

**HEARING ON NOMINATION OF JAMES B. PEAKE
TO BE SECRETARY OF THE DEPARTMENT OF
VETERANS AFFAIRS**

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ONE HUNDRED TENTH CONGRESS
FIRST SESSION
—
DECEMBER 5, 2007
—

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**HEARING ON NOMINATION OF JAMES B.
PEAKE TO BE SECRETARY OF THE DEPART-
MENT OF VETERANS AFFAIRS**

WEDNESDAY, DECEMBER 5, 2007

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 9:39 a.m., in Room SD-G50, Dirksen Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Webb, Tester, Burr, Specter, Craig, and Hutchison.

**OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN,
U.S. SENATOR FROM HAWAII**

Senator AKAKA. Aloha. The hearing will come to order.

Today's hearing is to consider the nomination of James B. Peake to be Secretary of Veterans Affairs.

Dr. Peake has a long and distinguished career, which our colleagues, Senator Inouye and Senator Dole, will describe in detail when they introduce the nominee.

For now, I just note the unusual combination of combat service as an infantry officer in Vietnam after his graduation from West Point, followed by medical school and a highly successful career as an Army physician, culminating in his service as the Army Surgeon General.

Dr. Peake, you have a tremendous challenge facing you, and I know you know that. Heading VA is never easy. Indeed, it may be one of the most daunting tasks in or out of government. Doing so in a time of war is dramatically more difficult. And taking over, as you will, assuming your confirmation, when there is only a little more than a year left in the current administration only compounds a demanding situation. Your ability to articulate clearly your priorities will be critical to your success.

I recognize that you come to this nomination with a wealth of experience, even though little of that experience has come from working directly with VA. I am confident, however, that you have a strong sense of empathy for those served by VA and a deep commitment to VA's missions, and that these traits will serve you well.

As you suggested in your answers to my pre-hearing questions—and I want to tell you I really appreciate your responses—VA has a strong and dedicated workforce. Things are not perfect within VA; few human endeavors are. But I am satisfied that VA is

staffed by people who seek to do what is right by veterans. What the Secretary must do, with the backing of the Congress, is give those employees the leadership and the tools—especially the resources—they need to carry out their jobs. If confirmed, you will appear before this Committee early next year in connection with VA's 2009 budget. It will be vital that you be prepared at that time to inform us whether the proposed budget is truly sufficient for the coming fiscal year.

A time of war puts tremendous strain on VA. Not only must the Department strive to continue to meet the needs of those from prior conflicts who already depend on VA, but it must quickly adapt so as to address the needs of those injured or disabled in the current conflicts. Each war brings different challenges, as you know—different demands, as well. In the current conflicts, VA is having to respond to relatively new challenges, such as the significant number of veterans suffering from Traumatic Brain Injury, alone or in combination with other debilitating injuries, in addition to wrestling with conditions that followed prior wars, as well, such as Post Traumatic Stress Disorder.

One area that needs special and immediate attention is the process by which an injured servicemember moves from DOD to VA. A great deal of work has been done on that front—especially over this year—and much is being done now. I am hopeful that, if you are confirmed, your long experience in the Army will enable you to continue to improve on those efforts. Returning servicemembers, especially those who are seriously injured, must not be made to struggle as they work with both DOD and VA. We must strive for, and we must achieve, a truly seamless transition.

Another area that is demanding attention and a focused effort is the systems—both DOD's and VA's—for compensating servicemembers and veterans for in-service injury. It is no exaggeration to say that VA's current compensation system is broken. The frustrating lack of timeliness; the need for fundamental rethinking of the overall compensation system (as recommended by the Veterans' Disability Benefits Commission and others); and the challenge of coordinating DOD and VA's systems, are all areas that must be addressed quickly and effectively. This Committee, indeed, the full Congress, stand ready to work with the administration on this effort. If you are confirmed, this must be one of your highest priorities.

In closing, I note and commend your strong commitment to avoiding even the appearance of any conflict of interest, not only with respect to your most recent employer, QTC, but also with those organizations where you served in an advisory capacity, as well as in connection with your stock portfolio. I personally harbored no concerns about your integrity, but I understand the worries of some that your brief time in the private sector might somehow have led you to favor corporate entities with which you were associated. I trust that all fair-minded individuals will appreciate the steps you have taken to preclude even an appearance of any conflicts of interest.

I look forward to your testimony today, your responses to questions from Committee Members, and to any post-hearing questions.

It is vitally important that the position of Secretary of Veterans Affairs be filled as soon as feasible.

Now I would like to call on our Ranking Member, Senator Burr. [The prepared statement of Hon. Daniel K. Akaka follows:]

PREPARED STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN,
U.S. SENATOR FROM HAWAII

Aloha. The hearing will come to order. Today's hearing is to consider the nomination of James B. Peake to be Secretary of Veterans Affairs.

Dr. Peake has a long and distinguished career which our colleagues, Senators Inouye and Dole, will describe in detail when they introduce the nominee. For now, I just note the unusual combination of combat service as an infantry officer in Vietnam after his graduation from West Point followed by medical school and a highly successful career as an Army physician, culminating in his service as the Army Surgeon General.

Dr. Peake, you have a tremendous challenge facing you. Heading VA is never easy. Indeed, it may be one of the most daunting tasks in or out of government. Doing so in a time of war is dramatically more difficult. And taking over as you will, assuming your confirmation, when there is only a little more than a year left in the current Administration only compounds a demanding situation. Your ability to articulate clearly your priorities will be critical to your success.

I recognize that you come to this nomination with a wealth of experience, even though little of that experience has come from working directly with VA. I am confident, however, that you have a strong sense of empathy for those served by VA and a deep commitment to VA's missions and that these traits will serve you well.

As you suggested in your answers to my pre-hearing questions, VA has a strong and dedicated workforce. Things are not perfect within VA; few human endeavors are. But I am satisfied that VA is staffed by people who seek to do what's right by veterans. What the Secretary must do, with the backing of the Congress, is give those employees the leadership and the tools, especially the resources, they need to carry out their jobs. If confirmed, you will appear before this Committee early next year in connection with VA's 2009 budget. It will be vital that you be prepared at that time to inform us whether the proposed budget is truly sufficient for the coming fiscal year.

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I look forward to your testimony today, your responses to questions from Committee Members, and to any post-hearing questions. It is vitally important that the position of Secretary of Veterans Affairs be filled as soon as feasible.

**STATEMENT OF HON. RICHARD BURR, RANKING MEMBER,
U.S. SENATOR FROM NORTH CAROLINA**

Senator BURR. Good morning, Mr. Chairman, my colleagues. I thank you for scheduling this hearing in a very timely manner to consider the nomination of General James Peake to be Secretary of Veterans Affairs. A number of my colleagues on this panel have said that it is important, especially now, to have a permanent leader at the helm of the Department of Veterans Affairs. With that in mind, I hope this Committee can schedule a markup as soon as possible after this hearing. I think we can move this nomination to the floor and, hopefully, quickly have a confirmed leader at the helm of VA.

General Peake, I have examined your application. I have examined carefully the Committee papers. I am convinced that you have really prepared for this job for a lifetime. In fact, I do not think you could have been better prepared for this job if you had actually planned it for a number of years. Your dedication to service to this Nation in uniform goes back to 1962, when you entered the military at West Point. After graduating from West Point, you led troops in combat in Vietnam. There you were wounded not once, but twice.

Your bravery, your valor have been recognized with military medals and commendations too numerous to mention. But, I will highlight just a few: two Distinguished Service Medals, the Silver Star, the Bronze Star for Valor, and two Purple Hearts.

Of course, as if your attendance at West Point and your dedicated combat service were not enough, you decided not only to stay in uniform but to go to medical school and to serve an additional 32 years in the military as a physician. Today, you are a board-certified thoracic surgeon, and a Fellow of both the American College of Surgeons and the American College of Cardiology.

Your dedication to duty and medical skills were obviously no secret to your fellow medical colleagues or senior military leaders. In 2000, you were selected to be the Army's 40th Surgeon General. Those experiences alone, in my mind, qualify you for this job.

You understand life as a soldier on the ground. You have experienced the challenges of recovery from wounds suffered during war. And you have led the next generation of men and women who followed you into service.

Mr. Chairman, VA is an agency dedicated to "care for him who shall have borne the battle and for his widow and his orphan." I believe we have found the man to lead the VA who not only understands combat service, the needs of our injured military personnel, and America's veterans; but a man who has spent the better part of his life taking care of those men and women and, more importantly, their families.

Dr. Peake, I fully intend to support your nomination to be the next Secretary of Veterans Affairs, and it is my deep hope today

that every one of my colleagues on this panel will, in fact, show their support and we will act very quickly.

Senator Dole, I welcome you today and thank you for the introductions, and I know Senator Inouye will be here.

Mr. Chairman, I thank you for this hearing and for an expeditious consideration of General Peake's nomination.

Senator AKAKA. Thank you very much, Senator Burr.
Senator Murray?

**STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON**

Senator MURRAY. Well, thank you, Chairman Akaka, for holding this hearing. General Peake, welcome. Senator Dole, it is good to see you again.

Mr. Chairman, I think we all know that this is a very critical and serious time in VA's history. Our troops are fighting overseas, and we see more veterans coming home and entering our system every day. We know we are facing unprecedented challenges as we try to provide the level of care that all of our heroes have earned.

I think it is no secret that you all know I think too many leaders at the VA have done the agency and our veterans a disservice over the last years and that we have seen too many apologists for the administration's policy rather than being strong advocates for our veterans. Our veterans have earned the benefits the VA is supposed to provide them, but we have seen them come home to long waiting lines to see a doctor, bureaucratic ineptitude, VA claims backlogs of months, and many other serious challenges that we have all witnessed over the past several years.

I do not think we should dwell on the mistakes of the past, but I really think we have to learn from them, and I think we have an opportunity to do that as we decide who will be the next Secretary of the VA. In fact, I think whether to confirm General James Peake may be the most important decision we make on how our veterans issues are dealt with over the next year.

I often say, that no matter how Americans feel about this war today in Iraq, they uniformly believe that we have an obligation to take care of our men and women when they come home; and they are ready and willing to stand up and do that today. And I want you to know that I stand ready and willing to work with any Secretary who is committed to truly fighting for the best interests of our veterans.

So, Mr. Chairman, I very much look forward to this hearing today and to hearing from General Peake. General Peake has had a very distinguished career and an impressive history of service to his country. For most of his nearly 40 years in the military, he has been devoted to improving medical care for our wounded servicemen and -women, including a stint as Army Surgeon General. He has held numerous positions within the Army, including Commanding General of the Madigan Army Medical Center in my home State of Washington. But, we all know a strong resume is not enough. We have to have a leader at the VA today who has the fortitude, the backbone, and the courage to stand up to the administration, to all of us; to be honest, and up front about our veterans' current and future needs; and to get us on the right course to car-

ing for these heroes who risk their lives for our country. I hope today we will find that General Peake is the VA Secretary that our veterans deserve.

Mr. Chairman, our VA system is uniquely positioned to recognize and treat the specialized injuries, medical conditions, and mental health challenges that are caused by combat and military missions. Our local VA doctors and nurses are some of the most caring and compassionate people I know, and I know they are dedicated to giving our veterans the best care possible. I was, in fact, out in Yakima, Washington, last week at a VA clinic. It was packed to the gills with veterans who had come to tell us about the serious challenges that they were facing. And I was most impressed by our VA officials on the ground—Sharon Helman from Walla Walla, Max Lewis who headed our VISN—who came to that hearing with a button on that sent a message to every veteran in the room, and it is the first time I have seen that happen. I shared with General Peake right before this hearing the button, and, General, when you put it on, I will know you have gotten the message. It says “Business As Usual” and has a slash through it. And I think the message sent to the veterans at that meeting is that people were going to sit up and take notice and make sure that their needs were met. And, General, when you put the button on, I will know you are the right man. So, I am glad you have it.

But I think, seriously, that our servicemembers really deserve better than what they have been getting from Washington, DC, and I hope that with a new VA Secretary we can change that attitude and really get back, on a bipartisan level, to making sure that the men and women who serve us are served well.

Mr. Chairman, we know that Congress has together worked to solve some of these problems. We have a lot of huge challenges ahead of us. Thanks to recent advances in battlefield medicine, our troops, as we know, are surviving incredible injuries that would have been fatal in earlier conflicts. And I know some of those advances were overseen by General Peake. However, many more of our servicemembers are coming home with devastating and debilitating wounds that are creating a lot of new challenges for our VA.

One of our biggest challenges is to ensure that our veterans are not waiting months or even years for compensation. As of earlier this year, the VA had as many as 600,000 disability compensation claims waiting to be answered. I heard at that Yakima hearing last week from a number of veterans who say they are at the end of their patience fighting for their own disability claims. We know the claims system is old and antiquated and needs to be fixed. Both the Dole-Shalala Commission and the Veterans’ Disability Benefits Commission have studied this issue and brought us recommendations, and in many ways their suggestions are similar. But, there are some key differences, and, General Peake, if you are confirmed, you will have to work with us to address those differences and help us move forward to reform this system aggressively.

Mr. Chairman, I am also particularly concerned about the challenges we face as we try to meet the mental health needs of our returning servicemembers. According to the VA, a third of all of our Iraq veterans who are enrolled in the system have sought treatment for a mental health problem. That is an astounding sta-

tistic. But we also know it is probably too low, because many of the veterans are not asking for care, because today, we still have a stigma surrounding treatment, or because they fear that a mental health diagnosis is going to hurt their military or their civilian careers.

We know that as our troops are deployed overseas for the third, fourth, and now even fifth tour of duty, the risk of suffering from PTSD and other mental health conditions is increasing. Just a few weeks ago, as I shared with the VA Committee, CBS News reported on a tragic result of not treating mental health conditions. CBS found that veterans are twice as likely to commit suicide as other Americans. And perhaps, I think, the most disturbing to me in that report was that the risk is highest among 20- to 24-year-olds, as high as 4 times that of non-veterans.

Now, the VA has taken steps to address that tragic situation. Congress has taken steps as well. A lot more needs to be done. The VA and the Defense Department have to focus their efforts on fighting the stigma of mental health treatment and improve screening, improve outreach, and improve care.

Finally, thousands of our servicemembers are suffering from Traumatic Brain Injury, which we know is the signature injury of this war. That means many of our soldiers are going to fight subtle injuries that are going to hurt their ability to work and communicate with their families and friends. There is still a lot we do not know, so, it is very critical that we continue to do research, to identify, prevent, and treat TBI so we can better care for our veterans suffering from this devastating injury.

Mr. Chairman, General Peake has already answered, as we know, a number of questions from us. I look forward to hearing his testimony today. I believe absolutely we have got to have a Secretary who is willing to roll up his sleeves and get to work because we cannot wait another year to start to deal with these many challenges in front of us.

So, General Peake, thank you for your willingness to take this on. I look forward to the hearing today and to your answers and responses to our questions.

Thank you very much.

Senator AKAKA. Thank you very much, Senator Murray.
Senator Brown?

**STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO**

Senator BROWN. Thank you, Mr. Chairman. General Peake, thank you for appearing here. I look forward to working with you. And, Senator Dole, nice to see you. And, Dan, good to see you, too.

I, of course, echo what Senator Murray just said about the importance of this agency. It is one of the largest in our Government. We clearly are not prepared for the next 20, 30, 40, 50 years with these injuries that Senator Inouye was talking about on the Senate floor one day—who survived and who did not survive these wars—and what all three of you have given to this country; and how so many of these young men and women will be with us for many, many, many years and will demand and deserve such a high level of care.

Senator Murray also talked about the backlog. My State, with a veteran population of a million veterans, has a backlog of over 14,000 claims—and as General Peake and I were talking on the street one day in front of the Russell Building—some 5,000 of those claims have been pending for over 180 days. And I know of his interest in dealing with this backlog. The President's request underfunded the VA, and we are fighting to get the funding with, so far, pretty good success.

Two other concerns. I am concerned about the culture of privatization that has in some cases led to bad contracts, misused taxpayers' funds, of which there has been a lack of accountability. The GAO found that not only did the VA not save jobs, it did not save money in its efforts at privatization in many cases. Four-fifths of the blue-collar jobs targeted for outsourcing to private contractors are held by veterans. So, for this agency to outsource jobs to private contractors, and cut the number of positions that veterans are now holding working for the VA, simply does not make sense. A large share of them are minorities. A large share of them are disabled vets with service-connected injuries that are using these jobs to return to gainful employment and financial independence.

I offered successfully an amendment on the Senate floor on the VA military construction bill which reaffirmed existing laws, ensuring the VA must conduct public-private competition before transferring Government functions performed by more than 10 employees. And you will hear more about that, and I think that is a very important part of your responsibility.

Last, I have done a series of roundtables with 15 to 20 veterans at each around my State—probably a dozen of them since I took office in January—and one was particularly troubling. In Cleveland, at the VA hospital, about 15 young men and women who recently had left—mostly Guard and Reserve soldiers, but some were regular Army, regular Air Force—had recently left active duty, and were back home trying to reintegrate into the community; going to school, going to work. Almost every single one of them said that when they left the military they were not told—this is not your responsibility, except we have talked about the transfer from DOD to VA—many of them were told very little about education benefits, and health benefits, especially; that once they said they weren't going to re-up, the military—their commanding officers seemed, frankly, to lose interest in them—they were told to turn in their equipment. They came home, and then they struggled.

There is a program at Cleveland State, one of the best, one of the only in the country, that really works to get veterans in the classroom and have special classes for them as they integrate into society. But there is not enough information coming from their commanding officers, coming from DOD, helping them integrate back into society and giving them knowledge of the access to veterans' services. I hope that that will be one of your top priorities as people struggle after serving their country to get back on their feet, disabled vets and non-disabled vets alike. It is something we absolutely owe them, especially education and health benefits.

Again, thank you, General Peake, for being here, and thank you, Mr. Chairman.

Senator AKAKA. Thank you, Senator Brown.

Senator Tester?

**STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA**

Senator TESTER. Thank you, Mr. Chairman. I appreciate you holding this hearing. I want to thank the two Senators, Senator Dole and Senator Inouye, for being here today. I especially want to thank Jim Peake for being here, and thank you for your service to this country, and thank you for wanting to do this job. You have a distinguished military career. That goes without saying. You seem to be a man of good moral character. That is very, very important.

If you get confirmed to this job, you have an incredible opportunity to impact the VA in a very, very positive way. Challenges for the VA are great, and they will continue to grow. It still takes too long for veterans to get an appointment with a VA doctor. That needs to change. It still takes an average of six months for a disability claim to get resolved. That absolutely needs to change. Too many PTSD claims are denied or given an unacceptably low rating, and the claims that are appealed by our veterans take, on average, two years to resolve. We all know that these are unacceptable.

Fixing these problems will be an enormously complicated process, and they will require substantial time and attention and sometimes money. I look forward to hearing much about General Peake's strategies for handling these issues. I hope that despite his extensive background in the private sector he agrees to address many of these issues without relying too much on privatization of the VA. The private sector needs to be involved in some of the areas in this country, particularly in the rural areas and the specialty care areas; however, as the American Legion has said, I believe the VA system is a system worth saving.

Finally, Mr. Chairman, I hope to hear more from General Peake about the particular needs of rural veterans. Montana being a rural State, and the fact that many of the veterans that live in rural areas do not live as long as veterans that live in urban areas, it is critically important. I look forward to hearing him expand upon the questions that he answered, the pre-hearing questions about rural medicine for vets, telemedicine, and how we can improve rural health care. Clearly, the needs of vets in Montana and in all areas of this country go well beyond just telemedicine.

As I have said, Mr. Chairman, General Peake seems to be a very good man. He has a solid military record. Really, the question is whether he can deliver the urgent leadership necessary to implement the solutions that will make the VA work better for the men and women who have put their lives on the line for this country.

I want to thank you very much once again for being here. Thank you, Mr. Chairman, for holding this hearing. I look forward to your comments and the questions that follow.

Senator AKAKA. Thank you, Senator Tester.
Senator Hutchison?

**STATEMENT OF HON. KAY BAILEY HUTCHISON,
U.S. SENATOR FROM TEXAS**

Senator HUTCHISON. Well, thank you, Mr. Chairman, very much.

First, I want to say that the two people who are sitting on either side of you have more credibility with the veterans community and for this country as the greatest patriots I know, and that they are here with you means a lot to me.

Secondly, I think at a time when we know that the biggest problem we have is making sure that our veterans get the health care they need, having a physician for the first time to be the head of Veterans Affairs I think was a very wise choice by the President. So, I, of course, have visited with you; and with your distinguished record, which Senator Burr has enumerated, I certainly intend to support your nomination because I believe you can make things happen.

I want to talk about the three issues that are of greatest concern to me. As you know, I am also Chairman of the Military Construction and Veterans Affairs Subcommittee of Appropriations. The claims processing, as has been mentioned here before—a wait of 177 days for a disability claim to be processed is unacceptable. This Congress, in a very bipartisan way, has passed appropriations through my Committee that would specifically target hiring more claims processors. In fact, we specified this year in our appropriations bill, which I hope honestly, Mr. Chairman, that we can pass free-standing, because it has been agreed to, but has not yet moved to the President, we specified \$124 million to hire an additional 1,800 claims processors. If we can get that bill through, I will be looking to you to expedite the hiring of those claims processors and trying to change the system.

Senator Dole and Secretary Shalala, who headed the Commission that we all know was so vital for the recommendations that it made for improvement in veterans health care, both said that the entire system needs to be restructured. So, that is something that I think should be first on your agenda, and we would certainly want to hear from you on that subject.

Secondly, I want to say something good about the VA because our veterans do deserve the very best care. But I hear complaints, complaints, complaints, and yet the good things that the VA does are largely unnoticed, and they never seem to be remarked on by Members of Congress or the groups that could talk about it, and that is the electronic records system. The VA is state-of-the-art. It is the very best. After the Katrina disaster in Louisiana, not one veteran missed a medical treatment or a medicine because the electronic transfer happened, and wherever the veteran was, that veteran went to a veterans' facility anywhere in the country, and they could be treated. That is remarkable. And I want to give many of those sitting on the front row here who have been with the Veterans Administration and previous administrators and Secretaries credit for that because it is phenomenal.

However, the Department of Defense is not up to speed in making sure that the people who are leaving active duty because of injuries are having the smooth, seamless transfer that we all expect to go into the veterans system. It could not be too complicated for the Department of Defense and Veterans Affairs to have the same system for electronic transfer of records. So, I think that is an area where you can take the accomplishments of past Secretaries and

the Department and transfer that into a success by working with the Department of Defense and having that seamless transition.

The third area that is very important to me and has been on my Appropriations Subcommittee, as well, is the research. We all know that the wounds of today's veterans are different from those suffered by the two wonderful, valiant men sitting at the table with you, and you, yourself, from Vietnam, theirs from World War II. The injuries are different today. We have more brain injuries, more traumatic impact injuries because of these IEDs. We have more Post Traumatic Stress Syndrome, or at least we are treating it. It could be that we had it before and we did not do enough. I think that is probably likely. But today we do know about it, and General Patton's word is wrong on this subject—as we all agree, I think—and that is, we have got to treat the injuries of today.

Research is doing so much more in that regard. The prostheses and the use of arms and legs that are missing or partly missing has taken phenomenal step in the right direction. But we need to continue that to make sure that we are doing the very best for these veterans, to have the most normal lives possible.

The Post Traumatic Stress Syndrome—we have mental health centers now that have been designated as centers-of-excellence for mental health for our veterans' treatment. We now have the traumatic injury centers in different areas of our country. This is all very good. Gulf War illness research, which is very important to me and I think is something that has been overlooked in the past, though not in the recent past; because the Veterans Administration has gone forward to see what the effects on the brain from coming in contact with chemicals does. And they are finding that maybe there is a connection between these debilitating sort of Lou Gehrig's disease symptoms that are connected with some contact with chemical weapons.

So, I hope that these three areas, which are major priorities certainly for me and many Members of Congress, will be addressed by you. And I think you can take some very good successes in the Veterans Affairs Department, and add to those with the help of the Dole-Shalala Commission recommendations and with veterans like Senator Inouye, who are in this Congress, and all of those on this Committee who have really focused on this and made sure that we did improve the service and increase the appropriations for this very important need.

So, with that, I look forward to hearing your remarks and supporting your nomination. And hopefully, Mr. Chairman, we can do this, so that we can have not an Acting Secretary but a Secretary who is going to hit the ground running and make things happen in the next year for our veterans.

Thank you.

Senator AKAKA. Thank you very much, Senator Hutchison.
Senator Webb?

**STATEMENT OF HON. JIM WEBB,
U.S. SENATOR FROM VIRGINIA**

Senator WEBB. Thank you, Mr. Chairman, and, General, welcome. I would like first to express my appreciation to you for your service, and particularly your service as a young Army officer. The

West Point class of 1966 has really been memorialized, I think, as having taken the most casualties of any of the West Point classes in Vietnam. As high as 10 percent of that class was killed in Vietnam, as I recall, a very difficult period during the war when you and others served. I have a great deal of appreciation for that.

I, as you know, am going to want to hear from you about your views and your ability to affect the views of the administration when it comes to a proper GI bill for the people who have been serving since 9/11. And, it is rather fortuitous that Senator Dole and Senator Inouye are sitting with you this morning, because when I have been speaking about the need for a GI bill that properly recognized the service of people since 9/11 and assists those who are readjusting, I continually come back to the World War II GI bill, which was an amazing piece of social legislation, as well as a piece recognizing properly the service of people. It gave people a true chance at a first-class future in a way that very few other programs in this country have.

I have three quotes I would like you to think about before you and I have a dialogue. This is, as I say, very fortuitous. I did not know that Senator Dole was going to be here, but this is what he said before this Committee in October: "I think the World War II GI bill was the single most important piece of legislation when it comes to education, how it changed America more than anything I can think of, and we ought to take the same care of veterans today."

And then I asked my staff—when I was trying to be able to explain why this is important and why this Montgomery GI Bill is not addressing the ability of these people who have been serving since 9/11 to have a first-class future. I asked my staff to take a look at the advantages our colleagues in the Senate who were World War II veterans were able to obtain through their use of the World War II GI bill. This is a chart that was put together, and Senator Inouye, who is a cosponsor of our GI bill, S. 22 that I introduced, is one of the people on here. But, if you take a look at this, you can see the institutions that those who served in World War II were able to attend on the World War II GI bill and what that would cost today and what percentage of that would be able to be paid for by this present Montgomery GI Bill, and you see the problem.

Senator Lautenberg, who also is a cosponsor of the bill, was able to go to Columbia on a full ride. Today it would cost \$46,874 to go to Columbia. The present GI bill, the average participation rate of \$6,000, would take care of not even 13 percent of that. This is what we are looking at.

The U.S. military is doing a very good job in terms of managing its career force. What it is not doing is understanding the difficulties in transition of the people who are leaving. Not everybody who comes in the military, as you and I well know, even under a volunteer system, comes in because they want to make it a career. They come in because they love their country; they want to serve for a while; maybe they want a soldier, they got a family tradition; these sorts of things. And, we are not taking care of these people.

And just out of fairness, I put myself on here. I would not be sitting here today, or it would have been a much more difficult jour-

ney for me to be sitting here today, without the help of Uncle Sam. You know, this country put me through undergrad at the Naval Academy. I do not know what the number is that we can put on that. In fact, they get a little shaky when you ask them how much it really costs to put each individual through. And then, because I had been wounded and was on a voc rehab program, I was able to go to Georgetown Law School. And that is the same benefit that the World War II veterans had. They paid my tuition, they bought my books, and they paid a monthly stipend. Today that would cost \$51,000 a year, and this Montgomery GI Bill would pay for 11.6 percent of that.

If we put the other chart up, this is you and me, General. Our country put you through school—put you through medical school; put me through school—put me through law school. We have got some really tremendous young men and women out there who have stepped forward at a time when a lot of other people have dealt with this situation intellectually, and we owe them absolutely the best transition that they can get into civilian life. It will reduce things like Post Traumatic Stress. It will give them something affirmative to bring back to the community. And I hear from DOD that they think this will affect retention. I do not think they are being creative enough. I think this will broaden recruitment. I spent a lot of time doing manpower issues in the Pentagon. I have got 5 years in the Pentagon, as you know—one as a Marine and the other 4 as a defense executive. And the word, the signal word when I was in the Pentagon was that the best recruitment tool you have is a proud veteran back in the community, someone who believes they have been treated right and is proud of their service. And this is the kind of thing that would help that.

So, I am looking forward to hearing your thoughts on this during your testimony. This is a time in the administration, toward the end of an administration, where I do not know how many minds you would be able to change. But at the same time, I hope we can have an honest broker in there; and from your own background I am really strongly hoping that you can help us make this happen.

Thank you, Mr. Chairman.

Senator AKAKA. Thank you very much, Senator Webb.

And now I would like to ask for the statements of our two Senators who have honored us by being present here today. I want to begin by saying they have so much in common. Both of them served in World War II. Both of them were badly injured. Both of them were in the same hospital. Both of them were distinguished Senators in the U.S. Senate. And they are here today to speak and introduce Dr. Peake. And being here long enough, I am struggling as to who to ask to speak first. If we go by age, I know who should speak first. And so, what I will do is I will ask Senator Inouye and Senator Dole to decide who will speak first.

[Laughter].

**STATEMENT OF HON. DANIEL INOUE,
U.S. SENATOR FROM HAWAII**

Senator INOUE. Thank you very much, Mr. Chairman. I am honored to join my dear friend Bob Dole, Senator Bob Dole, in presenting to the Committee the President's nominee for the position

of Secretary of the Department of Veterans Affairs. I would like to thank General Peake for agreeing to serve. Our country needs the General, and I am certain no one is more proud of you than your wife, Janice, and your children, Kimberly and Thomas.

This Committee carries the tremendous responsibility of ensuring that we live up to our enduring obligations to our veterans. The President's nomination of Dr. Peake sends a strong message that this administration is serious about transforming the care of wounded warriors to ensure that our veterans get the world-class care they deserve.

