots of essential information that is necessary to study to ensure that VA is meeting their full needs.

Section 102 would require VA to study any potential barriers to care faced by women veterans to determine any improvements that VA must make so that women veterans can access the care to which they are entitled. This is especially true of those women veterans who choose not to use VA care. Is it because of a stigma associated with VA, a previous bad experience or other reasons? To better prepare for the future, VA must know the answers to these questions and we strongly support this study. Along those same lines, section 103 would require VA to develop an in-

ternal assessment of the services it provides to women veterans, as well as plans to improve where it finds gaps. We, too, welcome this assessment.

We fully support the sections contained in Title II of the legislation, which deal with the improvement and expansion of health care programs for women veterans. We especially appreciate the addition of two recently separated female veterans to the VA Advisory Committees on Women Veterans and Minority Veterans.

The VFW supports section 204, which would create a pilot program to provide childcare for women veterans receiving health care through VA. This is a terrific idea, which has the potential to eliminate a barrier for care, especially for single mothers. We note, however, that there are also a number of single fathers who would also benefit from the pilot program, but would be prevented from using these child care services under the definition of "qualified veteran" in section 204(a)(3).

The VFW thanks Ms. Herseth Sandlin and Ms. Brown-Waite for the introduction of this important bill, and we would urge the Committee to approve it because of the difference it could make for our women veterans today, but also for long into the future.

H.R. 4204

The VFW supports the "Veterans Suicide Study Act," legislation that would require VA to determine the number of veterans who have committed suicide over the last decade.

VA has made improvements to its suicide prevention programs, improving training for VA staff and employees, and raising awareness of the seriousness and importance of this issue. VA has established a national suicide prevention hotline, and hired suicide prevention coordinators at its medical centers.

Nobody knows the true number of veteran suicides, for a variety of reasons, but even just one loss is a tragedy. VA's Epidemiology Service is using rates from previous conflicts to estimate the rate of suicide among OEF/OIF veterans. Although this may provide VA with an acceptable starting point, hard data is going to be much more valuable with VA's efforts to provide truly effective mental health coverage and to improve its suicide prevention efforts.

Recent studies have shown a demonstrable link between exposure to a combat zone and the risk of suicide, most notably in the November 2007 Institute of Medicine report on "Physiologic, Psychologic and Psychosocial Effects of Deployment-Related Stress."

While this legislation would not lead to the direct treatment and care of more veterans, the numbers and information collected by this report could help VA and DoD get an accurate picture as to the scope of the problem, and uncover cases and examples that might otherwise go hidden. With the seriousness of this problem and the attention we must pay to it, more information is certainly better. The more information available to VA, DoD and Congress, the more prepared we all are to live up to this Nation's responsibilities to care for her veterans. Suicide among our veterans, especially those newly returning from combat, is a tragedy, and we owe it to our heroes to do everything in our power to prevent it from ever occurring.

H.R. 4231

The VFW supports this legislation, which would create a pilot program to provide mental health counseling at non-VA facilities for veterans who live in rural areas. One of the challenges VA has faced since OEF/OIF began has been on how to best care for those veterans who live in more remote areas, especially with the intensive levels of care some of their illnesses and disabilities require.

This is an issue with no true satisfactory answer, especially as we would prefer that VA be able to provide a high level of care to all eligible veterans. As we have seen with many veterans who live in rural areas, this is not always feasible. Veterans living far away from VA clinics or medical centers simply have a more difficult time receiving the same level of care that a veteran who lives in a town with a clinic receives. *The Rural Veterans Health Care Access Act* recognizes this and takes steps to improve their access to care.

To achieve this, it creates a 5-year pilot program that allows VA to provide 6-month vouchers for enrolled OEF/OIF veterans who live at least 30 miles from a VA facility that provides full-time mental health services to receive care with private mental health counselors. We are pleased to see that the counseling services include family counseling, since they often suffer from the effects of the veteran's mental health illness, and counseling can increase family stability, which is often a critical component in the rehabilitation of these complex mental health illnesses.

While ideal circumstances would have VA providing this level of care to all eligible veterans, we understand the difficult situation today's veterans are in. We would

hope that VA not rely on contract care to provide these specialized services and that the Department continue to make attempts to provide these services, but in the meantime, we cannot afford to leave these brave men and women waiting. This is the least we can do to make them whole, and to ease their transition back into civilian life.

As with our support for H.R. 4053, however, we would urge vigorous oversight of this contract authority to determine whether veterans are truly being helped and that the services VA pays for live up to VA's clinical, safety and privacy standards.

Mr. Chairman, this concludes my testimony. I again thank you for the opportunity to present the VFW's views and I would be happy to answer any questions that you or the members of the Subcommittee may have.

**Prepared Statement of Richard F. Weidman,
Executive Director for Policy and Government Affairs,
Vietnam Veterans of America**

Good morning, Mr. Chairman, Ranking Member Brown-Waite, and distinguished members of the Subcommittee on Health. Vietnam Veterans of America (VVA) appreciates the opportunity to testify before you on the eight bills under consideration by the Subcommittee. I hope our comments and insights will prove of value to you.

H.R. 2790, Amends title 38, United States Code, to establish the position of Director of Physician Assistant Services within the office of the Under Secretary of Veterans Affairs for Health. Physician assistants are an extremely valuable resource for veterans who use the VA health care system. To ensure that they are properly educated and trained, and that they are appropriately utilized in the programs and initiatives of the Veterans Health Administration, should be facilitated with the establishment of such a position. Veterans will be well served if the directorship is filled with a physician assistant with uncommon vision and competence.

For too long the Veterans Health Administration (VHA) has essentially been allowed to thwart the clear intent of the Congress, and refuse to properly utilize physician assistants in the mix of vitally needed health care practitioners at VHA. It is worth noting that the VA is the largest single federal employer of physician assistants (PAs) with the exception of the military, with approximately 1,574 full-time PA FTEE positions. The VA has utilized PAs since 1969, when the profession first started. However, since the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) directed that the Under Secretary of Health appoint a PA advisor to his office, VHA has continued to assign this duty as a part-time field FTEE, as collateral administrative duties to their clinical duties. VVA has requested for the past six years that this be a full-time FTEE within VHA for six years. Most other veterans' service organizations have made similar requests.

All such requests have been ignored, and generally met with what can frankly only be characterized as condescending disdain if indeed not outright derision. VVA points out that this is just one of many instances where the VA ignores the clear will of the Congress, and even "black letter law" directing them to do something, such as complete the National Vietnam Veterans Longitudinal Study (NVVLS).

This is the fourth Under Secretary of Health who has refused to establish this important FTEE as full time. This is the case despite numerous requests from members of Congress, the VSOs, and professional PA associations. The current Under Secretary has maintained this position as a part-time, field-based position with a very limited travel budget, and no discernible access to policymaking. During the time that the current part-time PA advisor was authorized the number of PAs have grown from 1,195 to approximately 1,600 today. Despite the growth, a 34% increase, this important clinical representative has not been appointed to any of the major health care VA strategic planning committees, has been ignored in the entire planning on seamless transition, polytrauma centers, traumatic brain injury planning and staffing, and has not been allowed to participate in rural health care or been utilized for emergency disaster planning.

This is despite the facts that 36% of all VA employed PAs are veterans or currently serve in the National Guard or military reserves. These veterans who are also PAs could bring vital experiences with highly dangerous situations to new initiatives for improving veterans' health care access, particularly in disaster response planning and execution.

PAs in the VA health care system were vital primary care providers for millions of veteran encounters in each of the past few years, and PAs work in ambulatory care clinics, emergency medicine, and in 22 other medical and surgical subspecialties. VVA believes that PAs are a vital part of VA health care delivery. The PA Di-

rector must be included in VA Headquarters Patient Care Services, be full-time FTEE in Washington, DC. This needs to be just the first step toward the VHA changing the corporate culture that does not value PAs on a par with Nurse Practitioners. We urge Congress to enact H.R. 2790 and fund this FTEE within the VHA budget for FY 2009 and to ensure the position is in Washington, DC.

Frankly, what VVA believes the Congress and the VA should do in addition to prompt enactment and implementation of this bill regarding physician assistants is: (1) Take steps to dramatically change what is often a hostile work environment for PAs in the VHA; and (2) Ensure that the scope of practice of PAs in the VA is at least as extensive as it is in the Armed Services; and (3) Create a scholarship program for returning Navy corpsmen (and women) and Army Medics to become PAs in the VA system, with active recruiting of the separating and demobilizing Medics, and with partnering agreements with affiliated institutions. The seasoned expertise of these returning corpsmen (women) and Medics could be vital in the future to assist VA to deliver more effective and efficient services, especially in rural areas.

VVA strongly supports the bill as written.

H.R. 3458, Directs the Secretary of Veterans Affairs to carry out a pilot program on the provision of traumatic brain injury care in rural areas. While the goal of this bill, which calls for a pilot program, is laudable, we believe that the best treatment for TBI is to be had in the VA's polytrauma centers of excellence. Additional treatment "back home" ought to be done by clinicians who can communicate with their counterparts at these polytrauma centers.

Frankly, we need to change the current paradigm of service for TBI and other profoundly wounded veterans. While there were many problems with the VA care received by seriously wounded veterans during Vietnam, when you were in the VA hospital you were literally IN the VA hospital. That is no longer the case, as most of the health care at VA is delivered on an outpatient basis, even to those who cannot drive because of TBI or other wounds. The current model, which came out during a recent symposium with prosthetics, depends on an intact nuclear family with a spouse (or parent) who can take the veteran to the many medical appointments he or she may have in a given week.

However, it is not always the case that there is an intact nuclear family and a stable home situation near to the needed medical services needed by that particular veteran to help shoulder this travel expense and burden with the new veteran. The "freeze" and rule at VA nursing homes and domiciliary facilities leave them unable to adequately respond to this need. Perhaps there is need for low cost veterans housing units that are near VA medical centers or even constructed on their grounds if there is adequate land may be part of the answer. At a hearing before the House Committee on Financial Services last month there appeared to be some interest in such cooperative models by the Honorable Maxine Waters, a former member of this distinguished panel, in crafting legislation that would create such housing. Perhaps now is the time to move quickly on the possibility of such a new paradigm that would assist new veterans with TBI or other problems, but would also solve similar transport problems of other deserving veterans who are dependent on the ongoing treatment modalities at a VHA facility.

We would caution about the use of outside providers of care for this increasingly common wound of war. While it does make sense to contract with non-VA clinicians in areas where no VA medical center or outpatient clinic is convenient for a patient, that outside provider must be certified as able to care for those with this unique wound. We do not believe that such clinicians are going to be easy to find. Further, as VA has shown with the mishandling of the inaptly named "Project HERO" the VHA must be watched like a hawk to keep them from distorting a good idea that makes sense.

Having noted all of the above, VVA still favors enactment of this bill to create such a pilot program, but urge that you amend the bill to require frequent substantive input by the VSOs, frequent reporting to this Committee, and other accountability mechanisms to keep this good idea on track toward something that will strengthen the matrix of services for these deserving veterans.

H.R. 3819, Veterans Emergency Care Fairness Act of 2007, amends title 38, United States Code, and requires the Secretary of Veterans Affairs to reimburse veterans receiving emergency treatment in non-Department of Veterans Affairs facilities for such treatment until such veterans are transferred to Department facilities, and for other purposes. VVA strongly believes that veterans who receive emergency treatment in non-VA facilities until they can be transferred to a VA facility should be reimbursed for their out-of-pocket expenses. This should not be the onerous, often ugly, and lengthy process that it often is today, and which usually results in the veteran being stuck with the bill for this emergency care. If they are not among the

1.8 million veterans who do not have health insurance, the VA should be able to—and does—bill their insurance carrier, which is right and proper.