I am confident that there is no one more qualified to accomplish this task than Dr. James Peake. As the son of an Army nurse and a career Medical Service Corps officer, he grew up in a home where service to country was paramount and where respect for soldiers and their families was expected. He graduated from the United States Military Academy, as noted, in 1966. After completing airborne, ranger, and pathfinder training, he served as an infantry officer in the 101st Airborne Division in Vietnam. He was decorated three times for valor and earned a Silver Star. And many of you know that he was wounded in action and received two Purple Hearts. Dr. Peake attended Cornell University Medical College and later specialized in cardiothoracic surgery. He dedicated the rest of his 38-year career to caring for soldiers and their families.

In the year 2000, he assumed the highest position within the Army Medical Department when he became Surgeon General of the U.S. Army, and I have had the honor and privilege of knowing Dr. Peake since 1980, when he was assigned to Tripler Army Medical Center in Hawaii. He was then the Chief of Surgery and later became Deputy Commander.

As Army Surgeon General, Dr. Peake led the Army medicine transformation. He had a vision, a foxhole-to-hospital view of the entire medical system, with the goal that nine out of ten soldiers wounded on the battlefield would survive. That was a very ambitious role when considered that during the time of Bob Dole and myself, we were lucky if you had more than 75 percent.

Training every combat medic to be an emergency medical technician was critical to realizing his vision and was his emphasis on joint medical evacuations, establishing forward surgical teams, and placing mental health, nursing, and physical therapy at the brigade level.

In December of 2001, projecting the potential for a large number of amputee patients from the global war on terror, Dr. Peake directed the development of the Amputee Patient Care Program. Today, the VA and the Department of Defense work very closely in this program to meet the needs of our patients. The VA social workers, benefits counselors, vocational educational rehab counselors, and researchers have been detailed to Walter Reed in support of the care of our patients. The success of this program is due in large part to Dr. Peake's ability to anticipate the need for change and to lead people towards a common vision.

The time is right for change in the Veterans Affairs Department, and what we need at the VA is someone who cares, someone with a mission focus, someone who has managed large organizations, and someone who can build bridges with the Department of De-

fense, someone who can work with the bipartisan nature of the Committee to do the right things for those great men and women who are taking their places in history as our new combat veterans.

Dr. Peake is uniquely qualified to meet these challenges. Dr. Peake has the distinction of being the first physician and the first general to be nominated as Secretary of the Department of Veterans Affairs. His time as an infantry officer gives him a warrior's perspective on how we should care for our wounded. As importantly, his 40 years of distinguished military service gives him the wisdom and credibility of a proven leader.

Very shortly, I will be returning to Hawaii to participate in the events commemorating the December 7th attack on Pearl Harbor, the Day of Infamy that led to the largest generation of veterans this country has seen and a generation that is aging. This generation reminds us of the importance of the VA and the vital services the Department of Veterans Affairs provides.

I am confident that with this appointment the VA will meet the considerable challenges ahead, not just for our aging veterans but for all veterans. And so, Mr. Chairman and Members of the Committee, I thank you again for the opportunity to join my dear friend, Senator Dole, in presenting this great American, Dr. James Peake.

Senator AKAKA. Thank you very much, Senator Inouye.
Senator Bob Dole.

**STATEMENT OF HON. BOB DOLE, FORMER
U.S. SENATOR FROM KANSAS**

Senator DOLE. Well, Senator Inouye, we did not know many generals. We were lieutenants. But, it is nice to be seated next to these big shots. It is probably a first for both of us.

We are very proud of General Peake, and what really impressed me was the fact that his mother was a nurse, because our mothers are wonderful and we forget about that from time to time, until you end up in a hospital somewhere. And if you go to Walter Reed or a VA hospital and there is a young man or a young lady injured there, either there is going to be the spouse there or the mother, just as they were back in our days in World War II.

You all know his background: he is dedicated to service—a must for somebody to take on a 1-year job. I have often thought the VA Secretary ought to be like the FBI. It ought to be somebody we find out there, regardless of politics, who can serve for 10, 15 years uninterrupted. You know, maybe a lot of these problems would be cleared up in the process.

I remember being a service officer after World War II for the American Legion and the VFW and the DAV in my little home town. So, you know, we have had problems. There are always problems. We have got 25 million plus veterans, and there are problems. And veterans have rights to appeal, which extends the time they get their benefits, and they certainly should exercise that right. Sometimes we talk about how many days or months or how many cases. A lot of them are because the veteran does not think he got a fair shake the first round and he appeals the case, as he should.

You know, I think there is a great positive story to be told about the VA. It must be the largest medical organization in the world. When you stop to think about it. How many hospitals—107?

Dr. PEAKE. 153.

Senator DOLE. 153. And I do not know how many amputations a year, how many different cases they have. As Senator Hutchison pointed out, they have certainly got the best IT system, I think, in this country, and probably everywhere. But, you know, when I see a piece called “Waging War Against the VA,” and you find some outstanding people like Tammy Duckworth, who is a friend of mine, and others—Tammy said she owed her life to Walter Reed. So, you know, they do a lot of good things, and they take care of a lot of good people. I know it is easy to focus on the negative, and it is going to happen. Let’s face it. We are all normal Americans. We like to complain from time to time, and sometimes we are not treated fairly. If you are veteran and not treated fairly, you know, that should not be tolerated, as Senator Murray pointed out.

There are mistakes being made. I do not know what percent of the personnel in the VA system are veterans. A lot of these people who are taking care of you have been there, and they are certainly doing their best to make certain the veteran gets the care. And that is another plus as far as General Peake is concerned. I hope he does take a look at the GI bill. I would not be around and I do not think Senator Inouye would be around—there are 8.5 million of us that took advantage of it in World War II out of 16 million. It does not have to be 4 years. It could be whatever. And it did become, for me, the most important thing that ever happened; because once you get a college education, you want your children and everybody else in your family to have the same opportunity.

One thing that has occurred to me—this is a little off the point—I think the universities and the colleges ought to participate, too. There ought to be a little discount on the tuition or some way they can participate. They are not going to be overwhelmed with veterans from Iraq and Afghanistan, but certainly they can make a little contribution, which would lower the tuition cost in some cases. But, anyway, I would be happy to work with Senator Webb trying to figure out a good bipartisan approach to this.

I did a little checking around to see how other people described General Peake, and the words and phrases used to describe General Peake have been: tough, smart, hard-working, focused, fair, compassionate, pragmatic, thoughtful, measured. He is someone who listens, he has a vision, and he demands and expects results. That is what we are looking for, somebody who is demanding; somebody who expects results; and somebody who is going to respond to this Committee and the Members on this Committee and the veterans groups that are working with veterans and others around the country.

I think the fact that you are willing to do this for one year—it is a short time—there are many things you can do. I do not know of anybody in the Congress that I have ever known the 35½ years I hung around in the House and Senate that did not want to help veterans. We all want to help veterans. We just need the guidance and the facts to make certain that the deserving veterans, you know, are getting whatever they need. Whatever you think of

President Bush and whatever you think of the administration or the war—I remember the President telling me and Secretary Shalala to do “whatever it takes.” And that is where we are, and that is the responsibility. Whatever it takes—whether it is dollars, whether it is education, or whether it is whatever other concerns the Committee may have.

The general is going to have a tough, tough assignment. We are talking about, as you know, not just the Afghan and Iraqi veterans but, the Vietnam veterans—they are getting a little older—and the Gulf War veterans. People forget about the sacrifices made by the Korean veterans—that we lost 37,000-plus young men and women. And then there are still a lot of us around from World War II. I think we are down to about 5 million out of 16 million.

I want to thank Senator Brown for his participation in the Honor Flight program where they bring these old guys back here, and women—the women are not old; the guys are old. They charter airplanes, and they put them on a plane from Ohio. You have had many. They fly them back here without any cost to the veteran. They tour all the memorials, and they end up at the World War II Memorial. It is a very emotional, important time in their life. You can see the tears rolling down their cheeks. It is the greatest thing. I have had letters from some of these men who just said that nothing like this has ever happened. They thought they were forgotten. And just that little visit—and Ohio I think is the leading State; North Dakota is right behind. North Dakota is running out of veterans, they have had so many trips. And it does not cost them one dime; it is all raised locally. Like Spokane would raise money—they could not make it in one day, though, Spokane and back. But it is something you get on your website—Honor Flight. It is a great program.

But, anyway, General Peake is going to look after all of us older veterans, as well as all the others, and I want to thank him for taking on this responsibility. I sort of got involved in the process of—I am not that close to the White House—but in this case I wanted to have some input. I recommended some people. And I know that they have really worked at it. I talk sometimes two or three times a week with people who were doing whatever you would call it at the White House, looking at different candidates—and General Peake just rose to the top. They had other well-qualified men and women, but General Peake was the choice, and I think the right choice. So, Senator Inouye and I are honored to be here today, and I hope we do not hurt you too much.

Senator AKAKA. I want to thank you both very much for your statements today in support of Dr. Peake.

Senator Craig?

**STATEMENT OF HON. LARRY E. CRAIG,
U.S. SENATOR FROM IDAHO**

Senator CRAIG. Mr. Chairman, thank you very much, and I will be brief.

I have had the great opportunity to visit with the general.

Let me speak in as precise a way as I can so we can hear from our new Secretary. I have worked over the years and have spoken out about seamless transition. I now see an opportunity with a

leader who understands this—with a foot having just stepped out of DOD and into VA. I believe, after having visited with him, the vision to make that transition in a way that brings medical records and personnel records fluently and consistently through the process so that we get into the 21st century with our men and women in uniform as they transition out of defense, out of active service, into a veteran's status, in a way that can be called seamless. If this Secretary can accomplish that, I believe he will accomplish a great deal.

Lastly, Senator Dole, you spoke of a relationship in education and a responsibility this country has in working with veterans. Let me recommend you look at—and I will send it to you—a program that I helped the University of Idaho initiate over 2 years ago called “Operation Education.” They have since programmed it and sent it out to colleges and universities across the country. And it is simply this: an Iraqi or an Afghan vet who wants to come to the University of Idaho, with all of their veterans benefits, can come, and we will match whatever is necessary to make their stay there work. We have reached out to private sector folks and to foundations and to the university foundation.

For example, if they are married, then we find a job for the spouse. We provide daycare to the children. A combination of things that has brought, I think, the opportunity of that veteran coming out of Iraq or Afghanistan and using those benefits, we simply add to the benefits and leverage the benefits into a full benefit. That is what the public and private sector ought to be doing in cooperation.

I recommend it to you. I will send it to you. I think you would enjoy looking at it. It is working very well. It is called “Operation Education.” Thank you.

Thank you, Mr. Chairman.

Senator AKAKA. Thank you very much, Senator Craig. At this time I would like to ask Dr. Peake to stand for the administration of the oath.

Would you raise your right hand? Do you solemnly swear or affirm that the testimony you are about to give this Senate Committee on Veterans' Affairs will be the truth, the whole truth, and nothing but the truth, so help you God?

Dr. PEAKE. I do.

Senator AKAKA. Thank you very much.

Dr. Peake?

STATEMENT OF LTG JAMES B. PEAKE, USA (RET.), M.D., NOMINEE TO BE SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Dr. PEAKE. Well, Chairman Akaka, Senator Burr, ladies and gentlemen of the Committee. Senator Akaka, thank you so much for scheduling this hearing expeditiously. I deeply appreciate the confidence of the President in this nomination, and I am honored and I am humbled to be before you today seeking your endorsement to become the next Secretary of Veterans Affairs.

I want to thank Senator Inouye and Senator Dole for their wonderful words of introduction. I have held each of these great leaders in such high esteem over so many years, each of them representing

service to this Nation in the military, wounded in battle, a full career of public service to follow. Their endorsement alone underscores the responsibility that I know comes with this job.

As has happened so often in my Army career, my wife, Janice, is taking care of our family. My son, Tom, is graduating with his master's degree down in Texas, and she and my daughter are off to be with him. She has been my mainstay on this whole journey you have heard about, and I could not be more fortunate.

With the career I have had, though, there is also an extended military family, and there are a number in the audience today. I would like to introduce one special member of that Army family, and that is Mr. Rick Bungler. Rick was my radio-telephone operator when I was a platoon leader in Vietnam. He is a veteran, came home, went from rodeo bullrider to successful businessman, and he has traveled from Arizona to be with me here today. I never dreamed that in front of this Committee that cares so much about veterans that I would have the opportunity, Rick, to thank you publicly for your service. But with your permission, Mr. Chairman, I do that now for the record.

I want to thank each of you on this Committee for finding the time to meet with me individually. I was deeply impressed and appreciate your individual commitment to our veterans and to the mission of the Department of Veterans Affairs. I listened carefully to your concerns. They ranged from the very real challenge of the transition from DOD to VA care—the attendant issues of sharing information between the Departments, the importance of the continuity of care which that will help—to the very nature and the quality, of the care in the VA itself—and not just the quality, but access to that care, access that is timely and with minimal bureaucracy.

The special challenges of rural health care as it relates to access for our veterans was an issue that I heard from many of you and of the special challenges that this poses, particularly for mental health. I appreciate the universal concern that PTSD and Traumatic Brain Injury may be less apparent than some of the horrendous physical wounds that we are seeing fresh from the battlefields; but that these injuries are, nonetheless, real, and are likely to become the signature injury of this conflict.

The great advances in prosthetic devices that allow our amputees the opportunity for maximal functioning need to be matched with the same kind of advances in dealing with mental health issues of our veterans and of their families. That means research, developing the base of mental health providers, ensuring access, addressing stigma, developing practice guidelines, measuring the outcomes, and providing support to address the co-morbid conditions.

You spoke to me about Gulf War illness. Even now, 15 years later, we do not have clear answers for those who returned from Desert Shield and Desert Storm with unexplained illnesses. I know and share your concern that this not be forgotten, that we continue to care for these men and women and continue to seek the answers to the questions of why; not just for them but for future veterans as well.

I appreciate your concerns about the VA infrastructure, ensuring that VA forecasting is done well to ensure that we make the right

investments, to have the appropriate physical and human infrastructure to care for the evolving demography of our veteran populations.

I heard clearly the dissatisfaction with veterans waiting excessive periods of time to have their claims adjudicated; of the importance in reducing the backlog of claims, while at the same time ensuring consistency in our rating processes. While I am gratified that the VA has nearly 3,000 new claims people on board and in training, I look forward, if confirmed, to moving forward to making the system less complex, more understandable, and better supported with the tools of information technology. A veteran should not need a lawyer to figure out what his benefit is, and he should not need a lawyer to get it.

Every single one of these issues that I heard from you is important. Each one is complex, and each needs both short-term and long-term approaches as we honor our commitments to those who have served—those who have served before and to this new generation of combat veterans. It is important we get it right for them now. And as you said, Senator, it is not business as usual.

Well, the issue today I guess is why me—given the challenges I have outlined, the size of the organization, the complexity of the mission. You have seen my bio. My father and my mother, both buried at Arlington, were in the military. I was raised in the Army, chose a career, 38 years cared for soldiers and their families. I have spent time in medical centers and in troop units. I have been in combat zones and on disaster relief missions. I have worked in the joint and interagency arena, engaged with many stakeholders in military medicine, and appreciate the importance of working collaboratively with the veterans service organizations and the military service organizations. Fifty percent of our Army medical force is in the reserves. I spent a large amount of my time, and energy really, over multiple assignments, with and for these men and women who truly live up to the moniker of “twice the citizen.” I know they have unique veterans issues. Fifty percent of Army Medical Command personnel are civilians, so I have dealt with a large civilian workforce.

I have learned that one cannot micromanage large organizations. One needs to delegate and trust subordinate commanders. I do believe in accountability, in facts, in data-driven decisions. I have learned by asking questions and by challenging assumptions, and I will do that if confirmed at the VA. I will do that to try to make a difference in those issues about which we spoke in your office, and which I have heard from you today: to make a difference for our veterans, for those who served in World War II and Korea, whose needs may be different from the needs of my generation; the Vietnam veterans generation, my colleagues and my friends who are now finding an increasing need for VA services; to make a difference for this next generation of combat veterans returning from Afghanistan and Iraq, who have immediate needs that are quite different from those whose last battle was 40 years ago.

I know these young men and women, too. I have been responsible for training many of them; for helping build the system that is returning them from the battlefield despite serious wounds; for investing up front and providing them the best prostheses; for trying

to understand the mental health issues longitudinally, from the front edge of the battlefield. I care about them. I appreciate the debt that we owe them. I believe we must look proactively to their needs today while shaping the system for their needs of the future.

I thank this Committee for your unwavering commitment to the Nation's veterans, and if confirmed, I look forward to working with you with that same personal commitment.

Mr. Chairman, I thank you so much for this speedy hearing, and I look forward to your questions.

[The prepared statement of Dr. Peake follows:]

PREPARED STATEMENT OF LTG JAMES B. PEAKE, (RET.) M.D.,
NOMINEE TO BE SECRETARY OF VETERANS AFFAIRS

Mr. Chairman, Senator Burr, Ladies and Gentlemen of the Committee. Senator Akaka, Thank you for scheduling this hearing so expeditiously.

I deeply appreciate the confidence of the President in this nomination and am honored and humbled to be before you today seeking your endorsement to become the Secretary of Veterans Affairs. I want to thank Senator Inouye and Senator Bob Dole for their kind words of introduction. I have held each of these great leaders in such huge esteem for so long, each of them representing service to this nation—in the military, wounded in battle, and a full career of public service to follow—their endorsement, alone, underscores the responsibility that I know comes with this job.

As has happened so often in my Army Career, my wife Janice is taking care of our family. My son, Tom, is graduating with his Masters Degree down in Texas and she and my daughter are traveling to be with him. She has been my mainstay on this journey that brings me before you and I could not be more fortunate. With the career I have had, there is also an extended Military family. There are a number in the audience today, but I would like to introduce one special member of that Army family, and that is Mr. Rick Bunger. Rick was my Radio-Telephone Operator when I was a platoon leader in Vietnam. He is a Veteran who came home, and went from rodeo bull rider to a successful businessman. He has travelled from Arizona to be here with me today. I never dreamed that, in front of this Committee that cares so much about veterans, I would have the opportunity to thank him for his service, but I am delighted to do that now for the record!

I want to thank each of you on the Committee for finding time to meet with me individually. I was deeply impressed and appreciate your individual commitment to our veterans and to the mission of the Department of Veterans Affairs. I listened carefully to your concerns.

They ranged from: the very real challenge of the transition from DOD to VA care; the attendant issues of sharing information between these Departments; the importance of the continuity of care to the very nature and quality of that care across the VA system; and not just quality, but access to that care—access that is timely with minimum bureaucracy.

The special challenges of rural health care as it relates to access for our veterans was an issue that I heard from many of you, and of the special challenges this poses for mental health in particular.

I appreciate the universal concern that Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) may be less apparent than some of the horrendous physical wounds that we see fresh from the battlefields, but, that these injuries are nonetheless real, and are likely to become the signature injury of this conflict. The great advances in prosthetic devices that allow our amputees the opportunity for maximal functioning need to be matched with the same kind of advances in dealing with the mental health issues of our veterans and of their families. That means research, developing the base of mental health providers, insuring access, addressing stigma, developing practice guidelines, measuring the outcomes and providing support to address the co-morbid conditions.

You spoke to me about Gulf War Illness. Even now, 15 years later, we do not have clear answers for those who returned from Desert Shield and Desert Storm with unexplained illnesses. I know and share your concern that this not be forgotten, that we continue to care for those men and women and continue to seek answers to the questions of why, not just for them, but for future veterans as well.

I appreciate your concerns about the VA infrastructure, insuring that VA forecasting is done well to insure that we make the right investments to have the appropriate physical and human infrastructure to care for the evolving demography of our veteran populations.

I heard, clearly the dissatisfaction with veterans waiting excessive periods of time to have their claims adjudicated; of the importance in reducing the backlog of claims, while, at the same time, insuring consistency in our rating process. While I am gratified that the VA has nearly 3,000 new claims people on board and in training, I look forward, if confirmed, to moving forward with making the system less complex, more understandable, and better supported with the tools of information technology. A veteran should not need a lawyer to figure out what benefit is due, or to get that benefit.

Every single one of these issues that I heard from you is important. Each is complex and each needs both short-term and long-term approaches as we honor our commitment to those who have served before; to this most recent population of combat veterans; it is important that we get it right for them now.

The issue at hand today, is "Why me?" Given the challenges I have outlined, the size of the organization, the complexity of the mission You have seen my bio: my father and my mother, both buried in Arlington, were in the military. I was raised in the Army.

I chose a military career and for 38 years I cared for soldiers and their families.

I've spent time in medical centers and in troop units; I've been with them in combat zones and in disaster response operations.

50 percent of our Army Medical Force is in the reserves. I spent a large amount of time and energy over multiple assignments with and for these men and women who truly live up to the moniker, "twice the citizen." I know that they have unique veterans issues. 50 percent of the Army Medical Command personnel are civilians, so I've dealt with a large civilian work force.

I've learned that one cannot micromanage large organizations, one needs to delegate and trust subordinate commanders. I do believe in accountability, in facts, and data driven decisions. I have learned by asking questions and challenging assumptions. If confirmed, I will do that in the VA.

I will do that to try and make a difference in those issues about which we spoke in your offices: to make a difference for our veterans; for those who served in World War II and Korea whose needs may be different from the needs of my generation of Vietnam veterans, my colleagues, my friends, who are now finding an increasing need for VA services; to make a difference for this next generation of combat veterans returning from Afghanistan and Iraq who have immediate needs quite different from those whose last battle was 40 years ago.

I know these young men and women too. I've been responsible for training many of them, for helping build the system that is returning them from the battlefield despite serious wounds, for investing up-front in providing the best prosthesis, for trying to understand the mental health issues longitudinally beginning at the front edge of the battle field. I care about them. I appreciate the debt that we owe them. I believe we must look proactively to their needs today, while shaping the system to meet their needs of the future.

I thank this Committee for your unwavering commitment to our Nation's veterans. If confirmed I look forward to working with you with that same personal commitment.

Mr. Chairman, I thank you again for this speedy hearing.

I look forward to your questions.

RESPONSE TO PRE-HEARING WRITTEN QUESTIONS BY HON. DANIEL K. AKAKA TO LTG JAMES B. PEAKE, (RET.) M.D., NOMINEE TO BE SECRETARY OF VETERANS AFFAIRS

Question 1. What do you believe are the most important problems and challenges currently confronting VA? In the next year, which of these problems and challenges will you focus on and how do you intend to address them?

Response. Problems & Challenges:

- Transition: The transition from active duty servicemember to veteran of our current generation of returning, combat experienced, men and women is an important current challenge. The challenge is broader than just those with severe injuries found unfit for service. We must be proactive for those who need support from the VA in readjustment to and reintegrating in civilian life. We must anticipate and prepare for the fact that some of these Veterans who initially did not recognize or claim a disability will have legitimate claims that require timely and accurate adjudication.

- Mental Health/Traumatic Brain Injury: Understanding, appreciating, and intervening appropriately for those with mental health issues, particularly PTSD; and understanding the relation of the spectrum of Traumatic Brain Injuries and levels

of associated impairment will be both a short and long term issue for this newest generation of Veterans.

- Access to Care: Insuring access to care with compassion, timeliness, quality, and without hassle whether our Veterans live metropolitan areas or in the rural areas of our country.
- Backlog of Claims: Addressing the time required to execute the claims process to provide benefits, through reproducible, thorough and accurate ratings.

Approaches to address these issues:

- Creating clear expectations within the VA as to standards, attitudes, and Veteran focus supported by an investment in training.
- Crossing the information and cultural gaps and barriers with DOD.
- Measuring the outcomes against standards and a culture of accountability.
- Process analysis and re-engineering supported by information technology/automation tools.

Question 2. Some believe the Secretary of Veterans Affairs should be an independent advocate for veterans; others believe that the Secretary should be the executor of the Administration's policies relating to Veterans. What is your view of the appropriate role of the Secretary of Veterans Affairs?

Response. As a member of the President's cabinet, I appreciate that I am a part of the administration. But, I believe I am in the administration with the responsibility to not only advocate for Veterans, but to insure that our Veterans receive the best of care; that they have their benefits provided in a timely fashion, and that the many programs that serve them produce the outcomes that make a positive difference in their lives. I recognize that this means appropriately forecasting the needs and advocating for the funds to meet those needs while making sure that the funds provided are well used.

Question 3. What do you believe are the differences and challenges in heading a civilian department versus a military organization? As a result of any differences, do you anticipate that you will have to alter or modify your leadership style?

Response. Within the departments, there are more similarities than differences, i.e., a highly skilled work force, men and women who care deeply about the mission, many of whom have had long careers in the department. The civilian component of the DOD is larger than some might realize. In fact, 50 percent of the US Army Medical Command work force was made up of civilians during my tenure. The span of control with the VA is more diffuse than the military; the locations within the VA are relatively fixed compared to the deployable assets and characteristics of the military. Another difference is in the nature of our VA beneficiaries, spread throughout the land where advocacy groups have become partners in the delivery of services as well as within the department and with Congress in the shaping of these services.

I do not anticipate a fundamental difference in my leadership style which I would characterize as integrity based, mission focused and recognizing that the only way to succeed is through the men and women at every level who do the real work of the organization. To accomplish this I will make focused efforts on communication to insure clarity of intent; to insure that those men and women know that I value them and count on them; and to let them get to know me. In the Army I had the advantage of having been a general officer for 8 years before I became the Surgeon General and was known. Though many in the VA do know me, it is not at the same level. I will similarly need to reach out to and communicate with the VA's partners, the VSO's; to this Committee, and to those on the House side if I am to be an effective leader for the VA and for Veterans' issues.

Question 4. How have your previous experiences prepared you for heading the second largest Federal department? What lessons did you learn as Army Surgeon General that you plan to apply to leading the VA?

Response. I believe that there are several areas of my experience that are relevant:

Because of the mission of the Department of Veterans Affairs—Caring for those who have borne the battle . . . and their widows and orphans—I do believe my 38+ years in the Army, with service in the line as an infantry officer and in medicine as a physician, 38 years of taking care of soldiers, provides a personal background of caring, understanding and empathy that will keep my decisions true to the mission.

My management experience includes 10 years as a colonel with executive responsibility in medical teaching centers, in command of the Army medical forces in Korea, and as the Chief Consultant to the Surgeon General during Desert Shield and Storm. This was followed by 12 years as a general officer in command of progressively larger and more complex organizations with subordinate units geographi-

cally dispersed and with, particularly in my 4 years as Surgeon General, the important, direct interface with Congress, the joint and interagency community, and the Army staff. The lessons that I have learned in this journey, not just as the Surgeon General, are the importance of data driven decisions, measurement of outcomes and the notion that if something is measurable it can be improved; and that this approach supports a culture of accountability.

Leadership of units from a platoon in combat, to a team around an operating room table, to a department of surgical specialists many more senior than I, to the combat medical units of the XVIII Airborne Corps with active and reserve units up and down the east coast, to leading more than 50,000 men and women of 11 major subordinate commands is valuable and relevant experience that that has emphasized the importance of listening, of valuing people, and of communicating while maintaining a clear focus on the mission. Visibility and accessibility are important as a leader. I believe my progression over the spectrum of leadership described provides a foundation to apply this experience to the much larger VA.

Question 5. What is your management style? Are you a “hands-on manager”? Do you rely on significant delegation? Do you seek to achieve consensus with those on your management team before making a decision or do you generally gather relevant information and input, and then make a decision?

Response. The only way one can get anything accomplished in an organization much larger than even an infantry company, let alone an organization the size of the VA, is through delegation. But, with the delegation must come accountability supported by data. I do my homework on issues and ask questions to understand the issues. In that sense, I am a hands-on manager. As the “intent” of policy is communicated, my expectation is that those many operational decisions made at levels below the Secretary are made consistent with that “intent.” In decisionmaking, I welcome all input, encourage the dissenting view, and seek outside critical thinking. I am always impressed that a product can be made better. However, with that input, I will make decisions with or without consensus. As a corollary, when there is not full consensus, I recognize my increased obligation to communicate my rationale; engaging and seeing the decision to success (ownership); and in changing course if I am wrong.

- If confirmed, do you expect to visit various VA facilities in order to accurately capture what is occurring in the field?

Response. I look forward to visiting the facilities, meeting with the men and women of the VA and finding the venues to meet with those we serve. My Army experience supports the importance of “visiting the troops” in the field as well as “walking around” one’s own headquarters.

Question 6. As I am sure you are aware, many veterans have raised concerns about your coming to VA from QTC—a private sector firm that has significant business relationship with the Department. Two Questions:

- What will you do as Secretary to ensure that you have no dealings whatsoever with QTC or with any efforts on QTC’s part to continue or expand the company’s dealing with VA or on any other matters involving QTC and VA?

Response. If confirmed, I will terminate any connection with QTC, will have no ongoing or residual financial interest in QTC, and will recuse myself in any matters related to QTC.

- What Plans do you have with respect to QTC when you leave the position of Secretary? Do you expect to return to the firm?

Response. I have no plans to return to QTC, if confirmed; and, more specifically, I will not do so.

Question 7. Secretary Nicholson was accused, rightly or wrongly, of being out of touch with the needs of veterans. Are you satisfied that you are attuned to the needs of America’s veterans? If not, how do you plan to improve your understanding of the needs of America’s veterans?

Response. My whole life has been with soldiers. My mother was an Army Nurse, my father a Medical Service Corps officer. Those who came over to our house included active duty career officers and their families and those who had worked for or with my father but who were out of the Army, sergeants, privates, officers alike. Many of those had served in WWII and in Korea. As a surgeon throughout the 70’s and 80’s I had the great privilege of taking care of many in that last “Greatest Generation” who were dual eligible for DOD and VA care. As a commander myself, I know the faces of soldiers and their families and have dealt with their needs. As a medical commander, I’ve been involved with the medical and family needs of those injured. As the Chief Medical Director of QTC, I talked with veterans in our facilities or on the phone and dealt with their C&P examination issues.

Though I do have what I believe is a solid understanding and empathy for our veterans, I know that I will gain an even better perspective, should I be confirmed, as I proactively engage Veterans Service Organizations, our own dedicated work force, and the veterans themselves who seek the spectrum of VA services.

Question 8. If you were able to have a one-on-one meeting with every VA employee, what would you say? If confirmed as Secretary, how will you implement this message in terms of policies and actions?

Response. First, I would tell them how privileged I feel to be joining their team; that I believe deeply in the mission; and that I believe in them. I would want them to know of my background both in the military and in regards to my rather long association with the VA through the Special Medical Advisory Group; through working for the last year with the VBA; and even with my experience with a VA Cemetery as the commanding general at Fort Sam Houston. I would talk about our opportunity to look to the future of this next generation of combat veterans returning from Iraq and Afghanistan, getting it right for them and their families while simultaneously honoring our commitment to the WWII and Korea generation, and addressing the men and women of the Vietnam era (my generation), who are now finding more need for our services. I will commit to each of them my dedication to the mission, to them, and to creating the environment for their success as, together, we serve the needs of veterans and their families.

I will use the chain of command, all of the command information channels available and will find the personal venues to deliver this message. Policies and actions will be consistent with this message.

Question 9. How many staff do you plan to bring with you to VA? Do you anticipate asking the White House to allow you to replace any political appointees, including any confirmed by the Senate?

Response. I am impressed with the quality of the VA senior leadership. I have no preconceived plan to replace any political appointees and have not been in a position to assess the need to bring in additional staff. I am aware of the potential for an Assistant Secretary for Acquisition and look forward to the support of this Committee in moving forward with that position.

Question 10. The President noted in his introduction that you are the first physician and first general to serve as Secretary. While he was certainly correct about your credentials compared with prior Secretaries, there have been other generals, including perhaps the most famous of all, Omar Bradley, who headed the VA before it became a cabinet department in 1989. It is correct, however, that you are the first physician to head either the Veterans Administration or the Department of Veterans Affairs, and I think that there may be at least one compelling reason why a physician has not previously been picked for the job, namely, the potential conflict between the Secretary and the Under Secretary for Health, relating to VA's health care mission.

By law, the Under Secretary is a health care professional responsible to the Secretary for "the operation of the Veterans Health Administration." The Secretary, on the other hand, is responsible for "the control, direction, and management of the Department." This difference suggests that the Under Secretary for Health, like the two other Under Secretaries with respect to their Administrations, is expected to exercise direct operation control of VHA and that the Secretary's role is to supervise the Under Secretary, but not to be directly involved in the operation of the VHA.

If confirmed, how do you anticipate working with Dr. Kussman or whomever is the Under Secretary for Health to ensure that this division of responsibility is recognized and honored.

Response. The VA is extremely fortunate to have Dr. Kussman as the Under Secretary for Health—its "Top Doc". He has assembled a very talented team of professionals. If confirmed, I will seek to complement Dr. Kussman's efforts and initiatives in leading his administration, not to compete. With my medical background, I anticipate being able to more quickly make the decisions that he might bring to me since I do not anticipate needing "Medicine 101." As I execute my responsibilities as Secretary, I would anticipate that my guidance to him will be well informed because of my medical background and my military background. If anything, I anticipate a greater synergy supported by our common medical background and our long association.

I would note also that Dr. Kussman, Under Secretary Cooper, and I all share the background of being flag officers. Again, common backgrounds offer synergy rather than competition for authority.

Question 11. Please describe how you intend to work with the Deputy Secretary. Will the Deputy Secretary be VA's Chief Operating Officer?

Response. Gordon Mansfield is one of my heroes. I am delighted that he will continue as the Deputy Secretary. He will continue as the VA's Chief Operating Officer.

Question 12. Please describe how you intend to work with the General Counsel. Will the General Counsel be a key member of your management team?

Response. The General Counsel will be a key member of the management team. Ethical and Legal behavior are the hallmarks of a quality organization. The General Counsel is a major compass in this regard as well as one who will provide the detailed advice on specific policies, legislation, and initiatives. The General Counsel will have open-door access to me to ensure the communication necessary to provide that advice.

Question 13. Please describe how you intend to work with the Inspector General. Are you comfortable with the IG's dual responsibility, to the Secretary as the head of the Department, and to the Congress?

Response. I understand the Inspector General function from my military experience, appreciate their uniquely privileged role, and am comfortable with that role. The IG can be a very powerful force in maintaining the VA as a learning organization, identifying systemic issues that we can fix internally or acquire the support to fix externally. Their work will not sit on the shelf, but will be used to make us better.

Question 14. Please describe how you intend to work with the three Under Secretaries and with the Assistant Secretaries.

Response. We will, on a regular basis, meet as a group; we will have dedicated one-on-one time. The Under Secretaries have unique responsibilities to exercise direct operation control of their respective administrations and the Secretary's role is to supervise the Under Secretaries. I owe them guidance, objectives, and resourcing with the support of all of the assistant secretaries will be dedicated to their success.

Question 15. Are you satisfied with the current alignment of Assistant Secretaries or do you anticipate proposing any changes to the number of Assistant Secretaries or to their responsibilities?

Response. The addition of a proposed Assistant Secretary for Acquisition is the only Assistant Secretarial position change of which I am currently aware. I do not have any preconceived notion of other changes that might be required.

Question 16. How do you plan to work with the Veteran Service Organizations? Do you anticipate meeting with VSO representatives on a regular basis?

Response. I appreciate the unique roles of the Veterans Service Organizations and the Military Service Organizations and will work collaboratively with them as we develop policy, as we seek insights from their members, as we work with them as partners in the service delivery. I look forward to meeting with them on a regular basis.

Question 17. What are your views on the situation that was described in the media reports earlier this year about Walter Reed Army Medical Center and on earlier problems with the medical holdover detachments at Fort Stewart and Fort Knox? In hindsight, what might you have done as Army Surgeon General to prevent or mitigate the problems that surfaced at Walter Reed, Fort Stewart, and Fort Knox?

Response. Regarding the Walter Reed issues, I do not have first hand knowledge of the details having retired in 2004. However, it is unacceptable for soldiers to be housed in inadequate barracks. What was reported as a lack of caring for those wounded warriors who moved to outpatient status was disturbing as was the failure to bring these issues through the chain of command. I know that the Army has responded with a concerted effort to reestablish appropriate chain of command and accountability for those soldiers remaining at Walter Reed in an outpatient status and keeping them focused on their individual mission of medical improvement and rehabilitation. I also believe a valuable service was done in highlighting the convoluted and complex nature of the DOD Physical disability system, the overlap of the VA disability system, and the need, as highlighted by every group who has examined this recently, for revision, simplification, and modernization to accommodate for medical and societal changes. I was gratified to read, though often as an add-on comment, the recognition of the very high quality of inpatient care, of the amazing success in bringing soldiers home from the battlefield when, in prior conflicts they would have died.

Regarding the Fort Stewart issue of medical hold-over care, I was intimately engaged. The situation that the press highlighted included inadequate barracks, slow processing times, and medical resources that were not adequate to meet the demand. The majority soldiers who had reported to a mobilizationsite medically unfit. Others had suffered some condition in their train-up that made them non-

deployable. The first group was large and a result of policy (changed as a result of this experience) that kept soldiers who reported unfit to mobilizationsites on active duty for medical board disposition. I had not anticipated this category of soldiers to be large and had not expanded capacity to meet the demand.

My response: Within 24 hours of becoming aware of this issue I dispatched a general officer led team to meet individually with each of the 500 Soldiers at Fort Stewart. Questionnaires were used to collect and categorize their issues. The team also met with leaders on the installation; Division Commander, garrison commander, and other key leaders. I coordinated with the Army staff and other Army leaders to have their subject matter experts available to assist this team to resolve those issues outside of the medical arena. In addition to Fort Knox, the team followed the trip to Stewart with trips to Fort Benning, and Fort Campbell, again meeting with Soldiers at each installation and their family members as well. Assessing the teams input, we immediately looked at policy issues that needing changing, new ones that should be instituted, or resource related issues of more people, equipment or facilities. Immediate changes reduced the normal TRICARE access to care standards for appointments; for MRIs and other diagnostic imaging procedures, and for surgical procedures. I pushed greater use of the community assets (purchased care) while at the same time bringing in VA, public health service staff and borrowed staff from other Army locations. I worked with Army leadership to approve mobilization of additional personnel in anticipation of increased numbers of injured/wounded Soldiers returning from both Iraq and Afghanistan and justified additional funds for contract providers, physical disability advisors and other support staff. We reduced the ratio of case managers to patients, the ratio of soldiers to disability benefit advisors, and ensured that hospitals assign primary care physicians who would directly oversee this population of patients. I approved the establishment of a unique contract that would allow quick access to healthcare professionals to include mental health specialists.

Strict reporting requirements were enacted for the medical facilities and they were held accountable to the new standards. The medical holdover population was modeled and forecasts allowed resource distribution and monitoring of our progress in resolving the needs of this population of Soldiers.

Each soldier was mandated to have a case manager to stay with the soldier through their hand-off with the VA. I supported the development of the Community Based Healthcare Organization medical concept of operation. This initiative continues allowing soldiers to return home and receive their care locally but under the management of the community based organization with National Guard leadership.

Prior to this and before the war, the issue of the disability system was on my scope. I had insisted that "The Compassionate and Efficient Disposition of the Unfit Soldier" be placed as a key performance process on the Balanced Score Card Strategy Map for the United States Army Medical Command. In hindsight I could have recognized that the peacetime processing standards (a problem already) were inadequate to support a surge that potentially would come of wartime. I might have anticipated the impact of the flawed policy regarding the retention of soldiers unfit at the time of mobilization and fought harder to change it prospectively. I might have worked harder to create the imperative to reengineer the disability system. Though I was one of the outspoken champions of DOD/VA sharing, I could have pushed harder for advances that were more aggressive than the 50 VA caseworkers that we welcomed into Army hospitals or been more aggressive in staff sharing beyond the 4 cardiac surgeons that I detailed to the VA.

Question 18(a). What difficulties confronting wounded, injured and ill service-members transitioning from the military to the VA health care systems are the result of DOD policies and practices? Of VA policies and practices? Of some combination?

Response. If confirmed, I look forward to detailed briefings on the current status of policies and practices and the result of pilot programs that, I understand, are ongoing. Already addressed, as I understand from what I have read and in general discussion, are the establishment of specific standards for living quarters for wounded warriors, an expanded and aggressive case management approach; a strengthening of the chain of command for care and oversight of the wounded warrior; the beginning stages of the recovery coordinators as suggested in the Dole-Shalala report; information exchange as wounded warriors are moved into VA facilities for the next stages of their care. Each of these was an area that needed strengthening and focus. The VA has moved to expand the polytrauma capability with an additional polytrauma center planned as well as polytrauma expertise identified within each VISN. I am told that VA has pushed the limits of their authority to provide medical support to family members who are supporting their wounded warriors. The pilot program in the national capital region that began in November will provide lessons

in the single physical and VA rating for Medical Evaluation Boarded servicemembers. The incentive for the servicemember to move from one system to the other—or rather the incentive not to move from one system to the other—is only partially addressed by these measures and is not completely within the purview of administrative change.

Question 18(b). If confirmed, what do you believe you will be able to do to enable VA to change the current situation and to ensure that separating servicemembers are made aware of the benefits and services that are available to them?

Response. I believe that the different demographics of separating servicemembers require targeted approaches. The wounded warrior with recognized combat related injuries is one group. The active duty servicemember with an active duty unit affiliation with its full time chain of command who elects to separate from service prior to retirement is another. The retiring servicemember who may become dual eligible is a third group. The reserve (to include National Guard) servicemember, demobilizing and returning to civilian life while remaining in the reserve force, subject to call-up represents yet another group. Coordinating access for these unique groups, crafting and delivering a common message with the responsible service, appropriate counseling, the processes to deliver those services, and measuring the success of the engagement are steps that I would champion, if confirmed. I am fully supportive of web based access to assistance and would explore other methods to ease communication for veterans/families in need of assistance.

Question 18(c). Will your Army background be a plus or a minus in dealing with the relationships between VA and the Navy and the Air Force?

Response. I believe my background will be a plus. My joint experience at senior levels dates from my time in command of Army medical forces in Korea while serving as the Joint Surgeon with staff oversight for both armistice and wartime health care planning. As the first lead agent for TRICARE, I worked closely and collaboratively with Navy and Air Force medical commanders in our region as well as with the VA leadership in Washington State and Oregon. As Surgeon General I believe my relationships with my fellow Surgeons General was positive and I have sustained those relationships with those who have moved into the senior leadership positions within the Services since my retirement.

Question 19. Currently, the VA/DOD Senior Oversight Committee, co-chaired by Deputy Secretaries Mansfield and England, meets on a weekly basis to deal with joint VA and DOD issues. In part, the SOC has been addressing those Dole-Shalala Commission recommendations that can be corrected administratively. If confirmed as Secretary, what would be your priorities for the SOC?

Response. I am aware of the eight “Lines of Action” which, I believe, address the high level key areas. If confirmed, a first priority will be to gain an in-depth understanding of the level of progress within each of these “Lines of Action” and formulate my own assessment of progress, priorities, or potential areas for addition.

Question 20. If implemented as set forth in the draft legislation presented by the White House, the disability reforms recommended by the Dole-Shalala Commission would create a multi-tiered disability system.

- How would you ensure that any changes to the current disability system are fair, equitable, and uniformly administered for all veterans?

Response. With the system as it is today, I have heard concerns that there is unfairness, inequitable and non uniform decisions that occur from time to time and across different geographic areas. Working with Congress and the administration to revise the disability system offers the opportunity to simplify the process, create a way ahead for an equitable and uniformly administered system while meeting the needs of each of the tiers that might be identified.

- Do you believe that a disability system that treats veterans of different generations differently is desirable?

Response. The demographics of the Veteran population in the United States represent a spectrum. The needs at different parts of this spectrum may be quite different. The geriatric medical requirements of the World War II generation are quite different from the acute needs of the recently returned young Veteran; just as the social needs of the older Veteran who may be leaving the active work force is different from the vocational and rehabilitation needs of the your Veteran who aggressive assistance in re-entering that work force. In between is the Vietnam generation who’s medical and life circumstance may require yet a different focus. It is important that we provide the support and care needed that is appropriate to the Veteran.

- Do you believe that veterans of prior conflicts should be given a lower priority in claims processing than veterans of current conflicts?

Response. I believe that the VA should strive, through, process improvement, automation tools, training, and the expanded claims work force that the Committee has supported, to do “today’s work today and to standard” for all Veterans. A quality system must have the ability to identify and deal with uniquely urgent or emergent situations by exception.

- Do you believe that claims resulting from combat versus non-combat injuries or diseases should be prioritized differently?

Response. I believe the first priority for the VA is to those who have sustained service-connected disabilities whether injury or disease, physical or mental, and to those veterans in need. I understand that the term combat injury within the Dole-Shalala commission context is, according to their guidance, broadly understood to include training for combat whether in or out of a combat zone and with the opportunity for Secretarial discretion to be more inclusive if warranted.

Question 21. I understand that VA has solicited an outside bid to carry out two technical studies that are being sought as a result of the recommendations of the Dole-Shalala Commission. Once these studies are completed, do you believe that the Secretary has the authority to implement changes to the disability compensation schedule generally? Do you believe that the Secretary has the authority to distinguish between multiple systems of compensation and how they are to be applied to different groups of veterans?

Response. The change to the disability compensation schedule requires congressional approval. I do believe that legislation is required to change the disability system itself. If confirmed, I pledge to work closely with Congress, the Department of Defense, and the Veterans Service Organizations to create and manage the change necessary to meet the needs, both short-term and life-term, of this newest generation of combat veterans while insuring that we meet our enduring obligation to those of the “Greatest Generation” and of my generation who have served before.

Question 22. The Disability Benefits Commission recently released a report on its two-and-a-half-year analysis of the benefits and services available to veterans, servicemembers, their survivors, and their families to compensate and provide assistance for the effects of disabilities and deaths attributable to military service. That report contains 113 recommendations. In your view, how should VA analyze, and, if appropriate, implement the recommendations?

Response. Though I have not studied each of the 113 recommendations, I appreciate the work that went into developing such a detailed report. VA should analyze each of the recommendations and consider its value and validity in the scope of the larger revision and changes which are being considered in the disability system. I believe this is an area where the Senior Oversight Committee can add value, urgency and leadership and I will support their efforts at the big picture look and in ensuring appropriate improvements are implemented in a timely manner. For those recommendations which VA has the current authority to implement, an overall implementation plan with timelines should be developed based on a prioritization of the recommendations.

Question 23. The relationship between VA medical centers and medical schools has endured for more than 60 years and has been credited with improving quality of care for veterans. These affiliations draw the best and brightest physicians and help VA fulfill its research and educational missions. I am concerned, however, about the viability of the relationship. Please share your philosophy regarding the overall value of academic affiliations, including the role affiliates play in staffing VA facilities. What is your assessment of how Army medical interacts with academic medicine?

Response. The academic affiliations are one of the enduring strengths of the VA. I believe that a robust teaching environment and high quality research affiliations are contributing factors to the excellence of the Veterans Health Administration. As with any relationship, it is healthy to continue to reexamine the outcomes of the relationship to ensure the basis remains sound; that our Veterans benefit from the care of the affiliate, that the research is of high quality and supporting the Veterans’ needs; that our Veteran population is providing needed access to those in training, and that our changing demography of Veterans warrants the maintenance of the affiliation. The relationship of Army medicine with academic medicine is less interdigitated. Army Graduate Medical Education programs are individually accredited, but often work with civilian academic institutions for specific rotations. The Army training of ancillary medical specialties is, except for degree producing programs, done largely without affiliation with outside academic medical centers.

Question 24. Many veterans, especially those with complicated health issues, rely upon the specialized services of VHA. Many of these services, like spinal cord injury, blind rehabilitation, and prosthetics, are unique to VA and are unmatched by the

private sector. In an era of declining budgets and decentralization of funds, please describe your views on VA's responsibility to maintain capacity in these programs.

Response. I fully support the continued excellence of VHA in these highly specialized areas of expertise and service.

Question 25. Post Traumatic Stress Disorder is a major concern for the Committee, both in terms of compensation and health care.

- As a combat veteran, what is your experience with veterans and PTSD?

Response. In combat I had members of my platoon who handled the same level of exposure to the horrors of war quite differently; from a single soldier becoming overtly combat ineffective; to another providing effective fire in an ambush and then continuing to fire round after round, even after the action was completed; to the majority of my soldiers who were able to perform their duties even in the face of the same combat stressors. Personally, I experienced some of the symptoms of Post Traumatic Stress, but at a level that would not be classified as a disorder. In fact, it is part of what I believe is a "normal" range of adaptation. As long as two years after I returned, I would sometimes startle at an unexpected loud noise or have an occasional dream about combat. I was fortunate that these faded with time for me and did not affect either my professional or social life.

- Do you personally know veterans who continue to suffer from PTSD or veterans who were diagnosed with PTSD, but who are now no longer suffering from the condition?

Response. I do know Veterans who continue to suffer from PTSD. On a personal basis I know Veterans who have had PTSD symptoms, who now are coping well and are not disabled. I do not know if they had been formally diagnosed with PTSD meeting the DSM IV diagnostic criteria. I believe that this spectrum of mental health issues is treatable and we will learn more as we continue to do scientific inquiry.

- Under what circumstances, if any, is it possible for a non-combat veteran to suffer from PTSD?

Response. The circumstance in which an individual experienced, witnessed, or was confronted with an event, combat or otherwise, that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others and whose response involved intense fear, helplessness, or horror might cause that individual to suffer from PTSD.

- VA has significantly decreased its in-patient programs for veterans with PTSD. What do you view as the role of in-patient treatment for PTSD, in particular for veterans with co-morbid substance use disorders?

Response. I am not aware of the extent of the reduction of in-patient programs or of a backlog in access to these in-patient programs. I am aware that significant advances in outpatient and community-based programs for mental health treatment and support have enjoyed success and popularity, not only in the VA, but nationwide. If confirmed, I will look carefully at the balance between the various treatment modalities for PTSD and the co-morbid substance abuse disorders to ensure access to the right care in the right location.

- Please describe the priority that you believe VA should place on providing care to veterans with PTSD, and how would you ensure that priority is manifested in budget requests and programmatic planning?

Response. Care of our Veterans with PTSD and with related symptoms short of PTSD is, rightfully, a very high priority. I am aware of the recent increase in mental health workers recruited by the VA and, if confirmed, I would continue to support this initiative as well as exploring the issues of access in rural areas of the country. I will work with Congress, OMB, and the experts of the mental health community to identify new programs and emerging treatments and in programming the resources to support them.

- What are your views on the need for more research into the best treatments for PTSD?

Response. I believe that PTSD will be a hallmark condition of the current conflict. I am proud to know that the VA has been at the forefront of research in this area. I believe that there is still much to learn and that it is the VA's obligation to remain at the forefront of this learning.

Question 26. Last year VA suffered on, of the biggest losses of personally identifiable information in history. Fortunately, the data was recovered and there have been no reports of any personally identifiable information being compromised. Secretary Nicholson testified last year that he intended for the VA to become the "gold standard" for IT security within the Federal Government. If confirmed, what pri-

ority will you put on efforts to ensure that veterans' personally identifiable information is protected?

Response. The protection of personally identifiable information will be a high priority for me. Though I have not been briefed on the details, I understand that, subsequent to the noted event, many specific policies, procedures, and safeguards for information integrity have been put in place. A major information management restructuring and centralization has occurred, and investments have been made in hardware and security applications. If confirmed, I will work to ensure accountability through oversight and compliance monitoring. I understand that a specific office with this function has been established.

Question 27. The Dole-Shalala Commission recommended that a corps of well-trained, highly-skilled Recovery Coordinators be swiftly developed to ensure prompt development and execution of patient-centered Recovery Plans for every seriously injured servicemember. The Commission's recommendation called for members of the Commissioned Public Health Service to perform this role. On October 31, VA and DOD announced an agreement to provide "Federal recovery coordinators" for seriously injured, ill, and wounded servicemembers and their families. Under the current concept the "Federal recovery coordinator" will be VA employees and the program will apply only to those injured, ill or wounded in combat. Two questions:

- Do you believe the care coordination role is one VA should be performing prior to a servicemember's separation from the military?

Response. The complexity of the conditions and the complexity of the systems can be bridged by a coordinated effort from the beginning in laying out a recovery plan and monitoring its execution in conjunction with the patient, the patient's family and with the agencies involved. As the care coordinator's role evolves it must involve the VA while the servicemember is still on active duty.

- Do you believe that this program should be focused solely on those seriously injured, ill, or wounded in combat, or should it include others who are seriously injured or ill from service elsewhere?

Response. If confirmed, I will endeavor to insure that the broad inclusion of the "combat related" description is operative and that appropriate additional exceptions have a clear and easy process for approval.

Question 28. VA's vocational rehabilitation and employment program is one of the smallest, yet most important, programs within the Department. It is the linchpin for helping veterans who incur service-connected disabilities, achieve a fulfilling and gainful future. I am deeply committed to making sure that this program lives up to its full potential, especially when individuals who have sustained serious injuries in combat are involved. What are your thoughts on the role that vocational rehabilitation plays in terms of the total rehabilitation of an individual recovering from severe combat-related injuries?

Response. I agree with the importance of vocational rehabilitation in support of the critical objective of making our Veterans self-sustaining, proud, and independent financially, socially, and emotionally. I believe in finding the right incentives to get them into these programs and keeping them in these programs through the point of their transition to gainful employment. If confirmed, I will strongly support these programs for Veterans who need help in being productive citizens.

Question 29. There has been significant discussion for at least the last decade about the need for DOD and VA to create a bi-directional/interoperable electronic health record. In 2003, the President's Task Force to Improve Health Care Delivery for our Nation's Veterans recommended that the VA and DOD develop and deploy such a record.

- What involvement did you have with this effort while Surgeon General?

Response. As the Surgeon General, I invited the President's Task Force and personally briefed them on Army medicine to include being a champion for DOD/VA sharing. I was a vocal supporter of the development of a longitudinal, queryable patient record that would capture a servicemembers care from MEPS Station to VA Cemetery.

- Based upon your experience, do you believe that, to achieve this goal it is necessary for DOD's and VA's electronic health record systems to be combined or to simply have the ability to share data?

Response. I do believe this is an obtainable goal that does not necessarily require a single system. More important is the harmonizing and adoption of a common health care lexicon and standardization of processes.

- Do you believe the current problems in the area can be resolved in a timely manner so that VA doctors can have access to complete medical history, including military health records?

Response. Timely is yesterday! So my answer is that we need to move as quickly as possible with initiatives that do share digital data and records as we advance to the interoperative use of computable data as an achievable goal, while making up any short term shortfall with paper, and personal communication. We must ensure, even without perfect electronic transfer that providers have the information needed to provide outstanding care appropriate to the continuum of care.

- As a former practicing physician, what medical information do you believe VA health care providers need from DOD?

Response. I believe that VA physicians and the other health care providers within VA need the most comprehensive medical information that DOD can provide that is relevant to the patient's current active medical conditions. It would be impossible to list here the full spectrum of the specific data elements that might be required to do this. I would point out that I do not see this information flow as one-way from the DOD, given particularly: the service to those dual eligible Veterans; the potential for a Veteran to return to active service after care in the VA; and what our rehabilitative services might achieve in returning someone who had been unfit back to duty.

Question 30. VA currently uses the criteria of 170,000 unserved veterans within a 75-mile radius for purposes of establishing new national cemeteries. In the past, the Senate has supported this standard and has authorized new cemeteries based upon VA's recommendations. Do you believe this should continue to be the standard practice? In the absence of a VA recommendation, do you believe Congress should legislate location of new national cemeteries?

Response. I understand that the stated goal is: by 2011, to have 90 Veterans within 75 miles of a national or State veterans' cemetery. It is my understanding that Congress has been extremely supportive of this strategic direction—five new cemeteries are targeted to open in 2008 because of your support. If confirmed, I will continue to work closely with our National Cemetery Administration and Congress to insure the resources are available for new cemeteries and to insure the standards are maintained that mark the lasting tribute that commemorates Veterans' service to our Nation.

Question 31. What is your view of the correlation between combat service and homelessness?

Response. I have read that up to one-in-four of single male homeless people are Veterans. It has been estimated that nearly 200,000 Veterans may be homeless on any given night. Risks include poverty, lack of family support, precarious living conditions.

I am told that, currently, there is little information to suggest that combat service, per se, has a direct link to homelessness. But, deployments with disruption of family lives, the effects of traumatic events of combat, may very well contribute to homelessness and is a correlation that truly needs investigation.

- Do you believe that VA has a particular obligation to aggressively address homelessness among veterans?

Response. Yes

- Public Law 106-377 funds the Interagency Council on Homelessness and makes the Secretary of Veterans Affairs a rotating chair of the Council. What do you see as VA's role in working with other departments, agencies, especially HUD, to address the needs of homeless veterans and their families?

Response. I believe homelessness is a multifaceted problem that involves individual economics, skills development, mental health and social well-being. If confirmed, I look forward to supporting the inter-agency/interdisciplinary approach to understanding and supporting homeless Veterans.

Question 32. VA has a history of significant waiting times for care—a problem from which specialty care particularly suffers. What are your thoughts on the priority that should be accorded to reducing waiting times? In your view, how long should a veteran be expected to wait for a non-emergent health care appointment?

Response. Excess waiting times result in patient dissatisfaction in any health system and so must be a priority in a patient-centered, and, in our case, veterans-centered, care environment. In some cases excess waiting times can have an impact on the course of an illness or in extended period of patient distress. In other cases the Veteran him or herself may choose a visit time outside of specified standards for their own convenience and without compromising care. The waiting time standards should address this spectrum. I understand that the VA standard for a non-urgent specialty care appointment is within 30 days. This is consistent with the DOD TRICARE standard for non-urgent specialty access and is reasonable with the ca-

veat that the referring provider can decrease that time depending on the clinical assessment.

Question 33. The active-duty military has become increasingly more reliant on the Reserve components to accomplish its missions. What will you do, if confirmed, to ensure that governmental services, including pre-, during, and post-deployment services, including transition services, are equally available to National Guard and Reserve veterans?

Response. The “pre-, during . . . services” are largely within the purview of the Department of Defense. I believe in their recently instituted annual Personal Health Assessment and reserve health readiness initiatives. Where needed and feasible the VA should be supportive of these DOD efforts. Regarding the “post-deployment services, including transition services,” I will, if confirmed, work to make VA an integral participant from emphasis on the Benefits Delivery at Discharge program, to educating demobilizing Guard and Reserve veterans about their benefits, to encouraging their access to VA services in their immediate 24 months of post deployment presumptive period currently authorized, and to working with the reserve component leadership through DOD collaboration.

Question 34. In your view, how long should a veteran have to wait to have his or her initial claim for compensation adjudicated?

Response. I am aware that the VA has as its strategic goal to provide claims decisions in an average of 125 days. I know also that this goal has been very difficult to achieve for many reasons. However, I believe VA can and must do better. VA’s compensation claims process is complex and the evidence gathering often involves obtaining information from DOD, VHA, other Federal agencies, and private providers. I believe the recently introduced Disability Evaluation System pilot, a joint VA and DOD initiative, holds great potential for servicemembers undergoing a Medical Evaluation Board Proceeding. I am committed to working with all involved parties and the Congress to streamline the disability compensation claims process for all Veterans.

Question 35. VBA has come under fire for the lack of timeliness of its claims’ processing. While VBA has made progress in improving timeliness and accuracy of disability claims processing, further improvement is needed. VBA has turned its attention to decreasing the amount of time it takes to process a claim, but that improvement seems to be at the cost of a decrease in the quality of its decisionmaking. Do you have any views on how a more balanced approach can be reached?

Response. The nearly 3,000 additional personnel for the Veterans Benefit Administration dedicated to claims processing will help in the short term and as they become better trained (as I understand it, a major focus of Admiral Cooper) and experienced, the accuracy will improve in addition to the timeliness.

However, I support the observation by multiple recent groups looking at this problem, that a simplified disability system with updating of the rating criteria on a go-forward basis offers the best opportunity to have clear, fair, and reproducible ratings that are supportable by modern rules-based information technology tools.