VVA supports the bill as written.

H.R. 4053, the Mental Health Improvements Act of 2007, to improve the treatment and services provided by the Department of Veterans Affairs to veterans with post-traumatic stress disorder and substance use disorders, and for other purposes is one of the most important bills for your consideration. As more and more troops, some disturbed, others shattered by their wartime experiences come home, and it is patently and painfully obvious that neither the Department of Defense nor the VA have enough medical professionals on staff to meet their needs. The British Medical Journal released a study led by DoD researchers this past Tuesday that says that at least 1 in 9 returnees have problems with PTSD. Earlier DoD studies found a higher rate.

VVA has been pointing out the deficiencies in the number of mental health professionals at the Veterans Health Administration (VHA) for almost 10 years, and while there has been quite a bit of progress in the level of staffing in the past two years, they are still not where they should be, particularly in as to the substance abuse staff. Further most VAMC need more full-time mental health professionals as team members on the primary care teams (as distinct from the mental health clinic or the PTSD teams). We still hear often about veterans referred to the mental health clinic or the PTSD team at a VA hospital, only to be referred back to the primary health care team because the mental health diagnosis is not their primary diagnosis, and the mental health clinic does not have the resources to properly serve them.

DoD must be taken to task for having discharged some 28,000 servicemembers for “personality disorders” which allegedly pre-existed their entrance into the U.S. military. To send them off to war, and then to cut them loose because of some phantom “preexisting condition,” is damnable. It violates the covenant made with these men and women when they pledged life and limb in defense of the Constitution of the United States. They need the help of health care professionals, not the disapprobation of their superiors and the termination of their enlistment and all the mental baggage that goes along with it. Further, the military has done really very little on their pledge to change the corporate culture that punishes those who admit to problems with PTSD symptoms to one that gets those soldiers (and their families) much needed help.

VVA went to see Assistant Secretary of Defense for Health about three weeks before the war started to urge they do a better pre-deployment health assessment, including a mental health workup. We also urged that they move to be ready for significant PTSD problems, and that they set up nonpunitive modalities whereby war fighters could get help without effectively ending their military career. Dr. Winkenwerder essentially was dismissive of all we had to say, and stated that they saw no need to change any of their policies. Unfortunately, we were prescient of what was to come, and the deplorable situation that still exists today. As we are all aware, DoD’s mistakes and nonperformance becomes the problem of the VA as soon as the servicemember is no longer on active duty.

This bill needs to dovetail with mental health initiatives taken by the VA to ensure that there is no duplication of effort. More importantly, its provisions must have the funding needed to be effective. Anything less is unacceptable.

VVA requests that you modify the provision that mandates the Special Committee on PTSD to require that this Committee meet in public, at least to the VSOs and other key stakeholders. Our preference would be to require that they have consumer representatives meet with the Committee regularly as well. The current Undersecretary refuses to allow VSOs even to attend the Special Committee on PTSD meeting, and continues to conduct their business in secrecy. When asked why his response has been that they need to be able say things they might not say in public. VVA’s response has been and is that then they perhaps should not be saying something that cannot stand the light of day.

In this same vein, VVA urges the Committee to require that the Advisory Committee on (Serious) Mental Illness be public in the sense that the constituent representatives and the VSOs be allowed to attend the entire meeting, even if they are participants in the discussion for only a portion of the multi-day meeting. This Committee began to conduct much of their business in secrecy during the reign of Dr. Jonathan Perlin after he summarily fired the most senior and respected members of that body in what is still known in VHA as the “Friday Night Massacre.” We ask that the Congress require this Committee return to the way of business that is in keeping with an open and democratic government.

With the modifications noted, VVA favors passage of this bill.

H.R. 4107, the Women Veterans Health Care Improvement Act, amends title 38, United States Code, to expand and improve health care services available to women veterans, especially those serving in Operation Iraqi Freedom and Operation Enduring Freedom, from the Department of Veterans Affairs, and for other purposes should go a long way toward enhancing the health care services offered to—and needed by—women veterans. Women now constitute 16–18 percent of our Armed Forces. They are being killed and maimed in record numbers. It is vital for the VA to gear up to meet their needs now and over the coming decades.

Beginning a long-term study of the health status of women who served in Afghanistan and Iraq should be an invaluable tool in enabling the VA to assess current needs and anticipate future health care needs. And make no mistake: The PTSD that affects women is not a carbon copy of that which takes over the psyche of their male counterparts. There are other psychological ramifications that we are only now beginning to comprehend.

One would hope that VAMC directors, seeing a spike in the numbers of women veterans seeking health care, would gear up to meet their needs. They should not have to be prodded by legislation. Several years ago, Sanford Garfunkel, who then was the director of the VAMC in Manhattan, saw an influx of veterans with HIV and full-blown AIDS. He secured the funding, necessary approvals, and established the first ward for veterans with these then-fatal conditions. We know there are bright and committed medical center directors today who react to the needs of their patients; we would hope that passage of this bill would be of significant assistance to them.

At minimum every VA medical center facility should have a full-time women veterans coordinator who sits on the policymaking council for the hospital, and in the larger cities there should be a full free standing women's clinic, such as is found at Washington, D.C. VAMC.

H.R. 4146, Amends title 38, United States Code, to clarify the availability of emergency medical care for veterans in non-Department of Veterans Affairs medical facilities. This just seems to make a lot of sense. Amending section 1725(f)(1)(C) of title 38 by adding “. . . with the determination of whether the veteran can be so transferred to be based both on the condition of the veteran and on the availability of a bed in a Department facility that is no geographically inaccessible to the veteran” just makes sense. One has only to wonder why such a provision needs to be added into law.

VVA supports the bill as written.

H.R. 4204, The Veterans Suicide Study Act, directs the Secretary of Veterans Affairs to conduct a study on suicides among veterans is based on two unfortunate realities, recognized by Congress: That suicide among veterans is a serious problem; and that there is a lack of information on the number of veterans who commit suicide each year.

Anecdotally, suicide by active-duty troops and recently separated troops seems to be surging. DoD has tended to minimize the numbers, tracking only those on active duty who take their lives. No one, however, is tracking veterans who, months or years after they have reentered the civilian world, are overcome by war-induced demons.

We doubt very much if truly accurate numbers can ever be arrived at. But the VA—and DoD—really do need to try harder and not sniff that the suicide of someone six months removed from Iraq can not be attributed to his/her service over there.

H.R. 4231, The Rural Veterans Health Care Access Act of 2007, directs the Secretary of Veterans Affairs to carry out a pilot program to provide mental health services to certain veterans of Operation Enduring Freedom and Operation Iraqi Freedom. VVA believes that this bill needs some careful treading. While it is of the utmost importance that mental health problems be dealt with forcefully and in a timely manner, handing out vouchers for mental health services to veterans who reside in rural America is not necessarily the way to go—unless there is close communication with case managers and primary care clinicians at VA clinics and medical centers.

Our concern is that outsourcing a lot of this care can only lead to future difficulties if not carefully and closely monitored. And, to be quite frank, we can envision scenarios in which VA managers, rather than hiring the psychologists and psychiatrists they need, rather than ensuring that the Vet Centers are adequately staffed, outsource mental health to the detriment of veterans and their families. This must be guarded against.

VA Vet Center Staffing and Suicide Prevention—VVA is very concerned that the VA Vet Centers, operated by the Readjustment Advisory Service, have not received additional staffing that is vitally needed. The War Supplemental Appropria-

tions bill enacted early last March contained \$17 million to hire an additional 250 full-time mental health practitioners at the VA Vet Centers. These funds were not released to the RCS until mid-August, when it was too late to even get those staff on board before the end of the Fiscal Year, much less fully spend the money on additional personnel. So they bought a new computer system.

If the Congress wants to do something about the first line of defense against suicide, then forcing the VHA to increase the staffing of the VA Vet Centers is the single most effective action you can take, as well as the most cost effective and cost efficient step you can take. The Vet Centers are essentially the forward Aid stations to go out and get the wounded and get them into the medical services and treatment matrix. The Vet Centers see veterans of every generation who initially would not go anywhere near the VA medical center with a mental health or PTSD problem, for a variety of societal reason.

VVA thanks the Subcommittee for permitting us to present our views on these vital issues here today. I will be happy to answer any questions.

**Prepared Statement of Gerald M. Cross, M.D., FAAFP,
Principal Deputy 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 eight bills that would affect Department of Veterans Affairs (VA) programs that provide veteran health care benefits and services. With me today is Walter Hall, Assistant General Counsel.

H.R. 3819 Veterans Emergency Care Fairness Act of 2007

Mr. Chairman, the first bill I will discuss is H.R. 3819. VA strongly supports this measure, which would amend sections 1725 and 1728 of title 38 to make mandatory, standardize, and enhance our authority to pay expenses incurred when a covered veteran receives previously unauthorized emergency treatment in a non-VA facility. Those sections are currently discretionary (the Secretary "may reimburse" as opposed to "shall reimburse"), cover different veteran populations, and use different definitions of "medical emergency."

Currently, the Secretary may reimburse or directly pay the reasonable value of non-VA emergency treatment of a service-connected disability, a nonservice-connected disability aggravating a service-connected disability, any disability of a veteran with a permanent and total disability, or for a covered vocational rehabilitation purpose. When such claims are filed, VA medical professionals must determine whether there existed an actual emergency of such nature that delay in obtaining treatment would have been hazardous to life or health. Expenses incurred once the veteran had been stabilized and could have been transferred safely to VA or another Federal facility may not be reimbursed or paid.

The Secretary may also reimburse or pay for the reasonable value of expenses incurred by a covered veteran for non-VA emergency treatment where the treatment is sought for a non-service connected disability. The statutory standard for determining whether the treatment was emergent is whether a prudent-layperson would have thought it reasonable to seek immediate medical attention. This prudent-layperson standard means that if it turns out that the veteran's condition was not an actual medical emergency, VA can still reimburse or pay the expenses. This happens, for instance, when a veteran goes to the nearest emergency room believing a heart attack is underway but a severe case of heartburn is actually diagnosed. As with claims for service-connected conditions, the Secretary is only authorized to reimburse or pay for the reasonable value of the emergency treatment, and the emergency is considered ended at the point the veteran could have been transferred safely to a VA facility or other Federal facility.

H.R. 3819 would make it mandatory for the Secretary to reimburse or pay for the reasonable value of treatment for any veteran who meets eligibility criteria and would standardize the programs by applying the prudent-layperson definition of "emergency treatment" in both situations. Most importantly, it would define "emergency treatment" as continuing until (1) the veteran could have been transferred safely to a VA or other Federal facility, *or* (2) a VA or other Federal facility agrees to accept such transfer if, at the time the veteran could have been transferred safely, the non-VA provider makes and documents reasonable attempts to transfer the veteran to a VA facility or other Federal facility. While VA facilities work aggressively to accept the transfers once an emergency is stabilized, there have been cases

where VA has been unable to find a facility that had the resources needed to furnish the care required. In those rare cases, the veteran may ultimately be liable for post-emergency costs, imposing a serious monetary hardship. The bill would appropriately foreclose this result.

Effective reimbursement or payment of emergency treatment has been an issue of concern to the Department. H.R. 3819 appropriately resolves important billing issues, properly placing the financial onus on the Department to provide appropriate care either in the VA or Federal system or at a non-VA facility.

VA determined funds were available within the FY2008 President's Budget level for this expanded benefit.