Question 36. Accurate forecasting of usage of veterans benefits is essential in planning for resources to administer those benefits. What do you see as the Secretary’s role in insuring that VA forecasts the need for additional staffing resources so that Congress could appropriate those resources in a timely manner?

Response. I believe that the Secretary must use actuarially supported data combined with real information from practice patterns and collaborate with the DOD using their best data to provide accurate forecasting and appropriately identify the resources to support those forecasted needs.

Question 37. As one who knows first-hand the value of educational benefits under the GI Bill, I am deeply committed to making sure that this important benefit is available to today’s veterans. I recognize that this benefit is not just a readjustment benefit in today’s all-volunteer force. It also serves as a recruitment and retention tool.

- What are your thoughts about the delicate balance between these in aspects of the benefit? Do you believe that one outweighs the other?

Response. From my years in the military I appreciate the value that soldiers place on their educational benefits. For many, it is a way to take an economic burden of education off of their parents, for others, the GI Bill represents the only route to additional schooling past high school. It is perhaps most important as a motivator for service for those who enlist not specifically seeking a career. For the servicemember returning from combat, it can be a powerful readjustment benefit as described in the Bradley report of 1956. Education can produce a better adjusted Veteran and one who is better positioned to resume life as a productive citizen. I abso-

lutely share this Committee's belief, and appreciate your history of action, in investing in those who have served this Nation in uniform.

- How do you see the VA working with DOD on GI Bill issues, such as the size, scope, and details of benefits under the various GI Bills and in reaching out to eligible individuals to ensure that they are aware of and use their benefits?

Response. The forum for such collaboration exists with the DOD/VA Joint Executive Council. If confirmed, I would support a focused look at this subject, and would work with Congress and DOD and our Veteran Service Organizations to take the results of that work into an effective update of our GI Bill programs.

Question 38. There has been increasing pressure in recent years for VA to contract for services in local—especially rural—communities where VA facilities are not easily accessible. Mental health is one area of particular emphasis in this regard. What do you believe is VA's responsibility for meeting the needs, including mental health needs, of rural veterans? If confirmed, what emphasis would you place on this issue?

Response. Rural Health is a topic that has come up on several occasions in my pre-hearing meetings with the Committee Members and so I appreciate that emphasis is needed. I believe that Veterans in rural areas may be well served locally, if care is available, but that the VA has an obligation to monitor the quality of that care. I also appreciate the challenges of making this care part of the continuum of care expected of a quality health system. If confirmed, I will ask early in my tenure for an update from the recently-created Department of Rural Health, explore the various interagency opportunities, and the potential for leveraging technologies such as Telemedicine/Telepsychiatry, to better serve remote Veterans.

Question 39. There are a number of issues about the current GI Bill that I find troubling.

- One aspect that especially concerns me is that there are individuals who are serving in combat, placing their own lives in harm's way, who have had to make a monetary contribution in order to establish eligibility for GI Bill benefits. What are your thoughts on this issue?

Response. It is my understanding that the Montgomery GI Bill was enacted by Congress in 1984 and designed for a peacetime active duty service and supported a contribution that put skin-in-the-game. If confirmed, I will work with DOD and this Committee to re-examine this premise in light of the current conflict and the sacrifices of today's servicemembers and Veterans.

- I am also very concerned that there are individuals who are serving with the National Guard and Reserves and who may have completed multiple deployments in combat zones but who stand to lose eligibility to valuable educational assistance benefits if they separate from their unit. What are your thoughts about these individuals and the portability of their benefits?

Response. I do not yet have a detailed understanding of the full scope of this issue. However, my sense is that once these valuable educational assistance benefits are earned, they ought to follow our servicemember. If confirmed, I will follow up on this issue to fully understand the issue and make appropriate corrections within my authority or recommendations for change.

Question 40. All Federal agencies have certain responsibilities to maximize contracting opportunities for veteran-owned small business and especially service-disabled veteran-owned small businesses. In general, it appears that VA has a better record than most other Federal agencies. However, some have raised concerns that to meet the goal of increased contracting with these businesses, there has been increasing reliance on partnerships between large corporations and small service-disabled veteran-owned businesses, in which the involvement of the SDVOB is really only on paper. In your view, does the VA have an obligation to ensure that contracts with small service-disabled veteran-owned businesses truly involve and benefit these firms in the actual contracted activity?

Response. I am aware of the VA's emphasis on Veteran-owned and, especially, service-disabled veteran-owned small business as preferred contractors. Given the magnitude of some of the programs and projects it may be unrealistic to expect successful performance by any small business—veteran-owned or not—in the prime contractor role. I whole-heartedly endorse our government providing preferential treatment to our own Veteran small business owners and particularly those service-disabled small business owners. If confirmed, I will work closely with our contracting office to insure we have clear outcome objectives that include development of these veteran-owned small businesses (coaching, teaching, mentoring, investing and rewarding) and consider that such metrics may be applied to the large corpora-

tions who may be better positioned to function as a prime, but with a specified level of subcontracting to the veteran-owned concerns.

Question 41. I have long advocated strategies for recruiting and retaining highly trained medical professionals within the VA health care system. Just a few years ago, I supported legislation to create a more competitive pay system for VA physicians and dentists, as well as other legislative initiatives targeted at nurse recruitment. Despite these efforts, VA continues to face a growing nursing shortage, as well as vacancies for specialty care physicians. In your view, what should VA do to improve personnel recruitment and retention at VA health care facilities, particularly of nurses? What more can VA realistically do to improve recruitment in areas where there are fewer specialty care physicians overall?

Response. The recruitment of all health care personnel, including physicians and nurses, remains a challenge in U.S. health care. While I do not know all of the programs that are currently in place to support the recruitment and retention of VA physicians and nurses, I do believe that the VHA's reputation as a high-quality health care system is a strong recruitment incentive. Generally, VHA will have to continue to ask for authorities to allow it to match market pay and performance incentives that are offered in the community sector. Not to do so would jeopardize the quality of health care providers that treat Veterans. Additionally, I would look to ensure that the practice environment for our providers is supportive, collaborative, and an inducement to retention.

Question 42. Many in the newest generation of veterans are technologically savvy. Veterans can submit claims for compensation over the Internet. However, such applications are treated as e-mail copies of the application and are not integrated into the claims process. Do you believe that VA has a role in improving the use of technology for the processing of initial applications for compensation and to aid in the timeliness and accuracy of claims adjudication?

Response. Yes, I believe that the VA should quickly adapt an e-commerce model that enables those increasingly technologically savvy Veterans with a positive, secure, and easy experience.

Question 43. For some medical conditions that occur after service, the scientific information needed to connect the medical condition and the circumstances of service may be incomplete. When information is incomplete, Congress or the Secretary of Veterans Affairs has the authority to presume disabilities and diseases as service-connected for the purposes of compensation. If confirmed as Secretary, what would be your approach for evaluating whether a presumption is warranted?

Response. I am aware that there have been recommendations made by the President's Commission on Veteran's Disability Benefits and by the Institute of Medicine on presumption. I am also aware that this is a critical policy decision that determines benefits for millions of Veterans. If confirmed, I will study these recommendations and others in formulating my approach.

Question 44. As you know, women constitute an ever-growing segment of the Armed Forces and consequently, the overall veteran population. What do you see as the primary challenges to appropriately treat and serve women veterans in VA facilities? Are there aspects of your experience working with women in the military that can translate into innovative solutions for improving care for women veterans?

Response. I believe the challenges include facilities, culture, and expertise in women's health issues that have not traditionally resided within the VA. Military medicine has traditionally cared for all family members, with delivery of babies being one of the most common admissions in that system. Even with that base, we had adjustments to the deployment culture as more women came into the force. I had a specific consultant on women's health issues to focus on our active duty women. The importance of ambience, a sense of caring, of attention to the privacy needs and sensitivities to security are important in addition to the expertise and availability of equipment and services to address the physical and emotional needs of women Veterans. These capabilities need to be planned for prospectively as the number of women veterans grows to the anticipated 10 percent of the veteran population by 2020.

Question 45. A major issue in recent years has been the proposal for mandatory funding for VA health care, with many veterans' organizations calling for the guaranteed funding of the systems each year at a level set by law. What do you see as the benefits or drawbacks or both to such an approach to funding for health care?

Response. I appreciate this to be a very complex issue and one for which I will require detailed briefing to provide a more informed response. I understand that VA's position has been that annual actuarial projections, rather than pat formulas, are the most rational way to project the resource needs for Veterans health care.

I do have an open mind on the subject and intend to carefully study it before forming an opinion.

Question 46. At the present time, military recruiters are actively recruiting servicemembers from countries in the Pacific Islands, such as the Federated States of Micronesia. Some veterans benefits, such as vocational rehabilitation services, VA home loans, and health care are not normally provided outside of the United States. In your view, what obligation does the government have to provide non-citizen disabled veterans benefits and services needed to compensate for and overcome the disabilities which they incurred after being recruited into United States military service?

Response. I believe that all disabled veterans should receive the benefits earned through their service, regardless of citizenship status. I have been informed that VA has legal authority to furnish hospital care and medical services to any veteran residing outside the United States without regard to the Veteran's citizenship if such care and services are necessary for treatment of a service-connected disability. VA may also provide vocational rehabilitation programs outside the United States to assist veterans in becoming employable and obtaining suitable employment. The law, however, does not provide for independent living services outside the United States. I have also learned that VA guaranteed home loans and grants for Specially Adapted Housing for seriously disabled veterans cannot, by regulation, be made to veterans living outside of the United States and its territories. This is, in large part, because of problems in administering this type of benefit to veterans in foreign countries where there is no VA presence. If confirmed, I will ask for this area to be reviewed.

Question 47. In 2004, a blue-ribbon panel completed an exhaustive review of VA's vocational rehabilitation and employment program. In its findings, it made more than 100 recommendations. Of those, VA reports that 88 recommendations have been implemented to some extent. I remain concerned, however, that there are far too many eligible veterans who do not apply, complete the evaluation process, have a rehabilitation plan developed, or complete their plan. No one seems to really know why there is such a low completion rate when measured against the number of veterans who apply and who are determined entitled. What priority do you believe VA should place on determining why the successful completion rate for individuals in this program is so low?

Response. I have not had the opportunity to review the blue-ribbon panel review noted. However, I do believe that the VA should place emphasis on outcomes, not just participation, in all of our programs. If confirmed, I will review the panel recommendation and the results of our vocational rehabilitation and employment programs.

Question 48. Restructuring and downsizing in several VA health care facilities have led to contracting with community providers for care. Also, a large number of existing VA community-based outpatient clinics are run by non-VA providers. What do you believe is VA's responsibility for monitoring care furnished by contract providers and how might that monitoring be carried out?

Response. As VA works to provide access to meet the needs of Veterans, it is incumbent on us to maintain the same high quality standards that we have within the VHA.

Appropriate monitoring of claims, appropriate contracting; appropriate retrieval of health records to compliment the continuity of care are all mechanisms that might be used to meet this obligation.

Question 49. There is legislation currently pending in Congress that would provide World War II Merchant Mariners with a tax-free annual pension of \$1,000 a month, a payment based upon neither disability nor financial need.

- What is your opinion about VA providing certain groups with entitlement to a monetary payment that is based neither on being disabled nor in need?

Response. The VA administers the entitlements determined by law and I do understand that there are some historic precedents for such groups. However, I believe the priority should be given to those Veterans with service-connected disability or Veterans in need.

- Should VA provide such special compensation to a group without doing the same for similarly situated groups?

Response. The first priority of the VA should, I believe, be to those with service-connected injuries or disease whether physical or mental, and to those Veterans in need. The VA should administer what other benefits are legislated by Congress to the best of our ability with the resources applied to insure our first priority commitment is fulfilled.

Question 50. Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), employers—including the Federal Government—have certain responsibilities to re-hire individuals who are seeking to return to their jobs following a period of active service. It is particularly troublesome to me that an individual who has been sent into battle by the government would need to do battle with that same government for the right to regain a job and its associated benefits. However, it does happen and it happens far too often. Indeed, according to Department of Labor, more than 30 claims of violations of USERRA were lodged against the Department of Veterans Affairs in fiscal 2006. This should be embarrassing to the agency. If confirmed, what steps do you believe you can take to ensure that VA follows USERRA?

Response. I believe that the legal protection of employment for those men and women who have left their jobs to serve this country is yet another important contribution made by this Committee. I know that among our deployed reserve soldiers, it is a concern that is often on their minds. I also agree that the Federal Government and perhaps, most particularly, the Department of Veterans Affairs ought to be the positive example.

If confirmed, I will look into the practices that would have the Department of Veterans Affairs out of compliance with the law and make corrections where that occurs.

Question 51. Public Law 106–117 contains a provision mandating that VA provide non-institutional extended-care services to veterans who are enrolled in the VA health care system. While most veterans would prefer to stay out of nursing homes, GAOI confirmed that VA is nowhere near full capacity on the non-institutional side of long-term care.

- What is your view of the value of noninstitutional long-term care?

Response. I believe that non-institutional care can provide a high quality of life enhanced by societal and family interaction when so enabled.

- Do you have any personal or professional experience in this area?

Response. My personal experience in this area was with my mother-in-law who, because of Alzheimer's disease required progressive nursing home care and with my father who, until his death, eschewed a nursing home, but was enabled by home health and a capable caregiver to remain in a home setting that was much more satisfying to him. As a cardiac surgeon, I often worked with the social workers to find intermediate care for recovery and rehabilitation, but realized the quicker one could transition the patient back to non-institutional environment, the more likely it was that my patient would be productive and enjoy a higher quality of life.

- If confirmed, what steps will you take to promote VA's development of non-institutional extended care?

Response. First, I was gratified to understand that more than 90 percent of VA's medical centers provide home and outpatient long-term care programs and that about 50 percent of VA's total extended care patient populations receives care in non-institutional settings. I fully support VA's patient-focused approach and these programs, and, if confirmed, I will review the metrics of success and the incentives to support this program with our Veterans.

Question 52. VHA has had considerable success in using electronic health records. What are your views on how technology might be used to address problems that arise from VBA's reliance on paper files?

Response. I believe that this is a very important axis of advance. I understand that much work has been done toward the goal of automating VBA processes, but that the paper service medical records of the past have limitations on digitization potential. On a go-forward basis, this constraint should be eliminated and with a simplified disability schedule, decision support information technology should provide a valuable tool in addressing these problems.

Question 53. In 1941, Congress passed legislation which, in recognition of the difficulty of using official military records to establish the disability of veterans who were disabled in combat areas, provided for a relaxed evidentiary standard in the case of claims from veterans who served in combat areas. It has recently come to my attention that VA defines "combat" very narrowly when applying this standard, requiring a veteran claimant to produce proof of direct combat with an enemy. I have introduced legislation which would recognize service in a combat zone as "combat" for purposes of VA claims. Do you see this as an appropriate response to this issue?

Response. If confirmed, I will review the details of the definitions related to combat. My understanding within the Dole-Shalala description of "combat-related"—a

disability acquired while training and preparing for combat—does not have to be sustained in the Combat Zone to qualify.

Question 54. Recently, it came to the Committee's attention that there may be thousands of Reservists who have returned from mobilizations longer than 20 months, including extended deployments in Iraq or Afghanistan, to find that while their length of service qualifies them for Chapter 30 benefits, due to Army procedures, their orders fall short of the 730-day threshold, and thus, they are ineligible for full educational benefits. A specific example is the 1/34th BCT from Minnesota, which returned from Iraq in July after a 16-month deployment. Although almost 4,000 members of the unit had served 22-months on active duty, roughly half had orders that called for active duty service for up to 730 days and half did not. Thus despite all having served equal lengths, only half are eligible for Chapter 30 benefits.

It is the Committee's understanding that the Department of Defense has elected to pursue a remedy in this specific case through the correction of military records. They have also indicated that they are working with the VA to establish a mechanism for the processing of claims for affected individuals in the most expeditious manner possible.

If confirmed, I ask that you have appropriate officials work with DOD in an effort to avoid problems such as this in the future. Also, please let the Committee know if you believe a legislative remedy is necessary.

Response. If confirmed I will insure that we work with DOD to address this problem and to find the solution to avoid such problems in the future.

Question 55. VA research not only makes a major contribution to our national effort to combat disease, but it also serves to maintain a high quality of care for veterans through its impact on physician recruitment and retention. The Administration has made efforts to limit the types of VA research to those conditions associated with combat. What is your view of limiting the scope of research performed in VA facilities?

Response. The many different age groups and an increasing gender mix of Veterans expand the scope of research that is relevant to Veterans issues. Our first priority in the use of our discretionary research funding is to insure we are the experts in service-connected medical issues, but the influence of those conditions over a lifetime allows our researchers latitude in the scope of their inquiry.

Question 56. Through VA's vocational rehabilitation program, VA assumes certain responsibilities for the provision of employment assistance to veterans who complete a plan of vocational rehabilitation. This assistance can take a variety of forms. I believe it would be desirable that VA cooperate and coordinate with the department of Labor's Veterans' Employment and Training Service so that duplication of effort can be minimized. If confirmed as Secretary, what will you do to involve both DOL and DOD in efforts to ensure that employment-related issues are addressed seamlessly and without duplication of effort?

Response. If confirmed, I pledge to work diligently with both DOL and DOD to have a collaborative environment supporting the very important outcome of employment for our returning Veterans.

Question 57. What is your view of the VA's CARES process and VA's Capital Plan overall? How will you involve senior Veterans Health Administration leadership, Congress, veterans service organizations, affiliates, and other stakeholders in the remaining decisions related to the implementation of the Capital Plan?

Response. I believe in the importance of an overarching strategic planning process for long-term restructuring of capital assets and investment to meet the projected future needs. I have not had the opportunity for detailed briefings on execution of the CARES recommendations. I do note that those recommendations were based upon data only as current as 2004. In moving forward, I appreciate the importance of engaging senior Veterans Health Administration leadership, Congress, Veteran Service Organizations and other stakeholders to insure that our investments support the projected needs and demographics of our Veterans while addressing the realities of the significantly aging capital infrastructure.

Question 58. Diagnosis for substance use disorders (SUD) in veterans from the current war continue to increase. In your view, does combat play a role in increasing the likelihood for developing an SUD? Does VA have a particular responsibility for treating SUDs?

Response. I am aware of recent studies from our current conflict that support the role of the stress of combat in the development of substance use disorders. There is documented co-morbidity with PTSD that is well recognized. VA does have a responsibility to treat substance use disorders as they do any health issue that prevents a Veteran's reintegration into society.

Question 59. VBA has had some success in the past with improving the efficiency of claims processing by consolidating certain services into fewer offices. What are your views on the pros and cons of such consolidation?

Response. I appreciate the importance of the issue of the claims backlog and the time required to process a claim in an accurate and timely manner. I support exploring new models of claims processing, measuring the outcomes, and adopting best practices. I have not been briefed to the extent that I have formed an opinion on the pros and cons of consolidation in this claims environment.

Question 60. Under the VA's vocational rehabilitation program, there is authority for a program of independent living services for individuals who are severely disabled. However, there is an annual cap of 2,500 enrollees in this program. Concerns have been expressed that this enrollment cap may be adversely impacting the provision of services to those most severely injured in combat. Do you believe that this cap is appropriate or should these services be available to all who need them?

Response. Independent living services must be available to all service-disabled veterans who can benefit from them. I need to learn more about this issue. If an annual cap is keeping any disabled veteran from participating in the program, I will work with Congress to resolve this issue.

Question 61. Under current policies, there is a protracted period of evaluation and multiple reviews of decisions concerning seriously disabled veterans seeking independent living services. If confirmed, will you look into what steps might be taken to shorten the evaluation period and reduce the layers of review?

Response. If confirmed, I will look into what steps might be taken to streamline the evaluation of independent living decisions.

RESPONSE TO WRITTEN QUESTIONS FROM HON. DANIEL K. AKAKA TO LTG JAMES B. PEAKE, (RET.) M.D., NOMINEE FOR SECRETARY OF VETERANS AFFAIRS

Question 1. In response to a pre-hearing question, you described different subsets of separating servicemembers—those with combat injuries, those with an active duty affiliation who elect to leave service prior to retirement, retiring servicemembers, and finally those in the National Guard and Reserves who are demobilizing while remaining in the reserve forces. Please expand on what you see as VA's response to each of these groups—what priority should be accorded to each and what should be the focus of VA's outreach and message to each?

Response. I believe the VA has the same responsibility to the servicemember who becomes a veteran from each of the groups and that is a speedy and accurate adjudication of their claims, effective and efficient and compassionate delivery of their benefits, including the highest quality of health care. The difference in response is in finding the effective ways of reaching them, educating them on their benefits, assisting them in their access to the VA. The soldier separating from active duty without an unfitting condition has a period before discharge to plan his/her future, access to DOD support services, and the link to the VA system with the Benefits Delivery at Discharge (BDD) program. The retiring servicemember has a similar circumstance, but with the potential of dual eligibility for health care if there is service-connected disability. Again, the opportunity for education can be targeted and directed while on active duty. The reserve soldier who is demobilized may be eligible for VA benefits. Reaching this group for education, for screening, for helping them with service-related frustrations of getting back to their civilian jobs requires a different focus from the active component and it requires working with a different chain of command—both National Guard and Reserve. The family support structures are more of a challenge in the reserve component, yet are increasingly important as it is the family unit that needs to understand not only benefits, but issues of warning signs for service-related mental health issues such as I understand is being done for the active component families. Regarding the message, it is the same for each—"we value your service to country, we care about you, and support your successful transition back to the civilian world as a productive citizen of this great Nation. If you have been disabled by your military service, we want to insure you get the best in rehabilitative care for the most productive and rewarding life possible."

Question 2. You stated in a response to one of my pre-hearing questions that, as Army Surgeon General, you were a supporter of the development of a viable patient record that would capture a servicemembers' care from a MEPS facility to a VA Cemetery. At the same time, you also noted that you believe that a DOD-VA electronic health record system is an achievable goal that does not necessarily require

a single system. Do you believe that these responses are contradictory, and if not, if confirmed what will be your priority for solving this problem?

Response. I do not see these as contradictory responses. The important thing is that information is collected as close to the point of origin of that information as possible, that it is available to those who need it when it is needed and that it can be trended. That does require common standards, common definitions, and common protocols, which means very close cooperation and shared decision making in these areas. In a perfect world, a single system would seem desirable, but with that also comes vulnerabilities and acquisition challenges as well. As noted, this has been a particular interest of mine for many years and, if confirmed, the issue of common computable information will be a very high priority. I will quickly ask for updates from VA and DOD to find the best way to pursue this goal.

Question 3. You also noted that, even without a perfect electronic transfer, it is important that providers have the information needed to provide outstanding care, appropriate to the continuum of care. At this point, how encumbered is VA by DOD's lack of a complete digital record system?

Response. I know that the DOD has moved forward with computerized records for the ambulatory environment since I retired in 2004. I do not have current information on their progress, but do understand that there is agreement for both data and image sharing to be accomplished by October 2008. If confirmed, I would ask for detailed briefings on this area.

Question 4. As I have stated many times, members of our Armed Forces serve at the call of our Nation 24 hours a day, 7 days a week. Recently, the Veterans' Disability Benefits Commission presented its report and, in that report, agreed with my view, concluding that there should be no distinction between combat and non-combat injured servicemembers. Do you believe that there should be a system of compensation for those injured in combat or training exercises that is different from those injured under other conditions?

Response. I believe that those injured in combat or training exercises should be treated the same. I understand the Veterans' Disability Benefits Commission also supports an affirmative Line of Duty determination as a requirement for benefits, and I agree with that as well. I favor finding a way forward for a clear and simple to understand definition of benefits and look forward to studying the recommendations of the Scott Commission, the studies that I understand have been commissioned by the VA, the Dole-Shalala Commission and working with the Committee to provide assistance and support needed to those with service-connected disabilities.

Question 5. In response to one of my pre-hearing questions, you noted that you've been told that VA has pushed the limits of the department's authority to provide medical support to family members who are supporting their injured and ill family members. Historically, VA has provided only limited direct care to veterans' family members. I see at least two areas where it might be appropriate to change that—first, as part of the direct care of the veteran, such as providing counseling and other mental health care services to family members of veterans with PTSD; and second, as your answer suggested, when the family member is spending time in a VA facility or with VA caregivers in connection with the care of their family member. Please give me your initial thoughts on what you see as VA's role in this area and then, assuming your confirmation, please provide the Committee, within 60 days, recommendations for any legislation that might be needed.

Response. My initial thoughts are that the family is a unit when it comes to health—particularly to mental health. The spouse who becomes a caregiver for a severely injured/disabled veteran can best serve that role if mentally fit and that fitness can be challenged by this new role. VA should be able to be supportive. If confirmed, I will provide recommendations to the Committee within 60 days.

Question 6. In your view, do the majority of individuals who are entering military service today regard that as a career decision, that is, as a career from which they will retire?

Response. I believe that there are many factors motivating men and women to join the service today. One is the potential for a career from which they might retire. But, I believe that, while there may be an increased predisposition for a career in the volunteer force, most do not have that as a fundamental career commitment. In the Army it was clear that we recruited the individual, but retained families.

Question 7. In response to my question regarding GI Bill educational assistance benefits, you did not elaborate on the value of these benefits as a "retention" tool. Do you see such a benefit?

Response. I do believe that educational assistance is valuable as a retention and a recruiting tool.

Question 8. In response to one of my pre-hearing questions, you made reference to the so-called “Bradley report of 1956.” To what extent has that report influenced your views on VA and veterans benefits and services?

Response. The Bradley report of 1956 does highlight some of the same challenges for veterans that we see today. In that regard it is useful as a part of the background information that I will continue to read and consider as I further develop policy and recommendations for the way ahead. I appreciate the need to keep in mind the historical and societal context in which any report was written. It does remind us that the challenges to these newest of combat veterans are not without precedent. I appreciate the value that report gives to reintegration support.

Question 9. With respect to VA adopting an e-commerce model for filing claims, would you support the move away from a requirement for an actual signature on a piece of paper to some form of an electronic signature and will you take steps to do whatever is necessary to move VA in this direction?

Response. I do support this approach, note that industry successfully uses it, and I will do what is necessary to move VA in that direction to include a focus on security and oversight.

Question 10. In response to questions concerning the Dole-Shalala Commission Recovery Coordinator recommendation you responded, “As the care coordinator’s role evolves it must involve the VA while the servicemember is still on active duty.” Under the recently announced pilot, VA will be responsible for providing these coordinators. While I agree that VA should be involved in the process, do you believe that VA should be performing these services for servicemembers still on active duty?

Response. I believe the Recovery Coordinator, though housed in the VA, is really a joint asset and must be supported by and supportive of both agencies. I will seek ways to insure this function serves the intended function of coordinating all resources according to a recovery plan. I am anxious to learn from the pilot program and adjust accordingly.

Question 11. Do you believe that PTSD can be cured?

Response. I am dubious of the word “cured,” in general. I do believe there are people who, at some point, meet the six criteria for the DSM IV diagnosis that, “with treatment lead full and productive lives and whose response to the stressor causes no impact on their social or occupational life.” In that case, a specific criterion for the diagnosis is gone and one could declare the patient cured. We must continue to do research to learn more about this particular mental health issue, the likelihood of recrudescence and the ways to prevent or mitigate that once a diagnosis is made. Also, we need to understand better the interventions for those at risk before the diagnostic criteria are met so that we prevent PTSD. Our focus must always be in supporting and enabling the veteran to be a full and productive member of society.

Question 12. In your responses to pre-hearing questions, you addressed the decision-making process and the importance of reliable data upon which decisions can be made. Do you believe that all decisions can be quantified in some manner based on some data element, or do some decisions have to be made without such underlying data?

Response. Where things can be measured, I favor understanding the data in support of decisions. I also appreciate the real problem of “paralysis by analysis” and I do not intend to use the quest for perfect data as an excuse for not making a decision. There are some decisions which are based upon a philosophical principle—just doing what is right—that don’t necessarily require a lot of data-driven analysis to decide.

Question 13. Given VA’s post-conflict and long-term responsibility for providing prosthetic services to veterans, do you believe that VA should consider assuming responsibility for the Center for the Intrepid at Brooke Army Medical Center and to operate it as a VA Center for Excellence in prosthetic recovery, rehabilitation, and research?

Response. If confirmed, I would be willing to look at that. However, my first inclination is to find the right way to work jointly with the DOD. Ultimately, those patients will be at least a shared responsibility of the VA’s, and to insure we have the excellence of the continuum of care and the excellence of progressive research in this military related area of rehab, I favor partnership. In fact, when I directed the establishment of the Army’s Amputee Center of Excellence, I insisted that we invite governance participation from the VA.

Question 14.A. I have attached a letter from Senator Bond with some additional questions for you. I believe you have already answered his first question.

RESPONSE TO WRITTEN QUESTIONS FROM HON. CHRISTOPHER S. BOND TO LTG
JAMES B. PEAKE, (RET.) M.D., NOMINEE FOR SECRETARY OF VETERANS AFFAIRS

Question 1. Answered, as noted above.

Question 2. What are your budgeting and staffing plans to address the increase in PTSD and TBI patients amongst the veteran population and the impact on homelessness, for both the newest wars and prior wars, now estimated at more than 52,000?

Response. I have not had detailed briefings on the budget. I understand that VHA has made specific expansion of mental health workers to deal with these issues. I note that the Secretary of Veterans Affairs is one of the rotating chairs of the Inter-agency Council on Homelessness. I believe homelessness is a multifaceted problem that involves individual economics, skills development, mental health and social well-being. If confirmed, I look forward to supporting the inter-agency/interdisciplinary approach to understanding and supporting homeless veterans. I will also quickly assess the budget for mental health/TBI.

Question 3. What are your detailed budgeting and staffing plans to address the backlog of PTSD claims? Would you consider expediting the process by establishing a presumption of service connection for PTSD claims for veterans deployed to Iraq and Afghanistan where the service record supports evidence of PTSD symptoms.