As a technical matter, I would like to clarify that if a veteran currently meets the eligibility criteria on which the reimbursement or direct payment claim is based, VA invariably pays the claim. Thus, changing the Secretary's authority from "may" to "shall" for purposes of both types of claims would have no practical effect. Nevertheless, we do not object to such a change.

H.R. 4146 Emergency Medical Care for Veterans in Non-VA Facilities

H.R. 4146 would also amend section 1725 of title 38 to make clear that the determination as to whether a veteran can be transferred safely to a VA or other Federal facility is to be based both on the condition of the veteran and on the availability of a bed in a Department facility that is not geographically inaccessible to the veteran.

We favor the approach in H.R. 3819, which would make the same definition of "emergency treatment" apply to claims filed pursuant to both section 1725 and 1728. H.R. 4146 would amend only section 1725. As a result, a greater benefit (i.e., VA reimbursement or payment of non-VA emergency treatment up until the point in time a VA bed is available for the eligible veteran) would be provided to veterans with non-service connected disabilities than is available to veterans under section 1728 for service-connected disabilities, a discrepancy that cannot be justified. We therefore prefer the standardization of terms, and increased consistency in application, that H.R. 3819 would provide.

H.R. 4053 Mental Health Improvements Act of 2007

Title I. Substance Use Disorders and Mental Health Care

H.R. 4053 is the companion bill to S. 2162, on which the Department testified before the Senate Committee on Veterans' Affairs this past October. While we appreciate the attention given to the critical issues addressed in this bill, we cannot support its prescriptive approach of mandating forms of treatment, treatment settings, and composition of treatment teams.

Section 102 would require the Secretary to ensure that, at each VA medical center and community-based outpatient clinic (CBOC), available services would include, at minimum: short term motivational counseling, intensive outpatient care, detoxification and stabilization, relapse prevention, ongoing aftercare and outpatient counseling, opiate substitution therapy, and pharmacological treatments aimed at reducing cravings for drugs and alcohol. The Secretary could, however, exempt an individual medical center or CBOC from providing any of the otherwise required services, but the Secretary would have to report annually to Congress on the facilities receiving an exemption, including reasons for the exemption.

Section 103 would require the Secretary to ensure concurrent VA treatment for a veteran's substance use disorder and co-morbid mental health disorder by a team of clinicians and health professionals with expertise treating substance use and mental health disorders, in conjunction with other professionals as considered appropriate by the Secretary.

Section 104 would mandate that the Secretary carry out a program to enhance VA's treatment of veterans suffering from substance use disorders and PTSD through a competitive allocation of funds to VA facilities. Funding awarded to a facility would be used for purposes specified in the bill, such as peer outreach programs through VA's Vet Centers to re-engage veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) who miss multiple appointments for post-traumatic stress disorder (PTSD) or a substance use disorder. These peer outreach programs would need to be done in tandem with efforts of CBOCs and PTSD and substance use disorder treatment teams in VA's medical centers. Funds would also be used for collaboration between VA's urgent care clinicians and substance use disorder and PTSD professionals to ensure expedited referrals and for other specified purposes.

Section 104 would further require the Secretary to allocate \$50 million from appropriated funds available for medical care for each of fiscal years 2008, 2009, and 2010 to fund these programs; the Secretary would be required to submit a report to Congress within the first year regarding the program and the facilities for which funding had been allocated. The bill would require the total expenditure for PTSD

and substance use disorder programs to not be less than \$50 million in excess of a specified baseline amount. (The bill would define the baseline as the amount of the total expenditures on VA's treatment programs for PTSD and substance use disorders for the most recent fiscal year for which final expenditure amounts are known, as adjusted to reflect any subsequent increase in applicable costs to deliver those programs.)

Section 105 would require the Secretary to establish not less than six national centers of excellence on PTSD and substance use disorders, to provide comprehensive inpatient treatment and recovery services to veterans newly diagnosed with these disorders. Candidate sites would be restricted to VA medical centers capable of treating concurrent PTSD and substance abuse disorders and of providing inpatient care, and located in a geographical area with a high number of veterans diagnosed with both PTSD and substance use disorders. This provision would also require the Secretary to establish a process to refer and aid the transition of veterans from these national centers to programs providing step down rehabilitation treatment.

Section 106 would require the Secretary, acting through the Office of the Medical Inspector (OMI), to review all of VA's residential mental health care facilities, including domiciliary facilities. The OMI report must include a description of the care available in residential mental health care facilities in each Veterans Integrated Service Network; an assessment of the supervision and support provided in the VHA residential mental health care facilities; the ratio of staff members at each residential mental health care facility to patients at such facility; an assessment of the appropriateness of rules and procedures for the prescription and administration of medications to patients in such residential mental health care facilities; a description of the protocols at each residential mental health care facility for handling missed appointments; and any recommendations the Secretary considers appropriate for improvements to residential mental health care facilities. The bill requires OMT to submit to Congress a detailed report with these specified findings.

Section 107 would provide for Title I of this bill to be enacted in tribute to Justin Bailey, an OIF veteran who died while under VA treatment for PTSD and a substance use disorder.

VA does not support enactment of this title. Title I is overly prescriptive and would attempt to mandate the type of treatments to be provided to covered veterans, the treatment settings, and the composition of treatment teams. Treatment decisions should be based on professional medical judgments in light of an individual patient's needs, and experienced health care clinicians and managers are in the best position to decide how best to deliver needed health care services at the local level. It is more consistent with the principles of patient-centered medicine, as well as more efficient, to focus on making these services available to patients who require them, as opposed to requiring every VA facility to provide these services.

We are also concerned that section 104 would require all the competitively funded peer outreach services to be furnished through VA's Vet Centers. This would make Vet Centers reliant on the medical centers to provide funding needed to meet the peer outreach requirements of this program. Vet Centers generally receive their funding apart from the medical centers. And we do not support section 105. VA has previously expressed its difficulties with the concept of centers of excellence as opposed to the achievement of an overall standard of delivery of excellent care on a national basis; this provision is also overly restrictive and prescriptive. I refer you to the concerns VA has previously expressed regarding disease-specific treatment centers and models. Finally, section 106 would impose extremely onerous and time-consuming requirements on the OMI, which would overwhelm that office's capacity to meet its responsibility to oversee and investigate the quality of care furnished in all lines of service throughout the VA system—an absolutely vital function within the Veterans Health Administration. To meet the mandate, the Department would have to expand that office significantly. The OMI should be focused on its general mission, not on the narrowly focused duties set forth in section 106.

Title II. Mental Health Accessibility Enhancements

Section 201 of H.R. 4053 would require that, within six months after enactment of the bill, the Secretary establish a 3-year pilot program to assess the feasibility and advisability of providing eligible OIF/OEF veterans, particularly those from the National Guard or Reserve, with services including peer outreach and support, specified readjustment counseling, and other mental health services. Eligible veterans would include those who are enrolled in VA's health care system and who, for purposes of the pilot program, receive a referral from a VHA health professional to a community mental health center or to a facility of the Indian Health Service (IHS).

In providing readjustment counseling services and other mental health services to rural veterans lacking access to comprehensive VA mental health services, section 201 would require the Secretary, acting through the Office of Rural Health, to contract for those services with community mental health centers (as defined in 42 CFR § 410.2) and/or IHS facilities.

Sites for the pilot must include at least two Veterans Integrated Service Networks selected by the Secretary (VISNs). At least two of the sites would have to be located in rural areas that lack access to comprehensive VA mental health services. A participating community mental health center or IHS facility would be required, to the extent practicable, to provide readjustment counseling and other mental health services through the use of telehealth services. It would also need to utilize best practices and technologies and to meet any other requirements established by the Secretary and would have to comply with applicable VA protocols before incurring any liability on behalf of the Department. It would further be required to provide clinical information on each veteran treated, as required by the Secretary.

The Secretary would be required to carry out a national program of training for (1) veterans to provide peer outreach and peer support services under the pilot program; and required training for (2) clinicians at community mental health centers or IHS facilities to ensure they could furnish covered services in a manner accounting for factors unique to OEF/OIF veterans' experiences, including combat and military training experiences. This provision would also establish detailed annual reporting requirements for participating centers and facilities.

Mr. Chairman, all of these services are already available to OEF/OIF veterans, including those who served in the National Guard or the Reserves. No demonstrated need exists for the pilot program or these additional authorities, which are duplicative of currently existing authorities. It is also unclear to us how the peer outreach services to be provided under section 201 relate to the peer outreach program that would be established by section 104.

As to the requirement to contract with a community mental health center or IHS facility, VA has previously expressed a concern that imposition of such a requirement may inadvertently reduce the opportunity for a veteran to receive care from the most highly qualified contractor. Additionally, it is most often the case that when VA lacks capacity to provide mental health services in a certain rural area, the same situation exists for the community mental health centers and IHS facilities. IHS facilities, staff, and other resources should be focused on American Indians and Alaska Natives. VA and IHS have a Memorandum of Understanding (MOU) that provides the appropriate framework for cooperative ventures within the capacities of each of our two agencies, using that MOU and our current flexibilities to contract with the most appropriate provider when VA is not able to provide necessary services is the most effective way of assuring that rural veterans get the care they need.

Title III. Research

Section 301 of H.R. 4053 would require the Secretary, through the National Center for PTSD, to carry out a program of research into co-morbid PTSD and substance use disorder, including coordination of research and data collection and dissemination. The bill prescribes that the research address: co-morbid PTSD and substance use disorder; systematic integration of treatment for the disorders; and development of protocols to evaluate care of veterans with co-morbid disorders and to facilitate the cumulative clinical progress of such veterans. Section 301 would authorize \$2 million to be appropriated for each fiscal year 2008 through 2011 to carry out this program and specifically require the funds be allocated to the National PTSD Center in addition to any other amounts made available to it under any other provision of law.

Section 302 would continue the Special Committee on PTSD (which is established within VHA) through 2012; otherwise the Committee's mandate would terminate after 2008. VA strongly supports continuing the Special Committee.

With the exception of the extension of the Special Committee, VA does not support the provisions in title III. VA is a world-recognized leader in the care of PTSD and substance use disorders, particularly when these conditions co-exist. Please note that the recent scientific literature review by the Institute of Medicine did not find that VA's treatments for PTSD other than Cognitive Processing Therapy (CP Therapy) and Prolonged Exposure Therapy (EP Therapy) were not efficacious; rather, the IOM concluded that the scientific literature did not show that the other therapies used by VA met its standard for unequivocally and conclusively demonstrating their efficacy in the treatment of PTSD. The activities required by title III are also redundant of VHA's ongoing efforts, particularly of the research efforts being carried out by VA's National PTSD Center. We would welcome the opportunity to brief the

Committee on VA's achievements and efforts in this area, along with the role of the Office of Mental Health in overseeing the PTSD and substance abuse programs.

Title IV. Assistance for Families of Veterans

In connection with the family support services authorized in chapter 17 of title 38, United States Code (i.e., mental health services, consultation, professional counseling, and training), section 401 would amend the statutory definition of "professional counseling" to expressly include "marriage and family counseling." This provision would also ease eligibility requirements for such services by authorizing their provision when "appropriate" (as opposed to "essential") for a veteran's effective treatment and rehabilitation. Section 401 provides for that these services to be available to family members in VA medical centers, Vet Centers, CBOCs, or in other facilities the Secretary considers necessary. Currently, these family support services are restricted to care provided in inpatient care settings.

Section 402 would require the Secretary to carry out, through a non-VA entity, a 3-year pilot program to assess the feasibility and advisability of providing "readjustment and transition assistance" to veterans and their families in cooperation with Vet Centers. Readjustment and transition assistance would be defined as preemptive, proactive, and principle-centered, and would include assistance and training for veterans and their families in coping with the challenges associated with making the transition from military to civilian life. This provision would require the pilot program be furnished pursuant to an agreement between the Secretary and any for-profit or non-profit organization the Secretary selects as having demonstrated expertise and experience providing the designated services. The pilot program would be carried out in cooperation with 10 geographically-distributed Vet Centers, which would be responsible for promoting awareness of the assistance available to veterans and their families through the Vet Centers, the entity selected to conduct the pilot, and other appropriate mechanisms. Section 402 would establish detailed reporting requirements and authorize \$1 million to be appropriated for each of fiscal years 2008 through 2010 to carry out the pilot program. Such amounts would remain available until expended.

VA does not support title IV. It is unclear how these "readjustment and transition assistance" services are intended to differ from, or interact with, the readjustment counseling services and related mental health services already available to veterans and their families through our Vet Centers. The provision conflicts in many respects with VA's existing authorities to provide readjustment counseling and related mental health services and creates confusion, especially regarding client outreach, in what is currently a highly successful program. (Indeed, the 98-percent rate of client satisfaction with the Vet Centers is the highest of all VA's programs.)

We also do not understand the implied need for use of a non-VA organization for provision of these services. Vet Centers already provide marriage and counseling services to family members as necessary to further the veteran's readjustment. Let me assure you that, when necessary, our Vet Centers readily contract with appropriate organizations and providers to ensure veterans and their families receive covered family support services. In sum, this provision would not effectively enhance current authorities or Vet Center activities; rather, we see that it has serious potential to create confusion and disruption for both VA and our beneficiaries.

If the purpose of section 402 is to authorize readjustment and transition assistance services for family members that are other than those required for the veteran's successful readjustment, we would object. In contrast to the situation with veterans, if during the provision of readjustment counseling services, Vet Center staff identify a family member's need for more complex mental health care services or other medical care that is not in furtherance of the veteran's recovery or readjustment, VA can neither refer the family member to a VA facility for such care nor refer that family member to a non-VA provider. Consequently, both our Vet Center staff and the affected family member would be placed in an untenable position.

H.R. 4231 Rural Veterans Health Care Access Act of 2007

Mr. Chairman, VA strongly opposes H.R. 4231, which would require the Secretary to implement a 5-year pilot program using a voucher system to pay for mental health counseling at non-VA facilities for eligible OEF/OIF veterans. Those eligible for this benefit are veterans eligible to receive hospital care and medical services under section 1710 of title 38, United States Code, who also: served on active duty in support of a contingency operation (as defined in section 101(13) of title 10, United States Code); are diagnosed with a mental health condition for which a certified mental health provider recommends mental health counseling; and reside at least 30 miles from a VA medical facility employing a full-time mental health professional.

Under the pilot program, the Secretary would compile and maintain a list of mental health providers, including family counseling providers, who agree to accept a voucher as payment in full for counseling services furnished to the veteran bearing the voucher and to accept VA payment at the rates specified in the bill. Providers would be required to comply with all applicable VA protocols. H.R. 4231 would also permit an eligible veteran to use these vouchers as payment in full for visits to a family counseling provider (on the list) if a certified mental health provider or the Secretary recommends that the veteran and the veteran's family receive family counseling.

Once requested by an eligible veteran, the Secretary would be required to issue a 6-month supply of vouchers within 30 days. An additional 6-month supply of vouchers could be provided. To receive payment under a voucher, following provision of mental health or family counseling services, the provider would submit a voucher bearing the signatures of the provider and the veteran.

Prior to the pilot program's expiration, the Secretary would be required to conduct a study of its effectiveness and, based on that study, recommend whether the program should be extended or expanded. If the Secretary determines it should be extended or expanded, H.R. 4231 would authorize the Secretary to take such action.

VA strongly objects that as now drafted the bill would permit a veteran with a diagnosed mental health condition to be eligible for individual and family counseling services under the program based on a non-VA provider's recommendation. Without exception, a recommendation for a veteran's receipt of mental health counseling services by a non-VA provider should be made only by the appropriate Department mental health professional. This is necessary to ensure a continuum of care for the veteran as well as appropriate coordination and oversight of all the medical services furnished to the veteran. This would also lessen any potential for self-referrals and conflicts of interest by participating providers.

Second, this bill would result in fragmentation of care. Vouchers would be available only for some types of care (mental health counseling) but the bill does not address their possible need for biomedically based mental health services and evidence-based psychotherapy. H.R. 4231 could also lead to further barriers in integrating mental health services with other components of care and to the delivery of evidence-based interventions for mental health conditions.

The Office of Rural Health (ORH) is currently collaborating across VHA to develop policies and practices that expand and adapt current initiatives, and to develop new models of care delivery that may be most appropriate for rural veterans.

More importantly, ORH will leverage the VHA's capabilities to develop partnerships with governmental and nongovernmental entities to provide the best solutions to the challenges that rural veterans face and 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.

Lastly, we note the bill does not provide any criteria for determining the need or scope for family counseling services, whereas, it limits a veteran's eligibility to counseling services needed to treat the diagnosed mental health condition.

We further note the distance requirement would not limit this benefit to veterans residing in rural areas because those in many urban settings would likewise meet this requirement.

H.R. 2790 Director of Physician Assistant Services

H.R. 2790 would re-title the position of VHA's "Advisor on Physician Assistants" to "Director of Physician Assistant Services." This change in position title would appear to raise the incumbent and this discipline to the same level as VHA's other directors and lines of service. The bill would also expand the statutory duties of the position to require the incumbent to report to the Under Secretary for Health on all matters relating to the education and training, employment, appropriate utilization, and optimal participation of physician assistants within VA programs and initiatives. Finally, it would also require the incumbent to serve full-time and be located with the VA Central Office.

The current field-based Advisor position was established in 2000 and is successfully meeting the bill's objectives. Nonetheless, we do not object to the change in position title, although we note that physician assistant services do not constitute an actual service line. We do object to the provision in the bill that would restrict the locus of the position to VA Central Office. VA derives significant benefits from having the flexibility to use field-based clinicians in this and similar positions. Often the best candidates for such positions do not wish to give up their clinical duties entirely and relocate to Washington. It is also valuable for us to keep this position as a dual, as opposed to a full-time, role to enhance the incumbent's effectiveness

by maintaining a “hands-on” approach and frontline perspective. We estimate the cost of converting this position to one that is full-time would be \$34,252 for fiscal year 2008 and \$413,151 over a ten-year period.

H.R. 4204 Veterans Suicide Study Act

H.R. 4204 would require the Secretary to conduct a study to determine the number of veterans who have committed suicide between January 1, 1997, and the date of the bill’s enactment. The study would have to be carried out in coordination with the Secretary of Defense, Veterans Service Organizations, and State public health offices and veterans agencies. The bill would require the Secretary to submit a report to Congress on his findings within 180 days of the bill’s enactment.

We do not believe the study required by this bill would generate information that would further our understanding of how to effectively screen and treat veterans who may be at risk of suicide. It would merely provide us with the rates for this cohort of veterans. VA has studied suicide rates for multiple cohorts of veterans and, through such efforts, has already identified the major clinical risk factors for suicide. (In fact, we recently completed such a study for OEF/OIF veterans that we discussed at a recent hearing before the full House Committee on Veterans’ Affairs.) Using the data generated from those studies, we have developed protocols and processes to mitigate those risk factors. For these reasons, we do not support section 103.

Further, certain requirements mandated by the bill make its implementation not feasible. As now drafted, it would not afford VA the flexibility needed to develop a thorough and useful study. To design and carry out a study that is best designed to provide usable information to address the issue of veteran suicide rates, we believe the Secretary (not Congress) should determine the organization(s) with which the Department should coordinate the study. For instance, CDC currently studies suicide rates among the general population, while VA’s role has been to validate the information compiled by CDC.

Additionally the 180-day timeframe is not realistic, as there is currently a 2-year time lag in the information released by CDC on suicide rates. We would be glad to brief the Committee on study designs we believe would be more feasible and would better serve its ends. We estimate the cost of this bill to be \$1,580,006 in fiscal year 2008 and \$2,078,667 over a 10-year period.

H.R. 3458 Pilot Program on Traumatic Brain Injury Care in Rural Areas

Mr. Chairman, H.R. 3458 would require VA to carry out a 5-year pilot program to enhance care to veterans with traumatic brain injury (TBI) in five rural States (selected by the Secretary) in consultation with VA’s Office of Rural Health. VA would be required to assign a VA case manager to each VA patient diagnosed with TBI. The bill would further direct the Secretary to take specific actions in the pilot program States, including:

- Providing training to the assigned case managers, including coordinating with non-Department medical facilities, as appropriate, for such training;
- Determining an appropriate ratio of patients with TBI per case manager to ensure proper and efficient treatment;
- Seeking contracts with private health care providers in any area where no VA medical facility is easily accessible to TBI-diagnosed residents, with the independent contractors to be reimbursed by VA; and
- Providing updated information on the treatment of TBI to such private health care providers as have contracted with VA under the bill.

We do not support H.R. 3458 because it is not necessary. A number of TBI initiatives have been developed and implemented by VA under current authorities, including programs that address the issue of case management. In determining to provide care directly or by contract, VA considers not only local capacity and staffing issues but also the needs of the individual veteran and his or her family.

In our view, the bill would also establish a troubling precedent by establishing contract authority separate from our fee-basis contracting authority in chapter 17 of title 38, United States Code, for the treatment of a single condition/type of injury. These typically are very complex medical cases involving co-morbidities. Treatment of TBI and TBI related conditions cannot easily be singled out from other conditions requiring simultaneous medical attention. That is, TBI cannot be treated in a vacuum. For that reason the bill has potential to fragment care for the veteran population that most needs to receive its VA health care in a well-coordinated manner with continuous monitoring and oversight. We also note the number of eligible veterans covered by the bill is potentially great, because this bill is not limited to TBI due to injuries sustained during service in combat operations.

Since the time this bill was introduced on August 4, 2007, each VA facility has put into place an OEF/OIF case management program for severely injured OEF/OIF members. In October of 2007, VA established the Care Management and Social Work Service to ensure that each VA facility has an appropriate treatment team caring for these veterans (to include a program manager, clinical case manager(s), transition patient advocate, and a VBA OIF/OEF liaison). All enrolled severely injured servicemembers receive screening for TBI, and any OEF/OIF veteran who requests case management services may receive them.

H.R. 4107 Women Veterans Health Care Improvement Act

Title I. Studies and Assessments of Department of Veterans Affairs Health Services for Women Veterans

In general, Title I of H.R. 4107 would require VA to conduct a number of studies related to health care benefits for women veterans. More specifically, section 101 would require VA, in collaboration with VHA's War-Related Injury and Illness Study Centers, to contract with one or more qualified entities or organizations to conduct an epidemiologic cohort (longitudinal) study on the health consequences of combat service of women veterans who served in OEF/OIF. The study would need to include information on their general, mental, and reproductive health and mortality. The bill would require VA to use a sufficiently large cohort of women veterans and require a minimum follow-up period of ten years. The bill also would require VA to enter into arrangements with the Department of Defense (DoD) for purposes of carrying out this study. For its part, DoD would be required to provide VA with relevant health care data, including pre-deployment health and health risk assessments, and to provide VA access to the cohort while they are serving in the Armed Forces.