Response. I have not had detailed briefings on the budget. I am aware that nearly 3,000 new claims personnel have been hired and are in various stages of training. If confirmed, I will further review the budget and the pros and cons of this presumption, as well as other potential alternatives for expediting claims processing. I am particularly interested in getting assistance to those in need and, as quickly as possible, engaging them to keep the reaction to combat stress from becoming a disabling condition.

Question 4. What are your plans to address the significant disparity among the number of Iraq and Afghanistan war veterans diagnosed by VA with PTSD (52,375), compared to the much smaller number of Iraq and Afghanistan veterans receiving disability compensation for PTSD (19,015)?

Response. I am not familiar with the detail behind these numbers. If confirmed, I will aggressively investigate this disparity and propose solutions to address unfair practices.

Question 14.B. Attached are also some question from the Physicians for Human Rights.

RESPONSE TO WRITTEN QUESTIONS FROM PHYSICIANS FOR HUMAN RIGHTS TO LTG
JAMES B. PEAKE, (RET.) M.D., NOMINEE FOR SECRETARY OF VETERANS AFFAIRS

Question 1. During your tenure as Army Surgeon General, from 2000 to 2004, what involvement, if any, did you have in the development or approval of the BSCT (Behavioral Science Consultative Teams) program at Guantanamo and other facilities, which employed psychologists as interrogators in a military intelligence program using abusive tactics?

Response. Personnel were assigned to join these teams which were not under my command authority. To my knowledge medical personnel did not act as interrogators.

Question 2. What efforts did your office take to address the credible evidence of physicians and other health professionals serving as "safety" officers during abusive interrogations? Also, did you support the utilization of personnel within your command to provide sign-off on whether a detainee was physically or mentally "capable" to undergo SERE method interrogations?

Response. I am aware that medical personnel, not in a patient care capacity for the prisoners, provided medical advice to the interrogators in support of humane treatment of prisoners. I supported this policy. Care of prisoners was performed by different competent medical personnel assigned for this task. I was not briefed specifically on "SERE" method and cannot comment.

Question 3. Military medical personnel who practiced torture and other abuses of POWs and enemy combatants may well suffer lasting medical and psychological effects. These individuals who participated in torture or abuse may have unique problems with the potential to lead to significant social consequences. If confirmed, what steps will you take to ensure that the Veteran's Administration is prepared to adequately address the medical and psychological needs of these veterans?

Response. I am not aware of any medical personnel who practiced torture. Torture is illegal and is not supported by the military. As with all of our military personnel, exposures to the activities of war create the potential risk to psychological health. Our medical personnel in the combat support hospitals, for example, are exposed daily to severely injured U.S. and coalition servicemembers. If confirmed, I will keep the mental health sequelae of war to include PTSD, substance use disorders, and other potential co-morbid conditions as a focused area of treatment and research inquiry.

RESPONSE TO WRITTEN QUESTIONS FROM HON. RICHARD BURR TO LTG JAMES B. PEAKE, (RET.) M.D., NOMINEE FOR SECRETARY OF VETERANS AFFAIRS

Question 15. Dr. Peake, you retired from the Army having attained the highest rank and position possible for a medical doctor—wearing three stars on your shoulders and serving as the Army Surgeon General. You had authority over and responsibility for the entire Army medical system. What lessons did you learn while serving in that position that you believe would help you to serve as an effective Secretary?

Response. I have learned that the only way one can get anything accomplished in an organization much larger than even an infantry company, let alone an organization the size of the VA, is through delegation. But, with the delegation must come accountability supported by data. I have learned to do my homework on issues and ask questions to understand the issues. As the “intent” of policy is communicated, my expectation is that those many operational decisions made at levels below the Secretary are made consistent with that “intent”. In decision making, I will welcome all input, encourage the dissenting view, and seek outside critical thinking. However, with that input, I will make decisions with or without consensus. I recognize that without clear consensus, I have an increased obligation to communicate my rationale; engage and see the decision to success (ownership); and the responsibility to change course if I am wrong.

Question 16. For many years, there have been serious concerns about the backlog of claims at the Department of Veterans Affairs, the length of time it takes to process claims, and the accuracy of VA’s decisions. Have you thought about a strategy for how you would address these enormous challenges if you are confirmed?

Response. I understand that Admiral Cooper has been able to expand his claims workforce and has put in place an aggressive training program. If confirmed, I will be anxious to see the results of that. I also believe that a key to the future is automation and decision support tools for those who have to adjudicate records. Getting the right information up front, (and with this newest generation, working right now with DOD to do so) is important. The DD-214 that is now shared electronically is an example. Simplifying the disability system is also part of the road to more accurate and efficient claims processing and adjudication.

Question 17. Earlier this year, Secretary Nicholson started a new initiative at the Department of Veterans Affairs to provide priority claims processing for all OIF/OEF veterans’ disability claims. Although all claims are important and deserve prompt attention, do you share the view that we should provide a higher priority to veterans of the current conflicts who are transitioning to civilian life and seeking disability compensation for the first time?

Response. I am a believer in putting the systems in place to do “today’s work today.” This includes resources, processes, people, equipment, and time. If those resources are not calibrated to the demand, managers must prioritize. Up to 60% of claims, as I understand it, are reopened claims of veterans who are already getting benefits. We need to move these along expeditiously and to standard, but I do believe that those who need access to the benefits to reintegrate into society, to rehab from fresh battle experience and service-connected wounds ought to have priority while we develop the resources, human and otherwise, to meet all of the claims in line with that “today’s work today” philosophy.

Question 18.

- Dr. Peake, if confirmed by the Senate, your tenure as Secretary will likely last just about one year. That’s not a very long time to serve in any post. Why did you agree to leave the private sector for this temporary, one-year position?

Response. I can think of no higher calling that serving the country and particularly having the opportunity to care for our veterans. It is an extension of what I have devoted my adult life to doing. I consider it an honor and a privilege as well as a responsibility of citizenship.

- More importantly, with such a limited tenure likely at the helm of VA have you given any thought to what you would like to accomplish in that time period?

Response. We are a Nation at war. We have the best of this nation, our young men and women, in harm's way and returning as our newest generation of veterans. I will do my very best to set the azimuth for their future as veterans while working the more immediate issues of transition that insures continuity of care for those who need that; open the access to those whose health needs become apparent after transition; and remember the rehabilitation/reintegration missions as ones whose outcomes are jobs and economic self-sufficiency.

The issue of PTSD is an important one, as is the issue of TBI. We must get the best of science to help us guide the way we deal with this for our veterans—both our newest veterans and those who have served in prior conflicts.

Question 19. Dr. Peake, DOD continues to struggle to implement a fully-operational electronic health record. And we, in Congress, have been pushing DOD and VA to create a complete interoperable health record between the two agencies.

- First, how well do you think the Army has progressed in its implementation of an electronic health record system?

Response. I have not had a recent update on the electronic record for the military health system—to clarify it is a joint system. I do know there were some technical and cultural challenges and particular segments, some specialties for example, found it more difficult to adopt. But, having a longitudinal, queryable patient record that is accessible to all who need it for the care of the trooper is the right objective.

- Second, do you think an interoperable record between VA and DOD is attainable? And why do you think we continue to struggle to attain that goal?

Response. I do believe it is an obtainable goal and one we should fight to obtain. It is not just about hardware and software. I believe it has to do with developing the standard lexicons, the common processes that promote interoperability. It means creating a common information culture, the forums for shared decision making. With the centralization of IT at VA (a cultural shift in itself) the opportunity may be enhanced.

Question 20. North Carolina has a number of VA medical centers and outpatient clinics throughout the state, yet I am told that VA medical examinations for disability compensation claims are only provided at the Winston-Salem VA outpatient clinic.

- Are you aware of any reasons why it would be appropriate to require veterans to travel, in some cases up to four hours, to the Winston-Salem clinic when other VA facilities are closer to them?

Response. I have not been briefed on the issues of access related to the North Carolina VA network. I have heard repeated concerns about timeliness and ease of access from Members of this Committee. If confirmed, I will review this matter and respond.

- Do you believe that veterans may be better served, and that VA may even save money on travel reimbursements for scheduled examinations, if a wider selection of VA examination sites were available?

Response. The C&P examination can be quite complex. It is important that the quality of the examination is maintained. That focus will reduce rework, reduce remand rates, and provide a more timely and accurate adjudication. If confirmed, I will work with VHA and VBA to find creative solutions to the quality and access issues inherent in this question.

- Do you commit to examining this issue, specifically for North Carolina veterans, but also nationally, if you are confirmed?

Response. I do.

RESPONSE TO WRITTEN QUESTIONS FROM HON. JOHN D. ROCKEFELLER IV TO LTG
JAMES B. PEAKE, (RET.) M.D., NOMINEE FOR SECRETARY OF VETERANS AFFAIRS

Question 21. The press reports on PTSD and mental health issues among our returning veterans are compelling. In private roundtables with West Virginia veterans, I believe that many more veterans may come forward with such concerns over time. Given your career in the military, you have a unique ability to understand and appreciate the stigma that soldiers and veterans may face in seeking mental health care. Can you share your views and possible strategies to help combat the stigma veterans face in seeking mental health care in the VA, and with the public?

Response. I will start with an anecdote. Immediately after 9/11, with the Pentagon housing the remains of an airplane and having visited all of the wounded

from that attack, it was clear to me that mental health of the pentagon workforce had to be addressed proactively. I assembled my mental health team in a crisis action mode and with their recommendation, supported and resourced flooding the pentagon with mental health workers available in-clinic, outside of clinic on-call, outside of clinic walking around and visiting EVERY organization and office; outside of clinical settings, but in easily-accessible locations; and mental health workers located in the primary care areas that service the military and military dependent workforce. The approach was with medical professionals, but without medical records developed except for those referred for more advanced and in-depth therapeutic assistance. The senior army leadership, specifically General Shinseki, our Chief of Staff, and General Keane, our Vice Chief of Staff, personally, and forcefully encouraged the Army Staff leadership to ensure that EVERY person availed themselves individually on in-group sessions of this mental health access.

This was not done in response to someone acting “crazy” or having a traumatic response; rather, it was done proactively—effectively saying to people that they could normally expect to have been affected emotionally by the event and that it was ok and expected that they would avail themselves of the support, and that they could expect to be better. It worked! It is hard to prove the negative, but after a year, there were no suicides in that group of workers and there were a number of people who had, without fanfare, received longer-term treatment while the majority went back to work even while the pentagon was rebuilt. This anecdote has colored my thinking on this subject.

It prompted me to aggressively support an employee assistance program type of system that became Army One Source (now evolved to Military One Source). It provides a hotline for help; it allows up to 6 counseling sessions without medical records and without reporting (unless a serious mental health issue is surfaced); family and servicemember alike have access.

- What will you do to reach out to Guard and Reserve soldiers who may be less likely to seek VA care, and may have more difficulty with the paperwork and eligibility?

Response. I believe the VA must work with both the active duty and the reserve chains of command to insure we reach the Citizen Soldiers with meaningful engagement before they demobilize to educate them about benefits and the processes to get them. Particularly, we need to team with the DOD to have all of the Reserve Component Servicemembers who have deployed complete the Post Deployment Health Care Reassessment (PDHRA) and be proactive to assure the resulting follow-up plans are executed. In parallel we to need move forward with simplifying the disability system and the processes by which it is administered.

Question 22. As a follow up, Dr. Peake, I wanted to share estimates according to the DOD Task Force on Mental Health from June of 2007.

- Among active duty soldiers, it estimates to be up to 38% with general mental health needs
- For Marines, it estimates 31% will have general mental health
- Among, National Guard & Reserve soldiers it is higher, with as many as 49% facing general mental health issues.

The report also suggests that psychological concerns are significantly higher among soldiers with repeated deployments, and the numbers of such soldiers is growing. This is a stark summary of the problem we face. How do you intend to approach this once confirmed as the VA Secretary? How will you work with us on the major issues of resources and reforms to meet the stunning needs of our soldiers?

Response. I am familiar with the study and agree with the sense of the magnitude of the problem. If confirmed, I will work to strengthen and build upon the ongoing collaboration between the departments. It will be important to distinguish those among the groups above that truly have a Post Traumatic Stress Disorder diagnosis. As you rightfully point out, these numbers above include general health needs. Many of these can benefit from early recognition and early intervention and their negative effects can be significantly mitigated or even eliminated. Others will require more extensive intervention and may be compromised in their employment or life skills even with intervention. We do not want to treat these all the same. I will, if confirmed, give strong support to research as we continue to advance the science of mental health issues as military sequelae. I look forward to exploring innovative ways to engage the family unit of veterans who do not have the benefit of the DOD initiatives that might come out of the study. If confirmed, I will work within the administration, with the stakeholders represented by veterans, veterans service organizations, military service organization and the best researchers to identify the programs, resource the programs, and measure the outcomes.

Question 23. Traumatic Brain Injury (TBI) is a serious issue for veterans from Iraq and Afghanistan. The severe cases of TBI are getting real attention, but what about the moderate cases and the potential long-term effects? What research will VA engage in to study this problem?

Response. I have not had detailed briefings on the specific VA research initiatives in TBI, but am aware of the high interest in this area and the expansion of the polytrauma centers and polytrauma network that has a focus on the problem of TBI. I also am aware that both the Dole-Shalala Commission and the Marsh-West Independent Review Group both highlighted this issue. If confirmed, I look forward to proactively engaging with Colonel (promotable) Loree Sutton, a military psychiatrist who is tasked leading DOD's study of TBI, specifically, and ensuring active collaboration in her efforts and access to VA experts of our polytrauma team.

- How can we track veterans who do not have problems now, but may develop problems over time due to multiple exposures to TBI during combat?

Response. I believe this represents a long-term epidemiologic problem that must be studied in this population. Sports-related concussion (akin to "mild TBI") does have a body of evidence that suggests mild TBI recovers generally well, but again I do believe long-term studies are needed. In the meantime, perhaps we should be referring to that as concussion rather than Traumatic Brain Injury, which seems to take on an ominous connotation with servicemember and family member. Work is being done on cognitive testing, but again, I support research to tell us what productive screening might be useful as we look to problems over time.

Question 24. I realize that VA faces funding problems, but how can we justify a ban on Category 8 veterans, many who many be uninsured according to a private study this fall, and earning as little as \$28,000 per year? Rather than using administrative authority to bar enrollment, shouldn't we work together to get the funding we need to provide VA health care for such veterans?

Response. My understanding is that the Category 8 designation was established in 2003 as the system was overwhelmed and the core mission of excellent care for those veterans with service-connected disabilities and those veterans in need would be compromised. If confirmed, I will look forward to working with you to consider approaches to understanding the needs of non-service-connected veterans for health care coverage that is affordable and looking at the means testing that is currently in place with the "Category 7" veterans. It is essential that the core mission of specialized care and care for those service-disabled veterans and veterans in need, not be compromised.

Question 25. In 1990, there were only 1.2 million female veterans, by 2010, there will be 1.8 million female veterans. The number of female veterans is on the rise, as the number of male veterans is declining. Some estimate that by 2010, female veterans will be about 10% of the veteran population—that is less than 3 years away.

A VA task force notes that of the more than 263,000 veterans seeking VA care from Iraq and Afghanistan, 12% (or over 31,000) are women veterans. How will VA expand its outreach and adjust its services to provide care and meet the needs of the rising number of female veterans? What needs to change at our Vet Centers and in our medical centers to accommodate our female veterans?

Response. I believe the challenges include facilities, culture, and expertise in women's health issues that have not traditionally resided within the VA. Military medicine has traditionally cared for all family members, with delivery of babies one of the most common admissions in that system. Even with that base, we had adjustments to the deployment culture as more women came into the force. The importance of ambience, a sense of caring, of attention to the privacy needs and sensitivities to security are important, in addition to the expertise and availability of equipment and services to address the physical and emotional needs of women veterans. These capabilities need to be planned for prospectively as the number of women veterans grows to the anticipated 10% of the veteran population by 2020. I am pleased to know that there is a specific organization with a focus on women veterans' issues, and, if confirmed, will work within VA to insure this area has focus and resources.

Question 26. Staffing at VA Medical Centers and Vet Centers is vital to quality care. What is your philosophy on staffing centers, routing directors of VAMC, and replacing leadership?

Response. I am pleased to know that the Senate has recently confirmed Mr. Michael Hager as the new Assistant Secretary for Human Resources and Management. If confirmed, I look forward to working with him to get a detailed understanding of our personnel management programs and alternatives for the future. My experience in the military suggests that there is an advantage to movement in leadership positions, but not as frequent as dictated by military life. Managing the human re-

source with developmental opportunities and progressive responsibility allows a career path with a future and also affords a succession planning bench to insure the future of the VA leadership.

Question 27. The attached news article published in June of this year reported concern that of an upcoming \$90 million contract for information technology asset management software being directed to a particular company without the benefit of competition. If the press report is accurate, it is an indication of serious problems within the Department with regard to contracting procedures and compliance with the mandates of the Competition in Contracting Act including the requirements for full and open competition. As a new Secretary, how will you ensure that this particular procurement is properly competed and that all Department procurements meet statutory requirements for competition?

Response. I have not been briefed on this particular contract and do not know if the press report is accurate. However, I do believe in full and open competition. It is my understanding that this Committee has supported a new position, an Assistant Secretary for Acquisition. I strongly support this new position and believe that focused leadership and development of the acquisition workforce of the VA will improve what we ultimately are able to do for our veterans. Regarding this particular procurement, if confirmed, I will ask for a detailed briefing to address your concerns and take corrective action as required.

[Federal Computer Week Article follows:]

Federal Computer Week, Vendors claim VA contracts unfair

Industry alleges agency decisions give IBM wired advantage to win 10-year contracts. By Jason Miller, Published on June 11, 2007. Editor's note: This story was updated at 11:08 a.m. June 11, 2007. Please go to *Corrections & Clarifications* to see what has changed.

Several industry sources said two Veterans Affairs Department contracts for information technology asset management software and services worth \$90 million over 10 years appear to be wired for IBM. VA issued the contract solicitations through NASA's government-wide acquisition contract (GWAC).

Industry sources, who requested anonymity because they did not want to damage their relationships with VA, pointed to several unusual decisions the agency has made in the past few months and to specific instances in the agency's request for proposals to support their suspicions.

Those sources alleged that VA's decision to use NASA's Solutions for Enterprise-wide Procurement (SEWP) GWAC and to require integration with IBM's Maximo Software Suite are among the most troubling aspects of the procurement.

Industry sources said IBM is the only vendor on SEWP IV that provides software that easily integrates with the Maximo Software Suite. They also said other resellers in the market could compete on the contract if it were awarded through the General Services Administration's Federal Supply Schedule or FedBizOpps.gov.

"VA is looking for an agent-based solution as they say in the RFP, and Maximo is the only one" on the Solutions for Enterprisewide Procurement, said an industry executive. "All I'm looking for is full and open competition."

Industry sources said BDNA, CA and EMC Software are among the vendors that could compete in full and open competition.

A VA spokesperson denied the contract is wired to IBM, and said the agency wants as much competition as possible from SEWP vendors. VA officials in July 2006 mandated all software purchases must go through SEWP, the spokesperson said.

But because IBM is the only vendor on SEWP to provide these services, the industry sources said the procurement is unfair.

The spokesperson said VA is trying to ensure competition. "In addition to requesting information, the RFI affords vendors the opportunity to establish required relationships with resellers to further enhance competition," the spokesperson said.

Another red flag, industry sources said, is VA's request for 205,000 software licenses. On IBM's SEWP listing for Maximo, IBM quotes a price for 205,000 licenses, a price available only to VA.

"When IBM created their SEWP IV offering, isn't it striking that they had the insight to know that it should be 205,000 assets, and only VA could use it," said another industry executive. "And then there is an RFI that aligns directly with IBM's offering. Maybe if I was a little more naive, I would believe it was an accident."

An IBM official said VA is simply adding new modules to applications VA already uses.

The VA spokesperson said the agency specifically asked for Maximo because the other applications, including the IT asset management software, will run on IBM's Maximo.

Under the services contract, which is estimated to be worth \$54 million over 10 years, several vendors could provide integration, operation and maintenance support services.

However, several industry sources said VA is trying to direct the procurement to IBM, which according to procurement experts isn't necessarily illegal.

"Agencies go out of their way consistently to hide the fact that they are buying very large dollar amounts of goods and services by using indefinite-quantity, indefinite-delivery contracts to limit competition," said Bill Shook, a procurement attorney at Kirkpatrick & Lockhart Preston Gates Ellis, who is not representing any party in the dispute.

RESPONSE TO WRITTEN QUESTIONS FROM HON. PATTY MURRAY TO LTG JAMES B. PEAKE, (RET.) M.D., NOMINEE FOR SECRETARY OF VETERANS AFFAIRS

Question 28. VA disability reform—oversight of changes:

In the pre-hearing questions you answered for this Committee, you pledged to work closely with Congress, DOD and the VSOs to create and manage the change necessary to reform the Disability Compensation Schedule. You also talked about bringing accountability to the VA, if confirmed, in these pre-hearing questions.

As you know, the Veterans' Disability Benefits Commission, which was chaired by General Scott, recommended we establish an executive oversight group to ensure that the commission's recommendations are implemented quickly and effectively.

From what I can tell, the Administration's draft legislation doesn't include an oversight function to monitor the implementation of the action steps included in the bill. Given the monumental task of reforming the VA disability system, do you think establishing an oversight group is important—and if confirmed, will you do so?

Response. If confirmed, I will look at the Senior Oversight Committee (SOC) that might be re-chartered quickly as an initial oversight group leveraging what I understand to be established and effective working relationships. As the strategic plan is developed, it might be best to charter a new oversight group with more focused membership and expanded to other agencies as appropriate. I would work with the Committee to confer on the most satisfactory oversight approaches.

Question 29. Family members: I'm sure you would agree that veteran families are very much on the front line of this conflict, and often sacrifice to care for their loved ones. What more can the VA do to help veterans' families and give them the support that they need when assisting their loved ones?

Response. I believe the family unit is a social and an economic entity. The other family members of the veteran are also affected by the veteran's experiences with injury—physical or psychological. A healthy family caregiver and supporter is important to the veteran and to the family unit. The ability to provide appropriate medical support, particularly mental health support, including medications and the ability to support the family engagement in the therapeutic process in the form of finances, housing, and transportation when it is needed are potentially ways in which VA might support veterans' families.

Question 30. Mental health providers: How do you plan to address VA's workforce shortages in the mental health field, particularly as they relate to rural areas?

Response. If confirmed, I will work to quickly get a sense of the scope and demography of the problem. I am aware that there has been an expansion of the mental health workforce and a targeting of outpatient clinics. Though I am not familiar with all the programs the VA might have in place now, I believe there is a range of options to explore to expand mental health access that is a particular problem in the rural areas. These might include salary incentives, training subsidies in exchange for remote location service, tele-medicine as a tool, call centers, contract providers, and targeted educational programs for health professionals of other agencies.

Question 31. PTSD: Dr. Peake, do you believe that PTSD is a legitimate illness that has the capacity to impair the daily functioning of our men and women in uniform?

Response. Yes

- Do you believe that extended deployments, as well as multiple deployments increase the risk of developing PTSD?

Response. Rather than the deployment itself, it is the repeated exposures to specific "stressors" that are more problematic in increasing the risk of PTSD. Deployment itself can be stressful with family separations, unknown durations, austere liv-

ing conditions and may have an impact on mental health that is not necessarily Post Traumatic Stress Disorder.

- As a career military officer, what is your feeling on sending troops back into theatre who suffer from PTSD?

Response. I do not favor sending dysfunctional troops into a combat zone where they can be a danger to themselves and to their fellow soldiers. I believe the military supports this philosophy. However, I do not believe that everyone who carries a diagnosis of PTSD is dysfunctional. Rather there is a spectrum of symptoms, individual resiliency, and response to treatment that offers opportunity for individualized consideration. Blanket determinations can increase the stigma about which we are all concerned. I also believe that there are many different environments within the theatre that are less stressful and with greater levels of support for the servicemember than others. It is a decision that commanders must make, but with the best medical advice.

Question 32. Dual Diagnosis: As you know, PTSD is a risk factor for the development of substance abuse disorders and many veterans have both. What will you do as Secretary to address the problem of dual diagnosis disorders?

Response. If confirmed, I will support research to find the best ways to deal with the co-morbid conditions. I am aware of recent reports documenting an increase in post deployment alcohol abuse and recognize the potential long-term adverse outcomes that can result from employment impact, family distress, and homelessness. I will look for ways for the VA to be proactive by understanding programs in place now and what new programs might be needed to deal with this new generation of veterans. I look forward to establishing a constructive relationship with DOD to insure a common message on substance abuse, education of the servicemember and family, so that signs can be recognized early. I recognize that it is difficult to help someone who does not recognize a problem or who does not want to be helped.

Question 33. Waiting times: General Peake, as you found out in your meetings with Members of this Committee, waiting times for veterans to see doctors are a big concern among our constituents. If confirmed, what will you do to tackle this problem?

Response. If confirmed, I will ask for a detailed review and include the Inspector General who, I understand, has some disagreement with VHA. I am particularly interested in stratifying the problem to understand if it is access in general, or in specific areas, so that we focus on solutions that will have as quick an impact as possible while we evaluate a more comprehensive approach.

Question 34. Guard and Reserve Mental Health Problems: A recent Army study found that Guard and Reserve soldiers suffer from mental health problems at twice the rate of active duty soldiers. Given this discrepancy, how can the VA change to better reach out to Guard and Reserve soldiers, many of whom live in rural areas far away from VA facilities?

Response. I believe the VA must work with both the active duty and the reserve chains of command to insure we reach the Citizen Soldiers with meaningful engagement before they demobilize to educate them about benefits and the processes to get them. Particularly, we need to team with the DOD to have all of the Reserve Component Servicemembers who have deployed complete the Post Deployment Health Care Reassessment (PDHRA), and be proactive to assure the resulting follow-up plans are executed. In question 30 above I have described potential approaches to providing increased mental health services access, but providing a proactive outreach, perhaps even past the PDHRA, is worth exploring as part of a preventive program for psychological wellness. In parallel we need to move forward with simplifying the disability system and the processes by which it is administered.

Question 35. Mental Health: Given the attention in the media about mental illness in our servicemembers, why do you think a stigma still exists with respect to these illnesses in the military and what can be done to overcome this stigma?

Response. The DOD Task Force on Mental Health devotes a considerable amount of work on this continuing problem. They identify the need to create a culture of psychological health with a number of specific recommendations that include revising regulations that give the appearance of mental health issues leading to adverse career outcomes, while finding ways to protect the servicemember and the unit if the mental health issue would compromise the mission. Educating and inculcating mental health throughout military life is another of the recommendations that includes training leaders, training family members and training medical personnel. After 9/11 I supported additional mental health providers to be incorporated into the primary care environments, as well as having them circulate throughout the Pentagon and visiting every office space on a periodic basis to provide non-stigmatizing ease of access. Imbedding mental health workers in military units is another rec-

ommendation. Promoting early recognition and intervention in alcohol abuse; facilitating command referral are all important recommendations. Stigma is not restricted to the military. It is an area that I believe needs to be explored in relation to reemployment of our returning Reservists. I have heard anecdotes of the returning servicemember being asked if he or she is ok mentally after having been to war. This may represent a concern of companies, about functionality or about assuming liability; in either case, it sets up the stigma issues that the military is trying to actively combat. If confirmed, I look forward to working on this important subset of the larger mental health issues facing our returning servicemembers and newest veterans.

Question 36. Procurement: Dr. Peake, I assume that as Secretary of Veterans Affairs, you will be committed to ensuring that Department procurement policies will be formulated and executed to acquire the best products and services available at the lowest cost to the government. These principles ensure that both agency beneficiaries and the taxpayers at large receive the best services and the best value that the market can provide. To that end, I would be grateful if, upon your confirmation, you look into the Department's use of non-competitive inter-agency agreements to contract for human capital management systems and services in order to avoid using open competition that would also examine solutions available from the private sector. In particular, I am concerned with the announced purchase of a staffing system from the Office of Personnel Management and a position classification system from the Department of Health and Human Services. In both cases, I believe private sector solutions were available that were superior and more cost effective. If confirmed, will you look into this?

Response. If confirmed, I will.

RESPONSE TO WRITTEN QUESTIONS FROM HON. BARAK OBAMA TO LTG JAMES B. PEAKE, (RET.) M.D., NOMINEE FOR SECRETARY OF VETERANS AFFAIRS

Question 37. Congress has voted to hire additional claims workers to ease the backlog at the VA. What other immediate steps would you take to ensure that veterans receive quality, timely decisions about benefits?

Response. If confirmed, I would support the investment in training to make these people as productive as possible as rapidly as possible. I believe there are wait-time barriers to the speed of adjudication that have been put in place to offer support to the claimant. However, I believe some of these time frames if waived by an informed claimant could significantly speed up the process. I believe the opportunity for information technology support in records maintenance and decision support tools is great and I would invest in them. Fundamentally, I believe that the disability rating system is in need of revision and simplification and I would work with all stakeholders and Congress to find the way forward in this important area.

Question 38. In your view, in the lead-up to the war in Iraq, did the Administration adequately plan for the needs of our returning veteran population? What is your view on the appropriate role of the VA in planning for a possible military conflict? At what stage should the VA be involved with the Pentagon in anticipating and planning for the needs of returning servicemembers? What surge capacities should exist within the VA in order for the agency to be able to adjust during future military conflicts?

Response. I cannot speak for the VA pre-war planning; however, the military did expand its medical reception and evacuation platforms in anticipation of an acute surge. Reserve medical personnel were mobilized to support the backfill of active duty medical personnel who had deployed. Anticipating an increased number of amputees, the amputee centers of excellence at Walter Reed and Brooke Army Medical Centers were put in place and the burn unit was expanded at Brooke and a network of burn units across the country was coordinated. As the nature of war wounds evolved and the deployments have become protracted and repeated both systems have worked to adjust to the current picture of returning veterans. I believe the VA should be engaged as early in the planning process as casualty estimates are made. The ability of the VA to surge should be carefully examined in light, not only of supporting war returning veterans, but in the event of "war" here at home from terrorism to natural epidemics, to disasters. If confirmed, I will review existing surge capacity and review recommendations for the future.