Section 102 of the bill would require VA to contract with a qualified independent entity or organization to carry out a comprehensive assessment of barriers encountered by women veterans seeking comprehensive VA health care, especially for those who served in OEF/OIF. In carrying out this study, the bill recommends VA survey women veterans who seek or receive VA health care services as well as those who do not. Section 102 would also set forth specific elements to be researched as part of the study. They include the following:

- Perceived stigma with respect to seeking mental health care services.
- Driving distance or availability of alternate transportation to the nearest appropriate VA facility on access to care.
- Availability of childcare.
- Acceptability of integrated primary care, or with women's health clinics, or both.
- Comprehension of eligibility requirements for, and the scope of services available under, such health care.
- The quality and nature of the reception by providers of such health care and their staff of the veteran.
- The perception of personal safety and comfort of women veterans in inpatient, outpatient, and behavioral health facilities of the Department.
- Cultural sensitivity of health care providers and staff to issues that particularly affect women.
- Effectiveness of outreach for health care services available to women veterans.
- Other significant barriers identified by the VA Secretary.

Once the assessment is completed, the Secretary would be required to ensure the head of the Center for Women Veterans and the Advisory Committee on Women Veterans (as well as any other pertinent VA program offices) review the results of the study and submit their own findings with respect to it. The Secretary would need to include these findings in the Congressional report required under this section.

Section 103 would require VA to conduct a comprehensive assessment of all VA health care services and programs for women veterans. In particular, the assessment would need to address specialized programs for women with PTSD, homeless women, women requiring care for substance abuse or mental illnesses, and those requiring pregnancy care. In conducting this study, VA would be required to determine whether effective health care services, including evidenced-based health care services, are readily available to and easily accessed by women veterans in areas of health promotion, disease prevention and health care. The determination would need to be based on the following factors: frequency with which such services are available and provided; demographics of the women veterans population; sites where such services are available and provided; and whether, and to what extent, waiting lists, geographic distance, and other factors obstruct the receipt of any of such services at any such site.

In response to the comprehensive assessment, section 103 would further require VA to develop a program to improve the provision of health care services to women veterans and to project their future health care needs (including mental health care) and, particularly, those of women serving in the OEF/OIF combat theaters. In so doing, VA would have to identify the services available under each program at each VA medical center and the projected resource and staffing requirements needed to meet the projected workload demands.

Section 103 would also require VA to submit, not later than one year after the bill's enactment, a report to the Congress on the conduct of this assessment. The Comptroller General of the United States would then be required to review VA's report and to submit to Congress its own report on the Department's findings, together with any recommendations for administrative or legislative action.

Mr. Chairman, we do not believe section 101 is needed because a longitudinal study is already underway. Therefore, VA does not support this provision. For several years veterans, VA, and Congress have been concerned with identifying possible war-related illnesses among returning women veterans, including adverse effects on reproductive health. To that end, in 2007, VA initiated its own 10-year study, the "Longitudinal Epidemiologic Surveillance on the Mortality and Morbidity of OIF/OEF Veterans Including Women Veterans." Several portions of the study mandated by section 101 are already incorporated into this project; however, to comply fully, we will need to increase the number of women veterans in the original longitudinal study. We already have a proposal before the Under Secretary for Health to adjust the number of study participants accordingly.

Mr. Chairman, section 101(c) of H.R. 4107 would be objectionable because it requires the DoD to provide health data on active-duty women, as well as "access to the cohort of such women while serving in the Armed Forces." This provision could require active-duty women to participate in a VA survey while still in the military. It also could require the DoD to provide private medical information before separation.

Similarly we do not believe section 102 is necessary because a similar comprehensive study is already underway. VA contracted for a "National Survey of Women Veterans in FY 2007-2008," which is a structured survey based on a pilot survey conducted in VISN 21. This study is examining barriers to care (including access) and includes women veterans of all eras of service. Additionally, it includes women veterans who never used VA for their care and those who no longer continue to use VA for their health care needs.

Section 103 would require a very complex and costly study. While we maintain data on veteran populations receiving VA health care services that account for the types of clinical services offered by gender, we lack current resources to carry out such a comprehensive study within a one-year timeframe. We would therefore have to contract for such a study with an entity having, among other things, significant expertise in evaluating large health care systems. This is not to say that such a comprehensive assessment is not needed and we recognize there may well be gaps in services for women veterans, especially given that VA designed its clinics and services based on data when women comprised a much smaller percentage of those serving in the Armed Forces. (Since the fifties, the number of women veterans using VA services has averaged between 3-5% of all veterans. With women now representing 5% of all veterans using VA, and 38.9% of OEF/OIF returning women veterans using VA for their health care needs, it is incumbent on us to identify gaps in services and in availability of gender-related services.) VA's Strategic Health Care Group for Women Veterans already studies and uses available data and analyses to assess and project the needs of women veterans for the Under Secretary for Health. The study required by section 103 would unacceptably divert significant funding from direct medical care.

We estimate the costs of section 101 to be \$2,327,503 in fiscal year 2008 and \$10,857,000 over a ten-year period. We estimate no costs for section 102 because VA's own comparable study is underway, with \$975,000 in funding committed for fiscal years 2007 and 2008. Section 103 would have a cost of \$4,354,000 in fiscal year 2008.

Title II. Improvement and Expansion of VA Health Care Programs for Women Veterans

Section 201, titled "Improvement of Sexual Trauma Care Programs of the Department of Veterans Affairs," would require VA to train all mental health professionals who provide services to veterans under that program and to ensure such training is done in a consistent manner that includes principles of evidenced-based treatment. Section 201 would also require VA to train primary care providers in screening and recognizing the symptoms of Military Sexual Trauma (MST) and to ensure

procedures exist for prompt referral of these veterans to appropriate mental health professionals. The provision recommends that VA's care and services for MST include the services of therapists who are qualified to provide counseling and who demonstrate an understanding of the burden experienced by former service members who experience both combat and MST.

Section 201 would also require VA to establish staffing standards used at VA health care facilities for full-time equivalent employees trained to provide treatment for conditions related to MST. These standards would need to ensure availability of services, and access to MST treatment, for all veterans seeking this care. This provision would also establish detailed reporting requirements for the Department.

We do not support the training-related requirements of section 201 because they are not necessary. In Fiscal Year 2007, VA funded a Military Sexual Trauma Support Team, whose mission is, in part, to enhance and expand MST-related training and education opportunities nationwide. VA also hosts an annual four-day long training session for 30 clinicians in conjunction with the National Center for PTSD, which focuses on treatment of the after-effects of MST. VA also conducts training through monthly teleconferences that attract 130 to 170 attendees each month. Recent topics included overviews of several commonly used evidence-based treatment protocols (e.g., protocols for CP Therapy, PE Therapy, and Acceptance and Commitment Therapy). VA has also recently unveiled the MST Resource Homepage, a Web page that services as a clearinghouse for MST-related resources such as patient education materials, sample power point trainings, provider educational opportunities, reports of MST screening rates by facility, and descriptions of VA policies and benefits related to MST. It also hosts discussion forums for providers. In addition, VA primary care providers screen their veteran-patients, particularly recently returning veterans, for MST, using a screening tool developed by the Department. We are currently revising our training program to further underscore the importance of effective screening by primary care providers who provide clinical care for MST within primary care settings.

We object strongly to the provision in section 201 that would require VA to establish staffing standards for this program. Staffing-related determinations must be made at the local level based on the identified needs of the facility's patient population for MST treatment and services, workload, staffing, and other capacity issues. Imposition of national staffing standards would be an utterly inefficient and ineffective way to manage a health care system that is dynamic and experiences continual changes in workload, utilization rates, etc.

Section 202 would require VA, through its National Center for PTSD, to develop and implement a plan for developing and disseminating information regarding effective treatments, including evidence-based treatments, for women veterans with PTSD and other co-morbid conditions. The plan would need to include a proposed timetable for the dissemination to all VA facilities, but in no case could dissemination occur later than one year after the bill's enactment. Section 202 would also require the plan to include any proposed additional resources needed to provide MST training and MST counseling and treatment. The measure would establish detailed reporting requirements, as well.

VA does not support section 202 because it is duplicative of activities already underway by the Department. VA is strongly committed to making state-of-the-art, evidence-based psychological treatments widely available to veterans and this is a key component of VA's Mental Health Strategic Plan. We are currently working to disseminate evidence-based psychotherapies for a variety of mental health conditions throughout our health care system. There are also two programs underway to provide clinical training to VA mental health staff in the delivery of certain therapies shown to be effective for PTSD, which are also recommended in the VA/DoD Clinical Practice Guidelines for PTSD. Each training program includes a component to train the professional who will train others in this area, to promote wider dissemination and sustainability over time.

Section 203 would require VA to conduct a study of the Vet Centers' capacity to provide services for women veterans and to determine their capacity to provide a sufficient scope and intensity of services. Once completed, the Secretary would have to develop a plan to ensure that adequate counseling and mental health services for women veterans are available at each Vet Center, taking into account their specialized needs.

We do not support section 203 because it is not necessary and is duplicative of VA's ongoing activities in this area. VA's Vet Center program is one of VA's best-received programs as it currently exists, and it already provides the services sought by this subsection. We would be glad to brief the Committee on all of our activities, particularly our extensive outreach efforts and the significant expansion now underway to increase capacity (both in terms of staff and new facilities).

Section 204 would require VA, not later than six months after the bill's enactment, to carry out a two-year pilot program to furnish childcare services (directly or indirectly) to eligible women veterans receiving certain services through the Department. Sites for the pilot program must include at least three VISNs. Child care could only be provided for the period of time that the eligible veteran receives covered services at a Department facility and is required to travel to and from the facility for those services. Eligible veterans would include women veterans who are the primary caretaker of a child (or children) and who are receiving one or more of the following health care services: regular or intensive mental health care services, or such other types of intensive health care services for which the Secretary determines the provision of child care would improve access to those services. Moreover, under section 204, VA could provide the covered child care services through a variety of means, i.e., stipends offered by child care centers (directly or by voucher system), the development of partnerships with private agencies, collaboration with other Federal facilities or program, or the arrangement of after school care. Section 204 would authorize \$1.5 million to be appropriated for each year of the pilot and establish Congressional reporting requirements.

VA does not support section 204. Although we understand that the lack of available child care services can pose a barrier to access to care for some of our veterans, providing child care services—either in-house or through other arrangements—would divert funds and resources from our primary mission of providing direct patient care. We note that private health care facilities do not generally provide these services. Section 204 also unjustifiably discriminates against male veterans who, but for their sex, would otherwise meet the eligibility criteria. We estimate the cost of section 204 to be \$500,000 in fiscal year 2008 and \$2,500,000 in fiscal year 2009.

Section 205 would require VA to establish a two-year pilot program to evaluate the feasibility and advisability of providing counseling and transition adjustment assistance for newly separated women veterans that is conducted in a group retreat setting for as long as the Secretary deems is needed to be effective. Participation in the program would be voluntary and would not require a referral from any provider. Section 205 provides that the counseling services would be individually tailored to the participants' specific needs, and they could include some or all of the following types of counseling: mental health, family and marital, role and relationship, substance use disorder, or other counseling services determined to be necessary to assist the veteran before final repatriation with her family. Section 205 would also authorize \$2 million for each year of the pilot, and require VA to submit a detailed report to Congress within six months of the pilot's completion.

VA does not support section 205. We find the intent of the legislation confusing in that it would require that counseling be at the same time provided in a group setting but specifically tailored to the individual needs of each participating veteran. We know that counseling services provided in group therapy sessions are not appropriate or effective for all veterans and/or certain mental health conditions. Determination of the appropriate treatment milieu for each veteran should be based on the clinical judgment of a trained VA professional and should not be mandated—even as a pilot program. Likewise, we object to the precedent of permitting patients to self-refer for medical care. The need for these services should be made by the appropriate VA professional who can ensure they are medically appropriate and necessary. Moreover, the veterans participating in the pilot may assume in error that their medical and counseling problems can be completely resolved through this program with no need for future VA services. We note that VA has a number of counseling and transition adjustment programs underway to meet the needs of newly discharged/separated women veterans.

Finally, section 206 would require the Department's Advisory Committee on Women Veterans, created by statute, to include women veterans who are recently separated veterans. It would also require the Department's Advisory Committee on Minority Veterans to include recently separated veterans who are minority group members. (It is noted that section 206 contains a typographical error, as the Advisory Committee on Minority Veterans was established by section 544 of title 38, United States Code, not section 542.) These requirements would apply to committee appointments made on or after the bill's enactment.

We support section 206. Given the expanded role of women and minority veterans serving in the Armed Forces, the Committees should address the needs of these cohorts in carrying out their reviews and making their recommendations to the Secretary. Having the perspective of those who have recently separated would enable the Committees to, among other things, project the future needs of these veteran groups.

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 American Academy of Physician Assistants

On behalf of the nearly 65,000 clinically practicing physician assistants (PAs) in the United States, the American Academy of Physician Assistants (AAPA) is pleased to submit comments in support of H.R. 2790, a bill to amend title 38, United States Code, to establish the position of Director of Physician Assistant Services within the office of the Under Secretary of Veterans Affairs for Health. The AAPA is very appreciative of Representatives Phil Hare and Jerry Moran for their leadership in introducing this important legislation. The Academy also wishes to thank Chairman Filner and Representative Berkley for cosponsoring H.R. 2790.

AAPA believes that enactment of H.R. 2790 is essential to improving patient care for our Nation's veterans, ensuring that the 1,600 PAs employed by the VA are fully utilized and removing unnecessary restrictions on the ability of PAs to provide medical care in VA facilities. Additionally, the Academy believes that enactment of H.R. 2790 is necessary to advance recruitment and retention of PAs within the Department of Veterans Affairs.

Physician assistants are licensed health professionals, or in the case of those employed by the federal government, credentialed health professionals, who:

- Practice medicine as a team with their supervising physicians.
- Exercise autonomy in medical decisionmaking.
- Provide a comprehensive range of diagnostic and therapeutic services, including performing physical exams, taking patient histories, ordering and interpreting laboratory tests, diagnosing and treating illnesses, suturing lacerations, assisting in surgery, writing prescriptions, and providing patient education and counseling.
- May also work in educational, research, and administrative settings.

Physician assistants' educational preparation is based on the medical model. PAs practice medicine as delegated by and with the supervision of a physician. Physicians may delegate to PAs those medical duties that are within the physician's scope of practice and the PA's training and experience, and are allowed by law. A physician assistant provides health care services that were traditionally only performed by a physician. All States, the District of Columbia, and Guam authorize physicians to delegate prescriptive privileges to the PAs they supervise. AAPA estimates that in 2007, approximately 245 million patient visits were made to PAs and approximately 303 million medications were prescribed or recommended by PAs.

The PA profession has a unique relationship with veterans. The first physician assistants to graduate from PA educational programs were veterans, former medical corpsmen who had served in Vietnam and wanted to use their medical knowledge and experience in civilian life. Dr. Eugene Stead of the Duke University Medical Center in North Carolina put together the first class of PAs in 1965, selecting Navy corpsmen who had considerable medical training during their military experience as his students. Dr. Stead based the curriculum of the PA program in part on his knowledge of the fast-track training of doctors during World War II. Today, there are 139 accredited PA educational programs across the United States. Approximately 1,600 PAs are employed by the Department of Veterans Affairs, making the VA the largest single employer of physician assistants. These PAs work in a wide variety of medical centers and outpatient clinics, providing medical care to thousands of veterans each year. Many are veterans themselves.

Physician assistants (PAs) are fully integrated into the health care systems of the Armed Services and virtually all other public and private health care systems. PAs are on the frontline in Iraq and Afghanistan, providing immediate medical care for wounded men and women of the Armed Forces. PAs are covered providers in TRICARE. In the civilian world, PAs work in virtually every area of medicine and surgery and are covered providers within the overwhelming majority of public and private health insurance plans. PAs play a key role in providing medical care in medically underserved communities. In some rural communities, a PA is the only health care professional available.

Why are PAs so fully integrated into most public and private health care systems? We believe it's because they foster the use and inclusion of their PA workforce. Each branch of the Armed Services designates a PA Consultant to the Surgeon General. And, many major medical institutions credit their integration of PAs in the workforce to a Director of PA Services. To name just a few, the Cleveland Clinic, the Mayo Clinic, the University of Texas MD Anderson Cancer Center, and New Orleans' Ochsner Clinic Foundation all have Directors of PA Services. We believe that what works for the Armed Services and the private sector will also work for the VA.

How does the lack of a Director of PA Services at the VA relate to recruitment and retention of the VA workforce? As far as the AAPA can tell, there are no recruitment and retention efforts aimed towards employment of physician assistants in the VA. The VA designates physicians and nurses as critical occupations, and so priority in scholarships and loan repayment programs goes to nurses, nurse practitioners, physicians, and other professions designated as critical occupations. The PA profession has not been determined to be a critical occupation at the VA, so moneys are not targeted for their recruitment and retention. PAs are not included in any of the VA special locality pay bands, so PA salaries are not regularly tracked and reported by the VA. We've been told that this has resulted in lower pay for PAs employed by the VA than for health care professionals who perform similar medical care. Why are PAs not considered a critical occupation at the VA? Is it possible they were overlooked, because there was no one to raise the issue?

The outlook for PA employment at the VA does not differ from that for nurse practitioners and physicians. Approximately 40 percent of PAs currently employed by the VA are eligible for retirement in the next five years, and the VA is simply not competitive with the private sector for new PA graduates. The U.S. Bureau of Labor Statistics, *U.S. News and World Report*, and *Money* magazine all speak to the growth, demand, and value of the PA profession. The challenge for the VA is that the growth and demand for PAs is in the private sector, not the VA.

According to the AAPA's 2007 Census Report, PA employment in the federal government, including the VA, continues to decline. AAPA's Annual Census Reports of the PA Profession from 1991 to 2007 document an overall decline in the number of PAs who report federal government employment. In 1991, nearly 22% of the total profession was employed by the federal government. This percentage dropped to 9% in 2007. New graduate census respondents were even less likely to be employed by the government (17% in 1991 down to 5% in 2007).

Unless some attention is directed toward recruitment and retention for PAs, the AAPA believes that the VA is in danger of losing its PA workforce. The elevation of the PA advisor to a full-time Director of PA Services in the VA Central Office is the first step in focusing the VA's efforts on recruitment and retention of PAs.

The current position of Physician Assistant (PA) Advisor to the Under Secretary for Health was authorized through section 206 of P.L. 106-419 and has been filled as a part-time, field position. Prior to that time, the VA had never had a representative within the Veterans Health Administration with sufficient knowledge of the PA profession to advise the Administration on the optimal utilization of PAs. This lack of knowledge resulted in an inconsistent approach toward PA practice, unnecessary restrictions on the ability of VA physicians to effectively utilize PAs, and an underutilization of PA skills and abilities. The PA profession's scope of practice was not uniformly understood in all VA medical facilities and clinics, and unnecessary confusion existed regarding such issues as privileging, supervision, and physician countersignature.

Although the PAs who have served as the VA's part-time, field-based PA advisor have made progress on the utilization of PAs within the agency, there continues to be inconsistency in the way that local medical facilities use PAs. In one case, a local facility decided that a PA could not write outpatient prescriptions, despite licensure in the State allowing prescriptive authority. In other facilities, PAs are told that the VA facility can not use PAs and will not hire PAs. These restrictions hinder PA employment within the VA, as well as deprive veterans of the skills and medical care PAs have to offer.

The Academy also believes that the elevation of the PA advisor to a full-time Director of Physician Assistant Services, located in the VA central office, is necessary to increase veterans' access to quality medical care by ensuring efficient utilization of the VA's PA workforce in the Veterans Health Administration's patient care programs and initiatives. PAs are key members of the Armed Services' medical teams but are an underutilized resource in the transition from active duty to veterans' health care. As health care professionals with a longstanding history of providing care in medically underserved communities, PAs may also provide an invaluable link in enabling veterans who live in underserved communities to receive timely access to quality medical care.

Thank you for the opportunity to submit a statement for the hearing record in support of H.R. 2790. AAPA is eager to work with the House Committee on Veterans Affairs Subcommittee on Health to improve the availability and quality of medical care to our Nation's veteran population.

**Statement of Hon. Shelley Berkley,
a Representative in Congress from the State of Nevada**

Mr. Chairman,

Thank you for holding this hearing on the important issue of mental health legislation.

Nationally, one in five veterans returning from Iraq and Afghanistan suffers from PTSD. Twenty-three percent of members of the Armed Forces on active duty acknowledge a significant problem with alcohol use. It is vital that our veterans receive the help they need to deal with these conditions.

The effects of substance abuse are wide ranging, including significantly increased risk of suicide, exacerbation of mental and physical health disorders, breakdown of family support, and increased risk of unemployment and homelessness. Veterans suffering from a mental health issue are at an increased risk for developing a substance abuse disorder.

A constituent of mine, Lance Corporal Justin Bailey, returned from Iraq with PTSD. He developed a substance abuse disorder and checked himself into a VA facility in West Los Angeles. After being given five medications on a self-medication policy, Justin overdosed and died.

I have introduced the Mental Health Improvements Act, which aims to improve the treatment and services provided by the Department of Veterans Affairs to veterans with PTSD and substance use disorders by:

- Expanding substance use disorder treatment services at the VA medical centers.
- Creating a program for enhanced treatment of substance use disorders and PTSD in veterans.
- Requiring a report on residential mental health care facilities of the Veterans Health Administration (VHA).
- Creating a research program on co-morbid PTSD and substance use disorders.
- Expanding assistance of mental health services for families of veterans.

It is imperative that we provide adequate mental health services for those who have sacrificed for this great Nation and those who continue to serve. This bill takes a step in the right direction in providing our veterans with the care they have earned. I urge my colleagues to cosponsor this important piece of legislation, and I look forward to further action in this Committee.

Statement of Mental Health America

Mr. Chairman, Mental Health America commends you for scheduling this hearing, and for your and this Committee's ongoing concern about the mental health of our veterans.

Mental Health America (MHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. In partnership with our network of 320 State and local Mental Health Association affiliates nationwide, MHA works to improve policies, understanding, and services for individuals with mental illness and substance abuse disorders, as well as for all Americans. Established in 1909, the organization changed its name in 2006 from the National Mental Health Association to Mental Health America in order to communicate how fundamental mental health is to overall health and well-being. MHA is a founding member of the Campaign for Mental Health Reform, a partnership of 17 organizations which seek to improve mental health care in America, for veterans and non-veterans alike.

Unique Aspects of Operations Iraqi Freedom and Enduring Freedom (OIF/OEF)

Importantly, a number of the bills before the Subcommittee address mental health issues. While service-members have experienced mental health problems in every war, our operations in Iraq and Afghanistan differ markedly from prior combat engagements, with critically important implications for veterans' readjustment and recovery. It is critical therefore that the Committee target legislation to most effectively address the unique circumstances of these operations.

Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are unique in their heavy reliance on the National Guard and Reserves who make up a large percentage of our fighting forces. Reserve forces alone have made up as much as 40 percent of U.S. forces in Iraq and Afghanistan, and at one point, more than half of all U.S. casualties in Iraq were sustained by members of the Guard

or Reserves. These operations are also unique in their reliance on repetitive deployments. Deploying to a combat zone is necessarily enormously stressful to a soldier and to his or her family; that stress increases markedly with each subsequent deployment. The impact of those deployments on service-members has been profound.