Question 39. In your pre-hearing responses, you stated that the Secretary must use actuarially supported data combined with real information from practice patterns, along with collaboration with DOD, to provide accurate forecasting for the VA's budgeting needs. Given past VA budget shortfalls, what do you believe are the

current weaknesses in VA's budget planning process, and what actions would you take to correct these weaknesses?

Response. I have not had detailed briefing on the budget process. If confirmed, I recognize that we are going quickly into the "budget season" and I will quickly need to assess this process and will take action if weakness are found.

Question 40. If you thought that the VA required an appropriation on the scale of several billion dollars more than what the White House was willing to request from Congress, would you take your case straight to the President?

Response. Yes.

Question 41. During your time as Army Surgeon General, what warning signs, if any, did you receive about the woeful conditions and shortfalls in care at facilities like Walter Reed? In hindsight, were there preemptive actions you should have taken in that role in order to prevent our soldiers from having to wage a second battle at home to receive benefits and care?

Response. I left the Army in September of 2004. We had not had the huge number of returning wounded at that point and, for example, we did not have patients in "building 18". I visited Walter Reed frequently and was focused on the high quality of inpatient care (which, by all accounts, was maintained, and even with the problems in outpatient care, board processing, and housing, was lauded by even the harsh critics). Warning signs that I should have picked up on might have been the burden on the staff, the experience at FT Stewart where, though not returning wounded, similar problems with outpatient access and disability processing were experienced. Prior to this and before the war, the issue of the disability system was on my scope. I had insisted that the compassionate and efficient processing of the soldier who is medically unable to return to duty be placed as a key performance process on the Balanced Score Card Strategy Map for the United States Army Medical Command. In hindsight, I could have recognized that the peacetime processing standards (a problem already) were inadequate to support a surge that potentially would come of wartime. I might have anticipated the impact of the flawed policy, since corrected, regarding the retention of soldiers unfit at the time of mobilization and fought harder to change it prospectively. I might have worked harder to create the imperative to reengineer the disability system.

Question 42. With regard to Walter Reed and other military treatment facilities, you mentioned in your pre-hearing responses that you might have pushed harder for improvements that were more aggressive than the 50 VA caseworkers that you welcomed into Army hospitals. As VA Secretary, in addition to the new pilot program of joint DOD-VA disability evaluation, what other aggressive changes would you pursue to better integrate and coordinate DOD and VA care for our wounded warriors? Given the stream of returning wounded servicemembers, is there a "right size" for a VA presence at DOD medical facilities?

Response. The Recovery Coordinator program suggested by the Dole-Shalala Commission is in its inception. Working closely with DOD to make this a valuable joint asset with a focus on an overarching recovery plan for each wounded warrior and family and someone who can "bureaucracy bust" to insure it is effectively implemented can be a major step forward. There is significant variability among DOD medical facilities in the number and types of wounded warriors seen. If confirmed, I will explore with DOD optimal staffing to support the education, outreach, and benefits counseling not only for wounded warriors, but for servicemembers, active and reserve, leaving the active force.

Question 43. You have said you would recuse yourself from any future VA decisions or dealings that involve QTC. More broadly, what do you believe should be the appropriate role for private firms like QTC in performing core VA functions? When is it appropriate for a firm like QTC to perform VA functions; and how do you judge the right balance of using outside firms while avoiding any weakening of this important federal agency?

Response. I believe the correct focus ought to be on the veteran, insuring access and high quality for him or her, and mindful of their families. If provided within the VA facilities we must insure that the service is first rate and timely. If VA facilities are not available within reasonable access standards and services can be purchased, whether from another agency or from commercial vendors, a high quality acquisition and contracting function can contract for and provide contract oversight to insure high quality. As the demographics of our veteran population changes, we must keep them in our focus. A balance that must be made is in measuring and then maintaining the surge capacity needed to respond to crisis of the variety discussed earlier. If confirmed, I look forward to strengthening the acquisition and contracting function.

Question 44. What areas of VA specialty care should be expanded, and in what ways? Do you believe there should be a priority for certain areas of specialty care?

Response. VA is known for its focus and excellence in many areas such as spinal cord injury, Post Traumatic Stress, polytrauma rehabilitation, and blind veterans programs. VHA has led the way in using data for quality improvement and as the veteran population has aged, the clinical and research has moved to look at aging issues. If confirmed, I will review the current areas of specialty focus and their quality markers. I do anticipate that this next generation of combat veterans will define new areas that need to be created or refocused on a young population fresh from battle—a population that will include a significant increase in the number of women veterans. I want to insure that our way ahead will include the prosthetic support that will keep these new, highly-enabled amputees at the cutting edge of assisted functionality as they age. As our research into PTSD and TBI gives greater understanding of these potentially signature injuries of this current war, I believe specialty focus throughout the VA will be important to apply those lessons learned for the benefit of the veteran. The specialty must, beyond just medical care, include understanding the best way to motivate, encourage, enable a veteran to be as independently productive and self sufficient as possible.

RESPONSE TO WRITTEN QUESTIONS FROM HON. JON TESTER TO LTG JAMES B. PEAKE, (RET.) M.D., NOMINEE FOR SECRETARY OF VETERANS AFFAIRS

Question 45. As you know, the Wounded Warriors legislation, which is expected to be attached to the Defense Authorization bill, contains language that would allow the VA to raise the rate of travel reimbursement given to vets from 11 cents a mile to 28.5 cents per mile. The VA provides this benefit to veterans in recognition of the fact that the cost of travel can actually be prohibitive to receiving needed care. However, the current price of gasoline appears to be having an adverse impact on VA patient care despite the existing benefit. As you know, federal employees receive 48.5 cents per mile when they travel on official business. Now that you have had the opportunity to review the matter, do you view the 17.5 cent increase as sufficient, or do you believe that vets should get the same deal as federal employees?

Response. It is clear to me that the 11 cent a mile rate is inadequate reimbursement for travel given the cost of gasoline. If confirmed, I will have the opportunity to review this in detail to include the way that this benefit is administered to reasonably reimburse for the veteran's cost. I support the rate increase to 28.5 cents and commit to reviewing the need for increases in the future.

Question 46. At your confirmation hearing, I asked your opinion of raising the mileage reimbursement rates for veterans who must travel to a VA facility for care. What is your opinion of this legislation? Do you think it will adversely impact your budget? Do you think that it is time to recognize the costs borne by the veterans who travel, in some cases, great distances to VA?

Response. I believe the mileage reimbursement should be raised. I have not seen the legislation. The additional cost will have a budget impact, but if appropriately administered I would not anticipate that to be a show stopper. It is the policy now to provide the veteran reimbursement for travel. I agree that should continue with realistic reimbursement adjusted for the increased cost of gasoline for those veterans who are required to travel beyond a reasonable distance.

Question 47. I am extremely concerned about the pace at which the Office of Rural Health is moving. As I understand it, the ORH is staffed by only two people, even though 6 million veterans in America live in areas considered rural. What criteria will you use to determine how best to staff the ORH? What is your vision for the ORH's role in the VA? How will you use the ORH to improve the lives of veterans who reside in rural or frontier areas?

Response. I have heard from many Senators on this Committee and others about their concerns of rural health for veterans. I was pleased to understand that an Office had been established, but was surprised to learn that it had only two people to deal with this problem. If confirmed, I will assess the expertise, the size, and the authority of this office. I will review, for currency or cause, to be created a strategic plan for moving the ball forward in relation to serving Veterans in rural areas. I have committed to you that I will accept your invitation to visit your state and see and hear, first-hand, the issues around the rural veteran.

RESPONSE TO WRITTEN QUESTIONS FROM HON. ARLEN SPECTER TO LTG JAMES B. PEAKE, (RET.) M.D., NOMINEE FOR SECRETARY OF VETERANS AFFAIRS

Question 48. Veterans are an important constituency to me and I have long supported providing them the benefits they deserve. They served our country with valor, courage, and bravery. Many times there is a disagreement on whether veterans should be granted benefits. How do you see the current system for the adjudication of claims for VA benefits? Is it working efficiently, and what role do you see your office playing in ensuring that veterans who are entitled to benefits actually receive them?

Response. Though I have not been in position for detailed briefings I am aware of the chronic excessive time periods for adjudication of claims, and understand that many of these claims are resubmitted. I also understand the concern that there is inconsistent rating of claims for the same/similar disabilities. Having walked through several VA Regional Offices, I see serial processing, periods of required waiting, little in the way of automation of what is largely a paper-based system and legalistic communication to veterans that is prone to confuse. Acquiring the appropriate information to adjudicate the claim, whether military history or medical history, seems to be a rate limiting step. I also am aware that the number of claimed conditions has increased significantly, which increases the complexity of the claim. I understand that Admiral Cooper has been able to expand his claims workforce and has put in place an aggressive training program. If confirmed, I will be anxious to see the results of that effort. I also believe that a key to the future is automation and decision support tools for those who have to adjudicate records. Getting the right information up front, (and with this newest generation of veterans, working right now with DOD to do so) is important. The DD-214 is an example that is now shared electronically.

Question 49. I am aware that the VA had proposed a regulation that would require all attorneys practicing before the VA to pass a written accreditation exam. I believe this is unnecessary and counterproductive, especially considering the 109th Congress passed S. 3421, the Veterans Benefits, Health Care, and Information Technology Act of 2006, that eliminated the Civil War era policy prohibiting veterans from hiring lawyers to assist with claims for benefits until after the VA administrative process has been completed. Has the VA moved forward with this proposed regulation? If not, what does the VA plan on doing in relation to this issue?

Response. I have been advised of and, if confirmed, will support the final rule being proposed by the VA that will not contain an attorney examination requirement.

Question 50. If you are confirmed, you would be the first doctor to head the Department of Veterans Affairs. How do you think your experience in this field will impact the entire Department? How will this affect the role of the current Under Secretary for Health, Dr. Michael Kussman?

Response. Because of the mission of the Department of Veterans Affairs—Caring for those who have borne the battle . . . and their widows and orphans—I do believe my 38+ years in the Army, with service in the line as an infantry officer and, particularly, in medicine as a physician and 38 years of taking care of soldiers, provides a personal background of caring, understanding and empathy that will keep my decisions true to the mission.

The VA is extremely fortunate to have Dr. Kussman as the Under Secretary for Health, its “Top Doc”. He has assembled a very talented team of professionals. If confirmed, I will seek to complement Dr. Kussman’s efforts and initiatives in leading his administration, not to compete. With my medical background, I anticipate being able to more quickly make the decisions that he might bring to me since I do not anticipate needing “Medicine 101”. As I execute my responsibilities as Secretary, I would anticipate that my guidance to him will be well-informed because of my medical background and my military background. If anything, I anticipate a greater synergy supported by our common medical background and our long association.

Question 51. The key to any successful organization or agency is the manner of leadership from those at the top level of management. How do you intend to execute the mission of the VA, and how do you intend to ensure there are open lines of communication to all employees and veterans themselves?

Response. I do not anticipate a fundamental difference in my leadership style which I would characterize as integrity based, mission focused and recognizing that the only way to succeed is through the men and women at every level who do the real work of the organization. To accomplish this I will make focused efforts on com-

munication to insure clarity of intent; to insure that those men and women know that I value them and count on them; and to let them get to know me.

The only way one can get anything accomplished in an organization much larger than even an infantry company, let alone an organization the size of the VA, is through delegation. But, with the delegation must come accountability supported by data. I do my homework on issues and ask questions to understand the issues. In that sense, I am a hands on manager. As the "intent" of policy is communicated, my expectation is that those many operational decisions made at levels below the Secretary are made consistent with that "intent". In decision making, I welcome all input, encourage the dissenting view, and seek outside critical thinking. I am always impressed that a product can be made better. However, with that input, I will make decisions with or without consensus. As a corollary, when there is not full consensus, I recognize my increased obligation to communicate my rationale; engaging and seeing the decision to success (ownership); and in changing course if I am wrong.

Visibility and accessibility are important as a leader. I will use the spectrum of means to communicate with the men and women of the VA. That will include e-mail broadcast, video broadcasts, a column in the magazine that is published bi-monthly, and group sessions when I travel to visit the VA organizations in the field.

Question 52. It is my understanding that as centralization occurs, the VA is finding unique problems involving inconsistencies in hardware, software, and processes. How do you intend to ensure that there is a smooth transition to a centralized system under the Office of Information Technology?

Response. Though I have only had the opportunity for a brief courtesy visit with Major General (Ret.) Bob Howard, the "CIO" for VA, I was impressed with his evolving organizational structure, as well as the challenges in this major effort. The challenges are not only technical with hardware and software, but cultural. There are many legacy systems in the VA that have devolved as local modifications have been done. VISTA, one of the stars in the VA IT portfolio, particularly has the legacy MUMPS platform and will need to migrate to a new operating environment. Documentation has not always followed the local modifications, and clear and consistent IT policies have, apparently, in the past, not been the rule. If confirmed, I will take an active role in monitoring and resourcing this process and working to insure that the users of the IT tools are getting what they need to do their jobs effectively and efficiently. That secretary-level engagement and championship of the user will help with the cultural adaptations that are important to the success of this venture. I also believe in shoring-up the VA acquisition workforce so that these large and expensive programs have the best and brightest in support.

RESPONSE TO WRITTEN QUESTIONS FROM HON. JOHN ENSIGN TO LTG JAMES B. PEAKE, (RET.) M.D., NOMINEE FOR SECRETARY OF VETERANS AFFAIRS

On November 5, 2007, prior to your hearing, we had the opportunity sit down in my office and discuss some VA issues that are important to me and the people of Nevada. These questions are a follow-up to our discussion.

Question 53. During this meeting we discussed the construction of the new veterans medical complex in North Las Vegas and your views on the VA's CARES process. My understanding is that this complex is now scheduled to be completed in 2010 and start receiving patients in 2011. This is almost two years later than first planned. Can you provide my office with an update of how this project is progressing? Additionally, what will you do as Secretary of the VA to ensure that additional delays and cost overruns do not occur?

Response. If confirmed, I will provide an update shortly after my appointment. As Secretary, I will require routine updates on our major construction programs as part of monitoring a strategic capital program and will demand accountability for ongoing projects, as well as realistic forecasting and programming for future projects.

Question 54. You emphasized in our meeting that you understood the difficulties of making sure veterans living in rural areas receive quality health care from the VA. Can you provide a status update of the Community-Based Outpatient Clinic (CBOC) in Fallon, the Henderson CBOC, and the Elko Outreach Clinic? Additionally, as Secretary of the VA, what are your plans to ensure that veterans in rural areas receive quality health care?

Response. If confirmed, I will obtain and provide a status update on the Fallon, and Henderson CBOCs and of the ELKO Outreach Clinic. I have heard from many Senators on this Committee and others about their concerns of rural health for veterans. I was pleased to understand that an Office of Rural Health has been estab-

lished, but learned that it had only two people to deal with this problem. If confirmed, I will assess the expertise, the size, and the authority of this office. I will review for currency or cause to be created a strategic plan for moving the ball forward in relation to serving Veterans in rural areas. I have committed to visiting rural areas to see and hear first-hand the issues around the rural veteran.

Question 55. Earlier this year we learned that in 2006 the VA paid out annual bonuses to senior officials in the amounts ranging from \$7,000 to \$33,000. This was of particular concern given that at the time the VA had a backlog of 500,000 veterans' claims and that approximately a year ago the VA was forced to request emergency funding based on its own budget forecasts being short billions of dollars. I am fully aware of the need to attract and retain the highest caliber employees in government service, and I am not opposed to awarding reasonable financial bonuses to federal employees in recognition of superlative performance. However, I also believe that the individual performance being recognized with a bonus must truly be superlative and the amount of the bonus awarded must not be excessive. In light of the reported bonuses I committed to the people of Nevada that I would continue to monitor this situation and would raise your concerns in upcoming hearings and meetings with department officials. What are your views on issuing bonuses for those in government service and what will you do in your tenure to attract and retain the best, brightest, and hardest working individuals?

Response. I do not have first-hand knowledge of the incentive program for the VA although I did read of the concerns in the newspaper. I am very pleased to know that the Senate has recently confirmed and the President has appointed Mr. Michael Hager as the new Assistant Secretary for Human Resources and Management. If confirmed, I look forward to working with him to create a measurable, realistic, and transparent bonus program for the VA executive leadership. The bonus program is only one incentive and perhaps not the most important in attracting and retaining the best, brightest and hardest working for government service. If confirmed, I would work to acknowledge their individual contribution to the mission, to provide the sense of personal, as well as corporate accomplishment in service to our veterans.

RESPONSE TO ADDITIONAL WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO LTG JAMES B. PEAKE, (RET.) M.D., NOMINEE TO BE SECRETARY OF VETERANS AFFAIRS

Question 1. Recent media accounts have highlighted the issue of substance abuse among returning veterans. What additional steps should VA be taking, in coordination with DOD, to address this serious problem?

Response. I am aware of recent reports documenting an increase in post deployment alcohol abuse and recognize the potential long term adverse outcomes that can result from employment impact, family distress, and homelessness. If confirmed, I will support research to find the best ways to deal with the co-morbid conditions. I will look for ways for the VA to be proactive by understanding programs in place now and what new programs might be needed to deal with this new generation of Veterans. I look forward to establishing a constructive relationship with DOD to insure a common message on substance abuse, education of the servicemember and family so that signs can be recognized early. I recognize that it is difficult to help someone who does not recognize a problem or who does not want to be helped. Creating the supporting environment and de-stigmatizing receiving assistance with substance abuse will encourage early intervention.

Question 2. What specific policy changes, if any, would you support to improve access to rural health care for our Nation's veterans? What would be your preferred approach to provide care for veterans in areas in which VA coverage is inadequate or non-existent?

Response. I have heard from many Senators on this Committee and others about their concerns regarding rural health care for veterans. I was pleased to understand that an office had been established, but learned that it had only two people to deal with this problem. If confirmed, I will assess the expertise, the size, and the authority of this office. I will review for currency or cause to be created a strategic plan for moving the ball forward in relation to serving veterans in rural areas. I have committed to visiting rural areas to see and hear first hand the issues around the rural veteran. I am willing to look at models that partner with other agencies, which leverage telemedicine, expanding VA services where feasible or that purchases care where needed and ensures the appropriate oversight for quality and in-

tegration of that medical care information into the VA system of health for the purpose of continuity of care.

Question 3. Current education benefits provided to our veterans have not kept pace with the rising cost of education. What principles would you apply to reforming and updating GI Bill benefits? What level of educational benefits do you believe we owe to those who have worn the uniform?

Response. From my years in the military I appreciate the value that soldiers place on their educational benefits. For many it is a way to take an economic burden of education off of their parents, for others, the GI Bill represents the only route to additional schooling post high school. The current GI Bill was formulated in a peacetime environment. I believe with this current generation of combat veterans engaged in a shooting war, their required contribution for eligibility should be re-evaluated and ways to meet a greater level of their educational costs should be explored. I would consider partnerships with educational institutions that might support our veterans, as well as assistance with tuition, subsistence and educational materials if a full-time student.

Question 4. An increase in unexpected surgical deaths at the VA Medical Center (VAMC) in Marion, IL recently revealed major lapses in the VA's health quality assurance mechanisms, as well as its credentialing and privileging processes. It has become clear—although it took 6 months after the fact—that at least one physician involved in these deaths should not have been practicing at all. What immediate steps would you take as Secretary to institute safeguards so that such tragedies don't occur at other facilities?

Response. I understand that an extensive series of investigations is ongoing regarding Marion and that a wide review of credentialed providers systemwide has begun. If confirmed, I will review in detail the findings from these initiatives to understand if there is a lack or shortfall in procedural safeguards and process or an oversight function that needs to be strengthened to insure compliance, or both. Consistent application across the entire VA system is needed so that tragedies do not occur at other facilities. I have spoken earlier with Senator Durbin on this issue, discussed its importance, and have committed to taking aggressive action to meet this goal based upon the investigations.

Question 5. As you know, recent media accounts suggest that the military has been improperly and inconsistently using the diagnosis of a pre-existing personality disorder as a basis for administratively separating servicemembers who may have been suffering instead from other service-connected psychological injuries. When such a diagnosis occurs, it can result in a loss of benefits or access to VA care for treatment, such as PTSD counseling. I have worked in the Senate to stop this unfair practice and review the military's current policies. Until comprehensive reform takes place, what degree of latitude and authority will you exercise as Secretary to ensure any servicemembers who may have been discharged with a personality disorder can still access VA mental health care?

Response. I have read of such allegations in the press, but have not been briefed by VA or DOD on them. In my personal experience, I have not seen intentional use of discharge for personality disorder to avoid a ratable psychiatric diagnosis, but recognize that such an error can be made. I do understand that the Secretary has a level of case-by-case authority for waiver in such circumstances. I favor providing mental health assessment and assistance to servicemembers to mitigate the potential worsening of a mental health condition and to correct, where indicated, a missed diagnosis. If confirmed, I would err on the side of the veteran to provide this assistance.

RESPONSE TO ADDITIONAL WRITTEN QUESTIONS SUBMITTED BY HON. JON TESTER TO
LTG JAMES B. PEAKE, (RET.) M.D., NOMINEE TO BE SECRETARY OF VETERANS AFFAIRS

Question 6. I understand that the VA has committed to eliminating the wide disparity in disability compensation provided to Iraq and Afghanistan veterans diagnosed with PTSD. However, I have received reports that the level of disability compensation for PTSD cases in Montana is far below the national average, and that fewer than one-quarter of Montanans are diagnosed at 50 percent or above for PTSD—also far below the national average. This data suggests that VA is far from eliminating these disparities. Can you commit to examining why Montana's rate of PTSD diagnosis and compensation is so far below the national average? Will you also work to eliminate the wide disparity in PTSD-related disability compensation awards among regional offices?

Response. I share the commitment to improving consistency in rating. I know that other Senators share your concerns on rating disparity. Simplifying the claims system, supporting it with decision support automation, and enhancing the training of those who do the rating are some approaches. If confirmed, I will examine the issue of rating disparity in general and particularly the issue of PTSD and will work to eliminate such disparities. I will also examine this issue specifically as it relates to Montana.

QUESTIONNAIRE FOR PRESIDENTIAL NOMINEES

PART I: ALL THE INFORMATION IN THIS PART WILL BE MADE PUBLIC

1. Name: PEAKE JAMES B
(LAST) (FIRST) (OTHER)

2. Present Address: 209 10th Street SE Washington DC 20003
(CITY) (STATE) (ZIP CODE)

3. Position to which nominated: Secretary, Veterans Affairs 4. Date of nomination: 15 November 2007

5. Date of birth: 18 June 1944 6. Place of birth: St Louis, Missouri
(DAY) (MONTH) (YEAR)

7. Marital Status: Married 8. Full name of spouse: Janice Marie (Green) Peake

9. Names and ages of children: Kimberly E. Peake , Age 27 (Married – Blakely) Thomas H. Peake, Age, 26

10. Education:

| Institution (including city and State) | Dates attended | Degrees received | Dates of degrees |
|---|----------------|-----------------------|------------------|
| United States Military Academy, West Point, New York | 1962-1966 | BS | June 1966 |
| George Washington Univ Washington DC | Summer 1968 | None (pre-med Course) | None |
| Cornell University Medical College, New York City, New York | 1968 – 1972 | MD | May 1972 |
| United States Army War College, Carlisle, Pennsylvania | 1987-1988 | None | none |

11. Honors and awards: List below all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and any other special recognitions for outstanding service or achievement.

Military Awards:
 Distinguished Service Medal (with 1 Oak Leaf Cluster)
 Silver Star
 Defense Superior Service Medal
 Legion of Merit (with 3 Oak Leaf Clusters)

Bronze Star with "V" Device (with 1 Oak Leaf Cluster)
 Purple Heart (with 1 Oak Leaf Cluster)
 Meritorious Service Medal (with 2 Oak Leaf Clusters)
 Air Medal
 Joint Services Commendation Medal
 Army Commendation Medal with "V" Device (with 1 Oak Leaf Cluster)
 Humanitarian Service Medal
 Armed Forces Expeditionary Medal
 Combat Infantryman Badge
 Navy Meritorious Unit Commendation

Honorary Member, Korean Medical Society

Other honors:

Order of Military Medical Merit
 "A" Professional Designator (Army's professorial equivalent recognition)
 Medallion, Surgeon General of the United States
 2002 Baron Dominique Jean Larrey Award for Excellence in Military Surgery
 Distinguished Service Medal, Uniformed Services University of the Health Sciences, Board of Regents
 Founders Medal, 2004, Association of Military Surgeons of the United States

12. Memberships List below all memberships and offices held in professional, fraternal, business, scholarly, civic, charitable, and other organizations for the last 5 years and any other prior memberships or offices you consider relevant

| | Organization | Office held (if any) | Dates |
|---------|---|----------------------|-----------|
| Fellow: | American Medical Association | House of Delegates | 2000-2004 |
| | American College of Surgeons | | |
| | American College of Cardiology | | |
| Member: | Society of Thoracic Surgeons | | |
| | Association of Military Surgeons of the United States | President | 2003-2003 |
| | Society of Medical Consultants to the Armed Forces | | |
| | American College of Physician Executives | | |
| | American College of Occupational and Environmental Medicine | | |

13. Employment record: List below all employment (except military service) since your twenty-first birthday, including the title or description of job, name of employer, location of work, and inclusive dates of employment.

1. Project HOPE; November 2004 to November 2006; Executive Vice President & Chief Operating Officer; HQ location, 225 Carter Hall Lane, Millwood, Virginia. Work entailed travel to 24 foreign countries, many on several occasions during the course of my duties.

2. QTC Management, Inc: November 2006 to Present; Chief Medical Director, Chief Operating Officer; Location: Offices at 1350 Valley Vista Drive, Diamond Bar, California & 225 Reinekers Lane, Alexandria, Virginia.

3. Faircount LLC, Publishers of The Year in Veterans Affairs & Military Medicine: Guest Editor 2006-2007 edition; Tampa, Florida

4. Integrated Medical Systems, Inc; Board of Advisors; Signal Hill, California (04/05 to Present)
5. HealthNet Federal Services; Board of Advisors, Arlington, Virginia (11/06 to Present)
6. DefenseWeb Technologies, Inc; Board of Advisors, San Diego, California (01/06 to 03/07)

14. Military Service:

List below all military service (including reserve components and National Guard or Air National Guard), with inclusive dates of service, rank, permanent duty stations and units of assignment, titles, descriptions of assignments, and type of discharge.

Continuous Service from entry into West Point as a Cadet in 1962 to Retirement from active duty effective 1 September 2004. Ranks held: from Cadet to Lieutenant General

Military assignment history:

6/62 to 6/66 - Cadet, United States Military Academy, West Point, New York - Student
 7/66 to 11/66 - 2nd Lieutenant - FT Benning, GA, Airborne / Ranger Schools - Student
 11/66 to 5/67 - 2nd Lieutenant - Ft Campbell, KY, 101st Airborne Div - Platoon Leader
 6/67 to 5/68 - 1st Lieutenant - Republic of Vietnam, 101st Airborne Div - Platoon Leader; Battalion S-3 Air Operations Officer, Brigade Operations Officer
 6/68 to 8/68 - Captain - Student Detachment - Office of the Army Surgeon General - student, pre med courses - George Washington University, Washington DC
 9/68 to 6/72 - Captain - Student Detachment, Office of the Army Surgeon General - Cornell University Medical College, New York, New York - Student
 6-72 to 6/76 - Captain/Major - Brooke Army Medical Center, San Antonio, TX, - General Surgery training
 6/76 to 6/78 - Major / Lieutenant Colonel - Dewitt Army Hospital, Ft Belvoir, VA - Surgeon
 6/78 to 6/84 - Lieutenant Colonel / Colonel - Cardio-Thoracic Surgical resident and staff surgeon
 6/84 to 6/87 - Colonel - Tripler Army Medical Center, Hawaii; Chief of Surgery / Deputy Commander for Clinical Services
 6/87 to 6/88 - Colonel - US Army War College, Carlisle Barracks, PA, Student / Class President
 6/88 to 8/90 - Colonel - 18th Medical Command, Yongsan, Korea, Commander and Surgeon to the Commander in Chief
 8/90 to 4/92 - Colonel - Office Of The Surgeon General, Falls Church, VA; Chief Consultant to the Surgeon General
 4/92 to 11/94 - Brigadier General - 44th Medical Brigade / XVIII Airborne Corps, Ft Bragg, NC. Commanding General and Corps Surgeon
 11/94 to 1/96 - Major General - Madigan Army Medical Center, FT Lewis, WA - Commanding General / Tricare Lead Agent
 1/96 to 7/ 2000 - Major General - Army Medical Department Center & School and FT Sam Houston, Texas - Commanding General
 7/2000 to 9/2004 - Lieutenant General - The Surgeon General, US Army / Commander United States Army Medical Command. Falls Church, VA

15. Government record: List any advisory, consultative, honorary, or other part-time service or positions with Federal, State, or local governments other than those listed above.

- GS 2 Clerk Typist - Summer employment - June thru August 1961 - Office Of the Chief Nurse, Army Surgeon General

- Member, Special Medial Advisory Board to the Department of Veterans Affairs, Veterans Health Administration. From 1996 to 2007

16. Published writings: List the titles, publishers, and dates of books, articles, reports, or other published materials you have written.

1. Peake JB, Ziegler MG: "Thymolipoma: Report of Three Cases," *The American Surgeon* 43:477 – 479, July 1979.
2. Peake JB, Will RJ, Schuchmann GF: "A Simple Method of Intra aortic Balloon Removal to Postoperative Open Heart Surgery Patients," *Annual of Thoracic Surgery* 32:510 – 511, November 1981.
3. Peake JB, Roth JL, Schuchmann GF: "Pneumothorax: A Complication of Nerve Conduction Studies Using Needle Stimulation," *Archives of Physical Medical Rehabilitation* 63:187, April 1982.
4. Beresky R, Klinger R, Peake, JB: "Myocardial Contusion: When Does it Have Clinical Importance?" *Current Surgery* 43:6:419, September – October 1986.
5. Peake, JB (Invited Editorial): "Reflections on Injuries in the Military, The Hidden Epidemic," *American Journal of Preventive Medicine*, April 2000.
6. Peake, JB (Invited Editorial): "Memorial Day Message," *Veterans Health Systems Journal*, May 2001.
7. Peake, JB (as a member of the Institute of Medicine's Committee on the Options for Overseas Placement of U.S. Health Professionals): *Healers Abroad: Americans Responding to the Human Resource Crisis in HIV/AIDS*, June 2005.