Veterans' Mental Health Needs

A recently published DoD-conducted longitudinal assessment of mental health problems among soldiers returning from Iraq (published in the *Journal of the American Medical Association*, Nov. 2007) found that 42.4 percent of National Guard and Reserve-component soldiers screened by the Department of Defense required mental health treatment. The high percentages of Guard and Reservists among OIF/OEF veterans creates unique challenges that VA has not previously faced. First, these "citizen-soldiers" often live in communities remote from VA medical facilities. Yet they are as likely to have readjustment issues or to experience anxiety, depression or PTSD as veterans who have good access to VA health care. Long-distance travel is a very formidable barrier to a veteran's seeking (and continuing) needed treatment. That barrier is likely to be even higher for veterans with mental health needs, given the lingering stigma surrounding mental health treatment and the well documented reluctance of some veterans to seek VA help because of fears of disclosures that might compromise their military status.

The high incidence of mental health problems among returning service-members and particularly among Guard and Reservists should be cause for alarm, especially in rural and frontier areas, and the many places in the country where VA lacks any (or sufficient) specialized mental health service capacity. To be clear, VA is both a facility-based system, and a largely passive system that generally puts the burden on the veteran to seek care. While VA reports that significant numbers of OIF/OEF veterans have been treated at its facilities for behavioral health problems, there are compelling reasons to question how many veterans are not seeking and, therefore, not getting needed mental health treatment.

We should also be mindful of the expert advice of the Department's own Special Committee on Post-Traumatic Stress Disorder, which in a report in February 2006 advised that "VA needs to proceed with a broad understanding of post deployment mental health issues. These include Major Depression, Alcohol Abuse (often beginning as an effort to sleep), Narcotic Addiction (often beginning with pain medication for combat injuries), Generalized Anxiety Disorder, job loss, family dissolution, homelessness, violence toward self and others, and incarceration." The Special Committee advised that "rather than set up an endless maze of specialty programs, each geared to a separate diagnosis and facility, VA needs to create a progressive system of engagement and care that meets veterans and their families where they live. . . . The emphasis should be on wellness rather than pathology; on training rather than treatment. The bottom line is prevention and, when necessary, recovery." Importantly, the Special Committee also advised that "[b]ecause virtually all returning veterans and their families face readjustment problems, it makes sense to provide universal interventions that include education and support for veterans and their families coupled with screening and triage for the minority of veterans and families who will need further intervention."

Early treatment can help resolve post-traumatic stress disorder, depression, and other problems common in combat veterans. But those who do not get needed help too often self-medicate (using alcohol or drugs), develop chronic health problems, and experience interpersonal difficulties and even family breakup. As the Committee well knows, alarming numbers of returning veterans have even taken their lives.

H.R. 2874: Needed Legislation

In light of the issues outlined above, we believe this Committee, to its great credit, has taken a profoundly important step in developing and adopting H.R. 2874, the Veterans' Health Improvements Act of 2007, which the House passed last July. We regret that the Senate has not yet taken action on that measure. In our view, section 6 of that legislation provides critical solutions for the many OIF/OEF veterans with mental health needs who are not now getting the help they need from the VA. As you know, the key elements of the bill would require VA to mount a national program to train a cohort of OIF/OEF veterans to work as peer-outreach and peer-support specialists. In areas of the country where veterans cannot reasonably reach VA facilities, the bill calls on VA to partner with community mental health centers and similar entities to provide peer outreach and support services, readjustment counseling and needed mental health services. As a condition of such arrangements, those community providers would be required to hire a trained peer

specialist. That individual's role would be to help identify veterans in need of counseling or services, help overcome any reluctance to treatment, and navigate and support the veteran through the treatment process. We believe these provisions merit Senate adoption.

Among the bills before the Subcommittee is H.R. 4053, a measure that seeks to improve VA's behavioral health service-delivery. While a key focus of that bill is on improving such services at VA health care facilities, sections 201 and 402—which require VA to conduct modest pilot programs on peer outreach services and use of community mental health centers, in the case of section 201, and readjustment and transition assistance, in section 402—propose an approach very close to that in section 6 of H.R. 2847. Our concern is not with the program design proposed by the bill, but with its very limited scope. Enactment of sections 201 and 402 would, in our view, inadvertently shut a critical door to needed services for OIF/OEF veterans in rural, frontier and many areas of the country that are distant from VA facilities. Given the alarmingly high rate of mental health problems being experienced by returning veterans, we urge that the Committee not retreat from H.R. 2847 nor, in the absence of effective mechanisms to reach veterans who live at considerable distances from VA facilities, substitute limited pilot programs in lieu of a robust effort that offers the promise of helping all OIF/OEF veterans who are experiencing readjustment or behavioral health problems. We welcome the Committee's consideration of other sections of H.R. 4053, given the importance of ensuring that VA behavioral health service delivery does effectively serve veterans who are able to access VA care.

Family Services

In that regard, it is noteworthy that H.R. 2874, as introduced, included a provision that would have directed VA to establish a program to provide support and assistance to immediate family members of OIF/OEF veterans. (That provision, which would have authorized VA to provide immediate family members of OIF/OEF veterans with counseling and needed mental health services for a period of up to 3 years was not adopted in the Committee's markup of H.R. 2874.) Importantly, H.R. 4053 includes a section 401, which is apparently intended to clarify VA's authority to provide mental health services to families of veterans. It is not clear, however, that the proposed amendments in that provision in fact accomplish its admirable goal.

Current law and practice do in fact limit VA assistance to family members, and warrant change. VA is an integrated health care system which offers a relatively full continuum of care and services for eligible veterans. Among those services is "readjustment counseling." These services are provided principally at so-called "Vet Centers," many of which are located in population centers and are operated independently of VA medical centers and clinics. Typically provided by psychologists and clinical social workers, Vet Centers' services routinely include family therapy as a core component. But veterans and family members who do not have reasonable access to a Vet Center and rely instead on a VA medical center or clinic would not typically have access to family services. Most VA medical centers and clinics focus exclusively on the veteran patient (rather than on the veteran as part of a family unit). (Indeed those facilities employ measures of "workload" data that provide no workload credit for family services.) This focus and workload system effectively discourage clinicians from providing family therapy and support services. We see no sound programmatic rationale for encouraging family support at one set of VA facilities (the Vet Centers) and discouraging it at others. VA's Special Committee on PTSD reported in 2006 that "the strength of a war fighter's perceived social support system is one of the strongest predictors of whether he/she will or will not develop PTSD." VA health care, and particularly mental health care, would often be more effective if barriers to family involvement were eliminated.

Current law does provide VA some limited authority for counseling family members (but not for any other mental health services). But even that limited authority is circumscribed. Under section 1782(b) of title 38, family counseling is expressly limited to circumstances where such counseling had been initiated during a period of hospitalization, and continuation is essential to hospital discharge (unless the veteran is receiving treatment for a service-connected condition).

While H.R. 4053 suggests in the heading of section 401 that it would establish clarifying authority to provide "mental health services," its substantive provisions are limited to "marriage and family counseling." For a spouse who has experienced deep clinical depression or anxiety associated with a service-member's multiple tours of combat duty and with the profound fears associated with a war that has claimed thousands of casualties, marriage or family "counseling" will not necessarily meet that spouse's clinical needs. Moreover, as a technical matter, we believe any

effort to provide clarifying authority must address the limitations in section 1782(c) as well as the very practical “workload” disincentives.

Mental Health America would be pleased to work with the Committee to craft language to provide VA needed authority to assist family members consistent with its mission of serving veterans.

Statement of Paralyzed Veterans of America

Mr. Chairman and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit a statement for the record regarding the proposed legislation. We appreciate the continued emphasis on providing the best quality health care for veterans who experience mental illness as well as veterans who live in rural areas—two segments of the veteran population that present some of the most difficult challenges.

H.R. 2790, Director of Physician Assistant Services

PVA fully supports H.R. 2790, a bill that would establish the position of Director of Physician Assistant Services within the Veterans Health Administration (VHA) at the Department of Veterans Affairs (VA). This legislation mirrors the recommendation included in *The Independent Budget* for FY 2008 and that will be included in the FY 2009 edition as well.

As explained in *The Independent Budget*, Physician Assistants (PA) in the VA health care system are the providers for millions of health care visits every year in primary care clinics, ambulatory care clinics, emergency medicine, and in 22 other medical and surgical specialties. Since the PA advisor position was authorized by P.L. 106-419, the “Veterans’ Benefits and Health Care Improvement Act of 2000,” the number of PA’s in the VHA have grown significantly. And yet, four Under Secretaries for Health have all refused to make this position a full-time equivalent employee position. We appreciate the fact that this legislation will finally correct this senseless decision.

H.R. 3458, Pilot Program on TBI Care for Rural Veterans

PVA has no objection to the provisions outlined in H.R. 3458. The proposed legislation would authorize the VA to conduct a pilot program in five rural States. The program would be coordinated with the VA’s Office of Rural Health. The goal of the pilot program would be to provide the best available services for veterans who have experienced traumatic brain injury (TBI). We appreciate the fact that the legislation provides some protections to ensure that properly trained professionals are caring for the needs of this critical segment of the veteran population.

While we have expressed some concerns in the past with the idea of contract care for different groups of veterans, we understand that the VA must tap into the resources and expertise that private providers can offer. To that end, we have no objection to the provisions of the legislation that authorize contract care when necessary and appropriate. It is important that services for veterans who have incurred a TBI be coordinated between the VA and private providers.

H.R. 3819, the “Veterans Emergency Care Fairness Act”

PVA generally supports the provisions of H.R. 3819, the “Veterans’ Emergency Care Fairness Act,” as the legislation is in accordance with the recommendations of *The Independent Budget* for FY 2008. However, we remain concerned about some of the eligibility criteria that determine what veterans are eligible for this reimbursement. In accordance with *The Independent Budget* for FY 2008, we believe that the requirement that a veteran must have received care within the past 24 months should be eliminated. Furthermore, we believe that the VA should establish a policy allowing all veterans enrolled in the health care system to be eligible for emergency services at any medical facility, whether at a VA or private facility, when they exhibit symptoms that a reasonable person would consider a medical emergency.

H.R. 4053, the “Mental Health Improvements Act”

First, I would like to say that PVA generally supports this proposed legislation which improves services provided by the VA to veterans with Post-Traumatic Stress Disorder (PTSD) and substance use problems. Current research highlights that Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) combat veterans are at higher risk for PTSD and other mental health problems as a result

of their military experiences. In fact, the most recent research indicates that 25 percent of OIF/OEF veterans seen at a VA facility have received mental health diagnoses.

We are pleased with the provisions of section 102 and 103 of the legislation. In fact, *The Independent Budget* is set to recommend that VA provide a full continuum of care for substance use disorders including additional screening in all its health care facilities and programs—especially primary care. We also believe outpatient counseling and pharmacotherapy should be available at all larger VA community-based outpatient clinics. Furthermore, short-term outpatient counseling including motivational interventions, intensive outpatient treatment, residential care for those most severely disabled, detoxification services, ongoing aftercare and relapse prevention, self help groups, opiate substitution therapies and newer drugs to reduce craving, should be included in VA's overall program for substance abuse and prevention.