ARTICLES:

1. Peake, JB: "Perspectives from the AMEDDC&S", published in *Military Medicine Journal*, June 1997.
2. Peake, JB: "Fort Sam Houston – Home of Army Medicine," Published in: *Bexar County Medical Association Journal*, San Antonio, Texas, May 1998.
3. Peake, JB: "Reflections on Injuries in the Military, the Hidden Epidemic," *American Journal of Preventive Medicine*, April 2000.
4. Peake, JB: "The Army Medical Department's Transformation," *Army Magazine*, May 2001.
5. Peake, JB: "Memorial Day Message," (Editorial), *Veterans Health System Journal*, May 2001.
6. Peake, JB: "We Will Always Be There – Caring Beyond the Call of Duty," *Army Magazine*, October 2001.
7. Peake, JB: "Army Surgeon General Message on Expanded Health Care for Over-65 Retirees," Issue 1, *Army Echoes*, 2001.
9. Peake, JB: "Army Surgeon General Update on Changing Health Care Benefits," Issue 2, *Army Echoes*, 2001.
10. Peake, JB: "Army Medics Ready for Conflict," *U.S. Medicine*, January 2002.
11. Peake, JB: "Delivering Quality Health Care to Soldiers and Their Families," *Army Magazine*, October 2002.

- 12. Peake, JB: "Training to Respond to Terrorism," U.S. Medicine, January 2003.
- 13. Peake, JB: "Providing Quality Medical Care in the Crucible of Battle," Army Magazine, October 2003.
- 14. Peake, JB: "Warrior Protector – No Higher Duty than Protecting the Warfighter," Military Medicine/NBC Technology, Volume 7, Issue 8, November 2003.
- 15. Peake, JB: "Beyond the Purple Heart," New England Journal of Medicine, January 2005.
- 16. Peake, JB: "Turning Good Deeds Into Policy," Health Affairs Journal, May 2005.
- 17. Peake, JB: "The Project HOPE and USNS Mercy Tsunami 'Experiment'." Military Medicine, October 2006.
- 18. Peake, JB: "Coalitions of Compassion", The Year in Veterans Affairs & Military Medicine, 2006-2007 edition, Faircount Publication
- 19. Peake, JB. Monthly Commander's Column in The Mercury, the United States Army Medical Command newspaper , August 2000 - March 2004

17. Political affiliations

and activities: (a) List all memberships and offices held in and financial contributions and services rendered to any political party or election committee during the last 10 years.

None

(b) List all elective public offices for which you have been a candidate and the month and year of each election involved.

None

18. Future

employment relationships:

(a) State whether you will sever all connections with your present employer, business firm, association, or organization if you are confirmed by the Senate.

I will,

(b) State whether you have any plans after completing Government service to resume employment, affiliation, or practice with your previous employer, business firm, association, or organization.

I have no such plans and will not do so.

(c) What commitments, if any, have been made to you for employment after you leave Federal service?

None

(d) (If appointed for a term of specified duration) Do you intend to serve the full term for which you have been appointed?

N/A

(e) (If appointed for an indefinite period) Do you intend to serve until the next Presidential election?

I do.

19. Potential conflicts of interest:

(a) Describe any financial arrangements, deferred compensation agreements, or other continuing financial, business, or professional dealings which you have with business associates, clients, or customers who will be affected by policies which you will influence in the position to which you have been nominated.

None

(b) List any investments, obligations, liabilities, or other financial relationships which constitute potential conflicts of interest with the position to which you have been nominated.

VA Ethics Counsel and OGE have determined that the following companies in my stock portfolio might constitute real or perceived conflict of interest and I will divest, should I be confirmed, all of these investments.

| | |
|--|------------------------------------|
| Apple Computer | Accenture |
| Affiliated Computer Services | Alcon Laboratories |
| Allergan | Amgen |
| Astrazenca | AT&T |
| Aventis Pharmaceuticals (formerly known as Sanofi-Aventis) | Azko Nobel |
| Boston Scientific | Bristol Myers |
| C.R. Bard | Cardinal Health |
| Cisco | Dade Behring (now part of Seimens) |
| Danaher Corp | Dell |
| Dentsply International | Eastman Kodak |
| Electronic Data Systems | Fisher Scientific |
| Fujifilm Holdings | GE |
| Genentech | Gilead Sciences |
| Glaxoklinesmith | Haemonetics Corporation |
| Healthways | IBM |
| Ilex Corp | Informatica Corp |
| Kyphon | Medtronic |
| Micron Technology | Microsoft |
| Millipore Corp | Motorola |
| Nestle | Nortel Networks |
| Omnix Biopharmaceuticals | Palomar |
| Patterson | Pfizer |
| Psychiatric Solutions | Qualcomm |
| Quest Diagnostics | Sciele Pharma |
| Sirona Dental | Stericycle |
| Stryker | Symantec |
| Unisys | Varian Medical Systems |
| Walgreen Co | Wyeth |
| Zimmer Holdings | |

(c) Describe any business relationship, dealing, or financial transaction which you have had during the last 5 years, whether for yourself, on behalf of a client, or acting as an

agent, that constitutes a potential conflict of interest with the position to which you have been nominated.

QTC Management, Inc, my employer for nearly the past year, is a contractor for the Department of Veterans Affairs.

- (d) Describe any lobbying activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any Federal legislation or for the purpose of affecting the administration and execution of Federal law or policy.

NONE

- (e) Explain how you will resolve any potential conflict of interest that may be disclosed by your responses to the above items. (Please provide a copy of any trust or other agreements involved.)

Regarding QTC Mangement, Inc: Though I will have no financial interest whatever and no future relationship with this company, I will recuse myself from any action the department might have with this company.

20. Testifying
before the
Congress:

- (a) Do you agree to appear and testify before any duly constituted committee of the Congress upon the request of such committee?

YES

- (b) Do you agree to provide such information as is requested by such a committee?

YES

Senator AKAKA. Thank you very much, Dr. Peake.

I want the Committee to know I intend to have two question periods here of 5 minutes each. I will begin with this question, Dr. Peake.

If confirmed by the Senate, you will have just a little over one year in which to leave your mark on the Department of Veterans Affairs. As Secretary, what do you hope to leave behind as your legacy?

Dr. PEAKE. Well, Mr. Chairman, I am not much of a legacy guy, because everything is done with a team, but I will tell you what I believe I can add to this is: the ability to reach across and work with the Department of Defense as we work out this transition issue for the new generation of veterans. I believe I can bring my network of experience and colleagues and acquaintances to really come to common understandings and cross the cultural issues that we have on both sides of the two Departments.

I believe that understanding this issue of PTSD and TBI is an important one, and how that relates to this transition is something that I can bring an experience to bear on as well. So, I look forward to the opportunity of working with DOD and making that happen, and with this Committee to make sure that the things that are put in place are executable on behalf of the veteran.

Senator AKAKA. Dr. Peake, early in fiscal year 2005, when the Congress was debating the status of VA funding, then-Secretary Nicholson—despite his personal knowledge that budgeted funds were not adequate to furnish timely care and service to the numbers of veterans coming for care—wrote a letter saying that VA had sufficient funding. In response to a pre-hearing question, you indicated that, if confirmed, you would have the responsibility for advocating for veterans.

If you become aware in the coming year that funding is not sufficient for VA to keep up with the demand or that something is slipping, will you come to Congress and request additional funding?

Dr. PEAKE. Mr. Chairman, I would. I would work hard with the administration, with OMB, and be able to come forward, if I needed to, to get additional funding.

Senator AKAKA. It seems as though, Dr. Peake, the problems identified at Walter Reed earlier this year are directly related to those which occurred years earlier at Fort Stewart and Fort Knox while you were Army Surgeon General. Poor living conditions for the medical hold and holdover detachments, an overwhelmed chain of command, poor case management, and difficulties with a complicated, out-of-date disability process were noted.

In your response to pre-hearing questions, you stated that in connection with the initial problems of Fort Stewart, you immediately mobilized a team to respond to these concerns, mandated a case manager to stay with each soldier through the hand-off to VA, and worked with the Army leadership to garner and allocate resources to solve the problem.

In your view, why did this fairly comprehensive action plan not translate then or later to Walter Reed?

Dr. PEAKE. You know, Senator, I ask myself what I could have done differently as part of that, as well. When I saw that soldiers were living, again, in unsatisfactory conditions, there was a sense

of—or at least a perception of—a lack of caring for those who had transitioned out; patient care. I was concerned as well. And when I look back at the Fort Stewart issues, our quick response did, in fact, do some of the things that would have helped if we had carried those forward with Walter Reed.

I am 3 years from retiring from the Army, so I do not have direct knowledge of what was going on at Walter Reed; but I can tell you that when I was the Surgeon General, we had not seen that large number of returning wounded from Iraq and Afghanistan at that point. At Fort Stewart, we had a policy issue that kept soldiers who had just reported to the mobilization station on active duty, even if they were unfit, and that policy, ultimately, was reversed.

So, part of this is getting the policies right, and then following through with actions to correct the things that one can correct.

Senator AKAKA. Thank you very much.

Senator BURR?

Senator BURR. Thank you, Mr. Chairman.

Again, Dr. Peake, welcome. We are truly blessed that we have got somebody of your caliber, your experience, your expertise, that would consider this role for one year at a very difficult time. Senator Akaka and I were sent a letter by Senator Bond asking us to ask four questions. I am going to ask for unanimous consent to send those in writing to you, but I would like to ask one of them in public for the record, if I may.

Veterans groups have been raising concerns about the impact of PTSD and TBI on our servicemembers deployed in the Iraq and Afghanistan wars. What did you do, as Army Surgeon General, to prepare for the long-term outpatient treatment and disability benefits for PTSD and TBI patients observed by Army medical personnel during your tenure as the Army's senior medical officer?

Dr. PEAKE. My record on mental health in this particular environment goes back to 9/11 when we had an airplane in the building with us over there at the Pentagon. What we did immediately was create an operation called "Operation Solace," where we were very concerned about making sure that people had access to mental health counselors. We brought them into the building. We flooded the building with them—had them walking around—so that we tried to avoid any appearance of stigma, so it was not medicalized there. We had the senior Army leadership like General Shinseki stand up and really direct the Army staff to make sure you get your people out, because it is the right thing to do—to get them seen by these mental health providers.

We put mental health providers into the primary care system because we expected and my experts in this area expected the potential of somatization of mental health kinds of problems. And I think that was a very, very successful intervention, if you will, for a population of about 20,000—some people there in the Pentagon.

In the early days of Iraq, we invested in putting a mental health assessment team into the combat zone—earlier than we have ever done that kind of thing before—because I was very concerned whether we had the mental health assets right there. Because, if you take care of it at the front end of the battle area, the idea is that it would improve the returning veteran and returning soldier,

so that they do not have the problems that, potentially, we would have to deal with.

I think there is a lot to learn about PTSD we do not know about. The VA, I know, is one of the leading experts in all of that, but there is still a lot to learn about it. And so, what I wanted to do is set the base for that. Ultimately, during my time, there were two teams that went over, and we reported out fully because we did discover problems. We did discover things that we wanted to do differently. We did identify the number of people that at least had some of the stressors that might lead to PTSD.

We invested in surveys to try to understand—anonymous surveys, to try to understand what the soldiers were saying about it as well. It led to published papers in the *New England Journal of Medicine*. Recently, the follow-on was just in the end of November—a follow-up. It led to the post-deployment health assessment. We wanted to get that up front as far as we could, so we started looking at that, and putting it into Kuwait on hand-held computers, so that the soldiers could get into that early on.

Then, the post-deployment health reassessment has just been restudied, and we find even a larger number of veterans and soldiers that are reporting at the second go-round that did not report at the first go-round.

I guess the point I am making, sir, is that I have been involved in looking prospectively at mental health to try to understand what things are needed now. I think that there is a lot more to do. I think we are learning that we can be proactive. I do believe this is treatable and that we can intervene, and I look forward, if confirmed, to working on the VA side of the house and walking across to the DOD to make sure that there is a continuum in this treatment of what we are understanding better of the mental health consequences of war.

Senator BURR. Dr. Peake, I thank you for that thorough answer, and, Mr. Chairman, I see the clock. I will wait for the second round for my questions.

Senator AKAKA. Thank you very much, Senator Burr.

Senator Murray?

Senator MURRAY. Mr. Chairman, thank you very much. I know you are waiting to be called “Mr. Secretary,” but I am curious. Do you want us to call you “General” or “Doctor”?

Dr. PEAKE. Ma’am, I am comfortable being called whatever people are comfortable calling me, to be perfectly honest with you.

Senator MURRAY. Okay. Well, thank you very much. I have tried to listen closely to your answers so far. I did want to follow up on the Chairman’s question. He referenced a situation where we had a previous Secretary who was not forthcoming with knowledge about the budget, and that is a really critical issue for our Committee. I have often said that the VA Secretary has to be a truthful advocate for our veterans, not an apologist for any administration. And nowhere is this more important than in the Secretary’s dealings with the annual budget process. And I know, as the former Army Surgeon General, you are no-doubt familiar with that annual budget process and the conflicts that you are inevitably going to face.

There will be times when, in order to get resources for your troops, you will have to stand up to pressure from this administration to keep spending down. We know that is going to occur.

Can you share with this Committee an example from your time as Army Surgeon General when you bucked your chain of command and advocated for increased funding?

Dr. PEAKE. I can give you an example of a time when I garnered resources that weren't in the budget as we went through the hearings. I tried to explain what I couldn't do with the budget that I had, and what I talked about at that time was the opportunity that we had to do some things if I had only had the resources to be able to do them. And what came of that was a notion of a venture capital fund that came with no year money. It was not huge amounts in terms of perhaps the VA budget, but for me it was significant. They gave some \$30 million for each Surgeon General to have as an incentive fund to do the right thing, in terms of investment, that would allow us to be more efficient.

I was counseled that I should not be talking about venture capital in front of the Congress, but in my testimony that is what I did. I will tell you that I do believe in working within the system.

I will tell you, as I said in my written remarks, I understand I am part of the administration, but also I have a responsibility to the administration and to this Committee to lay out the issues as I see them, openly and honestly, and fight for the resources to do my job—which is to take care of veterans.

And so, if confirmed, ma'am, I will be working with this Committee very closely to try to do the right thing by our veterans.

Senator MURRAY. If you are confirmed, you know that you are going to get pushback from OMB on funding requests that you may see inside the VA as inadequate for the needs of the veterans. How do you reconcile the role of being a loyal member of the President's Cabinet and your role as the top advocate for veterans as the VA Secretary?

Dr. PEAKE. Well, I am aware that there is, I understand, about \$4 billion more than what was in the President's budget that is coming forward. I would be advocating getting that bill forward and getting it passed. I mean, we will be able to use that money to do good things for our veterans.

Senator MURRAY. Can we count on you, as a Committee that certainly cares across the aisle on both sides, to be honest with us about what the real needs are?

Dr. PEAKE. I will be honest with you about the real needs, Senator.

Senator MURRAY. Dr. Peake, I want to ask you about a story that I saw in the Washington Post this past Sunday that was very disturbing. It was about a young woman, First Lieutenant Elizabeth Whiteside. I do not know if you saw the article? She apparently served in the Army for 7 years, had exemplary service, and when she was in Iraq, according to the story, she presented herself to a psychiatric nurse and said she was suffering mental health problems that were related to stress from serving in the combat zone. From the story, it said she, ultimately, fired her weapon into the ceiling and shot herself in the chest, and is now, as we know, being

treated at Walter Reed where her psychiatrists are saying she was insane at the time of the incident in Iraq.

Major General Erik Schoomaker, I understand, has recommended dismissal of the charges, but the Army is apparently proceeding anyway, and this is forcing Lieutenant Whiteside to choose between accepting a less than honorable discharge and the loss of all of her veterans' medical benefits or a court-martial where she could be sentenced to life in prison.

In your experience, General Peake, are psychiatric findings routinely ignored by military authorities, as has apparently occurred in Lieutenant Whiteside's case?

Dr. PEAKE. Ma'am, I cannot address this particular case because all I know is what I read in the papers also. I will tell you my experience is that oftentimes the process needs to work its way through. I do not know that it has been decided that she is going to be court-martialed. I did not get that from the newspaper, actually. But my experience is that the medical evidence is fully considered; and, it generally is—again, in my experience—accepted and appropriately weighed, and that the right decision will be made by, ultimately, the line chain of command, which has the legal responsibility.

Senator MURRAY. Well, in her case, to use it as an example, she is going to either be court-martialed or she is going to be dishonorably discharged and lose all of her veterans' benefits.

Dr. PEAKE. I am not sure that is true, actually. From what I read, that is not exactly how I interpreted it. But, again, I am not sure—I would rather not comment on a specific case that I do not know.

Senator MURRAY. Clearly, this goes to the issue at-hand before all of us: in recognizing Post Traumatic Stress Syndrome; what occurs, what happens; and having that be part of understanding rather than something that is used against somebody. Maybe you could share with us, as Secretary of the VA, how we could move forward and correct injustices that appear like this.

Dr. PEAKE. I completely agree with you about the issue of looking at mental illness and not taking unfavorable action against an individual because of a mental illness, just like you would not because of a traumatic injury. If there is some problem about a veteran who may have a question of their access to the system, I believe those kinds of things are potentially waivable by the Secretary, and I would look favorably at ensuring that veterans who need care get care.

Senator MURRAY. Can you just tell me if someone like Lieutenant Whiteside is court-martialed, what kind of mental health care they would expect to get?

Dr. PEAKE. Ma'am, I would need to understand the legal issues specifically, and I would be happy to get back to you for the record about the particulars.

Senator MURRAY. Well, let me ask a more general question.

Dr. PEAKE. Sure.

Senator MURRAY. How do we get to a point where we recognize Post Traumatic Stress Syndrome, the impacts of that, and use it in a realistic way, so we are not punishing people for a real wound of war?

Dr. PEAKE. I agree with you that these are real wounds of war. I tried to make that point in my opening statement, and I think they need to be treated that way. It needs to be, and I believe it is, treatable. I think it is the kind of thing that you can make interventions and really make a difference in people's lives. I think we owe the soldier and the veteran that intervention.

Senator MURRAY. Okay. My time is up and I have more questions, but I think that the case is that we hear a lot of rhetoric about people talking about Post Traumatic Stress Syndrome in a better way. I am delighted to hear the rhetoric, but there are real live case issues that keep coming in front of us where the rules, the attitudes, and other things go against everything we are trying to do in trying to make mental health care wounds recognized and treated in an appropriate manner.

Thank you.

Senator AKAKA. Thank you, Senator Murray.

Senator HUTCHISON?

Senator HUTCHISON. Thank you very much.

I would just like to ask—I so appreciate what you said in your opening statement about Gulf War illness and the need to know—not only for the people who have come back with these debilitating illnesses and symptoms, but also for our future veterans. And I wanted to ask on that and the research on prostheses, what would you consider the priorities for the Veterans Administration on these research projects for the injuries of today?

Dr. PEAKE. I think, Senator, that at the front-end we are doing a lot of things with the prostheses; and giving our soldiers and our veterans the best in terms of the prostheses, at the beginning. We need to know where this is going to go for the future, because these veterans are going to someday be, you know, my age, and the opportunity for the advances in prosthetic care to continue are absolutely there. And, I think that between DOD and the VA, we ought to be, absolutely, the leaders in that. And, as the veteran moves through his or her life with a prosthesis, they ought to continually get the best that is available. I think we need to continue to do the research to make sure that that happens, as well as the investment to make sure that that happens.

Senator HUTCHISON. On the issue of the electronic records and melding the Department of Defense with the Veterans Administration, there are committees that are working on trying to make this happen. Do you think that in your year, if you are confirmed—and I certainly hope you will be before the end of this year—in your year, can you give me a confidence that you believe that can be accomplished by pushing it and making it a priority?

Dr. PEAKE. Senator, I do believe that we can make substantial progress in sharing information. I understand already that there are mandates by 2008 to have shared records, to share the images; and that there are already timelines leading to that. I understand that there have been studies commissioned to look at a common in-hospital record, and I would commit to you that, if confirmed. I would put this as a very high priority and find the ways to share the information between these two departments. I believe that really getting a common lexicon and common processes will go a long

way at trying to be able to have computable information, and really interoperable patient records between the two agencies.

Senator HUTCHISON. Well, I would say it would be among the very top priorities. And I know a lot of work has been done already, but it is essential that that be accomplished. And, it seems to me that a year would be a reasonable time frame. But, I would like to have periodic reports, if you are confirmed—back every quarter—to tell us what the progress is and if there is anything that needs to be done here to add to your ability to accomplish that.

Let me ask you another question on that and the claims processing, because that has also been mentioned. If we had the seamless transfer of electronic records, would that also expedite the claims processing for the disability benefits and care?

Dr. PEAKE. Senator, I think it would. The issue of claims processing—one of the issues, as I understand it—is getting all of the information you need finally gathered so that you can make a good adjudication of the claim. And the longer that takes, the longer it takes for the claim. If we can get all the information—not just the medical information, but all of the information about the soldier, sailor, airman, and Marine—available right away from DOD and be able to share that all electronically. I think an advance has already been made with the DD-214, and that is an important step. But it is not all the information that is always required. So, to get that and the medical information I think would speed up the claims processing significantly.

Senator HUTCHISON. What other specific things do you think you could do to speed up that claims processing?

Dr. PEAKE. I believe the issue of people and training is already being addressed, as you commented in your first remarks. I think that is important—making sure that there is quality training that is consistent across the system so that you have good inter-rater reliability. I do believe that we need to look at simplifying the system. It is complex, as about everybody that has looked at it has said. I have commented before, it is a 1945 system—is based really on the system that has been put in place back in 1945—and really needs to be relooked. And I think there is an opportunity for simplifying it so that the veteran himself and the people that are trying to do the adjudication have an easier time of being able to come to the right decision.

Senator HUTCHISON. Thank you. My time is up, but I certainly hope that these priorities can have a game plan very quickly after you are confirmed, and I look forward to reports. Thank you.

Dr. PEAKE. Thank you, ma'am.

Senator AKAKA. Thank you very much, Senator Hutchison.
Senator Tester?

Senator TESTER. Thank you, Mr. Chairman. I also want to once again thank General Peake for his willingness to serve in this position.

I want to talk a little bit about staffing. Over the last 11 months, I have had many listening sessions in Montana about staffing at the hospital, and particularly at the clinics. And one of the comments that comes up quite regularly, is that the clinics and the hospital are understaffed—particularly the clinics—from a recep-

tionist standpoint, to a nurse standpoint, to a doctor standpoint; there are some problems.

I have of a couple of questions around this. Number one, do you think that there is a staffing problem, and understaffing problem? My perspective comes from a rural perspective because Montana is a rural State. It may also be there in the urban areas, too. Do you think there is an understaffing problem in the rural areas? Do you think there is an understaffing problem in the urban areas? And if there is, how are you going to solve it?

Dr. PEAKE. Well, Senator, I have not had detailed briefings on what the staffing levels are or the staffing formulas. But if confirmed, I will take a look at that very quickly and come back to you.

Senator TESTER. That would be great. How would you anticipate solving it if it comes back and says, yes, we are understaffed—we need more doctors, nurses, and administrative personnel in the field? How would you solve that problem?

Dr. PEAKE. Well, in terms of the recruiting efforts and the locality adjustments, which those kinds of things are tools that, you know, the HR folks would have to be able to expand the workforce. We have talked in rural areas sometimes—that workforce is not there or is engaged in the civilian community. In those kind of cases, we need to take a look at how do we partner perhaps with other agencies, perhaps with DOD, perhaps with the civilian community, to make sure that there is access to care for the veteran.

Senator TESTER. Okay. I want to talk about the Office of Rural Health for just a second. The Office of Rural Health is staffed by two people, even though, as Senator Dole said, there are 25 million plus veterans; there are 6 million, I believe, that live in rural areas. Do you believe this staffing level is adequate in the Office of Rural Health? And if it is or is not, what is your vision for the Office of Rural Health?

Dr. PEAKE. I have not been over to meet the people in the Office of Rural Health, but I will quickly look at rural health. It is an issue that has come up while talking to many of the Members of this Committee. And I would look to ensure that we have an adequate staff to address these issues. If that is more than the staff that is available currently, I would expand it.

Senator TESTER. Okay. I want to step back a little bit to rural clinics, and you said that you did not—and it is reasonable. You do not have a firsthand knowledge of what the staffing levels are and if those claims are, in fact, true. Are you going to have the time to get out to see it? Or how are you going to get the information?

Dr. PEAKE. Senator, I would do a combination of things to get the information and get a feel for this big organization that I hopefully will be confirmed to run, and that is getting good briefings from the staff. From my time in the Army, you have got to get out and kick the tires and see the troops. So, I would make a commitment to you to get out and see the people, not only in the medical centers, but in the rural health areas as well, and to our outpatient clinics as well, because outpatient care has become a huge piece of and importance to the Department.

Senator TESTER. I look forward to that, and you have a standing invitation from Montana.

One of the things that I heard that was quite disturbing at one of the field hearings—in fact, a couple of the field hearings that we had, listening sessions—and I have said this before in this Committee—is that oftentimes veterans feel like the Veterans Administration is working against them, trying to outlive them.

What would you do? It is a delicate balance. Trust me, I know that, because you have got some people that deserve the benefits that are not getting them; others that claim they should get the benefits that maybe should not. How do you change that image? I agree with Senator Hutchison when she said there are a lot of good things that VA does, and I hear tons and tons of good stuff. But we want to solve some problems, so that is why I am talking about some of the negatives. How do you change that image where the VA will not allow people in and they are trying to outlive them? How do you fix that?

Dr. PEAKE. Well, sir, I would tell you I do believe that it may be a perception. I am not sure about the reality of that. My personal experience is that the quality of the people in the VA is excellent and they do care about the veteran.

Telling that story and getting out and communicating with the veterans themselves is an important piece. To be able to, you know, share the message is an important piece of it. And I would be anxious to work to try to get that message out, and not only to get the message out, but to make sure there are no pockets of real problems that need to be corrected. Because sometimes it is the anecdote that has some truth to it that, unfortunately, colors the whole organization.

Senator TESTER. Okay. I have run out of time. We will come back to that in the next round. Thank you very much.

Senator AKAKA. Thank you very much, Senator Tester.

Senator Webb?

Senator WEBB. Thank you, Mr. Chairman.

General, first I would say that the sentence that I most greatly appreciated in your written testimony was the one where you said, a veteran should not need a lawyer to figure out his benefits or to get that benefit. You know, you should not have to pay a lawyer to get your hearing aid. And, you know, we have had a debate back and forth on the extent of allowable legal representation and all that sort of thing. But for my part, I would like to say, having been around this system for 30 years now, from the time I was a counsel on the House side, the veterans groups—in particular, the Disabled American Veterans—have done an extraordinary job in developing a career cycle service officer program where they really do understand Title 38 and 38 C.F.R., and they are the greatest friend that the veterans have.

In fact, Mr. Chairman, we lost a real friend of the American veterans. We buried Butch Joeckel today in Arlington National Cemetery. He was a very fine Marine during Vietnam, a double amputee, did a long period of service with the DAV.

I read your written comments with respect to this GI bill issue, and I sense that you would philosophically agree with what we are trying to do here. I know that this administration has not supported this legislation. Having sat on the Defense Resources Board for four years, I can guarantee you I could find the money, you

know, looking at these huge amounts that are going over to places like Iraq and Afghanistan. I know you could find the money for this. Do you have any thoughts or any perspectives on how to change the mind of the administration on this?

Dr. PEAKE. Senator, as you know, the Montgomery Bill, I guess, was really done in peacetime.

Senator WEBB. Yes.

Dr. PEAKE. And things have changed. We are not in peacetime anymore, and my sense is this administration wants to do something right by these veterans that are coming home. And I would look forward to working with you to try to figure out the right road ahead to make a difference, like you showed in your charts and like all three of us at this table this morning had as opportunities.

So, I think that things are different than when the current GI bill was put in place, and we have the opportunity to take a look at what some new approaches might be. I look forward to working—

Senator WEBB. The clock is ticking in terms of people getting out of the military, and as I said, I think the U.S. military is doing a very fine job managing its career force, and I think it is doing a not very good job assisting people who are transitioning out. And the presumption—even when we had the Dole-Shalala Commission—the presumption was, since this is a volunteer system it is a career system. And as you know, it is an odd beast. Part of it is career, but a large part of the American military is people who come in with the intention of getting out. They want to check the box. I served the country, I honored my ancestors; you know, the country was in crisis, whatever their motivation is. A lot of them are hitting a brick wall, legitimately. This is not just rhetoric, you know, in a lot of these articles.

So, I would hope that you could work with us to figure out something that makes sense here. It is an affirmative tool to give somebody respect in a community and an avenue toward the future.

I was listening to the testimony thinking about all the different problems in the VA, and you are not expected to be the master of the process at this point. But, sort of an analytical prototype came to my mind while I was sitting here, and that is, when I was Assistant Secretary of Defense, we had moved into the Total Force Concept over a period of years. You would be very familiar with this, having been in the Army, where in 1968 the Army was fielding 18 $\frac{2}{3}$ divisions with about, as I recall, 1.7 million active duty people. By 1985, they still had 18 divisions, but they only had 761,000 active duty. And a lot of the active divisions were stove-piped with Guard and Reserve units, combat support, combat service support, it was not functioning terribly well when you started thinking about mobilization.

Cap Weinberger turned around to me one day—because I had all the Guard and Reserve programs; I had that first 120 days of war. He basically said, “I want you to show me where the broken points are.” And I took a year with our staff; we worked on this for a year. We laid out at that time where the break points were in terms of moving forward in things like: are we really making the right casualty estimates; where is the medical system; where should the combat medical stuff go; what does strategic airlift look like; have

we really got the right balance; can we train these Guard and Reserve people at the same tempo that we do the actives when one out of every five was over the age of 40, as opposed to 5 percent on the active side; et cetera, et cetera, et cetera.

So, I put this report out and a lot of people in the Army were rather skeptical, because Weinberger then made me Secretary of the Navy. But, a part of this report was, basically, where is the breaking point; what can be fixed, and under the present system, honestly, what cannot be fixed. You may be in this job for a year; then, again, we never know how political futures work, so you may be in the job longer than a year. But one thing that I am thinking, that with your background you might be able to truly contribute a study at the end of this. Some of the stuff is budget, some of it is policy, but some of it is just the momentum over the years of management policies here in the VA when we have got these backlogs and we have got all these different problems.

You know, maybe you could ask and work on from your perspective a management analysis of the VA, just from your perspective. What are the problems? Why do we have them? And what needs to be done—from your perspective or to your successor—to make this system work? Because it is not working.

Dr. PEAKE. You know, sir, in the Army I participated in TRADOC for a while and spent time with the “Army after next” looking out. I think you do need to have the long-term vision, and as I suggested in my remarks, these issues need some short-term solutions and they need some long-term solutions.

Perhaps one of the advantages I bring is that, even though I have had no significant exposure to the VA over quite a while, I am not an inside guy. And so to come in and to be able to step back a little and look and get the wisdom from—

Senator WEBB. I think you would be uniquely qualified to make that contribution. My clock is over, but I hope we can talk about that some more.

Dr. PEAKE. I look forward to following up with you.

Senator WEBB. Thank you, Mr. Chairman.

Senator AKAKA. Thank you very much, Senator Webb.

Senator Specter?

**STATEMENT OF HON. ARLEN SPECTER,
U.S. SENATOR FROM PENNSYLVANIA**

Senator SPECTER. Thank you, Mr. Chairman.

General Peake, I commend the President for your nomination for this very important post, and you certainly have extraordinary qualifications to undertake what may be the most important job right now in dealing with America’s veterans who are coming back from the battlefields. My light is on, but I do not know how the projection here is. I will move a little closer. Senator Thurmond used to say, “Pull the machine a little closer.” [Laughter.]

Senator Thurmond was on this Committee for many years, and he was the quintessential veteran. In fact, it was in this room that he had his famous 100th birthday party on December 2, 2002, then served another month to be at a ripe old age of 100 years and one month when he left the Senate. But this machine is stationary,

General Peake, so I cannot pull it forward. I have to move forward myself.

The attendance here does not reflect the importance of this Committee's work—there are so many other hearings going on simultaneously. I just came from the Judiciary Committee where we are reauthorizing the Juvenile Justice Act, and people are moving in many, many directions.

The background you bring is really extraordinary. You were simultaneously the Surgeon General and commander of the Army Medical Command at the same time. Combat experience, being wounded; hard to think of someone who has more credentials for this job than you do.

My concern for veterans benefits comes from the first veteran I knew, who was my father, Harry Specter. He was an immigrant from Russia and served in World War I, carried shrapnel in his legs until the day he died from the Argonne Forest. And I recall as a very young child—I think I recall, or I have read the history books about it—but the U.S. Government broke the promise to give the veterans a \$500 bonus, and there was a march on Washington. Veterans assembled on The Mall, and President Hoover called out the Army. The Chief of Staff was General Douglas MacArthur. There is a very famous picture of him on The Mall with his aide de camp, Major Dwight Eisenhower. The Army fired on veterans that day—one of the blackest days in American history. And in a sense, in a metaphor, I say, I have been on my way to Washington ever since to get my father's bonus. I have not gotten it yet, so I am running for re-election. There's a lot of work to do.

But I would urge you to become an advocate—an advocate for the veterans. It is a very rough and tumble process as to what happens at the Office of Management and Budget. And when we get the administration's figures, we have very substantial limitations as to what we can do; although, characteristically, the Congress does add funding because we are lot closer to the situation than the bean counters in the administration.

I think you are in a very unique position to be the advocate for veterans with this experience you bring.

General Peake, how tough can you be?

Dr. PEAKE. Well, Senator Specter, I think I can be pretty tough. My job is to fight for our veterans, to take care of them, and to make sure that we do that effectively and efficiently. As I have spoken with Senator Murray about this, I will come to this Committee to work with this Committee to make sure that we have the resources needed to do the right thing for our veterans.

Senator SPECTER. Well, we will back you up, General Peake. We will back you up. If you give us the leadership on the specifics as to what you need, this Committee will back you up. The whole Congress will.

Dr. PEAKE. Sir, I appreciate that, and that is absolutely clearly the sense that I have gotten from this Committee, meeting with folks individually, as well as the reassurance of that today.

Senator SPECTER. Well, you have a great staff backing you up. I see Bill Tuerk sitting in the front row. Bill was the Staff Director when I chaired this Committee for six years; he really knows his stuff. There are a lot of other good personnel—I do not mean to

pick Bill out. Well, I guess I do mean to pick Bill out, especially. I saw his work when he was Staff Director here, and we will back you up.

I have questions which I want to submit for the record. My red light just went on. Thank you very much for taking this job, General Peake, and thank you, Mr. Chairman.

Dr. PEAKE. Thank you, Senator.

Senator AKAKA. Thank you very much, Senator Specter.

We will begin with a second round of questions, Dr. Peake. In response to a pre-hearing question, you indicated a willingness to study the proposal for mandatory or guaranteed funding for VA health care. The multi-billion-dollar shortfall in fiscal year 2005–2006 indicates that something needs to be done. How and when do you propose to look more closely at this issue?

Dr. PEAKE. Senator, if confirmed, I will very early in my tenure get the full set of briefings on this issue. I understand the complexity of this issue, and I also understand the concerns that some pat formula, as opposed to really good actuarial forecasting, may not give the budget definition that the VA, particularly the VHA (because it is the largest piece of that), would need. But, as I mentioned in my comments, sir, I do have an open mind on this, and I would really want to understand the issue in detail.

Senator AKAKA. Thank you. In response to one of my pre-hearing questions, you stated the following, and I am quoting: “Working with Congress and the administration to revise the disability system offers the opportunity to simplify the process, create a way ahead for an equitable and uniformly administered system, while meeting the needs of each of the tiers that might be identified.”

I am concerned that the creation of dual systems of compensation, as some have suggested, is inherently inequitable. In your opinion, would the creation of a system of disability compensation that offers varying amounts of compensation dependent upon an era of service for the same disability be equitable?

Dr. PEAKE. Senator, almost by definition it is not equitable. However, I do think that there are different needs by the different groups of our veterans. And the most important thing is to meet those needs.

We have an obligation to this next generation of veterans to make sure that we get it right for their future so it is not confusing. It takes, as I understand it, two to three years to be able to get a VSR person that can adjudicate a claim fully trained. That alone talks to the complexity of the disability system. What I want to do is really understand the results of the studies that are being done, to analyze all of the information that has come forward from the people that have looked at this—with General Scott’s commission as an example—to really understand what the right direction forward is, and then find a way to move that system. It is a big system, and there are many, many people that are involved with it.

So, I want to do the right thing, but I do not see anybody being disadvantaged from their current position as we would move forward, sir.

Senator AKAKA. I agree with you that the issue of the transition from active duty service to veteran status is a key challenge. I am

hopeful that if you are confirmed, your background will be helpful in the ongoing effort to improve that process.

You mentioned in response to a pre-hearing question that for injured servicemembers, there is an incentive not to move from one system—that is, DOD—to the other, VA. I think that is a crucial point in the transition effort. Please expand on what you think is an incentive not to move from DOD to VA and what, if anything, VA can do in response to that incentive.

Dr. PEAKE. Part of the lack of the incentive to move is sort of the fear of the unknown. Part of it is the ability of the servicemember and the servicemember's family to understand what their real benefits are going to be as they move forward. And that, again, talks to the complexity of the system as it stands now.

The other is the notion of how well we can take care of the families. Because the family unit now is often a working spouse that is contributing substantially to the financial well-being of the family, if that spouse stops being a provider and starts being a care provider instead of a financial provider, that changes the dynamic of the family. Somehow we need to be able to take that into account and give them the confidence that, as they move to the VA system, they will be able to get all of the care that is required and be able to be supported as a family unit as well.

Senator AKAKA. Thank you, Doctor.

Senator Murray?

Senator MURRAY. Yes, thank you very much.

In my opening remarks, I talked about the CBS News report that was aired recently. I do not know if you saw it.

Dr. PEAKE. The——

Senator MURRAY. On suicide.

Dr. PEAKE. Yes, I did.

Senator MURRAY. I was particularly struck by the veterans aged 20 to 24—whose rates are 4 times higher than civilians the same age. Can you comment on that and tell me what you think the VA could be doing better?

Dr. PEAKE. I think this is another one of those issues, Senator, that really is part of this transition piece, because what goes on on the DOD side and the emphasis there on the family reunion, as the deployment cycle support kinds of aspects that help identify people that might have a problem, is important at the front end.

As we move into the VA system, we touch the people that have come to us. The question is, how can we outreach? And part of it is identifying for the family members what they ought to be looking for, and not just family members, but also coworkers. So, part of it is getting folks to recognize what the danger signs are.

My understanding is that the VA is already doing a lot to reach out. They're asking folks, "Are you okay?"—you know, all the right questions. "Have you thought about harming yourself?" All those kinds of things are really, I think, being inculcated—as I understand it from my at least preliminary discussions—into the primary care settings of the VA. So, there is that sensitivity of a safety net to find that individual that might have a problem.

I believe in the post-deployment health assessment, the post-deployment health reassessment. I would like to work with DOD to make sure we have all that information, that we are sharing; that,

in fact, all of the Reserve soldiers that come back get that second follow-up, so that we can identify the ones that we can reach out to. We do not want to just be passive and stand in the back waiting for somebody to have a problem if there are ways to reach out; and that will help de-stigmatize as well, I believe.

Senator MURRAY. And will that be a priority of your administration?

Dr. PEAKE. It will be. It is something that I think is a different approach to this issue of the panoply of mental health issues. As we discussed in your office, ma'am, I think not everything is PTSD, because there are six criteria to have that as a diagnosis. But, there are things short of PTSD or other mental health issues that are amenable to intervention and treatment and improving the well-being of our veterans.

Senator MURRAY. Part of the Joshua Omvig Suicide Prevention Act that we have passed requires all of the folks at the VA to be better advocates in dealing with veterans who are calling. I assume that you will really move forward to make sure that happens?

Dr. PEAKE. I will. And as I say, my understanding is that there is a lot being done from, you know, Mike Kussman and crew already in that arena. But I agree with you that it is one that we just need to continually stay on and push.

Senator MURRAY. All right. Let me change the topic a little bit. You are well aware that some of the veterans have raised some concerns about your previous employment with the QTC and possible conflicts of interest with the duties of being VA Secretary. You answered the pre-hearing questions in a very clear way that if you are confirmed, you will terminate all your connections to QTC; you will have no financial interest in QTC, remove yourself from all matters related to QTC. And we very much appreciate that clarification, but I would like to ask you how do you envision being able to perform your duties at Secretary if you cannot make decisions about a contract that is worth, as I am told, up to \$1 billion?

Dr. PEAKE. QTC has been in business with the VA since 1998—perhaps that figure is over the course of that whole period of time. But I would tell you that I have been with QTC less than a year when this was announced. I would be happy to work with this Committee; however you feel is the best way to deal with this. I will have, as you pointed out, no ongoing financial interest with them. I will not go back to them. I have made that clear and made that decision. I will have no deferred compensation or bonus or anything of that nature.

So, I do not see that I will really have a conflict. We have ways to create whatever firewalls are necessary.

Senator MURRAY. I understand from your statement that you are going to separate yourself from any decisions about that, but it is a contract that is worth up to \$1 billion, so who will make those decisions about that? And how will that be done if you, yourself, cannot do it? That is my question.

Dr. PEAKE. I will work with the Office of Government Ethics and with the ethics people at VA to make sure that the decision level will be at the Deputy, I would assume, but it would need to create whatever is necessary to have the appropriate oversight of the contract, which is important, I think, of any contract: is to have appro-

appropriate oversight and accountabilities. And so, I honestly will work however you want to be able to make this very clear, because I want no perception of any favoritism. I believe in full and open competition, and I would support that.

Senator MURRAY. Well, you will be out and about and hear much of what we hear; and I hear, you know, concerns about the system. I hear about providers who do not have the expertise in relevant areas. We have providers with poor English skills; evaluations that do not focus on the problems that have been identified; absence of VA medical records; QTC billing for more time than the provider spends with the veterans. And you will hear this as you are out there.

What will you tell veterans when you hear concerns about QTC in the field?

Dr. PEAKE. I will collect those concerns. I would take them seriously, and I would put them into the system to get them resolved appropriately through the contracting authorities.

Senator MURRAY [presiding]. Okay. My time has expired. I do have some more questions. Senator Tester, I will turn to you.

Senator TESTER. Thank you. There are a lot of issues here, but when we ended up, we talked about VA working for vets versus an adversarial situation with the vets. And I have been thinking about that as the other questions go around. I will just tell you that I have heard many times in Montana about getting through the door, the red tape that is involved, and the lost records that are involved, and there are excuses or issues, however you want to phrase it, down the line. And I will just say, I think it is really incumbent upon you and us to make sure that the veterans who deserve the health care get it, and that is really the bottom line.

I want to talk a little bit about contracting and how it applies to rural areas and what is your vision for contracting out VA services in rural areas.

Dr. PEAKE. Senator, what I would tell you is I want, as you said, to make sure veterans get the care that they need. My responsibility then will be to look at all of the ways in which we can make that happen—to make sure that it is not just, “okay, you got the care,” but to make sure that that care is of the quality that Mike Kussman runs in the VHA and our system; that it is care that is integrated; and that we get the information that is needed so that if there is other care that is done within the system, it is integrated into the full continuity of care.

And so, I think that what I want to do is make sure that the standards of access and the standards of quality are met, and how best to do that, as was pointed out earlier by, I think, Senator Dole—the VHA is an outstanding system, and we do not want that to go away. I have no philosophy about trying to get rid of the VA system if that is what you are asking, sir. But what I do want to do is make sure our veterans have access to the care that they deserve and that it is of the same high quality that we have within our VHA system.

Senator TESTER. In areas that are rural/frontier, would you be amenable to contracting out to local hospitals for VA services?

Dr. PEAKE. If we can ensure that the quality is of the nature needed and that we can get that information back into our system

so that we can, in fact, have the quality of continuity for the veteran.

Senator TESTER. I appreciate that answer. How would you ensure that quality of care? I mean, because it is going to be on your shoulders to do that.

Dr. PEAKE. I think it is certainly something that I would have to study and to understand what mechanisms we have in place to be able to reach it. But, if we are providing that care and we are paying for that care, we have the opportunity to monitor it, whether it is through records or through the claims processing or whatever; and perhaps surveying our veterans to understand what they think about their care.

Senator TESTER. Okay. I had a piece of legislation that was put on an amendment on a bill, the defense authorization bill, that would increase mileage from 11 cents to 28.5 cents per mile for disabled vets. Currently, Federal employees are receiving 48.5 cents a mile. Do you see this increase as adequate? Do you think it is a good idea? I am talking about mileage reimbursement for disabled vets to get to clinics and hospitals. Do you think it is adequate? Do you think it is a good idea? Do you support it?

Dr. PEAKE. I do not know about the specific numbers because I have not studied that, sir, but I do understand that the price of gas has gone up, and I do understand that it is a burden on the veteran that needs to be looked at and appropriately adjusted.

Senator TESTER. Okay. We are short on time so I will not follow up, but that really did not get to my point, that answer. I need to know if you think it should be increased up to 28.5 cents. Would you support that? And do you think that is adequate? Yes or no. Or, yes, I think it should be 28.5 cents, or, no, it is taking too much money from other programs, or whatever.

Dr. PEAKE. Senator, to be honest with you, I have not looked at that as an issue, and I—

Senator TESTER. No problem. I want to talk about—

Dr. PEAKE [continuing]. I can come back to you.

Senator TESTER [continuing]. Another problem real quickly, but it is not a problem we can discuss real quickly. It has been brought up here several times, and that is TBI, PTSD, the whole issue that revolves around mental health. And I want to talk about telepsychiatry because you mentioned it in your questions. And I have some reservations about it, but I am not a doctor. My question is: How familiar are you with telepsychiatry? And what kind of assurance are you going to utilize to make sure that this fits the need? Because we are talking about folks, as it has been pointed earlier by Senator Murray and others, who need help. And do you think telepsychiatry can really give them the kind of help they need, I mean functionally, to actually get them through incredibly difficult times?

Dr. PEAKE. Sir, I do believe that telepsychiatry has a role. It is not the panacea. There is usually not a silver bullet for any one of these things. There is not one thing that will fix everything. But, I do believe it is one of the tools that really ought to be in the armamentarium. It is one of the areas of telemedicine that very early on has been, I think, demonstrated to be effective in certain circumstances.

I do not claim to be an expert in telepsychiatry, but I have more than just a passing familiarity with it. I do believe that the whole notion of telemedicine, as we start to look at the full spectrum of that, where it reaches—has the potential to reach into somebody's home and monitor their vital signs and keep them out of emergency rooms—are the kinds of things that we ought to be looking at. That is particularly useful in the rural environment.

Senator TESTER. Okay. I have run out of time long ago, and I have got other questions, and I am not going to stick around because I have another meeting at noon, unfortunately; and we have been at this a while. But, I wanted in closing to say, I intend—unless something comes up between now and the confirmation out of this Committee or on the floor—I intend to vote for your confirmation. I think you are a good guy. I think you have got a tremendous responsibility ahead of you, and it is only 13 months or 12 months. You can do so much good for so many veterans in this country that I really hope that you grab the bull by the horns and really lead this agency. I think it is critically important. I think you have got a lot of great people in it. I think you have got a lot of great people in the field and clinics and hospitals that work incredible hours and make incredible sacrifices for service. And I would hope that you recognize that and move forward and make this agency all it can be, because I think the pressure on this agency over the next decade is going to be amazing. And if we are able to respond in a way that is appropriate, it can really be a golden time in this country's history.

So, thank you very much for your willingness to serve.

Dr. PEAKE. Senator, thank you very much.

Senator AKAKA. Thank you, Senator Tester.

Let me follow up with a couple questions, and I will also ask Senator Murray and you, Senator Tester, for any follow-ups here before we close.

Dr. Peake, going back to the transition and your comments about the fact that there is an incentive not to move from one system—that is, DOD—to VA, and then you touched on an issue that I think is at the core of the lack of success in the transition effort: the cultural gap between the military services and VA—a gap that is particularly noticeable in the context of an all-volunteer military.

What do you believe that VA might try to do to bridge that gap?

Dr. PEAKE. Sir, I think the opportunity for the VA to reach into all of the military facilities where we do briefings of people that are getting ready to leave—to work with at the senior level, to make sure that they have welcome reception on the DOD side, to come in and really tell the VA's story and to help people understand what those potential benefits are—is really an important thing. It is better educating—and that has been brought up a couple of places here today—the soldier, sailor, airman, or Marine about what the VA really has to offer them, from educational benefits, to voc rehab, to their health care. So, getting that message out is of number one importance.

The other is making it easy to do, comfortable for them to put in their claim, to establish the linkage, and apply for the appropriate benefit.

Senator AKAKA. It seems that one of the biggest hurdles that must be overcome is identifying the right time for what I call “the hand-off” from DOD to VA to occur. For instance, many injured servicemembers wish to remain on active duty. What role, if any, should VA play in either the decision about whether someone is leaving active duty or in working with an injured servicemember who may not be leaving active duty?

Dr. PEAKE. I believe that it is appropriate for the VA and the Care Coordinator for the servicemember that is injured to, early on, have somebody from the VA be a part of their recovery team. I think that the service really needs to make the decision about whether they are going to be fit for duty or not. That is really a service-specific decision, the way I see it, sir.

I am very open and would encourage looking at bringing even an active duty servicemember into the VA system, and we do that in specialized areas now. But for rehab and then, if possible, they want to go back to the service and they are capable of going back to the service, that ought to be a nice route back—one that is easy and coordinated with the services to do that. And then if they are not able to recover to that level or to be rehabilitated to that level, then we have got our arms wrapped around them as the VA that is going to give them the appropriate care for the rest of their lives.

Senator AKAKA. Thank you very much.

Senator Murray?

Senator MURRAY. Yes, thank you, Mr. Chairman.

I want to talk to you about an issue that is very near and dear to my heart, and that is the Walla Walla VA Medical Center. As you may have known, it was slated to be closed, and after numerous closed-door meetings with the VA and the Senate VA Committee field hearing that occurred there, the right decision was made—to keep that open. The community has been very, very involved with it, and the VA has now approved a 90,000-square-foot outpatient clinic to replace an existing facility there.

I have been told by the VA that the design and construction of that outpatient clinic is now going to be delayed by several years, and I want you to know that is totally unacceptable, and I would like to hear, if you are confirmed, if you will pledge to work with me to speed that construction up. This is a vitally needed center. The vets there have been told one thing and another for so long. They need the confirmation that their country is with them. I would just like to hear from you that you will work with me to make sure of that, and I would love to have you come out and see it personally.

Dr. PEAKE. Senator, I will commit to both, coming out there and visiting with you and holding a hearing in your area if you want me to. And I will commit to you that I will work with you to look at Walla Walla and what needs to be done there.

Senator MURRAY. I appreciate that, both for Walla Walla, and I want to follow up with you on that, but I also think as Secretary you need to be on the ground to hear what we are hearing. The world is very different inside of VA’s circle here versus what you see on the ground out there, as you can imagine in any agency. But I think you need to hear the passion, both from community members who support veterans and are concerned about what is going

on, and from the veterans themselves—the frustrations they have felt. This is why I gave you that button saying, “it cannot be business as usual.” The attitude needs to change. And I would love to have you come out to my State. We have a number of very, very active places, as you know from having been at Madigan. Come see what is happening at Madigan all the way through the VA system. I would love to have you join me there once, if you are confirmed.

Dr. PEAKE. If confirmed, I appreciate the invitation and I look forward to accepting.

Senator MURRAY. Okay, good. One other question and then I have a comment. We have heard a lot about this issue of personality disorders discharges, and in the last 6 years, the military has diagnosed and discharged more than 22,000 servicemembers because of so-called pre-existing personality disorders. I wanted to find out from you what your understanding of administrative discharges from the armed forces are, based on this diagnosis of personality disorder.

Dr. PEAKE. Can you clarify the question? You have a person with an administrative discharge—

Senator MURRAY. There is a concern about the process being fair. We are hearing from a lot of men and women who have been discharged because of a so-called pre-existing personality disorder, and they feel they are not being treated fairly. Are you aware of this issue?

Dr. PEAKE. I am aware of the issue. I would need to understand more specifically the individual cases.

Senator MURRAY. Okay. Well, that is a question I would like to work on with you. There is a very strong and real sense of the process not being fair, and I think it is something we need to pay some attention to.

Mr. Chairman, I do have a couple of other questions I will submit for the record.

I will say this, General Peake: We have had a vacuum at the top of the VA for some time that has to be filled. I am likely to support your nomination unless something else occurs. I cannot imagine that it will. We expect you to take this job and to take it seriously, and obviously, being confirmed is a major recognition of an achievement. But, I think where history will really judge this confirmation is a year from now; and whether you can begin to turn around an agency that for too long has really not gotten into the ball game at a time when men and women are at war and we have thousands of people returning, as well as those from previous generations, who really feel that they have not been given the service they need.

So, an attitude change at the top will, I think, serve all of us well. There are thousands of VA employees who work very, very hard, both within the agency here and out in the field, who I think are open and ready to take on a new challenge and to make sure that they are seen visibly as an agency that serves our veterans well, and I think leadership at the top a year from now will be judged on what that attitude is.

So, I look forward to working with you very much.

Dr. PEAKE. And I with you, Senator. Thank you.

Senator MURRAY. Thank you.

Senator AKAKA. Thank you, Senator Murray.

Thank you, Dr. Peake, for your full and open participation in today's hearing. Every organization needs an unquestioned leader. It is not optimal for the Department of Veterans Affairs to have an acting leader for an indefinite period of time. With this in mind, I will work to bring your nomination before the Committee and the full Senate as soon as feasible, following time for any post-hearing questions to be asked and answered. And so I will ask that all members submit any such questions before the end of this week to move it along.

With that, again, I want to say thank you so much. I want to thank you for what responses you have given. To have your radio man here to support you is great. I want to say also please convey our aloha to your family, and I wish you well in this process.

With that, this hearing is adjourned.

Dr. PEAKE. Thank you, Senator.

[Whereupon, at 12:08 p.m., the Committee was adjourned.]

A P P E N D I X

November 2, 2007.

Hon. DANIEL K. AKAKA,
Chairman,
Hon. RICHARD MURR,
Ranking Member,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR CHAIRMAN AND RANKING MEMBER: Recently, President Bush nominated Lieutenant General James B. Peake to serve as the next Secretary of Veterans Affairs. As Members of Congress representing the San Antonio area who have worked closely with Dr. Peake, we urge the Senate to give him the utmost consideration during confirmation proceedings.

As you may know, Dr. Peake has impeccable credentials that we believe can be beneficial at the Veterans Administration (VA). Dr. Peake is the former U.S. Army Surgeon General as well as a recipient of the Silver Star, Bronze Star and the Purple Heart. Along with his public service, Dr. Peake has served in the private sector as Chief medical director and chief operating officer at QTC Management Inc.

Dr. Peake began his Army medical career as a general surgery resident at Brooke Army Medical Center at Fort Sam Houston in San Antonio. He later went on to serve as both the commander of the U.S. Army Medical Department Center and School as well as commander of Fort Sam Houston.

The San Antonio area is in a critical period of expanding services to both our active duty troops as well as veterans. Fort Sam Houston is in the transformation stages to become the hub for training of all branches of service's enlisted medical personnel. The Center for the Intrepid, a four-story, 55,000 square-foot facility adjacent to Brooke Army Medical Center, was recently opened to provide advanced rehabilitation for amputees and burn victims. Additionally, San Antonio was recently selected as the home for the newest Level One Polytrauma Rehabilitation Center at Audie Murphy VA Hospital.

Because of Dr. Peake's familiarity with our community, we believe that he would serve with the needs of San Antonio veterans in mind. Although the VA is improving, it certainly is still in need of leadership to better prepare the agency to serve the growing number of new veterans while fulfilling the needs of current veterans. As Members of Congress from San Antonio, we hope you will closely consider his nomination to this important position and we thank you in advance for your prompt consideration.

Sincerely,

CIRO D. RODRIGUEZ,
CHARLES A. GONZALEZ,
LAMAR SMITH,
HENRY CUELLAR,
Members of Congress, San Antonio, Texas.

WOUNDED WARRIOR PROJECT
Jacksonville, FL, December 3, 2007.

Hon. DANIEL K. AKAKA,
Chairman,
 Hon. RICHARD BURR,
Ranking Member,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN AND MR. BURR: The Wounded Warrior Project (WWP), a non-profit organization that serves the men and women of the United States Armed Forces who have been injured during the current conflicts, strongly supports the nomination of Lieutenant General (Ret.) James B. Peake to be Secretary of Veterans Affairs (VA).

LTG Peake has spent more than 40 years as a soldier and physician in the U.S. Army. He has dedicated his adult life to serving our Nation as a platoon leader in the 101st Airborne Division in Vietnam, as a thoracic surgeon in the U.S. Army, and finally as the Surgeon General of the U.S. Army from 2000 to 2004.

The situation at Walter Reed highlighted the many obstacles our wounded warriors face. As a wounded Vietnam veteran and physician, LTG Peake would bring his personal and professional perspective to the Department of Veterans Affairs. In addition, his career-long experience in the military will enhance the cooperative efforts between the VA and the Department of Defense for the benefit of those injured in service to our country.

If confirmed, WWP looks forward to working with LTG Peake in his capacity as the Secretary of Veterans Affairs. Thank you and we look forward to his timely confirmation.

Sincerely,

JOHN MELIA,
Executive Director.

December 4, 2007.

Hon. DANIEL K. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

MR. CHAIRMAN: As you prepare for tomorrow's confirmation hearing for Lt. Gen. James Peake (Ret.) as Secretary of the Department of Veterans' Affairs, I would like to share my concerns and the concerns of some of my constituents.

In particular, I want to encourage you to consider not only the candidate, but the critically important challenges the next Secretary will face, and his or her ability to address them.

I am confident that Lt. Gen. Peake is a well qualified physician, and he has proven himself as a budget-conscious administrator as Surgeon General of the Army. He has deservedly earned respect and accolades from his colleagues and Members of Congress for this service in the Army.

However, making the necessary changes at the VA will require more than a few minor policy adjustments. The problems are so significant and systemic that I believe the next Secretary will need to lead a cultural shift. The status quo is unacceptable and our veterans cannot afford a Secretary who merely marks time until the next Administration. The next Secretary must be an active and effective agent of positive change.

The House Veterans' Affairs Subcommittee on Oversight and Investigations has uncovered some matters of serious concern, including the urgency to fix the 400,000 disability claims backlog, the continuous inability of the Defense Department to share medical records with the VA, and numerous bureaucratic hurdles facing servicemembers and their families when they return from war.

I am proud that this Congress has made veterans' benefits a priority, but as you are well aware, there is more work to be done. In the coming year we will be working to ensure that veterans receive the college education they have earned and deserve by modernizing the GI Bill. We will also be working on legislation to implement the recommendations of the Veterans' Disability Benefits Commission.

There is no doubt that these are all serious challenges. Now more than ever our nation's veterans need a Secretary who is committed to working with Congress, in a bipartisan way, to ensure that the men and women who have defended our freedom receive the health care and vital assistance they earned.

I appreciate you holding these hearings in such a timely manner. Your committee has worked tirelessly this year to improve the lives of our nation's veterans, and I urge you not to let up as you prepare for this week's hearing. Again, thank you for your consideration.

Sincerely,

HARRY E. MITCHELL,
Member of Congress, Tempe, Arizona.