Although we support the creation of PTSD centers of excellence outlined in section 105 of the legislation, we wonder whether this step is necessary. The VA already maintains a broad network of PTSD treatment centers. Furthermore, in 1989, the VA established the National Center for Post-Traumatic Stress Disorder as a focal point to promote research into the causes and diagnosis of this disorder, to train health care and related personnel in diagnosis and treatment, and to serve as an information clearinghouse for professionals. The Center offers guidance on the effects of PTSD on family and work, and notes treatment modalities and common therapies used to treat the condition. This Center already functions as a center of excellence. At the very least, it should be incorporated into this new network of centers of excellence.

PVA has some concerns with the pilot program outlined in Title II of the bill. While we certainly support the emphasis placed on peer counseling and outreach, we maintain our concerns about contract services with community health centers. The VA should be able to provide the services described in the legislation through judicious application of its already existing fee basis authority. We do, however, appreciate the emphasis on ensuring that the non-VA facilities are compliant with VA standards, particularly through additional training managed specifically by the VA.

While we also support Title III of the legislation regarding research into co-morbid PTSD and substance use disorder, we wonder if this is duplicative with activities already taking place at the National Center for PTSD. However, PVA has long supported research initiatives into various types of conditions and the treatments associated with them.

Finally, we recognize the unique challenge associated with providing mental health services to families of veterans. This is an area that the VA has had little experience with in the past. Likewise, we see no problem with the VA examining the feasibility of providing readjustment and transition assistance to veterans and their families. It is certainly an issue that has become more apparent as more men and women return from conflicts abroad broken and scarred. The impact that this has on the veteran and his or her family cannot be overstated.

H.R. 4107, the "Women Veterans Health Care Improvement Act"

PVA supports H.R. 4107, the "Women Veterans Health Care Improvement Act." This legislation is meant to expand and improve health care services available in the Department of Veterans Affairs (VA) to women veterans, particularly those who have served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). More women are currently serving in combat theaters than at any other time in history. As such, it is important that the VA be properly prepared to address the needs of what is otherwise a unique segment of the veterans population.

Title I of the bill would authorize a number of studies and assessments that would evaluate the health care needs of women veterans. Furthermore, these studies would also identify barriers and challenges that women veterans face when seeking health care from the VA. Finally, the VA would be required to assess the programs that currently exist for women veterans and report this status to Congress. We believe each of these studies and assessments can only lead to higher quality care for women veterans in the VA. They will allow the VA to dedicate resources in areas that it must improve upon.

Title II of the bill would target special care needs that women veterans might have. Specifically, it would ensure that VA health care professionals are adequately trained to deal with the complex needs of women veterans who have experienced sexual trauma. Furthermore, it would require the VA to disseminate information on effective treatment, including evidence-based treatment, for women veterans dealing with Post-Traumatic Stress Disorder (PTSD). While many veterans returning from OEF/OIF are experiencing symptoms consistent with PTSD, women veterans are ex-

perienicing unique symptoms also consistent with PTSD. It is important that the VA understand these potential differences and be prepared to provide care.

PVA views this proposed legislation as necessary and critical. The degree to which women are now involved in combat theaters must be matched by the increased commitment of the VA, as well as the Department of Defense, to provide for their needs when they leave the service. We cannot allow women veterans to fall through the cracks simply because programs in the VA are not tailored to the specific needs that they might have.

H.R. 4146, Emergency Medical Care in Non-VA Facilities

While we support the intent of this proposed legislation, we believe that this issue is handled in a more comprehensive manner by H.R. 3819. Therefore, we recommend that the Subcommittee table this bill in favor of approving H.R. 3819.

H.R. 4204, the “Veterans Suicide Study 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. Any measure that may help reduce the incidence of suicide among veterans is certainly a good thing. As such, PVA supports this legislation. This bill would require the VA to conduct a study to determine the number of veterans who have committed suicide since January 1, 1997.

It is important to note that VA has made suicide prevention a major priority. VA has developed a broad program based on increasing awareness, prevention, and training of health care staff to recognize suicide risk. A national suicide prevention hotline has been established and suicide prevention coordinators have been hired in each VA medical center. Research into the risk factors associated with suicide in veterans and prevention strategies is underway.

However, it is equally important to point out that suicide prevention is something that can be addressed early on in the mental health process. With access to quality psychiatric care and other mental health professionals, many of the symptoms experienced early on can be addressed in order to reduce the risk of suicide down the road. This extends to proper screening and treatment for veterans who deal with substance abuse problems as well.

H.R. 4231, the “Rural Veterans Health Care Access Act”

PVA opposes this proposed legislation. H.R. 4231 would establish a pilot program that would require the VA to provide vouchers to veterans who served in OEF/OIF who need mental health services, and who reside at least 30 miles from a VA facility that employs a full-time mental health professional. These vouchers could then be used to purchase mental health services with private providers. PVA finds it difficult to comprehend the rationale for establishing a precedent for veterans to seek services outside of the VA health care system, as this proposed legislation would do.

First, let me say that we are absolutely opposed to any suggestion that veterans be given a voucher to seek health care services outside of the VA. This step amounts to nothing more than privatization of the VA, turning the VA health care system into an insurer of care instead of a provider of care. Likewise, *The Independent Budget* has also taken a position against vouchering in the past. Veterans who would seek care in the private sector would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records and medication verification program. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, that are generally not available in private sector systems, would equate to diminished oversight and coordination of care.

We are also very concerned about the seemingly arbitrary nature with which a veteran's eligibility for this voucher is established. The legislation states that if a veteran resides 30 miles or more from a VA medical facility that does not employ a full-time mental health professional, then that veteran is eligible for a voucher. Given the fact that the definition of rural is very subjective, I would suggest that 30 miles from a facility does not qualify as rural.

Furthermore, we believe that it is patently unfair to suggest that the VA cannot meet the need if the mental health professional in that local facility is not a full-time employee. If a VA facility is able to provide a mental health appointment in a timely manner, regardless of the employment status of the mental health professional, then it is unnecessary to allow a veteran to go into the private sector with a voucher. Otherwise, this represents mandating private care for the sake of convenience and not for the sake of demonstrated need.

Ultimately, we cannot support vouchering of any health care services in the VA because we believe it will only diminish the quality of care in the VA health care system. Furthermore, we believe that this pilot program would set a dangerous precedent, encouraging those who would like to see the VA privatized. Privatization is ultimately a means for the federal government to shift its responsibility of caring for the men and women who served.

We look forward to working with the Subcommittee to develop workable solutions that will allow veterans to get the best quality care available. We would like to thank you again for allowing us to submit a statement for record on these important measures. We would be happy to answer any questions that you might have.

MATERIAL SUBMITTED FOR THE RECORD

Ohio Hospital Association
Columbus, Ohio
October 18, 2007

The Honorable Sherrod Brown
United States Senate
455 Russell Senate Office Building
Washington, DC 20510

The Honorable Zack Space
United States House of Representatives
315 Cannon House Office Building
Washington, DC 20511

Dear Senator Brown and Congressman Space:

On behalf of the Ohio Hospital Association (OHA) and our more than 170 hospitals and health systems, we appreciate your recent introduction of the Veterans Emergency Care Fairness Act of 2007 (S. 2142/H.R. 3819). The legislation will address a significant concern regarding the reimbursement of medical care provided to America's veterans.

Currently, veterans who present at a community hospital for emergency treatment are stabilized and then transferred to a regional Veterans' Affairs (VA) hospital. The Chief of the Health Administration Service authorizes reimbursement be made from the U.S. Department of Veterans' Affairs to the community hospital and the patient for necessary stabilization services and transfer costs.

Unfortunately, especially in rural areas, the VA hospital is unable or unwilling to admit the patient for a period of time until transportation arrangements can be made or until an inpatient bed is available at the VA. In these circumstances, a community hospital must care for the patient for an extended period prior to transfer. Current law is unclear on whether the patient, the community hospital, or the Department of Veterans' Affairs is responsible for the cost of this care. Title 38 USC 1725 states that the Department may reimburse for such treatment.

Your legislation clarifies this issue by requiring the Department to provide reimbursement to the veteran patient or directly to the hospital for care provided during the post-stabilization "waiting" period, provided the hospital documents reasonable attempts to transfer the patient to a VA. Hospitals already must document such transfer attempts, so we do not believe this provision would add an administrative burden to the community hospital.

Again, thank you for championing this important clarification in veterans' health policy. We look forward to working with you during the 110th Congress to ensure enactment of the bill.

Sincerely,

Jonathan Archey
Manager, Federal Relations

Air Force Sergeants Association
Temple Hills, MD
November 5, 2007

The Honorable Zachary Space
315 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Space,

On behalf of the members of the Air Force Sergeants Association, we offer our support for H.R. 3819, the "Veterans Emergency Care Fairness Act of 2007." Your bill would provide reimbursement for emergency care when veterans obtain immediate care at nearby medical facilities. AFSA's 130,000 members represent the quality-of-life interests of current and past enlisted members of all components of the Air Force and their family members. Your bill is important to many of our members.

Many veterans do not live near a VA medical facility. Accordingly, one of the great challenges is how to obtain emergency care until the veteran can be transported to the nearest VA facility and how to pay for it. Under current law this presents a financial hardship to many. Your legislation would help rectify such unfortunate situations.

Mr. Space, we support your effort in this regard and I offer AFSA's assistance in

advancing this important legislation. Please let me know if we can assist you on this and other matters of mutual concern.

Respectfully,

Richard M. Dean, CMSgt (Ret.)
Chief Executive Officer

DEPARTMENT OF VETERANS AFFAIRS

News Release

FOR IMMEDIATE RELEASE

July 9, 2008

VA Vet Centers Coming to 39 Communities
Peake: Provide Counseling for All Combat Veterans

WASHINGTON—Combat veterans will receive readjustment counseling and other assistance in 39 additional communities across the country where the Department of Veterans Affairs (VA) will develop Vet Centers by fall 2009.

“Community-based Vet Centers—already in all 50 States—are a key component of VA’s mental health program,” said Dr. James B. Peake, Secretary of Veterans Affairs. “I’m pleased we can expand access to bring services closer to even more veterans, including screening and counseling for post-traumatic stress disorder.”

The existing 232 centers conduct community outreach to offer counseling on employment, family issues and education to combat veterans and family members, as well as bereavement counseling for families of service members killed on active duty and counseling for veterans who were sexually harassed on active duty.

Vet Center services are available at no cost to veterans who experienced combat during any war era. They are staffed by small teams of counselors, outreach workers and other specialists, many of whom are combat veterans. The Vet Center program was established in 1979 by Congress, recognizing that many Vietnam veterans were still having readjustment problems.

The centers have hired 100 combat veterans who served in Iraq and Afghanistan as outreach specialists, often placing them near military processing stations, to brief servicemen and women leaving the military about VA benefits.

VA’s 2009 budget proposal seeks \$20 million more than this year’s budget for Vet Centers, to include operating and leasing space for the new centers. Eighteen of the counties that will have new centers already have one or more; the other 21 do not.

A list of the new Vet Center locations is attached.

Vet Centers 2/2/2

Communities Receiving New VA Vet Centers

Alabama—Madison

Arizona—Maricopa

California—Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego

Connecticut—Fairfield

Florida—Broward, Palm Beach, Pasco, Pinellas, Polk, Volusia

Georgia—Cobb

Illinois—Cook, DuPage

Maryland—Anne Arundel, Baltimore, Prince George’s

Michigan—Macomb, Oakland

Minnesota—Hennepin

Missouri—Greene

North Carolina—Onslow

New Jersey—Ocean

Nevada—Clark

Oklahoma—Comanche

Pennsylvania—Bucks, Montgomery

Texas—Bexar, Dallas, Harris, Tarrant

Virginia—Virginia Beach

Washington—King

Wisconsin—Brown